Abstract: Housing is the place we spend the majority of our lives and is well established as a key determinant of health, but the relationship between housing and health is complex and poorly understood. Regardless of the complexity of the relationship, it is clear that good housing and good health go together. This paper considers the health implications of the current process of generational reform to the way housing is provided to low income households in Australia and especially South Australia. In response to a gradual shift in Australian housing policy over recent years away from the public provision of housing, the South Australian Government recently announced a process of ‘generational reform’ to the public and low-income housing sector. Central to these reforms will be a loss of public housing, and an increased movement of low-income households into the private rental sector and low-income home ownership. Government policies aimed at housing necessarily affect the health of populations, and low-income households are especially vulnerable. This paper examines the relationship between housing and health and discusses implications of the current reform process in South Australia.

Keywords: Social Housing; Public Housing Reform; Health; Australia

1. Introduction
Housing is the place we spend the majority of our lives and one of “the main settings that affect human health” (Bonnefoy, 2004; p. 13). It is well established that housing is a “key determinant of health” (Jacobs, 2004; p. 35), but the relationship between housing and health is complex (Smith, Alexander & Easterlow, 1997; Macintyre, Hiscock, Kearns & Ellaway, 2001; Hartig & Lawrence 2003). Both health and housing are definitionally ‘fuzzy’ concepts, and their relationship is one of multi-factorial causality (Thomson, Petticrew & Morrison, 2001). Regardless of the complexity of the relationship, it is also clear that “tackling inequalities in housing also addresses health inequalities ...Good housing and good health go together” (Best, 1995; p. 68; and quoted in Smith et al., 1997; p. 203). This statement is especially pertinent for Australian policy makers in the current climate of ‘generational reform’ to the housing system. In a time when central government is shifting the funding focus away from providing social housing infrastructure to giving rent assistance in the private rental sector, the health inequality implications of such a change are imperfectly known.

This paper is a contribution to an emerging international debate on the health impacts of housing in a changing environment of provision (for example Murphy 2003; Smith, Easterlow & Munro, 2004; Easterlow & Smith, 2004). As a response to a Federal Government policy move away from public housing, significant changes to the social housing sector in South Australia have recently been announced. Among the changes are the large scale devolvement of public rental stock and encouragement for low-income households to enter private rental and home ownership. Acknowledging the previous statement about good housing and good health, such large-scale changes to the way that housing is provided to low-income and high needs groups will undoubtedly have significant impact on their health and wellbeing. The paper is an initial exploration of housing and health, it begins with a discussion of the two concepts and their relationship – what we mean by housing and health and how housing influences the health of individuals and populations. It then describes the reform environment and the planned changes to public housing in South Australia. In the following section, the paper discusses the likely housing outcomes of reform and the related health implications, concluding with a list of key considerations for minimising the negative health effects of the reforms.

2. Housing and its Influence on Health
Housing is a place in which we live our lives. More than the dwelling structure and the location it occupies, an understanding of housing should incorporate an acknowledgement of the life it permits us to live. Housing is thus (and more than) a place with access to social networks, employment and services; a home from which we draw our identity and store much of our wealth; and a shelter that
permits comfort and security. Many of these ways of understanding housing are inter-connected (for example, a poorly located dwelling may inhibit employment and wealth creation). As is commonly stated, housing is not ‘bricks and mortar’ alone, it needs to be adequate, affordable, appropriate, and secure (UNCHS, 2001).

Housing is widely perceived on three levels – the Dwelling, the Residential Environment, and what it means subjectively to us as Individuals. The Dwelling – as the place we spend a great proportion of our lives – is highly important as a safe place from which to ‘venture outside’ (Tognoli, 1987). The conception of dwelling is based centrally around the structure, as a shelter with space and protection from outside and others. Beyond the dwelling, is the Residential Environment, this is perceived in terms of the access and proximity that housing provides, such as to services (like shops and transport), social networks, green areas, and amenity. The subjective environment of Individual perception includes our understanding of home, and our perceptions of control over our housing. At this individual level, “housing is a reflection of self-identity and pride, a place of refuge, a site for the exercise of control, a source of social status, etc.” (Dunn, 2002; p. 672).

