Low-Income Housing Tax Credit: Optimizing Its Impact on Health

Affordable housing in safe environments provides a foundation for lifelong health. However, such housing is in short supply, with nearly half (49%) of low-income households spending more than 30% of their incomes on housing.[1] The lack of affordable housing leads to housing instability and homelessness, consigns people to live in substandard housing or neighborhoods with conditions detrimental to health, and diverts resources for basic needs such as food and health care.

The health sector has increasingly recognized the importance of helping families who would otherwise be priced out of the market find safe and affordable homes. However, there is relatively little discussion of how the government's largest initiative for developing affordable housing—the low-income housing tax credit (LIHTC)—may be used to improve population health and increase access to health-promoting neighborhoods.

Unique among affordable housing programs, LIHTC is a tax credit program operated by the Internal Revenue Service in partnership with state housing finance agencies that has, since its inception in 1986, created more than 2.8 million units. The housing is privately owned and managed and often built or rehabilitated to market rate standards of quality. Tax subsidies are shallower than are subsidies provided by the US Department of Housing and Urban Development and sufficient only to make rents affordable to households at 40% to 60% of area median income; however, LIHTC can be used with vouchers and additional US Department of Housing and Urban Development or state subsidies, allowing units to be allocated for people with special needs and extremely low-income renters. Considering its scope and structure, LIHTC offers multiple potential points of collaboration between the health and housing sectors.

SUPPORT FROM HEALTH INSURERS AND INSTITUTIONS

Health insurers and institutions may directly support the creation of LIHTC developments by providing financing for affordable housing projects or buying the tax credits themselves. UnitedHealthcare has provided more than $240 million in financing since 2011 for 26 housing development projects in 14 states, creating more than 1300 affordable housing units.[2] Nonprofit hospitals, which are required to demonstrate that they provide a community benefit to maintain their tax-exempt status, may also consider supporting affordable housing as a community building activity toward this requirement.

As demonstrated by the proposed Medicaid redesign in New York, federal or state Medicaid funds can be used to provide supportive housing-related services in affordable housing developments. Allowing Medicaid to contribute to the cost of building or operating the housing itself has been proposed but would involve changing existing Medicaid policy.

EMBEDDING HEALTH IN TAX CREDIT ALLOCATION

The health sector is uniquely suited to ensure that LIHTC housing supports health by informing the state policies that guide its allocation. Because the number of tax credits available each year is limited, developers compete for these credits—and thus the ability to construct or rehabilitate affordable housing—on the basis of criteria established by the Treasury Department and supplemented by individual states in a Qualified Allocation Plan (QAP).

The plans stipulate a range of factors, including features of the housing, its financing, its location, and the population served. Many of these features are also associated with health outcomes, as demonstrated in a health impact assessment on Georgia's 2015 QAP,[3] which highlighted aspects of housing developments meant to promote walkability, physical activity, and home safety, as well as locating the housing in healthy neighborhoods near high-performing schools.

ENSURING HOUSING QUALITY AND REDUCING HAZARDS

Housing quality standards are a prime example of how QAPs may be used to support health. Features of housing quality—such as heating and cooling mechanisms, nontoxic building materials, and lead hazard abatement—have been associated with health outcomes. Although there are financial incentives to ensure that LIHTC housing is of high quality and free of health hazards, individual states can choose whether to incorporate federal quality standards into their QAP.

Federal and state agencies could do more to ensure that LIHTC housing is intentionally designed to support beneficial health outcomes and that, particularly when LIHTC is used to rehabilitate older housing, lead exposure and other potential health and safety hazards have been mitigated.

