Women, Health and Housing Assistance: Implications in an Emerging Era of Housing Provision

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Abstract
Women and the households that they head are over-represented among the most economically and socially disadvantaged households in Australia. Recent changes in the provision of housing assistance for low income households in Australia have distinct implications for women and this paper examines the implications of these changes. Shifting the emphasis in housing assistance away from publicly provided and rent-controlled housing to direct subsidisation of rents for private tenants has important, largely negative, consequences for the health, affordability and security of housing for many women. This situation is made worse given the current housing affordability crisis in Australia; a crisis that extends across all private housing tenures.

Key words: Housing, Health Inequalities, Gender, Housing Assistance
Introduction

In this issue on gender and health inequalities, we explore housing-related health inequality with a focus on women and the households that they head. Housing is a key social determinant of health (Krieger and Higgins 2002: 758; Shaw 2004: 202) and a 'significant engine of social inequality' (Dunn 2002: 681). Unequal access to adequate, affordable and secure housing is a potential source of health inequality in Australia. Some groups within our society are especially vulnerable to poor housing outcomes and related health effects. In Australia, such vulnerability appears most apparent in households who are unable to buffer poor housing outcomes in other ways, because of, for example, low income or social disadvantage. This paper explores the health implications of housing and housing assistance interventions for women and the households that they head. We have adopted this focus because, while both men and women are susceptible to housing-related health effects, women and the households that they head have an above average likelihood of also being low income, older, lone person, or sole parent and these types of household are acknowledged as highly vulnerable to housing that is unaffordable, unsuitable, or with insecure tenure (for example Yates and Milligan 2007: 5; Baker and Beer 2007: 166).

The following section discusses the relationship between housing and health and explores the key housing characteristics that influence health in the Australian context. In a market economy such as Australia’s, access to healthy housing is largely based on affordability, and for those households unable to afford healthy housing, the form and availability of housing assistance shapes both their housing and resultant health outcomes. Women and the households that they head are shown to be particularly vulnerable to housing-related health inequalities, and this is likely to be amplified by recent and ongoing changes to the way that housing assistance is provided in Australia. The remaining sections of the paper discuss the Australian housing system, and female headed households within it, emerging changes to the provision of housing assistance in Australia, and how such changes are impacting on (and determining) the health and housing circumstances of female-headed households. It shows that women and the households that they head are dominant among households with poor housing affordability, and similarly, among households in receipt of housing assistance.

Housing and health

As part of the right to a standard of living adequate for health and well-being (UN 1948, article 25: 1), everyone has the right to housing, but it is important to note that housing is more than 'bricks and mortar'; it needs to be adequate, affordable, appropriate, and secure (UNCHS 2001). Housing is thus — and usually more than — a place with access to social networks, employment and services. It is also a home from which we draw our identity and store much of our wealth, and a shelter that permits comfort and security.

Separately, housing and health are complex, multidimensional concepts incorporating objective and subjective components. Housing both directly and indirectly influences the health of individuals. As examples, damp and cold dwellings have been directly associated with respiratory illness (Shaw 2004) and tenure has been shown by many authors to act indirectly on health through, for example, ontological security and attachment to neighbourhood (Mcntyre et al. 2001). The interaction between housing
and health is difficult to measure. Neither housing nor health can be simply measured, both are dependent on individual, subjective perception and assessment, and both are liable to change over time. Regardless of the complexity of the relationship, it is clear that ‘good housing and good health go together’ (Smith et al. 1997: 203, after Best 1995).

Though the health/housing relationship is acknowledged to be largely indirect and to 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 (such as female-headed households) are especially prone to negative health effects from their housing.Acknowledging some conceptual and methodological problems (as, for example, detailed in Thomson et al. 2001a), a strong but fragmented evidence base (Shaw 2004) does exist around the influence of housing on health. Figure 1 summarises a number of these known relationships.