In order to better understand the housing influences on health, it is important to view housing in wider terms than those of basic housing needs. Just as good health is more than the absence of disease (WHO, 2006), good housing is more than the absence of need. Necessarily, each individual’s understanding of housing, and therefore their requirements, is different, made up from varied experience, aspiration and subjective influences. Individual’s perception of their housing as meeting their needs (for example size, cost, tenure, access, and amenity) is crucial to residential satisfaction and therefore wellbeing.

Health in this discussion is taken to be “a condition of physical, psychological, and social well-being subject to multiple influences on multiple levels” (Hartig and Lawrence, 2003, p. 456). It is important to note following this quote that health is a ‘state’ or ‘condition’, and as such is not fixed; it is the ongoing result of various interrelated determinants, such as income, genetic characteristics, lifestyle behaviours, environment, and importantly for this discussion, housing.

“Housing and health is not and never will be an exact science.” (Ranson 1991, preface, cited in Bonnefoy, 2004)

Separately, housing and health are complex, multidimensional concepts incorporating objective and subjective components. Our housing and our health act upon each other and us as individuals, and as individuals we also shape our health and our housing (Hartig and Lawrence, 2003). Because housing is the place we live our lives, the investigation of its influence on health is confounded by the living of those lives. Even when a disease or injury is well defined it is difficult to identify housing’s role within it. At the individual level, housing both directly and indirectly influences the health of individuals. At the population level, housing is a “significant engine of social inequality that has both material and psychosocial dimensions that may contribute to health differences” (Dunn, 2002; p. 681).

There is a well established link between health and housing, but the details of cause and effect are unclear and many of the relationships are indirect. In fact, in many cases “direct evidence is unlikely to be produced, no matter how strong the effect” (Raw et al., 2000 quoted in Bonnefoy, 2004; p. 17). Shaw describes the evidence as ‘piecemeal’, but,

“when amalgamated, the sum of the extensive range of ways in which housing is related to health is quite considerable. Thus in public health terms, it can be argued that housing now affects health in a myriad of relatively minor ways, in total forming one of the key social determinants of health” (2004; p. 402).

Shaw’s (2004; p. 398) four-zoned framework (shown in Figure 1), where ‘hard’ and ‘soft’ housing factors can affect health in ‘direct’ and ‘indirect’ ways, is an especially useful means of conceptualising this relationship. In it:

- Hard/direct ways refers to the material ways that housing can affect health. This would include the heating/respiratory illness relationship, or homelessness;
- Soft/direct ways are related to feelings about the home, for example well-being, ontological security, the perception of social status;
- Hard/indirect ways centre on the use of housing as a means of storing income and wealth, as well as the access to services that it provides; and
- Soft/indirect ways refer to the much harder to measure “prevalent culture in an area, the sense of community and shared values” (p. 398), and the social capital in an area.
Figure 1: Housing and Health Conceptual Framework

Source: Shaw, 2004; p. 398

Acknowledging the many conceptual and methodological problems (as, for example, detailed in Thomson, Petticrew & Morrison, 2001a), a fragmented evidence-base does exist around the influence of housing on health. Figure 2 summarises a number of these known relationships. Many of these are particularly relevant to a discussion of the current South Australian housing reform process. This package of reforms, and the housing policy backdrop they sit within, will be discussed in the following section.

Figure 2: An Evolving Evidence Base of Housing Effects on Health

3. Social Housing Reform: the Australian Context

The Australian Federal Government's approach to public housing provision has changed significantly since the sector emerged in the 1940s. In that immediate post war period public housing was regarded as an alternative to home ownership and was accessible to all in need. The role of public housing changed gradually through the 1960s to incorporate more households on rental rebates, a higher needs population, and a move away from its role as a mechanism for home ownership (as is well documented in Hayward, 1996). By the early 1970s, the focus of public housing was broadly on
welfare provision. The sector has continued this gradual change (most sharply in the last decade) towards a welfare role, where access to public housing is only available to those “in greatest need” (Stevens, 1995; p. 82), for the “duration of their need” (Newman, 1999; p. 7). Public renters in Australia are now characterised largely by age and disability, as illustrated in Table I below. Data presented in this table are largely taken from the most recent Survey of Housing Conditions and Costs. Readers will note that this was last published in 2000, and though it would be expected that these two populations are even more dissimilar in 2007, it highlights the generally high level of disadvantage among the public tenant population.


