Evidence based strategies to enable health promoting housing and communities in the private sector.

Jill Louise Stewart

Degree awarded by the University of Greenwich

Submitted in partial fulfilment of the University's requirements for the award of
Doctor of Philosophy (PhD)
by Published Work

December 2006

ACKNOWLEDGEMENTS

I am grateful to Professors Mark Cross, Annmarie Ruston, David Isaac and Liz Meerabeau for their guidance and support.

ABSTRACT

This work contains 18 publications exploring evidence based strategies to enable health promoting housing and communities in the private sector. It examines housing's contribution to health in the public health agenda; policy priorities and arrangements to deliver healthier housing; partnership working and health outcomes in housing; and measuring evidence of health gain in housing from practitioner interventions and has required a multi-method research programme of theory and practice including case studies, focus groups, comparative studies, telephone and face-to-face interviews/semi-structured discussion in a variety of settings.

The work consolidates housing and public health policies, exploring their wider ideological shaping. It particularly focuses on New Labour policies since the launch of the current public health agenda in delivering new evidence-based interventions. These rely on a new relationship between government (as governance) and communities to deliver health improvement and to address health inequalities through partnership working, although barriers remain. Simultaneously, policy developments in private sector housing renewal have emphasised personal responsibility in the sector, and focus more closely on meeting individual and community need. The current situation can present something of a dilemma between seeing housing as a health determinant or as a commercial asset for both owner-occupiers and private sector landlords.

The work brings together different sets of literature and fields of research which link housing and health in the private sector, and also different elements of policy as part of the government's emphasis on joined up government, finding that although the strategic public health frameworks are in place, there remains pressure for organisations to revert to core activities.

The impact of the work is demonstrated through acceptance in peer reviewed and professional journals as well as reviews, citations and requests for presentations resulting from the published work.

CONTENTS

LIST OF TABLES AND FIGURES

GLOSSARY OF TERMS

CIEH	Chartered Institute of Environmental Health
DCLG	Department for Communities and Local Government (previously ODPM)
DETR	Department of Environment, Transport and the Regions (now part of DCLG)
DoE	Department of Environment (now part of DCLG)
DoH	Department of Health
DTLR	Department of Transport, Local Government and the Regions (now part of DCLG)
DCLG	Department for Communities and Local Government (previously ODPM)
EH	Environmental Health
HDA	Health Development Agency (now under the auspices of NICE)
HEA	Health Education Authority
HNA	Health Needs Assessment
HIA	Health Impact Assessment
HHSRS	Housing Health and Safety Rating System
LA	Local Authority
LDP	Local Delivery Plan
LSP	Local Strategic Partnership
NICE	National Institute for Health and Clinical Excellence (see HDA)
NHS	National Health Service

ODPM	Office of the Deputy Prime Minister
PCT	Primary Care Trust
RRO	Regulatory Reform Order

PART A

EXPOSITION

1) BACKGROUND

2) THE PROGRAMME OF RESEARCH

3) DELIVERING HEALTHY HOUSING IN THE PRIVATE SECTOR

- ***Housing's contribution to health in the public health agenda***
- ***Evidence-based practice in housing and health***
- ***Integrating health and housing policy***
- ***The policy environment for health and housing***
- ***Partnership working in the public health agenda***
- ***The unique challenges of the private housing sector***
- ***'Personal responsibility' and private sector housing conditions***
- ***Partnership agreement on health and housing***
- ***Evidence of health gain arising from private sector housing strategies***

4) CONCLUSION

5) REFERENCES

6) IMPACTS

EVIDENCE BASED STRATEGIES TO ENABLE HEALTH PROMOTING HOUSING AND COMMUNITIES IN THE PRIVATE SECTOR.

1) BACKGROUND

Between 1998 and 2006 I produced 33 papers, two books and a chapter in an encyclopaedia. 12 peer reviewed, 4 non-peer reviewed papers and extracts from both books are included in this submission, representing a coherent body of work of 18 publications exploring evidence based strategies to enable health promoting housing and communities in the private sector.

The body of work examines housing's contribution to health in the public health agenda; policy priorities and arrangements to deliver healthier housing; partnership working and health outcomes in housing; and measuring evidence of 'health gain' (as defined in section 3.2) in housing from practitioner interventions. This has required a multi-method research programme of theory and practice. Empirical work has included several regeneration centred case studies, focus groups and comparative studies, and techniques have included telephone and face-to-face interviews/semi-structured discussion and application of the principles of a Health Impact Assessment methodology. The research programme was also informed by theory from disciplines including policy studies through analysis of historical and contemporary literature reviews in exploring housing renewal and wider regeneration in different political contexts.

This submission focuses around the importance of evidence based interventions in private sector housing that are able to deliver health improvements to residents. In particular, it pivots around the opening paragraph of Stewart and Nunn (1999:216) (Publication 1), which states that:

> *"As anyone dealing with private sector housing renovation will know, finding solutions to suit all interested parties is rarely straightforward. This is particularly true where there is mixed tenure – privately rented and owner-occupied."*

Overall, this body of work is about putting current policy into practice to optimum effect in the particularly challenging private housing sector, which has a multitude of different stakeholders, holding a multitude of objectives and views. It therefore

draws out the relationship between evidence-based policy, how this is implemented, professional roles and multi-agency partnerships involved in seeking to achieve sustainable results in the complex area of private sector housing interventions.

The research sought to consolidate literature in housing and public health policies. It explores public health's wider ideological shaping since the inception of the public health movement. This research particularly focuses on current New Labour policies since the current public health agenda was launched in 1997 to deliver new evidence-based interventions. These rely on a new relationship between government and communities to deliver health improvement and to address health inequalities through partnership working, although barriers remain. Simultaneously, policy developments in private sector housing renewal have emphasised personal responsibility in the sector as well as focusing more closely on meeting individual and community need. The current situation can sometimes present a dilemma between seeing housing as a health determinant or as a commercial asset for both owner-occupiers and private sector landlords.

