MIGRANT & REFUGEE
WOMEN'S HEALTH PARTNERSHIP

## Information brief

## Impact of housing on health

## February 2018

## Background

The Working Group of the Migrant and Refugee Women's Health Partnership (the Partnership) has identified the issue of housing and its impact on individual and community health and wellbeing as of significant relevance to the health sector.

This brief is prepared by Secretariat of the Partnership. It reviews key evidence on housing as a social determinant of health. It seeks to highlight the importance of enhanced coordination between the housing and the health sectors in the development of relevant programs and policies.

## Social determinants of health

According to the World Health Organization (WHO), effective public health policy is based on 'interventions in two broad domains: the biomedical domain that addresses diseases; and the social, economic and political domain that addresses the structural determinants of health.'[1]

The WHO Commission on Social Determinants of Health identifies two main groups within the scope of the social determinants of health.[2] One group encompasses the structural determinants—those determinants that generate social stratification in the society and include income, education, gender, age, ethnicity and sexuality. The other group encompasses the intermediate determinants of health—such as living and working conditions, housing, access to health care and education—that emerge from underlying social stratification and determine differences in exposure and vulnerability to health-compromising conditions.

[1] World Health Organisation, Social Determinants of Health Sectorial Briefing Series 1, Housing: Shared Interests in Health and Development, 2011, p. 3/
[2] Report to the WHO Commission on Social Determinants of Health from the Knowledge Network on Urban Settings, Our cities, our health, our future: Acting on social determinants for health equity in urban settings, July 2007, p. 9.

## Housing and the impact on health

A growing body of evidence has been developed recognising the connection between housing and health.[3] According to WHO, housing is comprised primarily of four interrelated dimensions—the physical structure of the house (or dwelling), the home (psychosocial, economic and cultural construction created by the household), the neighbourhood infrastructure (physical conditions of the immediate housing environment), and the community (social environment and the population and services within the neighbourhood).[4] Each of these dimensions has the potential to have either a direct or indirect impact on an individual's physical, social and mental health.[5]

An individual's housing will be considered precarious and as a consequence unsuitable, if two or more of the following aspects are experienced concurrently:

- unsuitable housing (overcrowded and/or in poor condition and/or unsafe and/or poorly located);
- unaffordable housing (high rent or mortgage costs relative to income);
- insecure housing (insecure tenure and subject to forced moves).[6]

Multiple aspects of precarious housing are recognised as creating health risks responsible for considerable disease and deaths worldwide.[7] According to research undertaken by VicHealth, people in precarious housing have on average worse health than people who were not precariously housed, regardless of other demographic factors.[8] Despite this, no one component of precarious housing (unaffordability, dwelling condition, overcrowding, forced moves, private rental) was identified by VicHealth as clearly more important in its relationship with health.[9]

Overcrowding is one of the most common ways individuals experience precarious housing. In all of the last three Censuses, people living in severely crowded dwellings have comprised the largest homeless group.[10] Overcrowded housing can affect health through a variety of channels, including through inadequate access to ablution, cleaning and cooking facilities and subsequently a more rapid transmission of infectious disease.[11] Overcrowding might also induce psychological stress that could lead to verbal and physical abuse.[12]

## Barriers to housing experienced by migrant and refugee communities

Cultural and linguistic complexities can create and enhance risks with regard to housing and homelessness. Further, people from migrant and refugee backgrounds may lack awareness about housing services or these services may not be able to offer culturally appropriate

[3] H Thomson, S Thomas, E Sellstrom, M Petticrew, Housing Improvements for Health and Associated Socio-Economic Outcomes (Review), 2013, p. 3.
[4] World Health Organisation, Environmental burden of disease associated with inadequate housing: A method guide to the quantification of health effects of selected housing risks in the WHO European Region, 2011, p. 1.
[5] *ibid.*
[6] VicHealth, Housing and Health: Research Summary, 2011, p.2.
[7] World Health Organisation, Healthy housing: Raising standards, reducing inequalities Factsheet, 2017, p. 1.
[8] VicHealth, Precarious Housing and Health Inequalities: what are the links? 2011, p. 3.
[9] *ibid.*
[10] Mission Australia, Review of Homelessness, 2015, p. 4.
[11] A Booth and N Carroll, Overcrowding and indigenous health in Australia, 2005, The Australian National University Centre for Economic Policy Research (Discussion Paper No. 498) p. 1.
[12] *ibid.*

support.[13] Structural factors such as discrimination within the housing market, housing supply and affordability also increase difficulties for migrants and refugees.[14]