<table>
<thead>
<tr>
<th>Public Housing Renter</th>
<th>% 65 years and over (*)</th>
<th>% In the Labour Force (*)</th>
<th>% With Disability</th>
<th>% Single Parent Household</th>
<th>% Lone Person Household</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.7</td>
<td>22.0</td>
<td>38.7</td>
<td>28.7</td>
<td>40.5</td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>20.6</td>
<td>65.3</td>
<td>16.5</td>
<td>8.6</td>
<td>23.8</td>
</tr>
</tbody>
</table>

Source: ABS, 2000, cat no. 4182.0; AIHW, 1999

Note: * Household reference person

The Federal Government previously supported public housing mainly through grants to State Governments for housing infrastructure (through the Commonwealth State Housing Agreement (CSHA)), however, in recent years these grants have been reduced and housing for the most needy subsidised by private rental assistance (Commonwealth Rent Assistance) provided directly to households. While private rental assistance has existed as a welfare mechanism for many years in Australia, it has only recently become the dominant housing subsidy method. CSHA funding has fallen in recent years (for example Commonwealth of Australia, 1999 and 2006), as shown in Figure 3 below. This reduced funding has effectively encouraged State Governments to comply with the Federal Government's changed policy focus towards the private provision of housing.

**Figure 3: Government expenditure on CSHA funding and CRA, 1994–95 to 2003–04**

![Graph showing government expenditure on CSHA and CRA between 1994-95 and 2003-04](image)

Source: AHW, 2005; p. 287

### 3.1 The South Australian Case

The economy, history and demography of South Australia (SA) have made it particularly prone to the negative effects of the central government move away from public housing. A range of factors have worked together to reinforce the negative effects of this shift in policy in the State. First, compared with the rest of Australia, South Australia has relatively high unemployment, an older age profile, and more public housing tenants. At its peak, 18 per cent of the total housing stock in South Australia was publicly provided (Hayward, 1996), and although this proportion has now fallen to around 8 per cent
(ABS, 2001), it is still the highest rate for a state in Australia. Second, the State’s public housing provider has, for many years, carried a huge burden of debt, much of it to the Federal Government. In 1993 this debt was $1.29bn (Commonwealth of Australia, 1993; p. 28) and this, coupled with the falling levels of infrastructure funding for public housing for many years, have meant that less money has been, and is available, to support the public housing sector. Third, and closely related to this last point, much of the public dwelling stock in SA was built as temporary housing more than 40 years ago and has never been replaced. What remains at the current time in SA then, is an increasingly ageing stock of public housing dwellings, mismatched to the needs of a population that is reducing in size, but increasing in terms of their ‘high and multiple need’. Thus, at the same time as Federal Government funding for public housing has been restricted, the South Australian Government has been faced with the problems of a large social housing stock that is run-down and expensive to maintain, and a public housing tenant population that is increasingly made up of older, sicker, disabled and welfare dependent individuals.

In response to this situation the Government of South Australia has begun a process of reforming the way that social housing is provided. The State’s housing minister made this statement in the most recent announcement …

Its no secret that the Housing Trust [the State public housing authority] has been under considerable financial pressure for a number of years…Commonwealth funding has plunged 31 per cent since 1996…Currently the Housing Trust is selling hundreds of houses a year just to stay afloat – and this will continue if we do not act to restore the viability of the social housing system…South Australia, like the rest of the nation, is in the midst of a housing affordability crisis (Weatherill, J, March 15 2007, press release)

The policy reforms central to this process of “generational change” (Weatherill, May 2, 2006) in housing provision in South Australia are the creation of an Affordable Housing Trust focused upon the sale of housing (initially 8,000 dwellings from the public stock) to low-income households and ‘institutional investors’ willing to rent affordable housing; and a newly formed Housing Trust directed principally as a welfare “provider of high needs housing” (Weatherill, 2006) for those households who are unable to obtain housing elsewhere. These changes potentially affect all in the low-income housing sector - not just public tenants, but low-income private renters and mortgage holders as well. Two of the outcomes of these major housing reforms and their health implications are considered in this paper:

1. A loss of public housing in the state. The public dwelling stock has been gradually reducing in recent years, from a peak of 18 per cent of South Australian dwellings in 1966 to around 8 per cent at the last published Census (ABS 2001). Over the last decade alone the number of public dwelling units has fallen from 60,208 in 1995 (SCRGSP, 1995) to 44,817 in 2006 (SCRGSP, 2007). The planned reforms will initially reduce the stock by a further 8,000 over the next 10 years. It has also been suggested that the total stock in South Australia may eventually fall to about 15,000-20,000 (Community Housing Council of South Australia quoted in Orchard and Arthurson, 2006); although in addition to this reduced number of properties there is expected to be an expanded community housing sector.