The work brings together different sets of literature and fields of research which link housing and health in the private sector, and also different elements of policy as part of the government's emphasis on joined up government, finding that although the strategic public health frameworks are in place, there remains pressure for organisations to revert to core activities.

The impact of the work is demonstrated through acceptance in peer reviewed and professional journals as well as reviews, citations and requests for presentations resulting from the published work.

2) THE PROGRAMME OF RESEARCH

Various methods were employed during the research. The relationship between health and housing and the policy context were established through literature reviews and policy analysis in the context of the author's practitioner and academic experience.

Research methods included case studies, including a private sector housing regeneration scheme (Gadebank) (Publication 1) and an analysis of a Fuel Poverty Strategy, applying a Health Impact Assessment (HIA) methodology (Publication 18). The latter sought to assess health gain arising from local housing interventions and barriers to the process, providing recommendations for further integration of health in policy development and implementation as part of an evidence based, partnership approach to improving health and reducing health inequalities.

Focus groups were conducted in the Bellenden Renewal Area, Peckham to engage with communities likely to be affected by (then) forthcoming policy change. This developed a three year relationship with housing practitioners who commissioned research to investigate what low income home owners would find helpful in carrying out maintenance and repairs to their homes as grants were withdrawn as a policy option (Publications 9, 14 and 17).

In order to compare housing and health outside of England's public health agenda, a comparative study was carried in Scotland (Publication 11). Methods for research involved a telephone survey, before undertaking semi-structured discussions/interviews in Edinburgh about the nature of current policy. This offered exploration of regeneration initiatives in different political contexts.

Finally, in order to establish the extent to which the new public health partnerships / practitioners were understanding and agreeing housing as a health determinant, a Chartered Institute of Environmental Health research grant was obtained to explore the issues involved through telephone survey and document analysis (Publication 16).

3) DELIVERING HEALTHY HOUSING IN THE PRIVATE SECTOR

Introduction

The Conservative administration's 'public choice' policy favoured the private

sector as housing provider, challenging the very nature of council housing since its rapid development as part of the Welfare State, which had until then largely received cross party support. However, with ideological distinctions between political parties becoming increasingly blurred, the current Labour administration has maintained an emphasis on the private housing sector and personal responsibility for its condition. Stewart (2005) (Publication 10) demonstrates how public health and housing policies have been ideologically driven in five distinct eras.

Current polices provide a new role for government in the overall organisational and policy framework and emphasise the importance of partnerships with communities and individuals in achieving health improvement (DoH, 1999a; Harrison, 1998; Jones *et al*, 2001). Evidence-based practice, rather than a strict ideology is key, requiring successful joined up government strategies to deliver sustainable health improvement where inequalities are at their most acute. For the purposes of this submission, housing – as an internal and external living environment – needs to be recognised as a fundamental health determinant as part of the public health agenda. Some of the approaches and indeed dilemmas of appropriate interventions to address health inequalities arising in the private housing sector under currently policy arrangements are explored in this submission.

The Labour administration has focused on public health, and has argued for government intervention to address growing health inequalities. This is largely implemented by a new relationship or 'social contract' between the government (national and local), other health agencies, communities and individuals. The White Paper, *'Saving Lives: Our Healthier Nation'*, (Department of Health (DoH), 1999a) introduced many of the organisations, partnerships and foci for public health, with an emphasis on evidence-based practice. It is therefore only relatively recently that government has attempted to realign health and housing policy. However, without a history of health and policy integration, there is a limited evidence base about good practice, and what works in contemporary housing policy to improve health.

Some professional organisations – such as mine, the Chartered Institute of

Environmental Health (CIEH) – have been watching these changes closely. Many practitioners have moved to higher profile public health positions in the NHS, showing the change of emphasis from a reactive medical to a proactive socio-economic model of public health, with a focus on health determinants. The report, *'Environmental Health 2012 - A key partner in delivering the public health agenda'* (Burke *et al*, 2002) showed how environmental health practitioners can increasingly contribute to public health. Particularly it emphasised the need to rigorously assess, correct and regulate the impact of environmental stressors, and their risks, which are presented later in this submission. The CIEH has more recently (2006) called for an evidence base within the profession, referred to later in this submission and in Appendix 2.

Alongside these changes there has been a general return to 'personal responsibility' for housing conditions in the private housing sector, which has distinct funding and regulatory regimes. Owner-occupation now accounts for some 70 per cent of English housing stock, and the private rented sector has also increased, displaying some of the nation's poorest housing conditions and most vulnerable occupiers (Department of Environment, Transport and the Regions (DETR), 2000a; Office of the Deputy Prime Minister (ODPM), 2003a). Practitioners need to increasingly align and consolidate the various positions and tensions in private sector housing interventions to improve health and address health inequalities through their strategic interventions (Stewart 2003; Stewart, Clayton and Ruston, 2006a; Stewart, Ruston and Clayton, 2006). (Publications 8, 14 and 16).

In view of the above, the following overriding themes are explored here:

- Housing's contribution to health in the public health agenda;
- Evidence-based practice in housing and health;
- Integrating health and housing policy;
- The policy environment for health and housing;
- Partnership working in the public health agenda;
- The unique challenges of the private rented housing sector;
- 'Personal responsibility' and private sector housing conditions;
- Partnership agreements on health and housing; and

- Evidence of health gain arising from private sector housing strategies.

3.1 Housing's contribution to health in the public health agenda

Public heath is defined as: 'The science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.'(Acheson, 1988; Wanless, 2004). It is essentially about improving health and addressing health inequalities. The Public Health Green and White Papers (DoH, 1998; DoH, 1999a) raised housing as a social determinant of health, although more recently the public health agenda has tended to shift toward lifestyle issues (DoH, 2004).

Housing is a key health determinant (Dahlgren and Whitehead, 1991; Scott-Samuel *et al*, 2001) and housing can affect health as both an internal and an external living environment (Health Education Authority (HEA), 2000; Krieger and Higgins, 2002; Ormandy, 2004; Thomson *et al*, 2001; Wilkinson, 1999). Housing is important in maintaining and improving public health as well as quality of life and well-being. There has been a growing interest in health and housing locally, nationally and internationally, as for example seen through the 2004 4th Ministerial Conference on Environment and Health in Budapest, and the 2nd World Health Organisation's International Health and Housing Symposium in Vilnius.