DEVELOPMENT IN LOW-POVERTY NEIGHBORHOODS

It is also widely recognized that location is associated with a wide range of outcomes for health and child development. Living in high-poverty neighborhoods has been shown to decrease access to health-promoting resources such as fresh foods, strong schools, and health

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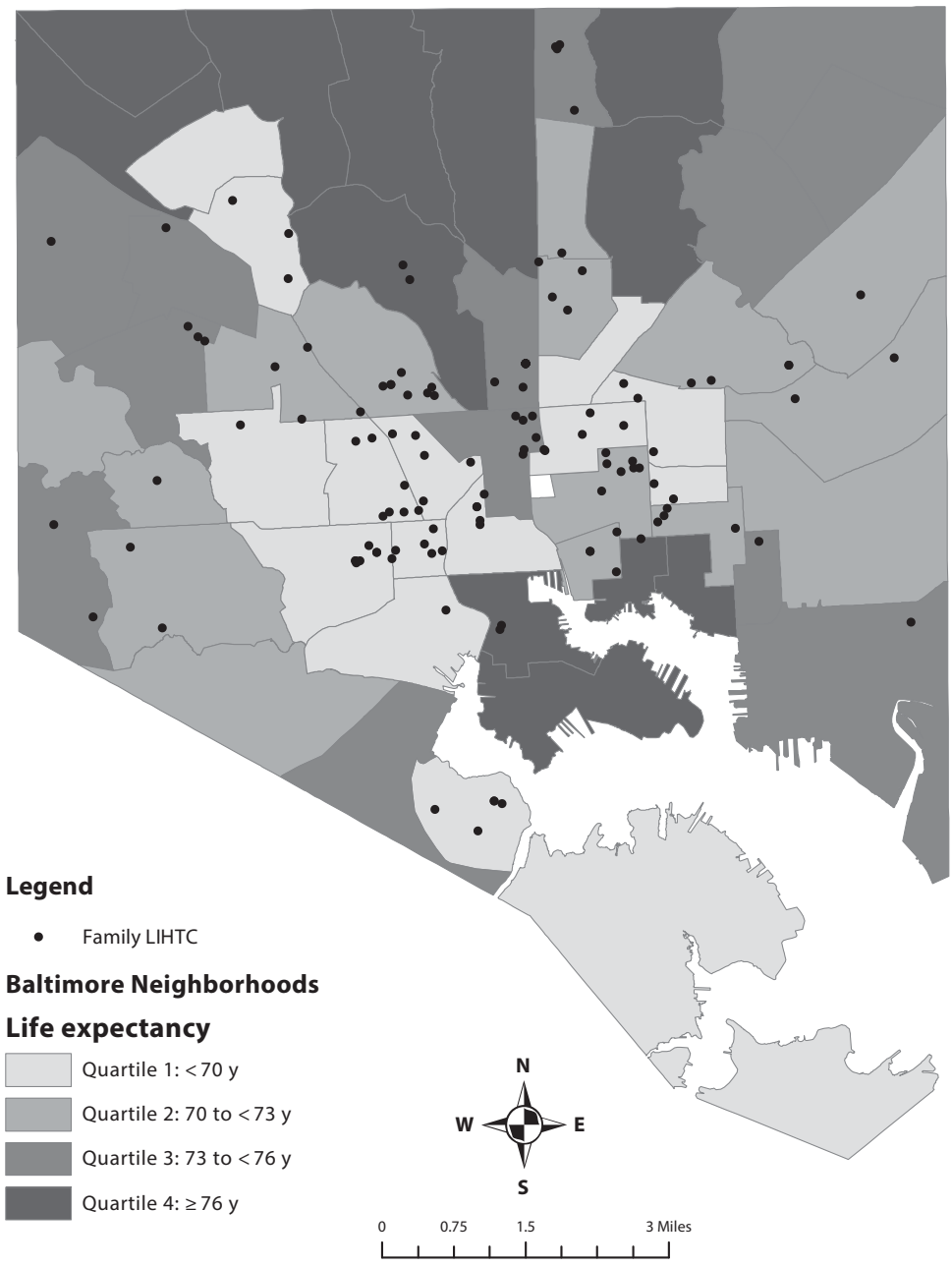

Source. American Civil Liberties Union of Maryland LIHTC Database (1986-2012)[5] and Baltimore Neighborhood Indicators Alliance (2014 life expectancy data).[6]

FIGURE 1—Location of Low-Income Housing Tax Credit (LIHTC) Units and Life Expectancy in Quartiles: Baltimore, MD

care facilities while increasing exposure to environmental hazards and racial segregation.[4] However, in most major metropolitan areas, LIHTC projects built for families with children are placed in higher poverty neighborhoods. Baltimore, Maryland, is not alone in experiencing gaps of 20 years or more in life expectancy from one neighborhood to another. Yet, most of Baltimore's family LIHTC units have been situated in economically and racially segregated neighborhoods with the city's lowest levels of life expectancy (Figure 1[5,6]).