Dominating the housing and health evidence base is a well established pool of research that investigates material housing features and related health outcomes (see for example Thomson et al. 2001b). This dominance is unsurprising considering that – in the complex and largely subjective concept of housing – these material conditions tend to be the most straightforward to isolate and measure. Significantly, in Australia 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 (Paris 1993) (an important exception is the Indigenous population, who are vulnerable to the diseases and illnesses of the developing world, living in some of the worst housing conditions, and often at the same time, living in the most climatically extreme parts of 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 in explaining health outcomes. Further explanation for the limited measurable effect of dwelling characteristics on health in Australia is probably related to generally milder climatic conditions than those experienced in Europe, New Zealand, and the United States – where measurable evidence is emerging that directly links health outcomes to material dwelling characteristics. A recent example of this is a large scale randomised controlled study conducted in New Zealand (Howden-Chapman...
et al. 2007) where there are acknowledged problems of climate and poor quality housing. The study found that by providing warmer houses through the use of insulation, a number of health measures could be improved such as self-rated health and reports of wheezing, visits to the General Practitioner, or days missed from work or school.

While it is well established in the international literature that housing influences health, in the Australian context the influence of housing upon health tends to be an indirect result of the quality, characteristics and tenure of the housing we can afford. In this way housing can be seen as a ‘health promoting resource accessed through income’ (Waters 2001: 25) where more income buys a better quality dwelling. This is especially relevant in this examination of the housing of Australian women because, as will be discussed in the following section, female-headed households are especially likely to be affected by increasing housing unaffordability – largely because of the lower incomes of women compared with men.

As in similar countries, housing is Australians’ principle means of creating and storing wealth (Badcock & Beer 2000), and for the majority of households housing costs (mortgage, rent and insurance) are their greatest category of expenditure – and this expenditure is increasing (Australian Bureau of Statistics 2006c). For those households that own their own homes, housing represents (on average) 55 per cent of their net wealth (Australian Bureau of Statistics 2007b: 1). Affordability is therefore a major influence on the housing people can and choose to occupy and is a key influence on health (Waters 2001). It directly influences a 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 accounting for 22 per cent of total household income for Australian renters in 1999 (Australian Bureau of Statistics, 2000) – affordable housing has a significant effect on a household’s ability to access non-shelter requirements such as food and medical care.

Affordability also varies greatly by tenure. Outright home ownership – which should be clearly distinguished from home purchase in a discussion of housing affordability – generally has the lowest levels of housing cost. In comparison, private renters are most prone to housing affordability problems, and public renters are to a large extent sheltered from extreme un-affordability by capped rents (as is well illustrated in Australian Bureau of Statistics 2000).

Tenure is a key health indicator and numerous international studies have found a relationship between tenure and positive health outcomes (for example Hiscock et al. 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: 579; Macintyre et al. 2001: 29; Macintyre et al. 2003). The generally better overall condition of privately owned and mortgaged dwellings and the preferable living conditions homeowners enjoy (Macintyre et al. 2001) may partly explain the better health of owner-occupiers compared with other housing tenures. Owned homes generally have fewer problems of overcrowding and damp, or exposure to incidents of crime or anti-social
behaviour from neighbours (see Macintyre et al. 2003). Home owners also experience greater ‘protection, autonomy, and prestige’ (Hiscock et al 2003: 536).

For a great majority of Australian households renting has been a stage in the transition to home ownership, but this trend is changing (Australian Bureau of Statistics 2007a, 2006a; Beer et al. 2006; Wulff & Maher 1998). Home ownership is rapidly becoming unaffordable, and younger households are now renting for longer, or choosing not to enter home ownership. 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 (defined as those in the lowest four deciles of the income distribution and paying more than 30 per cent of their income in rent or mortgage costs). The most recent measurement of Australian Housing Occupancy and Costs (Australian Bureau of Statistics 2006d) shows that over 50 per cent of low income private renters were paying more than 30 per cent of their income in housing costs, and nine per cent were paying more than half. The current low vacancy rates in the private rental market in Australia are contributing to this reduced affordability. These rates are at present less than two 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 (Australian Institute of Health and Welfare 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’. Some of the explanation for this lower level of self-perceived health is no doubt due to the selection of public tenants based on their vulnerable position in the housing market (due to problems such as illness, disability and age), but it is interesting to note in the findings of a study by Smith et al. (1997) that when ill tenants are moved to better housing (or similarly, when the condition of their housing is improved (Barton et al. 2007)), their self-perceived health improves significantly. The work undertaken in the United Kingdom by Smith et al. is especially valuable in understanding the health effects of public renting, as it examined the self-reported health of public renters before and after relocation for Medical Priority Re-housing. This study, and a similar one by Blackman, Anderson and Pye (2003), showed that the great majority of ill tenants who were relocated to better housing reported improvements in many self-reported conditions, including reporting improvements in depression and overall health. These findings point to the 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 inequities 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 especially important. Though public housing is widely regarded as an effective health intervention (see Howden-Chapman 2002; Smith et al. 1997), 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 where in
Australia entry to public housing is now (and increasingly) based upon need such as disability, poverty, and broad disadvantage. In nations where the public rental sector is focussed on a welfare role, the sector aims to meet the housing needs of tenants. However, 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 housing or housing-related ‘need’ — 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 (Australian Institute of Health and Welfare 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. Importantly, the findings of this study also showed that the majority of tenants felt that public housing had 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 2) which presents the self-perceived benefits respondents experienced from living in public housing. It portrays many of the factors that 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 as more direct health benefits.