The relationships of health and housing are summarised in table 1.

Table 1: Health and Housing: the relationship

Health / safety issue	Comments
Poor domestic conditions	Disrepair, insufficient facilities & sanitation (e.g. external WC) can have detrimental health impact
Home accidents / fire	More accidents (including fatalities) than other environments; closely correlates to housing standards and vulnerability of occupant; fire safety
Tenure / high cost of rent or mortgage / homelessness	Can lead to feelings of insecurity, stress, instability
Asylum seekers / cultural needs	Anomie, alienation
Special needs housing	Suitability of housing for actual / future needs e.g. age, disability, ill health
Temporary accommodation	High numbers in B&B; socio-economic impact, detrimental impact on children's and adult's physical and emotional health

Cold and damp / Fuel poverty	Low income, poor housing, poor heating leading to respiratory disease, accident, discomfort, hypothermia
Indoor air quality / pollutants	Poor quality can cause ill-health or death e.g. carbon monoxide poisoning, radon
Community	Integration with local community; support networks; access to health and welfare services; empowerment
High rise municipal flats	Poor design & architecture; socio-economic exclusion; polarised communities
Emotional health/depression	Poor housing environments (e.g. some temporary accommodation) can exacerbate poor emotional health
Overcrowding	Mainly found in multiply occupied premises (B&B); increases risk of infectious disease e.g. TB; opposite is loneliness and isolation
Noise pollution	Can cause tension, stress
Pest invasion	May result from lack of refuse disposal provision / architecture, rat & cockroach infestations increasingly common

Source: Stewart (2005) (Publication 10)

I have published both books and papers on the relationship of health and housing since 1998. My book, *'Environmental Health and Housing'* (Stewart, 2001) (Publication 4) was the first in the profession to draw together the complexities of the private housing sector and consolidate a range of housing and health literature, with an emphasis on putting theory into practice (see also, Section 5: Impacts). This book also took an early look at urban regeneration funding (see Publication 4: Chapter 5.5, pp. 247-257) suggesting that competition in bidding for funds presented too narrow a focus when seeking to develop sustainable strategies, although it also showed how some local authorities and other organisations were already becoming more creative in the regeneration processes before the public health agenda really took off. My subsequent joint authored book, again the first such book within the profession, *'Environmental Health as Public Health'* (Stewart, Bushell and Habgood, 2005) (Publication 13) developed this theme, with a greater emphasis on evidence based practice. Sections of these books are included as relevant in this submission.

3.2 Evidence-based practice in housing and health

Evidence-based practice is essentially about doing what works best to improve health, a relatively new concept in (socio-economic) public health, and a subject of continued development. Health is largely determined outside the confines of the health services domain (US Office of Disease Prevention and Promotion, 1996) and

it is here that resources could be utilised more cost effectively to prevent ill health in the first place. There is a range of available evidence on causes and prevalence of poor health, there is rather less evidence on the effectiveness of interventions amongst different socio-economic groups and indeed on actual health gain arising and a real need for more information in these areas (Macintyre, 2003).

The concept of health gain was first pioneered by the Welsh Health Planning Forum in 1989 (NHS Wales, last updated 2006). Health gain has however been a difficult term to locate and define in its current application to public health. It is quite a vague concept and the term appears in some literature to be interchangeable with the term 'health improvement'. For the purposes of this submission, health gain is seen as part of health improvement. The health gain resulting refers to identifying the health outcome(s) arising from the *effectiveness of intervention*, rather than defining the health (care) input. The term 'health gain' still appears to be used in Health Impact Assessment (HIA) where it is seen to represent added value in 'non-health' policies (DoH, 1999b; NICE, 2006; see also later sections in this submission on fuel poverty).

Health gain relies setting evidence based targets specific to a particular subject area and recognises the need for partnership based working in achieving health improvements (Gabbay and Stevens, 1994). Health gain is said to be a more specific and quantifiable concept than health improvement and helps establish current health status, needs and outcomes as part of the strategic process (see section 3.8). In order to be fully effective, health gain measures need to be founded on valid evidence and herein lies a problem, as there is still insufficient evidence, although this area is developing and Macintyre (2003) argues for increasing attention to evaluating the impact of a given policy as well as systematic collation and dissemination of best evidence of effectiveness, with reference to addressing health inequalities.

Despite the range of health and housing research evidence available, there is relatively little longitudinal evidence of health *gain* arising from interventions, particularly in the private housing sector. The relationship between housing and

health is complex and difficult to 'measure' by empirical evidence alone. Quantitative data needs to be supported by qualitative data about what is working, how and why. A sound evidence base should be contemporary, valid and reliable and based on a consolidation of sound research and good practice that should help deliver high quality, effective approaches in the longer term. It needs instead to be continually developing and revisable as new data is presented (Trinder, 2000); made readily accessible; and regularly evaluated so that its use is maximised in relevant interventions (Muir Gray, 2000).

The (then) Health Development Agency (HDA) Evidence Base (now under the auspices of the National Institute for Health and Clinical Excellence (NICE)) was the government's new online dataset consolidating the best research and NICE is currently working on a new research based system about how this research can be delivered in practice. The Evidence Base provided an information resource to help develop and disseminate such public health evidence, with a focus on reducing health inequalities. 'Evidence Briefings' establish current levels of evidence, identify gaps and recommend future research needs, with discussions of the implications of this evidence for policy and practice, a key focus of this PhD. One aim of this Evidence Base was that it is widely accessible. (It should be noted that the Evidence Base did not exist at the instigation of this PhD work).

Three of my papers were cited on the HDA Evidence Base (see Appendix 1), one of which is included in this submission (Stewart and Bushell, 2002; Publication 6). The other two are noted in Part C, 'Papers not relied upon for this submission'.