2. The increased movement of low-income households into the private rental sector and home ownership. The current reforms include a focus on encouraging movement of those who would normally be housed in public housing out of the public housing sector and into low-income private rental (with rent assistance) and home ownership (under various shared equity schemes etc.).

There are a number of housing related implications of these outcomes, most obviously there will be further residualisation of both the public housing stock and tenant population. There will be fewer public dwellings, and necessarily fewer households will be housed in the public rental sector and those housed will be selected for their high and ‘complex need’. Public housing in this new environment will be a focussed welfare tool, and as a welfare tool, the remnant stock will probably be the lower valued dwelling units and concentrated into lower value locations. For those waiting to be housed in the public sector, the time spent on waiting lists (and hence in insecure, unaffordable and inappropriate

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1 The two Australian mainland ‘Territories’ (NT and ACT) have a similar, though slightly higher rate.
2 Much of this was ‘non-concessional’, thereby attracting very high rates of interest.
3 It must be noted here that there is active discussion in South Australia (for example Stretton 2005) on alternative responses to the social housing ‘problem’.
housing – i.e. unhealthy housing) will possibly increase. While the reform plans assume that a number of existing tenants will leave the sector voluntarily to enter low cost home ownership or the private rental market, it must be remembered that large proportions of the existing public renter population are poor, ill, or disabled, and this would limit their ability (and inclination) to make a tenure transition. While some places may become available in the newly welfare-focussed Housing Trust there are already nearly 30,000 applicants on the waiting list (SCRGSP, 2007), all of whom have been guaranteed retention of that place.

A further implication of these reforms will be reduced affordability within the low cost housing sector in the state. Rents and housing costs are not able to be rigidly controlled in the open market, as they are in the public system. Adelaide currently has the lowest private rental vacancy rate in Australia (0.5% in Dec 2006, REISA, 2006) and there is fierce competition for the housing stock that is available. Expanding the role of the private rental sector in housing low-income tenants (especially by providing tenants with a rental assistance subsidy) will act to increase competition (and likely raise rents as landlords absorb the subsidy) in that, already stressed, part of the market. The reforms will also mean an increase in competition among low-income households at the more affordable end of the home ownership sector.

While it is likely that urban regeneration programs that upgrade existing stock and their residential environments will continue, it would be assumed that (as has been seen in the UK and NZ) the focus of the 8,000 dwelling sales outlined in the reforms to the South Australian public housing sector would be the better located, better quality stock that would provide greater capital returns. The direct effect of this ‘cherry-picking’ would be a remnant stock of less saleable, lower quality housing, probably concentrated in areas of lower amenity and possibly with poorer accessibility to services (such as transport). Historically, urban regeneration has also meant a decline in the overall quality of dwellings in the public stock that are earmarked for renewal or replacement. As has been well documented (for example Baker and Arthurson 2006), in the lead up to urban regeneration (which can be a process taking a number of years) dwellings and the surrounding infrastructure tend to be only basically maintained. Poor dwelling quality has direct and obvious health implications.

Before discussing the likely health effects of such changes, it is valuable to examine a case study of very similar reforms – that of New Zealand.

### 3.2 New Zealand – A ‘Unique Experiment’ Abandoned

The South Australian reforms appear to replicate many of the reforms implemented by the New Zealand Government in the early 1990s. The New Zealand reforms, at the time were regarded as a “unique experiment ...(that) effectively removed the social component from the social rented sector and, although challenged and modified over time, have had significant impact on state tenants and adversely impacted upon housing affordability for low income groups” (Murphy, 2003; p. 90)