The increase in the number of people born overseas living in severely crowded dwellings was a major contributor to the overall increase in homelessness between 2006 and 2011.[15] In 2015, persons living in severely crowded households were more likely to be unemployed or not in the labour force, to not speak English well or at all, and to have arrived in the last five years from India, Afghanistan, Vietnam or Iraq.[16] At the same time, Mission Australia also identified that after being in Australia for five years, people born in Afghanistan, Nepal and Iraq were also more likely to still be living in "severely" crowded dwellings.[17]

While there is some data available on this issue, much of the remaining homelessness experienced by migrant and refugee communities involves people moving between temporary arrangements, keeping the phenomenon largely hidden.[18]

There is a number of at-risk groups within migrant and refugee communities. They include: refugees and asylum seekers, women, young people, and older people.

**Refugees and asylum seekers**

Refugees and asylum seekers are an under-reported group, particularly vulnerable to housing insecurity, stress and homelessness,[19] which creates a significant structural barrier for this cohort.[20] Having experienced hardship and trauma prior to arrival, they may arrive in Australia with limited financial resources.[21] Family relationships may be more complex among refugees with the added burdens of trauma, overcrowding, high expectations and differing acculturation.[22]

The Refugee Council of Australia's annual consultations revealed that affordable and adequate housing is nominated as one of the three key concerns for refugee communities in Australia.[23] In the Building a New Life in Australia: The Longitudinal Study of Humanitarian Migrants, respondents were asked if there was anything else they would like to say about their time in Australia and more than one-third commented on housing, especially the cost in relation to income.[24] Moreover, within the first 18 months of resettlement, less than ten per cent of refugees were able to successfully access public housing.[25]

**Women**

Women from migrant and refugee backgrounds face particular vulnerabilities when seeking to access housing services. Unequal distribution of caring responsibilities and increased vulnerability to domestic and family violence are just two factors that shape the housing needs of women.[26] Housing affordability is one contributing factor, which undermines

[13] Mission Australia, Review of Homelessness, 2015, p. 24.
[14] *ibid.*
[15] *ibid.*
[16] *ibid.*
[17] *ibid.*
[18] *ibid.*
[19] Australian Government Department of Social Services, Building a New Life in Australia (BNLA): The Longitudinal Study of Humanitarian Migrants – Findings from the first three waves, 2017, p. 58.
[20] Mission Australia, Review of Homelessness, 2015, p. 26.
[21] *ibid.*
[22] *ibid.*
[23] *ibid.*
[24] Australian Government Department of Social Services, Building a New Life in Australia (BNLA): The Longitudinal Study of Humanitarian Migrants – Findings from the first three waves, 2017, p. 59.
[25] Mission Australia, Review of Homelessness, 2015, p. 26.
[26] Equality Rights Alliance, Gender and Housing – An Overview of Data Issues, 25 July 2017.

women's access to safe and appropriate housing.[27] Furthermore, homelessness service models are not always suited to the cultural norms of people from diverse backgrounds. For example, many youth crisis accommodation models may not be appropriate for young Muslim women who are unable to share accommodation with men.[28]

Household-based census data also obscures the intra-household gendered relations that impact on women's housing experience. As a result, there is very little data on the experiences of women who are living and remaining in violent relationships because of the affordable housing shortage.[29]

**Young people**

For young refugees, disconnection from family, school and community are major precursors to homelessness.[30] Young people from refugee backgrounds identify social isolation, economic hardship, racism and discrimination by real estate agents and employers, language barriers and cultural ignorance, family breakdown and poor mental health due to traumatic refugee experiences as exacerbating their vulnerability to homelessness. [31]