The previous section briefly reflected on affordability and tenure in the Australian housing system. These factors are presented in this paper as key pathways between housing and health for Australians. The following section describes women in the Australian housing market, highlighting these households as especially vulnerable to poor housing-related health outcomes.

**Women in the Australian housing market: a snapshot**

Women represented 50.6 per cent of the total population and 55 per cent of the population aged over 65 years at the time of the 2006 Census of Population and Housing (Australian Bureau of Statistics 2007a). Despite this numerical dominance we know little about the gendered nature of housing generally and especially about tenure by gender (Tually et al. 2007). That said, we do know from existing research that female-headed
households have an above average likelihood of being low income, older, lone person, or sole parent and we also know that these types of household are highly vulnerable to poor housing outcomes, and are over-represented among households living in housing stress.

Though women are over-represented among vulnerable households in the housing market, it should also be noted here that housing vulnerability is not always directly related to gender. In fact, many women are doing well in the housing market, accumulating significant housing wealth. This situation is certainly likely among the approximately 65 per cent of Australian women (and men) living in couple families with or without children who are purchasing their home or own their home outright (Australian Bureau of Statistics 2007a). It is also especially likely to be the case among homeowners who entered the market prior to the recent housing boom. Nevertheless, many Australian women and their households are also experiencing significant social or economic disadvantage including low incomes, less superannuation (for discussion see Clare 2004), or are experiencing circumstances that limit their income earning capacity such as caring responsibilities or disability. Many of these disadvantages are the result of, or shaped by, now well established patterns of family formation and dissolution in Australia as well as the fact that women have longer life expectancies than men. When considering vulnerability to poor housing, it should also be remembered that one predisposition to housing vulnerability is often related to another. For example, women in low income households are obviously predisposed to housing stress just as sole parent households are likely to have lower household incomes. All of these factors work to disadvantage many women in the housing market, making them especially susceptible to changes in the cost or affordability of housing – across all tenures.

At the last published Census (2001), over 83 per cent of sole parent households in Australia were female-headed, as were almost 55 per cent of lone person households (Australian Bureau of Statistics 2006a & b; 2004b). The dominance of women in these living arrangements is important in the context of this discussion, because there is known to be a clear over-representation of sole parent households and lone person households with affordability problems and living in housing stress (see Australian Bureau of Statistics 2004c; Baker & Beer 2007; Yates & Gabriel 2006). Around 20 per cent of sole parent households, for example, are classified as being in housing stress (Australian Bureau of Statistics 2004c) – that is, with low incomes and paying a high proportion of their income in rent or mortgage costs. As women comprise the majority of households in both of these groups it follows that many, if not most, of the households in housing stress are female-headed. Moreover, recently published statistics show that households headed by women are the major recipients of both public housing assistance (64 per cent) (Hulse 2007: 5) and Commonwealth Rent Assistance (62 per cent) (Department of Family and Community Services 2005). Considering the vulnerability of sole parent and lone person households in the housing market, it is important to also note that these two types of household are projected to grow strongly into the future (Australian

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1 At Census 2001 approximately 11 per cent of all households in Australia were sole parent households (762,632 of 7,072,202 households) and 1.6 million or almost 23 per cent were lone person households (Australian Bureau of Statistics 2006a & b; calculations are based on Australian Bureau of Statistics figures for persons in occupied private dwellings on Census night 2001 as a proportion of all households enumerated). Sole parent families also accounted for 15.4 per cent of all families in Australia at the same time (15.8 per cent at Census 2006), up from 14.5 per cent at Census 1996 (Australian Bureau of Statistics 2007 & 2006a).
Bureau of Statistics 2004b) primarily because of sustained high rates of family dissolution and divorce and the ageing of the large cohort of baby boomer women over the next 20 years (see AMP/NATSEM 2005; Healy 2003; Jain 2007). It is likely then that women in these household types will remain prominent among households most vulnerable in the housing market.