Prior to this process, the New Zealand social housing sector was similar in history, focus, and size to that in South Australia. Both emerged in the WW2 era, and were initially focussed on meeting the housing needs of working families, both gradually assumed a welfare role, and by the early 1990s, they represented a relatively small (~5%) housing sector with a specific focus on meeting the housing needs of those in “greatest housing need” (Murphy, 2003; p. 99). Interestingly, the NZ stock is comparable in size to that in SA (69,928 dwellings in 1992 at the beginning of the reform process, compared to 44,817 currently in SA at the beginning of ours). Essentially the New Zealand reforms represented an experimental move away from a socially-based housing model to a more market-based one. Prior to the reforms in 1992, there was a ‘mixed’ (Waldegrave, 2002) system where those in high housing need were able to rent social housing at a cost based upon their income, and assistance for those in less need was provided through a cash, Accommodation Benefit. Under the changes, all socially housing was rented at market rates, and the one horizontally applied (Waldegrave, 2002) Accommodation Supplement was made available to all. Additionally, the NZ social housing stock was ‘reconfigured’ by selling off around 10,000 properties to both private investors and sitting tenants through tenant purchase schemes between 1992 and 1999 (Murphy, 2003; p. 93).

The housing outcomes of this process were significant, and have clear health implications. Firstly, the affordability in the social rented sector was greatly reduced and became similar to that of the private rental sector leading to “serious problems of affordability in the low-income sector” (Murphy, 2003; p. 96). Second the size of the dwelling stock was reduced, and this did not occur evenly across the sector, but because a degree of ‘cherry-picking’, those dwellings left in the socially rented sector
tended to be spatially concentrated and of lower overall quality. Importantly, this led to a degree of "socio-spatial polarisation in the socially rented sector" (Murphy, 2003; p. 94), an increase on "every indicator of poor housing quality (except overcrowding)" (Waldegrave, 2002; p. 72), and an overall increase in the numbers of households in "serious housing need" (Waldegrave, 2002; p. 70). Thirdly, the changes led to increased housing insecurity as tenants moved from the protected social sector to the open private market. Finally, the move to a housing allowance system and its subsequent design is thought by Murphy (2003) to have resulted in the creation of a poverty trap for recipients and contributed to labour market disincentives. In addition, it is widely thought that such an allowance was to some extent absorbed by private housing providers, a process terms by Murphy (2003, following Murphy & Kearns, 1994) as "landlord capture".

What began in 1992 as a ‘unique experiment’, was to a large extent overturned in 2000, when New Zealand retreated from a profit driven housing sector back to a socially driven housing sector. There are a number of lessons to be learned from this NZ reform process, especially as South Australia commits to a process of reform apparently based upon New Zealand’s ‘abandoned experiment’.

The following section discusses some of the main housing-related factors that have an established health relationship (however weak) that are relevant to this exploration of public housing reform. These are centred on housing tenure and affordability. As has been established in the above discussion, the housing and health relationship has many more dimensions than tenure and affordability (such as the influences of perceived control, access to services, and the amenity and social mix of the residential environment) all of which influence outcomes in the complex relationship. This paper represents an initial exploration, focussed on the central housing effects of a housing reform process.

4. Generational Reform: Some Health Implications of Housing

As in similar countries, housing is Australians’ principle means of creating and storing wealth (Badcock & Beer, 2000), and housing costs (mortgage, rent, insurance, etc.) are Australian households’ main expenditure – and this is increasing (ABS, 2006, cat no 6530.0). Affordability is therefore a major influence on the housing people occupy and a key influence on health (Waters, 2001) it has direct impacts on the household’s ability to obtain adequate, appropriate and secure housing. In an open market, reduced affordability forces households to ‘trade-off’ other elements of their housing, such as its location, quality, access to services or size. In addition, housing’s effect on the financial endurance of the household is significant. Because housing is one of the major costs associated with household function (on average, 22 per cent of total household income for Australian renters in 1999, ABS, 2000, cat no. 4182.0) affordable housing has a significant effect on non-shelter requirements, such as food and medical care.

