Testimony
Submitted to the Subcommittee on Civil Rights and Civil Liberties
Committee on Oversight and Reform
U.S. House of Representatives

Hearing
"A Threat to America's Children:
The Trump Administration's Proposal to Gut Fair Housing Accountability"
February 5, 2020

Statement of Dr. Megan Sandel
Megan Sandel, MD, MPH
Co-Lead Principal Investigator, Children's HealthWatch
Co-Director, Grow Clinic for Children
Boston Medical Center
801 Albany Street
Boston, MA 02119
(Tel): 617-414-3680
megan.sandel@bmc.org

Chairman Raskin, Ranking Member Roy, and Distinguished Members of the House Oversight and Reform Subcommittee on Civil Rights and Civil Liberties:

Thank you for the opportunity to provide testimony. My name is Dr. Megan Sandel and I am a pediatrician at Boston Medical Center where I am the Co-Lead Principal Investigator for Children's HealthWatch and the Co-Director of the Grow Clinic for Children. I am also an Associate Professor of Pediatrics at Boston University School of Medicine. Throughout more than twenty years as a clinician and researcher, I have witnessed and documented the importance of housing on the health and well-being of children and their families.

The evidence on the connection between housing and health is clear: when children live in quality, stable homes their families can afford in neighborhoods connected to opportunity, they are better able to thrive. Previous research documents the ways in which these four domains – quality, stability, affordability, and location – impact the short- and long-term health of children. Research also demonstrates the importance of ensuring all four domains are adequately met in order to form the foundation for children's health. Current efforts by the U.S. Department of Housing and Urban Development (HUD) to weaken the Fair Housing Act of 1968 through proposed changes to the 2015 Affirmatively Furthering Fair Housing (AFFH) rule threaten the health of children and their families by exacerbating risks in all four of the housing domains, particularly through increased segregation – a strong predictor of health inequities. My testimony today will focus on the ways in which research and clinical experience indicate changes to AFFH rule will negatively impact child and family health.

Changes proposed by the Administration will increase segregation, a well-documented determinant of lifelong health.

Health and economic disparities are deeply rooted in systemic and institutional factors that have been shaped over our country's history. The Fair Housing Act of 1968 sought to address two of these institutional factors by preventing individual acts of discrimination in housing and addressing historic patterns of segregation. Residential segregation and its association with disparities has been extensively documented in scientific literature. Where a child lives influences their health; it determines where they go to school – the quality of which is often tied to the income of the neighborhood – and dictates access to safe spaces in which to play and exercise (such as parks and green space), nutritious food, and other opportunities that impact health and well-being across the lifespan.[1] Current housing discrimination, even when unintentional, unfolds in this historic context of government-sanctioned discriminatory policies, and often reinforces racial and ethnic inequities in neighborhoods.[2] As a result, most American metropolitan areas remain moderately to highly segregated, and Black and Latinx families, regardless of income or economic means, have a far greater likelihood of living in high-poverty and resource-limited neighborhoods.[3] In the U.S. today, of the nearly 10 million children living in neighborhoods of low opportunity, 4.5 million of them are Latinx and 3.6 million are Black.[1] This impacts child health because these neighborhoods not only lack economic and social opportunities, but are also more likely to have lower quality housing stock, higher rents relative to property values, and greater risk of residential mobility – all of which are independently associated with adverse health across the lifespan.[4]

Take the example of one patient I saw in the Grow Clinic – a clinic for children with Failure to Thrive. My young patient lived with his mother and older sister in a neighborhood with a high concentration of poverty. His mother was stressed because she worried about the lack of educational and economic opportunities for her children which was compounded by public disinvestment in their community that

resulted in absence of adequate green space, walkable streets and sidewalks, and safe neighborhood conditions. Fortunately, the family was able to obtain a mobile rental voucher, which enabled them to move to a higher-opportunity neighborhood. In their new neighborhood, the mother expressed less stress, better sleep, and more opportunities for work that paid a living wage. Her older daughter no longer needed to share books with other classmates at school and started to excel in her education. And my patient, her young son, was able to enroll in a high-quality early education setting, which promoted healthy development. As a result, he began to grow to a healthy weight and thrive. This is the power of living in a stable, affordable home in a neighborhood connected to opportunities where parents and children are able to reach their highest potential.