Housing assistance: implications for women?
The health effects from housing are most apparent in households who are unable to buffer negative housing-related health effects in other ways, for example, because of low income or social disadvantage. The form and availability of housing assistance is therefore crucial to shaping the housing and health outcomes of vulnerable women and their households. This section discusses the way that low income housing assistance is, and is likely to be, provided in Australia and then reflects on the implications for women of these changes.

The Australian Government provides three main types of housing assistance: home ownership assistance, private rental subsidy (known as Commonwealth Rent Assistance) and social housing. Comparing expenditure across these three forms of assistance, one recent Australian study estimated that in 2001 the Australian government provided $22 billion in home ownership assistance, compared with just $2 billion in private rental subsidy and $1 billion provided to the social housing sector (Yates 2003). This comparison underlies an historical and continuing importance placed upon home ownership by Australian governments. Home ownership assistance is available irrespective of income and as such should not be considered a low income housing assistance measure. In fact, many low income households are also unable to access home ownership and are hence reliant on the much smaller assistance sectors of private rent subsidy and social housing.

The Australian Government’s approach to providing low income housing assistance has changed significantly over the last five decades (as discussed in Baker & Beer 2007; Baker & Arthuson, 2007). There has been a deliberate policy shift away from the public provision of housing towards subsidising private rental housing for those most in need. The Australian public rental sector currently houses around 4.5 per cent of Australian households (Commonwealth of Australia 2006), and tenants in the sector are increasingly selected for their high and multiple needs. 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 (see for example Commonwealth of Australia 1999 and 2006; Australian Institute of Health and Welfare 2005). The effects of this changed approach to housing assistance are most visible in the form of fewer public dwellings, a focus upon housing to those most in need, and increased public housing waiting lists. The direct and indirect effects of these changes have clear health implications for households in greatest housing need. For example, a reduction in the number of public rental dwellings risks further residualisation of both the public housing stock and tenant population, meaning fewer public dwellings and necessarily fewer households housed in the public rental sector. For those waiting to be housed in the public sector, the time spent on waiting lists – and hence in insecure, unaffordable and inappropriate housing or more unhealthy housing – is likely to increase. A further
implication of the current reform process is reduced affordability within the low cost housing sector. Rents and housing costs are not able to be as rigidly controlled in the open market, as they are in the public system. 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 in the already highly competitive, low income housing market, and is also likely to raise rents as landlords adjust rents to absorb the subsidy. The reforms will also mean an increase in competition among low income households at the more affordable end of the home ownership sector, disadvantaging those with the most significant affordability problems.

Changes to the provision of housing for low income households have a number of significant and interrelated implications for women and their health. Specific changes such as tighter targeting of social housing to most ‘needy’ clients, reducing the number of public housing dwellings available for rent and directing housing assistance subsidies to the private rental market will fundamentally limit the number and range of affordable housing options available to those most in need in the housing market. As we know from the discussion in this paper, these changes will disproportionately affect women and their households. This is because women are over-represented among public housing tenants generally and female-headed households are over-represented among low income, older, sole parent and lone person households – the households most vulnerable to poor housing outcomes. Moreover, changes in housing assistance policy that limit the number of public housing tenancies, and the tighter targeting of such tenancies to need, also removes a relatively secure housing option for vulnerable households. These two issues are especially important concerns in terms of health, as public housing provides affordability, security of tenure and buffers occupants against many poor health outcomes.