It should be noted here that affordability varies greatly by tenure. Home ownership, for example (which should be clearly distinguished from home purchase in a discussion of housing affordability) generally has the lowest levels of housing cost. This is neatly demonstrated in Figure 4 below. This graph is also relevant to the discussion of renting later in this section, showing that private renters are most prone to housing affordability problems, and public renters (referred to as ‘State or Territory housing authority renters) are to a large extent sheltered from extreme un-affordability.
Dominating the housing and health evidence base is a well-established pool of research that investigates material housing features and related health outcomes (for example, Thomson et al., 2001). This dominance is unsurprising considering (in the complex and largely subjective concept of housing) these material conditions tend to be the most straightforward to isolate and measure. Significantly for the current investigation, there is thought to be no robust evidence of a material relationship between housing and health for the non-Indigenous population at the national level (though at the regional level, due to the uneven distribution and quality of the socially rented stock and the significant variation in climate across the continent, there is likely to be a relationship). In a country such as Australia, like most other post-industrial nations, the epidemiological transition and the generally high quality of housing (even the socially rented stock) has meant a decreasing relevance of the most basic dwelling related factors. Further explanation for the limited measurable effect of dwelling characteristics on health in Australia is probably related to generally milder climatic conditions than, for example, in Europe, NZ, and the US where measurable evidence is emerging that directly links health outcomes to material dwelling characteristics. A most recent example is the large-scale randomised controlled study (Howden-Chapman et al. 2007) in New Zealand (where there are acknowledged problems of climate and poor quality housing). This study found that by providing warmer houses through the use of insulation they could improve health on a number of health measures, such as self rated health and reports of wheezing, visits to the GP, days off work, and days off school.

Tenure is a key health indicator and numerous studies have found a relationship between tenure and positive health outcomes (for example Hiscock, Macintyre, Keams & Ellaway, 2003; Macintyre et al. 2001). Owner-occupation is widely regarded as the "healthiest sector of the housing system in developed market economies" (Smith et al., 2004; p. 579). Some of the explanation for this comes from the generally better overall condition of privately owned and mortgaged dwellings (such as from overcrowding and damp) and the preferable living conditions (such as perceptions of proximity to crime, or local social mix). It also comes from the greater "protection, autonomy, and prestige" that home owners perceive (Hiscock et al. 2003; p. 536). In this way housing can be seen as a "health promoting resource accessed through income" (Waters, 2001; p. 25, after Macintyre, Ellaway, Der, Ford & Hunt, 1998) where more income buys a better quality dwelling.

Entry into home ownership – while a healthy tenure for healthy people – can "damage the health prospects" of those experiencing illness (Smith, Easterlow, Munro and Turner, 2003; p. 509). For these purchasers, declining health often leads to lowered incomes at the same time as increased costs. "The evidence here is that home ownership is not as ‘healthy’ an option for sick people as it might be for those who are well" (Smith et al., 2003; p. 521). Though home ownership has benefits for

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4 It should be noted here that there is one important population group in Australia that is vulnerable to health effects from material dwelling feature - the Indigenous population who are both vulnerable to the diseases and illnesses of the developing world, living in some of the worst housing conditions, and at the same time, many are living in the most climatically extreme parts of Australia.
those who are ill, the process of home purchase (or even maintenance) can become increasingly
difficult for those who are ill or become ill.

It is well established in the literature on residential satisfaction that buying and owning a home is a key
indicator of satisfaction and wellbeing. Without exception, each investigation reveals residential
satisfaction to be much higher for home owners than renters (Lu, 1999; Rent & Rent, 1978; Joseph
Rowntree Foundation, 1995; Fried, 1982; Loo, 1986). “Home owners … are almost always more
satisfied with their homes and neighbourhoods” (Lu, 1999, p. 266). Mirroring findings in the health and
housing literature, one suggested explanation for this difference is that renters in general, have a
lower housing quality (Loo, 1986).

Within Australia, renting has, for a great majority of households, been a stage in the transition to home
ownership, but this trend is changing. Home ownership is rapidly becoming unaffordable, and
younger households are now renting for longer, or choosing to remain within the sector. Renting in
the private market has a number of housing related health implications, such as insecurity of tenure
and reduced affordability. It is clear that low-income private renters are especially vulnerable to
problems of affordability and hence housing stress. The most recent measurement of Australian
Housing Occupancy and Costs (ABS, 2006, cat no. 4130.0.55.001) shows that over 50 per cent of
low-income5 private renters were paying more than 30 per cent of their income in housing costs, and 9
per cent were paying more than half. The current very low vacancy rates in Australia are contributing
to this reduced affordability. These rates are currently less than 2 per cent across most Australian
capital cities (Shelter Australia, 2007)