In public health, there have been calls for more evidence-based activities. The Wanless Report (Wanless, 2004) focused attention on how deprived communities might become more 'fully engaged' in their own health; how front line organisations can prioritise interventions and target priority groups; and the necessary evidence to do this better. The (then) HDA collated research around what works to deliver healthier housing and communities, and acknowledged that housing refurbishment is, "likely to have beneficial health outcomes, including improvements in mental health" (HDA, 2004a: 5), a view shared by Acheson

(1998) who argued that it is logical that housing interventions improve health. The Acheson Report also refers to the importance of organisations working with communities reporting that more involvement leads to greater health impact, particularly where specific groups are targeted and organisations are flexible and responsive to local need.

Historically policy and legislation around private sector housing renewal has failed to address many known health issues. The situation started to change around the later 1980s when more emphasis was given to involving affected communities in addressing the socio-economic circumstances surrounding deprived, poor housing areas, and focusing more closely on need through new client centred organisations, such as Home Improvement Agencies. Such changes have a significant impact on the nature of delivery mechanisms (including partnerships) around private sector housing renewal. However, there was no wider political focus on health *per se*, or its measurement, until the public health agenda was formally launched in 1997, which brought with it a new political and policy arena to focus on health inequalities through evidence based practice. For environmental health practitioners, this requires a move away from a traditional rigid, enforcement led approach to ensure that their work addresses health inequalities in areas such as private sector housing (Burke *et al*, 2002).

It can however be difficult to locate valid public health and health promotion research (to inform practice), and much evidence remains unpublished (Howes *et al*, 2004). Indeed, there is very little on the evidence base specifically about private sector housing interventions. Traditionally, research had been published and thereby disseminated on the basis of its academic rigour in scientific journals (assessed through peer review), rather than at the level of successful practitioner implementation (HDA, 2004). The HDA sought to plug this gap and augment widely accessible published evidence with authoritative and realistic practitioner interventions in a cyclical process, with an emphasis on including evidence from experience and local practice. Scrutiny of this site in 2004 however revealed little about the role local authorities could be playing in implementing healthier private sector housing, particularly important at a time of such a fundamental shift toward

'personal responsibility'.

One approach under consideration by the (then) HDA was the proposed 'Learning from Effective Practice Standard System' (LEPSS) (HDA, 2004b), which is currently under development (discussed further in Stewart and Gray, 2005) (Publication 12). LEPSS seeks to capture and share effective practice of successful interventions to improve front line service delivery, based on available academic research to improve health. It is recognised that effective front line activities need targeted community involvement from the outset to help maximise success (HDA, 2004a), synthesising personal choice and social responsibility as aspects of health promotion (World Health Organisation (WHO), 1984; 1986). At the time of writing, LEPSS remains under development, yet it shows the importance of this type of practice-based research in ensuring that health features in relevant policy in the future. This reiterates other research (Lawrence, 2004) that much housing research lacks a broader conceptual framework and rarely addresses practical guidelines or policy issues required for innovative interventions.

In April 2006, *Environmental Health Practitioner* (previously *Environmental Health Journal*, the official magazine of the CIEH) ran a Special Campaign Edition. This called for an evidence base of peer reviewed research, case studies and examples of initiatives which have already attracted research funding to help influence government policy, gain academic credibility and access resources. It has been argued that *Environmental Health* needs to be a field of study in its own right, rather than a Research Assessment Exercise (RAE) 'allied to' subject as it currently is. It also argued that the continuing culture of change required that we demonstrate the positive effects of environmental health (see detail in Appendix 2). Notably, all my papers for this submission were by then published or in the latter stages of the peer review process, and cover the range of evidence types suggested by the CIEH.

3.3 Integrating health and housing policy

Stewart, Bushell and Habgood (2005) (Publication 13: Chapter 6 pp. 164-170) explores some of the challenges involved in dealing with private sector housing and working within the remits of mandatory and discretionary legislation, whilst

simultaneously seeking to work within a public health agenda and improve health. Private sector housing renewal policy is currently the subject of major overhaul to integrate health and housing and it emphasises personal responsibility for conditions in the sector. The range of measures includes the introduction of:

- The Housing Act 2004 which seeks to integrate housing and health policy (ODPM, 2003a); most notably this includes the introduction of the Housing Health and Safety Rating System (HHSRS), providing a completely new evidence based way forward in assessing the impact of housing conditions on the occupier (ODPM, 2004a) as well as wider changes to the private rented sector, such as licencing some private sector landlords (see also Stewart, 2002) (Publication 5);
- The Decent Homes Standard now applies across all housing tenures, although the deadline for private sector housing meeting this standard is unclear (ODPM, 2004b; Stewart, Bushell and Habgood, 2005) (Publication 13);
- The Community Plan ('Sustainable Communities: building for the future') seeks to promote sustainable communities in the longer term (ODPM, 2003c; Stewart, Bushell and Habgood, 2005) (Publication 13);
- Best Value in housing (DETR, 2000b); and
- Regulatory Reform (Housing Assistance) (England and Wales) Order 2002, which subsumed all earlier grant legislation and provides a new power for local authorities to provide 'assistance' in delivering their private sector housing renewal strategies (DTLR, 2002), which is now being implemented to varying degrees (see also Publications 8, 9,14 and 17).

The HHSRS superseded the statutory standard of fitness, and provides a completely new evidence-based approach to assessing housing conditions (ODPM, 2004a). It seeks to rate the effect of a defect on a resident's health and safety and to trigger appropriate enforcement intervention. The HHSRS has been under development for some time and the earlier stages of its evolution, appropriateness and application are discussed in some of my papers (see Stewart, 2002) (Publication 7 specifically, but also earlier in Publications 2, 3 and 4). The HHSRS is now supported by a literature review and analysis of data of the impact of housing conditions on health, and ODPM (2004a) recognises that this evidence base is a continuing process whereby

practitioners are responsible for keeping themselves informed of the latest evidence in its application.

In practice, applying the standard involves identification of 29 hazards, which are assessed and recorded individually. These are in four groups around health requirements, which are subdivided into the following categories:

- Physiological requirements (including hygrothermal conditions and pollutants);
- Psychological requirements (including space, security, light and noise);
- Protection against infection (including hygiene, sanitation and water supply); and
- Protection against accidents (including falls, electric shock, burns and scalds, and building related conditions).