Enforcement of the Fair Housing Act of 1968 and desegregating communities are critical for child health. The 2015 AFFH Rule was designed with years of input from non-partisan researchers, including a seminal report from the Government Accountability Office (GAO), civil rights experts, local and state governments, and housing authorities. This rule was specifically created to strengthen oversight for agencies and communities to evaluate ongoing discrimination in housing and develop plans to address it. In order to achieve these outcomes, the rule provided evidence-based tools for assessing discrimination and developing concrete plans for action and also required an implementation timeline in order to ensure accountability to address issues identified.

The current Administration's proposal would undermine the effectiveness of the 2015 AFFH rule by replacing evidence-based and analytically sound evaluation metrics with a check box system that lacks sufficient detail for assessing discrimination. As a researcher and physician, I know the importance of accurate measurement rooted first, in the best available evidence and second, in concrete treatment plans in order to effectively respond to a given condition. The current proposed rule meets neither of these standards and will very likely have harmful short- and long-term effects on child health.

We see the importance of policies of neighborhoods that promote health across many health conditions. One example of this is found in survival rates for childhood leukemia. Survival rates have increased from less than 5% in the 1950s to more than 80% today with the advent of effective therapies. But there are large racial differences in survival that have been shown to be linked with neighborhood poverty rates. Overall, survival rates by race vary: white children have an 84% survival rate, Asian children have 81%, Black children have 75% and Native American children have a 72% survival rate.[5] These differences in outcome by race are linked access to the efficacious intervention (chemotherapeutic and/or bone marrow transplant) as well as living in well-resourced neighborhoods. The latter is demonstrated through national data showing children with leukemia and access to treatment living in neighborhoods with high concentrations of poverty, most of whom are children of color, had lower overall survival rates and higher early relapse rates than children with leukemia in lower poverty neighborhoods.[6] The reasons for these differences in outcomes by neighborhood is multifaceted, but based on previous research, two aspects of living in a high poverty neighborhood are likely contributing to these outcomes: (1) children in high poverty neighborhoods are more likely to be in fair or poor overall health at baseline due to adverse housing and neighborhood conditions; and (2) the competing needs of poverty make it more difficult to adhere to stringent requirements for leukemia treatment to be successful. As a result, though there are no differences in the rate of occurrence of leukemia in children from these different groups, the difference in survival, even when treatment is available and accessible, is a factor of living in a neighborhood connected to resources and opportunities

that support health. When we weaken the rules that underpin fair housing, we are allowing those different realities to remain and even grow.

A child's zip code is more important for health than their genetic code.

The concentration of poverty as a result of discrimination, redlining, exclusionary zoning, and investment in "white-only" enclaves are intertwined with population-level health, especially for children and communities of color.[4] The local economy and infrastructure determine access to jobs, schools, commerce, transportation, and other resources that facilitate economic stability.[7] In turn, lack of economic stability, including inability to afford enough food, utilities, medical care or medicines, negatively affects a child's cognitive development, physical growth, and overall health. Further, residential segregation has an enduring and intergenerational impact on families as it has been shown to restrict the amount of capital, resources, and opportunities available to communities to build wealth. Beginning in the prenatal period, when children live in families who are not only able to afford basic needs, but also have access to wealth-building resources, including homeownership and the ability to save for the future, they are more likely to have better physical and mental health as well as higher educational attainment.[7,8] In contrast, children in families that lack these resources are at greater risk of experiencing toxic stress – a chronic form of stress that damages the architecture of the brain early in life.[9,10] My own research with colleagues in Boston has demonstrated the ways in which neighborhood-level access to opportunity impacts child health. We found three year-olds in in lower opportunity neighborhoods in Boston had high prevalence of elevated blood pressures (higher than the 95 percentile by age) at age 3.[11]

The enduring effects of a child's neighborhood are compellingly described in the research of economist Raj Chetty. His work showed that when young children in low-income families moved to neighborhoods with lower concentrations of poverty and more opportunity, they earned on average $302,000 more over their lifetime compared to peers in lower opportunity neighborhoods.[12] Given that today Black and Latinx children are significantly more likely to live in neighborhoods with high concentrations of poverty that lack opportunity compared to white families,[1] it is no surprise that racial wealth disparities persist. Unless action is taken to reverse these disparities, the current and future health of children will hang in the balance.

The 2015 AFFH rule was designed to address these disparities and, if implemented fully, would have been effective in improving health. Through rigorous criteria for evaluating the underlying conditions of segregation in cities and towns across the U.S. and the requirement that municipalities to develop tangible, time-dependent plans for addressing these issues, the 2015 AFFH rule would have improved child and family health by directly responding to a key determinant of short- and long-term health – segregation. The current proposal to weaken the 2015 AFFH rule and replace it with a system that is not rooted in evidence will fail to address the drivers of health created by segregation and the concentration of poverty and, as a result, perpetuate and likely exacerbate health disparities.