Australian public tenants have lower levels of self-perceived health than found among the total
population. One recent study (AIHW, 2005) found that these renters were much less likely to rate their
health as ‘excellent’ than the general population (35 per cent compared with 59 per cent), and more
than twice as likely to rate their health as ‘fair’ or ‘poor’ (16 per cent compared with 37 per cent in the
total population). Some of the explanation for this lower level of self-perceived health is no doubt due
to the selection of many tenants who have higher levels of illness, disability and age, but it is
interesting to note in the findings of the following study (Smith et al. 1997), that when ill tenants are
moved to better housing, their self-perceived health improves significantly. A study by Smith et al.
(1997) is especially valuable in understanding the health effects of public renting. In this study, they
surveyed the self reported health of public renters before and after relocation for Medical Priority Re-
housing. This is one of a few studies which examine health effects of one population in two residential
settings and this method is powerful in disentangling the relationship between health and housing. In
this study, and another similar one by Blackman, Anderson & Pye (2003), ill tenants who were
relocated (in the great majority of cases to better housing) reported improvements in many self
perceived conditions such as depression and overall health. This points to the objective or perceived
quality of housing as a major influence on the health of public tenants.

Public housing is thus an important health intervention for individuals and a tool to reduce health
inequalities within a population. It is a means used by many governments to improve the housing
circumstances (and therefore the health) of groups within a population – especially those unable to
access housing that is adequate, affordable, appropriate or secure. The housing related health effects
of renters in the public housing sector are interesting. Though public housing is widely regarded as an
effective health intervention (for example Smith et al., 1997; Howden-Chapman, 2002) tenants within
the sector still have worse overall health than home owners. This common finding is partly a reflection
of the illness and disability profiles of those entering the sector. In nations where the public rental
sector is focussed on a welfare role, the public rental sector aims to meet the housing needs of
tenants. Promoting good health requires more than addressing basic housing needs. Considering that
the needs of public tenants are increasingly high and complex – especially in Australia where the
Federal Government is forcing states to target those most in ‘need’ – and, importantly, not just housing
related, it is hardly surprising that public tenants still have low levels of health on many measures.

One recent large-scale survey of Australian public housing tenants (AIHW, 2006) reinforces this
interpretation of public housing as a health intervention, it found that the previous housing of tenants
was unaffordable for a great majority (67 per cent) and did not provide sufficient security of tenure for
many. Public housing also appears to be perceived by a majority of tenants surveyed as having
improved the quality of their lives and their health. Some insight into the ways that public housing
enabled this improvement is contained in the following graph, Figure 5. This represents the self-
perceived benefits respondents found from living in public housing. It portrays many of the factors that

5 In the lowest 4 deciles of the income distribution
are well known to be included in the Good Housing/Good Health relationship – security, affordability, access to services and social networks and employment, as well direct health benefits.

**Figure 5: Benefits of Public Housing**

It is noteworthy that the evidence base on the health effects of housing closely mirrors what we know from the mobility and residential satisfaction literature (for example, Marans & Rogers, 1975; Hourihan, 1984; Amerigo & Aragones, 1997). This is logical because, within constraint, people try to maximise their residential satisfaction (and therefore wellbeing) through mobility. To the best of their ability, households and individuals attempt to bring together an ideal residential bundle. A residential bundle describes the housing and residential environment that a household commands. Mobility occurs to maximise the components of this bundle in relation to the household’s needs and potential well-being; that is, within the constraints that they have imposed upon them. This can be visualised as an equation of pushes and pulls, choices and constraints, or attractors and attracted, as has been done throughout the behavioural literature (for example, Longino, 2001; Boheim & Taylor, 1999; McHugh, 1984; Clarke & Onaka, 1983; Golledge & Stimson, 1997). As such, “moving home is one of several housing strategies with the capacity to secure health gains” (Smith et al., 1997; p. 209).

The discussion in this section has highlighted, importantly, that not all groups within our societies are equally vulnerable to negative housing-related health effects. Though the health/housing relationship is acknowledged to be largely indirect and have substantial subjective influence, housing can act either directly to improve health or indirectly to ‘buffer’ other negative influences on health. In addition to certain tenure groups, some population groups within our society are especially prone to negative health effects from their housing. It is important to note that South Australian public tenants are now (and increasingly being) selected for many of these characteristics of vulnerability. Therefore, without public housing these tenants are a group that are especially likely to be prone to poor health. The poor are an obvious example of a group vulnerable in the housing market and likely prone to poor health outcomes. In an unregulated market, housing is valued by its desirability and those with less ability to pay are less able to secure an ideal housing bundle and one with few negative housing effects. Social housing, to some extent restricts this more-or-less direct relationship between ability to pay and ability to access healthy housing. Not only does housing affect health, but also “poor health affects housing attainment, so that people with health problems have the double burden of living with illness in unhealthy homes” (Smith et al., 1997; p. 203). It is interesting to note here that in the Smith et al. study existing health problems enabled individuals to have better access to improved housing because of the way that they were positively dealt with in the social housing system.
As has been discussed, the health outcomes of housing are dependent on the interaction of a large number of contributors and, notably, are not fixed over time. As individuals and their households evolve through their housing career (even a very traditional one), housing needs and situations change, affecting health outcomes. In terms of vulnerability to negative health effects, the individual and their household can move in and out of vulnerable groups. It is worth briefly referring to the model developed by Williams (2003) and adapted by Beer, Faulkner and Gabriel (2006) showing housing careers in industrial and post-industrial Australia, to highlight the fact that housing careers in Australia (as with most other post-industrial nations) have become more varied and changeable (Figure 6). This instability gives greater potential for negative health effects to develop from housing conditions (for example reduced stability of tenure, more time in the private rental sector etc).