Because of the relationship between housing location and health, LIHTC can intentionally support health through a better balance in the location of affordable housing. States can motivate development in low-poverty neighborhoods that rank high on health indices. Some states, such as New Jersey, have updated their QAPs to provide incentives to offset potential higher land acquisition costs, restrictive local zoning laws, and delays caused by antipathy to affordable housing in low-poverty areas. Access to health-promoting neighborhoods should be an explicit aim of these modifications.

MITIGATING HEALTH RISKS

At the same time, if built strategically, affordable housing could support concurrent investments in high-poverty neighborhoods undergoing comprehensive revitalization. An existing federal statute stipulates that to receive incentives for development in high-poverty neighborhoods, LIHTC housing must contribute to a Concerted Community Revitalization Plan (CCRP), a multisector strategy that comprehensively addresses community needs. However, a recent US Department of Housing and Urban Development report found that, at the state level, what constitutes a CCRP is often ambiguously defined or weakly enforced.[7] The result is that many LIHTC developments are located in poor neighborhoods marked by poor health outcomes, without the concurrent investment in broader community development needed to mitigate adverse conditions and improve quality of life for residents.

Development is under way for federal standards of what constitutes a CCRP. As those standards are created, they should explicitly reference neighborhood elements that enhance health resources, reduce exposure to

violence and community hazards, and otherwise address social determinants of health. Being attentive to health effects when constructing criteria for CCRPs would help ensure that affordable housing resources used in low-income communities are coupled with investments aimed at promoting health and reducing longstanding health disparities.

NEXT STEPS FOR PUBLIC HEALTH RESEARCH

An important step toward demonstrating the potential health benefits of the LIHTC would be to include health impact assessments as a regular component in the evaluation of QAPs and developments themselves. Rigorous research from the health community could demonstrate the cross-sectoral benefits of LIHTC, identify promising strategies for targeted housing interventions that improve population health, and provide evidence for increasing the overall stock of affordable housing.

As the primary source of federal funding for the development of affordable housing, the LIHTC should be recognized as an important public health tool, requiring creative collaboration between health and housing sectors. As budget cuts threaten existing housing programs, cross-sectoral partnerships are necessary to advocate affordable housing as a means to support better health. AJPH

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Effect of Police Training and Accountability on the Mental Health of African American Adults

Seeing a police officer evokes different emotions for different people in the United States. Some react with a sense of vicarious pride, respecting the officer's sacrifice for working in a potentially dangerous job to protect the safety of the public. Some react with neutrality, assuming that the police are there for the "others"—the criminals or the victims, of which they are neither. Finally, a significant number of Americans appears to react with fear, apprehension, and an acute sense of urgency and danger.

These different ways of viewing the police are not evenly distributed across the population, and perhaps the best predictor of how one views the police may be one's own race/ethnicity. We see this in media reports depicting the killing of African Americans by police officers. We see this when African American mothers and fathers give their children "the talk" by teaching them how to safely interact with police officers when confronted. Lagging far behind this shared cultural sense of distrust, we are beginning to see a growing awareness among health practitioners, policymakers, and other stakeholders that police mistreatment is an important public health problem.

INTERACTIONS WITH RACIAL/ETHNIC MINORITIES

Recently, concern about police interactions with racial/ethnic minorities has intensified as a result of several high-profile cases that showed police officers using excessive force against citizens of color. Such incidences have highlighted the potentially harmful effects of police practices based on racial profiling procedures toward racial/ethnic minorities, especially African American males. Although concerns about police interactions with racial/ethnic minorities are not new, these recent publicized cases generally corroborated the view that racial/ethnic minority men are "the primary targets of negative police experiences."[1]

In addition to studying the strained relationships between the police and racial/ethnic minority communities, public health researchers have begun to examine the health consequences of law enforcement policies

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