ODPM (2004a) disseminates extensive guidance on each of the hazard profiles, providing information on the hazard description; potential for harm; health effects; causes; preventative measures and the ideal; relevant matters affecting likelihood of harm outcome; and hazard assessment. Overall, this represents a distinct move away from the earlier statutory standard and now provides relevant practitioners with the basis for ensuring that housing interventions are evidence based.

3.4 The policy environment for health and housing

Current policies favour sustainable, evidence based practice over a strict ideology, arguing that this promotes better services (Hudson and Lowe, 2004), responding to an evolving labour market, new family structures and increased consumerism (Page, 2005). There has been an emphasis on involving service users in public services, with a new relationship between state, community and individual, encouraging personal responsibility and more active community involvement (Page, 2005). These changes have been felt throughout new policies in health and housing, posing new challenges for the policy process.

The policy environment comprises a complex mixture of players operating with different interests, values, power levels and professional and personal allegiances at different phases of the policy-making, implementing and evaluation (or accountability) process. Whilst the government sets the overall agenda what is

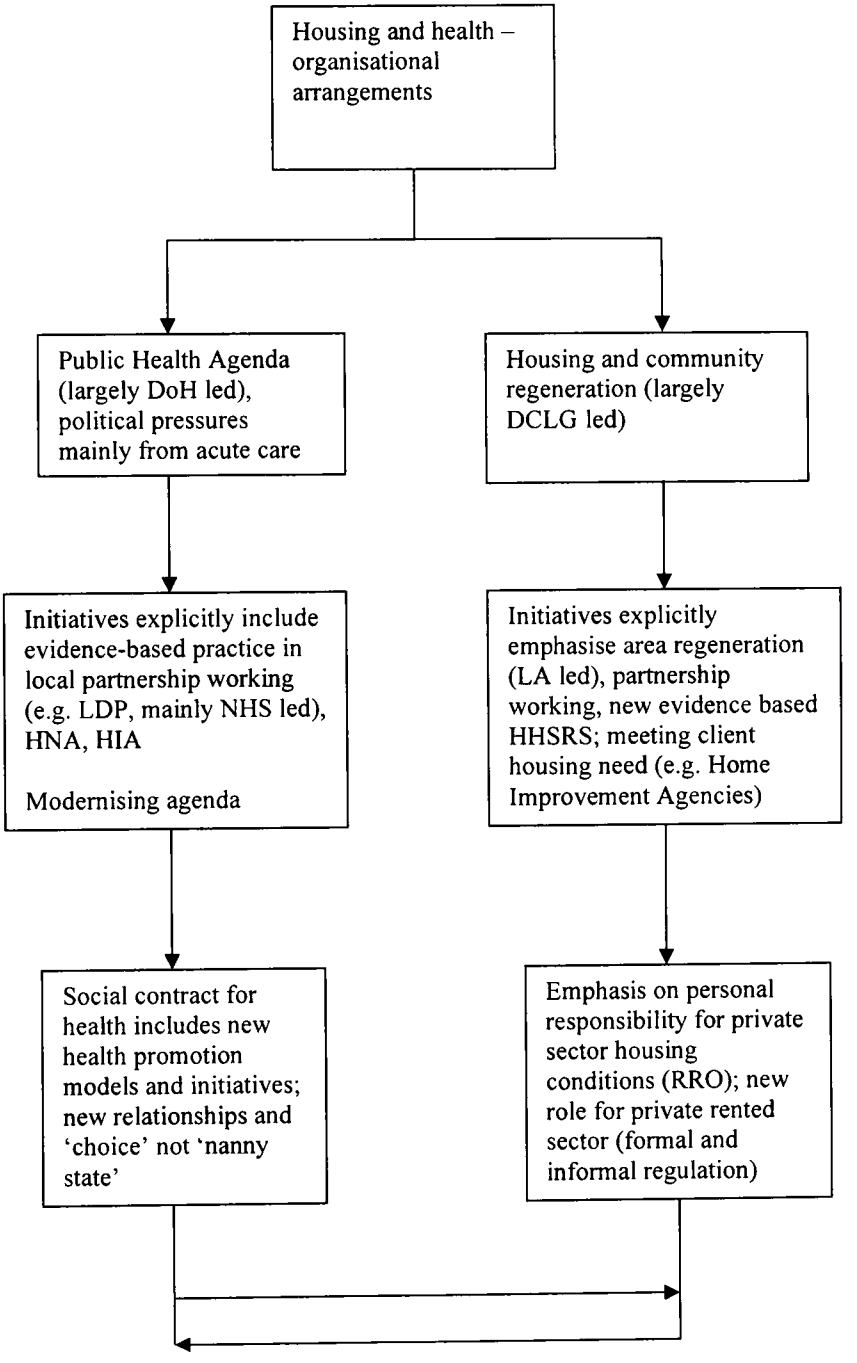
actually delivered may be affected through these stages as policy making is essentially interactive. This is because there are so many different organisations and people involved in the policy process, so the original intention may be diluted by time, bureaucracy, rules and discretion (Baldwin, 1995), professional involvement, affiliation, change and uncertainty (Hill, 1997; Walt, 1994).

There has been a theoretical emphasis on local strategy with devolved decision making based on local evidence, which has given rise to some tensions across partner organisations and implementation has been affected by lack of resources, with managers balancing rules and discretion within budgets (Hill, 1997). Although Primary Care Trusts (PCT) carry overall control for health improvement, they are not responsible for local authority budgets. Indeed, Hill (1997) argues that health is largely defined by the medical profession and the dominance of acute care, ironic when most health is determined by socio economic factors (see Stewart, Bushell and Habgood, 2005) (Publication 13). Ideally formative and summative evaluation should be fed directly back into the policy making process, but Walt (1994) questions how and which knowledge finds its way into policy, a theme of my research. Sustainable outcomes and effects of health improvement policy may take years to identify and regular organisational change continues to interrupt this process. As Hogwood and Gunn (1984) argue, policy-making processes rely on thorough analysis early on, and politicians can frequently expect too much too soon, with a risk of insufficient resource, time and confounding factors distorting the policy process.