Children need high-quality housing to be healthy.

When I began working as a clinician and researcher at the intersection of housing and health over twenty years ago, I began by focusing on housing quality – a clear predictor of child health. Decades of research demonstrate the negative impact of poor housing quality, including the presence of pests, mold, and lead paint, can have on the health and development of children.[13] Exposure to lead in the

home irreversibly damages a child's brain and nervous system[14] and mold and pest infestation are strongly correlated with poor child health and asthma exacerbations.[15]

Affirmatively Furthering Fair Housing is necessary to reduce these risks given the high concentration of substandard housing stock in disadvantaged communities. This has a direct impact on child health. Children of color have much higher rates of lead exposure in their homes, mostly attributed to older housing stock in neighborhoods with higher concentrations of poverty, than white children.[16] When it comes to asthma, disparities among children in the U.S. are also alarming. Black children are three times more likely to be hospitalized and die from asthma compared to white children.[17] Asthma prevalence is also higher among Puerto Rican, Black, and American Indian/Alaska Native children compared to white children. While the causes of these disparities are complex, research shows substandard housing concentrated in neighborhoods where children from these racial and ethnic backgrounds live is a major contributor to this preventable outcome.[18]

Housing affordability is critical for child and family health.

A family's ability to afford rent is important for positive child and adult health. Our research from Children's HealthWatch shows families who fall behind on their rent are at increased risk of having parents in fair/poor health, mothers with depressive symptoms, and children with multiple lifetime hospitalizations and in fair/poor health. Moreover, the household was more likely to struggle to afford enough food, utilities, and the health care they need.[19] Each of these is independently associated with poor child and adult health outcomes.[8,20,21] Given these wide-ranging and harmful risks, ensuring families live in safe, quality homes they can afford is critically important for families, but also for their communities and for the country at large. Unfortunately, recent research from sociologists Matthew Desmond and Nathan Wilmers demonstrates that housing exploitation is greater in communities of concentrated poverty. They found that families with low incomes, especially families of color, in neighborhood with high concentrations of poverty experience the highest rates of housing exploitation – meaning they are charged higher rents for lower quality housing compared to rent pricing in lower poverty neighborhoods nationwide.[22] The effect of paying higher rents for low quality homes has a compounding impact on child health. Families may struggle to afford rent which leads to poor health outcomes in housing whose very condition already compromises health.

While the current Administration's AFFH proposal included a check-box for affordable housing development, it does not directly address the concentration affordable housing development nor the exploitation of renters in neighborhoods of concentrated poverty. Under the new proposal, a municipality would permitted to concentrate affordable developments in a limited number of communities while failing to address affordability for all communities. In doing so, children and families are forced to choose between affording rent or living in a neighborhood of opportunity. The 2015 AFFH, by contrast, sought to respond to both the need for more affordable housing in communities across the country while also balancing the necessity of desegregating neighborhoods, reducing discrimination and exploitation and increasing access to opportunities for all. All of these are necessary for improving child health.

Children need residential stability for optimal growth and development.

Finally, neighborhoods with high concentrations of poverty are more likely to experience high rates of residential instability – some of which is attributed to higher rates of eviction than neighborhoods with

lower concentrations of poverty.[26] Research from Children's HealthWatch has shown when families move frequently, they are more likely to have other economic hardships, their children are at greater risk of developmental delays, children and caregivers are more likely to be in fair/poor health, and mothers are more likely to report depressive symptoms.[19] Throughout childhood, residential instability is linked to adverse mental and behavioral health, which can continue into adulthood.[27] When families are forced to move, they may be at even greater risk of adverse health outcomes. Evictions, which are also more prevalent in low-income neighborhoods and more likely to occur for women of color, are associated with poor physical and mental health for children and adults, which extend years after an eviction has occurred.[28-30]

One of the most extreme forms of instability for families with children is homelessness. As is the case with other forms of adverse housing circumstances, racial disparities persist among families experiencing homelessness and family homelessness is often concentrated in communities of color.[31] Beginning in the prenatal period and extending throughout childhood, any duration of homelessness – from the briefest experience to extended periods - is associated with adverse child physical, mental, and developmental outcomes.[32-34] Moreover, the effect is cumulative. When infants experience homelessness prenatally and postnatally, they are at even greater risk of adverse health outcomes compared to either experience alone.[34]

Instability has ripple effects on communities and the destabilization of one family often results in the destabilization of another. I see this in my patients often. When one family is evicted or forced into homelessness, they often rely on the support of other family and friends, many of whom are also struggling to make ends meet given the lack of investment and opportunity in their neighborhood. Expanding access to opportunities for all and deconcentrating poverty is necessary to stem this cycle. The 2015 AFFH rule would have made significant progress in this area. It would have ensured that the destabilizing conditions of particular neighborhoods are addressed and that more people have access to economic opportunities to help them avoid evictions, forced moves, and homelessness. By weakening the standards of responding to the underlying causes of housing instability, we undermine efforts to improve child and family health.