Tighter targeting of social housing to those in most need has advantaged some groups of women in the housing market. This would clearly be the case for some women with disabilities as a large proportion of new (and existing) public housing tenancies are now allocated to people with disabilities (Australian Institute of Health and Welfare 2007), and modifications are made to dwellings to suit the circumstances of tenants if they are needed. This last point is a critical one given that many people with disabilities have difficulty living in private tenures because of problems accessing appropriate dwellings and the cost of modifications for disability to homes (Krohn et al. 2007). Of course, it is also the case that dwelling modifications for disability are sometimes not possible for private rental tenants because decisions regarding whether these modifications are allowed rest with the private landlord. In terms of health outcomes then, it should be noted that, State Housing Authorities are generally obliging when it comes to necessary access and disability modifications needed by aged and disabled tenants.

The shift in housing assistance away from direct provision of housing for low income earners to subsidisation of rent in the private market also has implications for the health and housing of many women, particularly when such changes are occurring at a time of decreasing affordability in the private rental market (for discussion see Yates et al. 2007). As discussed earlier in the paper, the private rental sector is the housing tenure most associated with poorer health outcomes, largely because of the cost and variability in the quality of dwellings within the sector. It is also the tenure where housing stress is most
concentrated (Baker & Beer 2007). Moving more already vulnerable and disadvantaged households into this tenure will logically have significant impact on the incomes and the health of tenants in this sector—especially at the current time when private sector rents are increasingly unaffordable. The shortage of low rent dwellings within the private rental market makes this situation even more precarious for certain vulnerable households, and particularly for households that have low or fixed incomes such as female-headed sole parent and lone person households dependent on government benefits or income support for all or most of their income (for example, persons in receipt of the Age Pension, Parenting Payment, Disability Support Pension, or the Carers Payment).

Measures to assist low income households into home ownership, such as the First Home Owner Grant or low income government secured loan packages, are promising means to provide entry into home ownership for some households, providing opportunity for the positive housing-related health benefits of home ownership. However it is important to note (following Smith et al. 2003) that for some households home ownership is disadvantageous. There will always be households unable to maintain a dwelling—physically, mentally or financially—as well as an increasing number of households who are unable to afford (even with assistance) housing that is well located and healthy. Despite this requirement to maintain alternative housing options, there is clearly a need for more low income home purchase assistance programs (a point strongly emphasised by Tually et al. (2007) in their report on the future of women's housing). It is of concern that an increasing number of households—and especially female-headed households—cannot enter this tenure or fall out of it due to changes in their personal or financial circumstances, and consequently (women) miss out on this opportunity to accumulate wealth for their retirement. Moreover, and related to this last point, outright home ownership is one of the best means households have to reduce their housing costs in retirement, cushioning outright owners against high housing costs at a time when their incomes are likely to be low, or even at their lowest. Given these two points, it is not surprising then that low income older women living alone in the private rental market are considered to be one of the most vulnerable household types in the Australian housing market.

The fact that the majority of women continue to accumulate much less superannuation across their lifetimes than men is also a point that must be raised here for two important reasons. First, and obviously, women’s much lower superannuation balances mean that fewer women than men are able to use their superannuation to supplement their income and raise or maintain their living standard (and thus health) in retirement. This is a particular concern for women living alone in older age and for women living in all tenures. Second, many people use their superannuation or part of it to pay off their remaining mortgage at retirement, thereby reducing their housing costs. For women with limited superannuation and a mortgage remaining at retirement this is less of an option, meaning many will be left with higher housing costs than men or couples with significant superannuation. This is a particular problem for the many women who have been out of the workforce for significant periods caring for others (as detailed in AMP. NATSEM 2006: 9-10) and for female divorcees, especially those who divorced prior to the introduction of superannuation splitting laws in property settlements in December 2002.
Conclusion

This paper has explored the health implications of housing for women and their households. It has focussed upon those households most vulnerable to poor housing outcomes because it is these households who are least able to buffer poor housing quality through other means, such as income. At the household level, vulnerability to poor housing outcomes has a clear gendered dimension; women disproportionately head many of these household types. Because housing and health are so closely related, the housing that households have access to has direct and indirect implications for health outcomes. Housing is an effective health intervention and housing assistance packages such as private rent subsidy and public housing are a means to direct intervention to those most in need. Emerging changes to the size and definition of housing assistance in Australia risks further disadvantaging many of the female headed households who we currently regard as 'most in need'.

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