Policy-making is still in progress when it is delivered (Hudson and Lowe, 2004) and the implementation phase is complex and interactive (Walt, 1994), with implementers themselves active in the process of change and innovation. At the sharp end of policy delivery, 'street level bureaucrats' (Lipsky, 1980) can carry enormous power and are often forced to deliver policy using their discretion, with dilemmas arising from many and varied constraints (organisational, resource). There is potential for enormous variation with discretionary services, whose success is frequently dependent on motivated individuals within supportive environments.

The organisational arrangements for housing and health interventions are split across two government departments, the Department of Health (DoH) and the Department for Communities and Local Government (DCLG) (created on 5 May 2006). This creates some dilemmas in delivery in integrating health and private sector housing policies (see figure 1), creating a potential tension between medical versus socio-economic public health. Some of these tensions and dilemmas are felt across many of the papers presented in this work, and are raised as appropriate in the course of this submission.

Figure 1: Housing and health – organisational arrangements [1]



[1] See Glossary of Terms (*vii-viii*) for abbreviations

3.5 Partnership working in the public health agenda

The government sees partnership working as pivotal to the public health agenda in bringing together a range of interests, strategic interventions and resources in tackling health inequalities where they are at their most acute. The NHS leads these new partnerships, not local authorities or other health agencies (see table 2). This is ironic, since the NHS does not have the remit to tackle wider social determinants of health (including housing, local environments and community networks) in the way that local authorities, and some other health agencies, do (Stewart, Bushell and Habgood, 2005) (Publication 13). Partnerships occur within and between organisations, but also involve communities to deliver new client centred, focused services that meet a given community's need (Stewart and Bushell, 2002) (Publication 6).

Table 2: Current strategies to address health (and housing) inequality

Strategy	Lead	Strategic purpose
Local Delivery Plan	PCT	Emphasis on health inequality to tackle poverty, poor housing, pollution, low educational standards, joblessness & low pay
Healthy Living Centre	Joint	Focus on deprived & rural areas, raising awareness on diet, smoking, drink, drugs & activity
Health Action Zone	Joint	Priority areas of need; local integrated agreed strategy to sustainably improve health (now disbanded)
Local Strategic Partnership	Joint	Cross sector initiatives & services to support & work together; non statutory, non executive organisation; operates closely with individual neighbourhoods - community based decisions, aligned with LA boundaries, clear vision, objectives & commitment to partnerships - seen as pivotal to joined-up approach to tackle key local priority areas e.g. crime, jobs, health & housing
Community Strategy	LA	To sustainably promote socio-economic & environmental well-being, partnerships to meet community need; enhance quality of life; long-term vision focusing on outcomes, addressing national & global concerns through local action, needs assessed priorities subject to resources
Public Service Agreement	LA	LAs commit to delivering key national & local priorities in return for operational flexibilities & finance; focus on exclusion & targets include education, housing & employment & reducing crime & health inequalities, partnerships, linked to Best Value
Best Value	LA	Service reviews examine extent of existing services meeting community priorities cutting across traditional service boundaries and revisit providers across a wide range of service delivery

Source: Stewart and Rhoden (2006) (Publication 15).

Stewart, Bushell and Habgood (2005) (Publication 13: Chapter 3, pp. 74-81) explore partnership working in relation to public health, but also question how successful partnerships can be expected to be with barriers such as differing performance regimes both within and between organisations. Some of the main dilemmas arise from issues such as different organisations being pulled in different directions to meet mandatory requirements and discretionary interventions. Even within one organisation, balancing mandatory duties, such as the duty to act in respect of substandard private sector housing, would take precedence over a discretionary power such as a fuel poverty strategy[2], which may in fact have a greater health impact. Between organisations, different reporting regimes for local authorities and Primary Care Trusts can again create tensions even though they share partnership working for health improvement. Other problems have included regular reorganisation of the public health function, and that many public health initiatives, such as fuel poverty strategies, continue to be short term and not sustainable, championed by individuals, lacking statutory status and sufficient funding (Wanless, 2004).

My work has focused several times on fuel poverty strategies, a good example of a public health intervention in housing which features partnership working and one which illustrates some of the difficulties in putting policy into practice. The links between fuel poverty and health are well documented, yet strategies remain discretionary and there are no statutory reporting requirements relating to the health gain arising from them. Stewart (2001) (Publication 4: Chapters 2.1 and 2.2) emphasised some of the challenges for environmental health practitioners working in reactive and sometimes inadequate legislation in attempt to address issues such as fuel poverty at policy implementation level. Stewart, Bushell and Habgood (2005) (Publication 13: Chapter 5, pp. 143-154) developed the fuel poverty theme, and in particular raised some of the difficulties in addressing the private housing sector where fuel poverty is at its most acute, as the sector is disparate and 'hard to reach'.

[2] *Fuel poverty arises where households are not able to afford sufficient heating due to a combination of low income, poor heating and inadequate thermal insulation.*

3.6 The unique challenges of the private rented housing sector

The private rented sector is unique and the English House Condition Survey (ODPM, 2003a) reported that it contains the poorest conditions and some of the most vulnerable occupiers. Environmental health practitioners face daily challenges of addressing conditions, whilst also working with landlords and tenants in attempt to balance enforcement and other intervention activities. This is perhaps where some of the dilemmas and anomalies current stated policy objectives are most keenly felt, as local authorities seek to secure and encourage better conditions for tenants (particularly at the bottom end of the private rented housing sector, where there is often no alternative social housing option/choice), through initiatives such as Landlord Accreditation Schemes, as explored in Stewart (2002) (Publication 5).