A future where all children live in neighborhoods of opportunity will promote health and reduce health care costs

The conditions described in this testimony are not only avoidable, but they are also costly. Children's HealthWatch conservatively estimates that our country will spend $111 billion on the health-related costs of housing instability over the next ten years if we do not act to improve housing stability and promote equity.[35] These costs include treatment for mothers experiencing mental and physical health issues linked to their housing instability as well as the cost of excessive ambulatory visits, hospitalizations, dental procedures, and emergency room visits and special education for children. Preventing these conditions and costs is possible. As a country, we could chose to invest in children and families before their housing instability makes them sick.

The tools and requirements in the 2015 AFFH rule made progress toward not only ending residential segregation and addressing the root causes of discrimination, but would have also advanced health equity by addressing multiple forms of adverse housing circumstances. Ensuring that all children live in homes and communities that promote health in not just a wise choice for today – it's an investment in our future economic stability and national prosperity. When children are healthy, they better able to

succeed in school and grow up to become healthy, more productive adults. When parents are healthy, they are able to support the health and development of their children and contribute to the prosperity of all of us. To achieve this vision, we must ensure all communities have equitable access to the supports and resources necessary for people to reach their highest potential. Recognizing the ways in which our national history and discriminatory policies have contributed to inequitable systems where some communities have access to housing and opportunities for thriving when others do not, we must seek evidence-based solutions, like the 2015 AFFH rule, for responding to this reality. In doing so, we secure a brighter future for us all.

As a pediatrician, I can prescribe medical treatments that respond to clinical symptoms of a broken system. But I know the most effective medicine for treating my patients is not found in the pharmacy. What my patients need for a healthier future is to live in homes that are safe, stable, affordable, and connected to opportunity. As a country we can fill this prescription and ensure a brighter and more equitable future for our children by working together to affirmatively further fair housing in communities across our nation.

Thank you for this opportunity.

Sincerely,

Megan Sandel, MD, MPH

1. Acevedo-Garcia D, Noelke C, McArdle N. The geography of child opportunity: Why neighborhoods matter for equity. In: Diversity Data Kids; 2020.
2. Rothstein R. *The Color of Law: A Forgotten History of How Our Government Segregated America.* New York: Liveright Publishing Company; 2017.
3. Sharkey P. *Stuck in place: Urban neighborhoods and the end of progress toward racial equality.* Chicago, IL: University of Chicago Press; 2013.
4. Williams DR, Collins C. Racial residential segregation: a fundamental cause of racial disparities in health. *Public Health Rep.* 2001;116(5):404-416.
5. Kadan-Lottick NS, Ness KK, Bhatia S, Gurney JG. Survival variability by race and ethnicity in childhood acute lymphoblastic leukemia. *JAMA.* 2003;290(15):2008-2014.
6. Bona K, Blonquist TM, Neuberg DS, Silverman LB, Wolfe J. Impact of socioeconomic status on timing of relapse and overall survival for children treated on Dana-Farber Cancer Institute ALL Consortium Protocols (2000-2010). *Pediatr Blood Cancer.* 2016;63(6):1012-1018.
7. Woolf SH, Aron L, Dubay L, Simon SM, Zimmerman E, Luk KX. How are income and wealth linked to health and longevity? In. Washington, D.C.: The Urban Institute and Center on Society and Health; April 2015.