5. Concluding and Moving Forward
The current process of ‘generational reform’ to the South Australian social housing sector presents significant health risks to the low-income population. This paper has been an initial exploration of the housing and health relationship and an evidence-base of likely outcomes of the proposed reforms. In summing up this brief examination, it is clear that the current reform process will increase the likelihood of housing situations that present health risks to low-income householders. The findings of this paper suggest that in order to minimise negative health outcomes from this process, there are five main considerations that should be incorporated into the enacting of the reforms:

1) The maintenance of affordability and housing quality,
2) The limiting of extreme residualisation in the public sector,
3) The avoidance of ‘cherry-picking’,
4) The importance of maintaining security of tenure, and
5) The need for cautious administration of any housing supplement to avoid ‘landlord capture’ and poverty traps.

The current South Australian reforms represent a natural experiment about to take place. This paper is an initial step in exploring what the health outcomes of such change will be, and is part of a wider investigation of the health and housing relationship. This wider investigation is based upon the belief (following Smith et al. 1997) that residential mobility and relocation research provide a promising and novel, but under-utilised approach to improving understanding of the health-housing relationship. Being able to examine the health and wellbeing of households in two residential settings is a potentially valuable means of disentangling the complex set of processes that shape the relationship between housing and health. This research will focus on the health and housing experiences of 20
SAHT lead tenants[^6] who enter public housing. These tenants will be interviewed twice – once before and once after they have been allocated public housing. All respondents will be Category 1 applicants, that is, assessed as having the most urgent need for housing and for whom private housing is unsuitable in the long term. This project will represent the creation of an initial evidence-base on the effects and impacts of housing on the health and well being of Australians. It will also represent a testing of the promising and novel mobility approach to understanding the relationship between health and housing. The study will be designed with the flexibility to investigate other tenure groups in later, further development of the research. These groups would be private renters, home purchasers, and home owners. The effects of housing on households with low incomes are of specific interest because these households are more vulnerable to the effects of poor housing.

[^6]: A Lead Tenants is the householder listed on the rental agreement
Bibliography
Australian Institute of Health and Welfare and the Commonwealth of Australia, 2006, 2005 Public Housing National Social Housing Survey—Key Results, cat. no. AUS 78.
Hiscock, R, Macintyre, S, Kears, A, and Ellaway, A, 2003, Residence and Residents: Factors Predicting the


Jacobs, DE, 2004, Housing and Health: Challenges and Opportunities, paper presented to the 2nd WHO Symposium on Housing and Health, Vilnius, Lithuania.

Joseph Rowntree Foundation, 1995, Older People’s Satisfaction with their Housing, Housing research findings 146 (York: JRF).


Marans, RW and Rodgers, W., 1975, Towards an Understanding of Community Satisfaction, in Hawley, AH and Rock, VP, (eds.) 1975, Metropolitan America in Contemporary Perspective, John Wiley and Sons, New York.


Real Estate Institute of South Australia, 2006, Adelaide Rental Shortage Heightens, Media Release, 26 December.


Smith, S. J., D. Easterlow, Munro, M, 2004, "Housing for health: Does the market work?", Environment and


Weathrill, J, 2006, Ministerial Statement on Governance Changes in Housing and Disability, Minister for Families and Communities, Tuesday 2nd May.

Weatherill, J, 2007, News; Affordable Homes Program to Address Housing Trust Viability, Press Release, Minister for Families and Communities, March 15th.