Several of the papers included are concerned with wider challenges of private sector housing interventions. Stewart (1999) (Publication 2) considered the role of the (then) environmental health officer, flagging up the poor conditions in the private housing sector, raising the question of (then) reactive legislation and arguing for wider changes to address poor private sector housing, including new legislation and learning from wider regeneration schemes in social housing. Stewart (2001) (Publication 3) was again concerned with reactive, insufficient legislation in the area of home safety, developing arguments for new national standards. Some of these points are consolidated in Stewart (2002) (Publication 7), which present an early discussion and analysis of proposed legislative changes to integrate health, housing and safety, and these are addressed more fully elsewhere in this submission.

Stewart and Nunn (1999) (Publication 1) discussed some of the complexities involved in private sector housing renewal due to the multiple stakeholders involved, who may have different agendas and priorities. For example, owner occupiers may wish to have works carried out that may or may not fall under statutory requirements or grant assistance regimes; landlords may seek to raise the capital value of their property through maximising grant investment; and tenants may wish to have minimum works carried out for fear of resulting rental increase they may struggle to afford. It discusses conditions in mixed tenure areas of owner-

occupied and privately rented housing and the need to balance issues around discretionary and mandatory interventions, whilst overall seeking healthier housing for residents.

The public health agenda is fundamentally about addressing inequalities, most keenly felt by some of the most vulnerable in society. Again, some of the discrepancies and dilemmas of implementing current policy objectives are felt as homeless households with children find it difficult to access decent housing, the backbone of accessing a healthier lifestyle. Stewart, Bushell and Habgood (2005) (Publication 13: Chapter 5, pp. 135-143) considers issues around (private sector) temporary accommodation and the lack of joined up working due to insufficient suitable, secure, affordable housing provision elsewhere. It also raised the question of emotional ill health, a major concern of poor housing, but frequently not addressed in strategy. This part chapter explores emotional health for residents, including children, in temporary accommodation. Many low-income families continue to be housed in such unsatisfactory accommodation, illustrating the disjoined policy about meeting immediate housing need, but failing to address parallel public health needs, particularly for children already faced with major social inequality. It also raises the cyclical possibilities of ill health, poor internal and external living environments and how residents might fall between safety nets in established welfare regimes. Stewart and Rhoden (2006) (Publication 15) takes the issue of children, housing and health forward, considering private sector temporary accommodation (and social housing) and some of the strategies now starting to focus particularly around children.

3.7 'Personal responsibility' and private sector housing conditions

The Conservative administration explicitly referred to housing as a 'private asset' (as opposed to a health enabling environment) in 1996 (DoE, 1996). The (Labour) Housing Green Paper (DETR, 2000a) carried forward this position, arguing that homeowners should carry primary responsibility for stock condition. This requires new relationships at the local authority / client interface, with local authorities having an increasingly enabling, rather than providing role (see also DETR, 1998; 2001).

An emphasis on 'personal responsibility' is now inherent in private sector housing policy as the government has shifted from service provider to enabler. In private sector housing renewal, this translates as a move away from interventionist housing grants, to home-owners themselves having to access and manage other forms of financial assistance. 'Personal responsibility' is invariably limited by age, health and available funds for home maintenance and repair. In addition, the move away from grant assistance also suggests a move away from local authority strategic control over housing condition, and therefore associated health status, as a local authority's strategic housing objectives will not necessarily go hand in hand with what an owner may choose to spend any of their income on.

The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) (DTLR, 2002) subsumed earlier private sector grant legislation and provided local authorities with a new power for 'assistance', with new responsibilities for individuals and communities. The RRO is pivotal to the new approach to personal responsibility, bringing substantial change to local authority housing renewal strategies, although there has been very little research into the practicalities of how the RRO might be implemented, and with what possible success. The RRO has required local authorities to develop new approaches to private sector housing renewal.

The RRO essentially requires that largely market-led solutions are absorbed into helping to address housing as a social health determinant. Bearing in mind that most poor housing is occupied by lower income households (particularly ethnic minority and lone parents) (ODPM, 2003b), government preferred options include targeting grants more effectively and encouraging home improvement loans and equity release schemes (DETR 1998). Many low income households are not in a position to afford necessary maintenance and repairs to their homes, and are normally those with the greatest housing-related health risks with least (financial) ability to do much about it.

Housing grants had existed for decades, providing local authorities (and more

recently other organisations such as Home Improvement Agencies) with a major interventionist tool to help fund private sector housing renewal. Even where grants existed, it was sometimes difficult to encourage and ensure relevant works in this sector (Stewart, 1999; Stewart and Nunn, 1999) (Publications 2 and 1). This said, there remains insufficient self initiated and funded maintenance, repair and renewal, possibly brought about to some extent by a culture of dependency on grants (DETR, 2001; Mackintosh and Leather, 1992).

Traditionally, outcome measures for grants have been quantitative (e.g. number of houses passing the fitness standard on grounds of repair, provision of internal WC) and not about health gain arising. Grants were historically provided only for issues of unfitness and disrepair, but have more recently implicitly become about needs based issues (such as suitability of housing for an older person enabled by a smaller scale grant). There is now an emphasis on evaluating health gain from interventions, and there is a risk that this will be complicated as grants are withdrawn further and the market sector – which has no health outcome incentive for housing conditions – takes priority. This is ironic at a time when the public health agenda is seeking cost effective interventions into health improvement and tackling health inequalities (Wanless, 2004) and there is currently no evidence to show how the RRO might assist in meeting this objective (Stewart, Clayton and Ruston, 2006a) (Publication 14).

Consolidating an ongoing relationship with officers in a South London local authority, colleagues and I secured funded research to explore what low income owner occupiers in an ethnically diverse area would find useful in helping them to maintain and repair their own homes. Our study revealed that some of the wider policy options put forward by the government were not always what respondents favoured; that many would do further maintenance and repairs given the right support opportunities; and that there needs to be something of a revival of social capital if neighbours are to increasingly help one another and keep costs to a minimum (Stewart, Clayton and Ruston, 2004; Stewart, Clayton and Ruston, 2006b) (Publications 9 and 17). The research found that home-owners were faced with barriers, but also facilitating factors that would assist and enable them to

maintain and repair their homes. It was not just a case of having money, but assistance with technical, organisational and other issues, where local authorities can also play a role in the overall condition of the nation's housing stock. In this study, owners seemed to favour options giving them maximum scope to keep a sense of control over their own houses, and favoured looking for cost effective solutions. This ties in with a more individualistic approach to home ownership, with personal responsibility for condition, yet it is low income households who are particularly vulnerable to poor housing conditions, with perhaps less ability to be able to access some of the resource options now on offer (see Stewart, Clayton and Ruston, 2004; Stewart, Clayton and Ruston, 2006a; Stewart, Clayton and Ruston, 2006b) (Publications 9, 14 and 17).