8. Frank DA, Casey PH, Black MM, et al. Cumulative hardship and wellness of low-income, young children: multisite surveillance study. *Pediatrics.* 2010;125(5):e1115-1123.
9. Shonkoff JP, Phillips DA. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Washington, DC: National Research Council and Institute of Medicine;2000.
10. Slopen N, Shonkoff J, Albert M, al. e. Racial disparities in child adversity in the U.S.: Interactions with family immigration history and income. *American Journal of Preventive Medicine.* 2016;50(1):47-56.
11. Sandel M, Faugno E, Mingo A, et al. Neighborhood-Level interventions to improve childhood opportunity and lift children out of poverty. *Acad Pediatr.* 2016;16(3 Suppl):S128-135.
12. Chetty R, Hendren N, Katz LF. The Effects of Exposure to Better Neighborhoods on Children: New Evidence from the Moving to Opportunity Experiment. *American Economic Review.* 2016;106(4):855-902.
13. Jacobs DE. Environmental health disparities in housing. *Am J Public Health.* 2011;101 Suppl 1:S115-122.
14. Screening for elevated blood lead levels. American Academy of Pediatrics Committee on Environmental Health. *Pediatrics.* 1998;101(6):1072-1078.
15. Institute of Medicine (US) Committee on the Assessment of Asthma and Indoor Air. Clearing the Air: Asthma and Indoor Air Exposures. In:2000. https://www.ncbi.nlm.nih.gov/books/NBK224477/
16. White BM, Bonilha HS, Ellis C. Racial/Ethnic Differences in Childhood Blood Lead Levels Among Children <72 Months of Age in the United States: a Systematic Review of the Literature. *J Racial Ethn Health Disparities.* 2016;3(1):145-153.
17. Reducing asthma disparities. National Institutes of Health: National Heart, Lung, and Blood Institute. https://www.nhlbi.nih.gov/health-pro/resources/lung/naci/discover/disparities.htm. Published 2012. Accessed.
18. Hughes HK, Matsui EC, Tschudy MM, Pollack CE, Keet CA. Pediatric asthma health disparities: Race, hardship, housing, and asthma in a national survey. *Acad Pediatr.* 2017;17(2):127-134.
19. Sandel M, Sheward R, Ettinger de Cuba S, et al. Unstable Housing and Caregiver and Child Health in Renter Families. *Pediatrics.* 2018;141(2).
20. Cook JT, Frank DA. Food security, poverty, and human development in the United States. *Annals of the New York Academy of Sciences.* 2008;1136:193-209.
21. Cook JT, Frank DA, Casey PH, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics.* 2008;122(4):e867-e875.
22. Desmond M, Wilmers N. Do the poor pay more for housing? Exploitation, profit, and risk in rental markets. *American Journal of Sociology.* 2019;124(4):1090-1124.
23. Coley RL, Leventhal T, Lynch AD, Kull M. Relations between housing characteristics and the well-being of low-income children and adolescents. *Dev Psychol.* 2013;49(9):1775-1789.
24. Sandel M, Cutts D, Meyers A, et a. Co-enrollment for child health: how receipt and loss of food and housing subsidies relate to housing security and statutes for streamlined, multi-subsidy applications. *J Appl Res Child.* 2014;5(2).
25. Meyers A, Cutts D, Frank DA, et al. Subsidized housing and children's nutritional status: data from a multisite surveillance study. *Arch Pediatr Adolesc Med.* 2005;159(6):551-556.
26. Desmond M, Gershenson C. Who gets evicted? Assessing individual, neighborhood, and network factors. *Soc Sci Res.* 2017;62:362-377.
27. Jellyman T, Spencer N. Residential mobility in childhood and health outcomes: a systematic review. *Journal of Epidemiology & Community Health.* 2008;62(7):584-592.

28. Desmond M, Kimbro RT. Eviction's fallout: Housing, hardship, and health. *Social Forces.* 2015;9(1):295-324.
29. Desmond M, Shollenberger T. Forced displacement from rental housing: prevalence and neighborhood consequences. *Demography.* 2015;52(5):1751-1772.
30. Desmond M. *Evicted: Poverty and profit in the American city.* New York City: Broadway Books; 2016.
31. Olivet J, Dones M, Richard M, et al. Supporting partnerships for anti-racist communities: Phase one study findings. In. *Center for Social Innovation*March 2018.
32. Buckner JC, Bassuk EL, Weinreb LF, Brooks MG. Homelessness and its relation to the mental health and behavior of low-income school-age children. *Dev Psychol.* 1999;35(1):246-257.
33. Cutts DB, Coleman S, Black MM, et al. Homelessness during pregnancy: a unique, time-dependent risk factor of birth outcomes. *Matern Child Health J.* 2015;19(6):1276-1283.
34. Sandel M, Sheward R, Ettinger de Cuba S, et al. Timing and duration of pre- and postnatal homelessness and the health of young children. *Pediatrics.* 2018;142(4).
35. Poblacion A, Bovell-Ammon A, Sheward R, et al. *Stable Homes Make Healthy Families.* Children's HealthWatch. 2017. https://childrenshealthwatch.org/wp-content/uploads/CHW-Stable-Homes-2-pager-web.pdf