Young people from refugee backgrounds are six to ten times more likely to be at risk of homelessness than Australian-born young people.[32] It is estimated that between 500 and 800 young refugees are homeless Australia-wide and this number is growing.[33] However, the number of young refugees experiencing homelessness may be substantially higher, as couch surfing is common for young refugees and may not be reported.[34]

**Older people**

Older renters from culturally and linguistically diverse backgrounds often experience discrimination and hardship in the private rental market.[35] They also have less access to resources that may help them with housing problems and to find secure, affordable housing. This puts them at significant risk of becoming homeless.[36]

## Intersection of housing and health: The role of health services and practitioners

Internationally, there are examples of systems—grounded in health/housing partnerships—that have been developed to enable health practitioners to refer patients for housing advice where patients present with health conditions that could be related to housing conditions, such as Conseiller Médical en Environnement Intérieur (CMEI) in France or the Green Ambulance in Brussels. Both seek to address housing conditions that create health risks. In France, the CMEI intervenes exclusively at the request of a health practitioner and investigates possible exposures and risks in the home environment.[37] At present, however,

[27] Equality Rights Alliance, Submission of the Equality Rights Alliance to Setting the Agenda, September 2017.
[28] Mission Australia, Review of Homelessness, 2015, p. 24.
[29] Equality Rights Alliance, Gender and Housing – An Overview of Data Issues, July 2017.
[30] Mission Australia, Review of Homelessness, 2015, p. 26.
[31] Jen Couch, Homeless Twice, Journal of Social Distress and the Homeless, 2012, p. 3.
[32] *ibid.*
[33] *ibid.*
[34] *ibid.*
[35] A Joint ECCV-HAAG Paper, At Risk of Homelessness: Preventing Homelessness in Older and Culturally and Linguistically Diverse Communities, November 2015, p. 7.
[36] *ibid.*
[37] Conseiller Médical en Environnement Intérieur, http://www.cmei-france.fr, accessed 15 February 2018.

CMEI is under-utilised due to the lack of knowledge of the service among health practitioners.[38]

The Green Ambulance was established by the regional environmental administration in partnership with the Scientific Institute for Public Health and the Fund for Respiratory Ailments.[39] The ambulance brings a team of analysts to a person's home and have inhabitants fill out a questionnaire on their lifestyle.[40] Once a diagnosis is made, the staff provide advice on remedial measures, which may be subsidised by regional authorities.[41] The information collected by the service is also put to use in the evaluation of indoor pollution in the Brussels-Capital Region in order to formulate a longer term strategy to prevent health problems from indoor pollution.[42] Consequently, these examples illustrate that housing can also be considered an important issue for primary care coordination.

Increased collaboration between housing and health services provides an important opportunity for improving population health outcomes. WHO has identified several practical examples which may be adopted to facilitate effective collaboration between the health and the housing sectors.[43] With regard to housing affordability, health sector can contribute to policy formulation, so that the health and health equity impacts of housing affordability proposals are fully considered.[44]

With stable tenure being linked to a reduced exposure to disease, the legal status under which people occupy land and dwellings is critical.[45] The health sector can play a role in the development and application of guidelines for eviction processes.[46] It can also contribute to highlighting and documenting the impacts of forced evictions on vulnerable groups, and developing evidence—such as by utilising health data—to inform programs and policies.[47]

The health sector can also inform urban planning to ensure housing plans have access to economic and social opportunities, with positive impacts on dwellers' health.[48]

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[38] *ibid.*
[39] OECD, Environmental Performance Reviews: Belgium, 2007, p. 206.
[40] *ibid.*
[41] *ibid.*
[42] *ibid.*
[43] World Health Organisation, Social Determinants of Health Sectorial Briefing Series 1, Housing: Shared Interests in Health and Development, 2011, p. 8.
[44] *ibid.*
[45] *ibid.*
[46] *ibid.*
[47] *ibid.*
[48] *ibid.*