The situation is different in Scotland where the approach tends to mobilise around property management and maintenance, rather than wider area based interventions addressing socio-economic regeneration as in England and Wales. With much housing stock in Edinburgh being tenements, the City Council has been able to pioneer a successful, cost effective strategy to promote maintenance with minimal public sector cost. Like England and Wales, the emphasis is personal responsibility and continual withdrawal from the sector. The Scottish public health function is distinct, and at the time this work was carried out, appeared quite separate from housing interventions with no emphasis on measuring health gain arising (Stewart, 2005) (Publication 11), although this is slowly finding a place in some areas.

3.8 Partnership agreements on health and housing

Any strategic approach should start with four considerations:

- Current status of local housing condition and health;
- Aspirational status of housing condition and health;
- Means of reaching aspirational level; and
- Means of accounting for and evaluating success.

As partnerships are now pivotal, it follows that these partnerships must reach joint agreement on the above to move forward in viable ways.

The public health agenda has renewed emphasis on strategic mechanisms to

encourage the players to fully participate in health improvement and to address health inequalities at their most acute. Stewart and Bushell (2002) (Publication 6) were the amongst the first in the profession to publish around Health Needs Assessment (HNA), a policy tool enabling partnerships to jointly focus on community health needs and assets, enabling gaps in services to be identified so that appropriate services can be developed and implemented. The community may comprise a geographical area (e.g. a Renewal Area), or a more dispersed social community (e.g. children in temporary accommodation or a sub-group such as a specified ethnic group of asylum seekers). In contrast to HNA, Health Impact Assessment (HIA) is about measuring health gain deriving from a policy or process, with an emphasis on maximising positive, and minimising negative health gain. Whilst HNA and HIA should provide an impetus pivot for health focused partnership working, neither is a statutory requirement so it can be difficult to sustain support for them, and the extent to which they are routinely applied is unclear.

My (joint) research – applying the principles of a HIA to a local fuel poverty strategy – has demonstrated some of the challenges involved at delivery level and the difficulties in measuring health gain from interventions, even where a strategy has received national recognition (Stewart and Habgood, in press) (Publication 18). This generally reinforces the position that although there is a partnership in place, and interventions are being delivered, there is not a focus on health gain *per se*, and the partners involved are currently not able to qualify their strategy in terms of health gain locally, mainly due to different performance monitoring criteria. In addition, the research reiterated some of Wanless's concerns that it can be difficult to sustain support for non-statutory strategies, and it is largely down to individuals in organisations to champion such processes, even though they are key to addressing key health inequalities.

If routinely applied at each stage of the policy process, HNA and HIA could provide a useful basis to consolidate and promote partnership working so that joint decisions could be made in the context of the public health agenda. This would encourage discussion and agreement of local population health and health

inequalities across the various partners involved before proceeding to the policy implementation and evaluation stages. This would help enable appropriate and valid health gain performance indicators to be jointly developed and established, suited to existing and proposed public health monitoring regimes over a realistic timescale.

However, there remain barriers in place at all levels of the strategic process. Private sector housing renewal is primarily delivered by environmental health practitioners, relying on wider partnerships for shared agreement and support on key objectives, funding (and other resources) as well as agreed outcomes. There may be tensions between the different partner organisations charged with delivering public health. However, a main benefit of the modern public health agenda is that it allows multiple strategies to be applied (Krieger and Higgins, 2002). This is important in meeting local need in ways that work. Adopting various approaches can maximise the contribution of housing to health and well-being by continuing to challenge barriers.

Recent research suggests that although public health partnership frameworks are now well established, there remain concerns over the extent to which they are aligning and sharing values, focus, vision, direction and objectives (Hunter and Sengupta, 2004; Wills and Woodhead, 2004). There also appears to be some uncertainty about public health roles (Evans, 2004). A 'fully engaged' public health scenario is not yet happening (HM Treasury and DoH, 2002), and much further work is still needed (DoH, 2001 and 2003). My (joint) research – investigating how partnerships see housing as a health determinant – adds weight to the argument that views and interventions are very fragmented, with little reliance on an evidence base (Stewart, Ruston and Clayton, 2006) (Publication 16).

Several recent government reports, including the recent White Paper (DoH, 2004) have referred to the need for further partnership working to improve health and address health inequalities (DoH, 2003). Remits include overcoming barriers and helping to ensure relevant measures are put in place to tackle social and geographical health inequalities. The *'Wanless Report'* (Wanless, 2004) raised concern around the plethora of public health information, but the lack of sustainable

solutions and the lack of evidence of their effectiveness. He reported a general paucity of funding for public health research and gaps in knowledge around the cost-effectiveness of policies, which lacked clear objectives and quantifiable outcomes. Wanless's concerns are similar to those barriers identified by Burke *et al* (2002) which relate specifically to environmental health, including a continued focus on health care rather than health, narrow use of targeting and a lack of appropriate evidence basis for interventions.

3.9 Evidence of health gain arising from private sector housing strategies

Public health is now about identified governmental programmes, policies and resources that will have the greatest impact on health improvement and inequalities in health. *'Environmental Health 2012 - A key partner in delivering the public health agenda'* (Burke *et al*, 2002), showed how environmental health practitioners can increasingly contribute to public health, notably through private sector housing interventions. Particularly it emphasised the need to rigorously assess, correct and regulate environmental stressors. These 'environmental stressors' may be biological, chemical, physical, social and/or psychosocial, and appropriate and effective interventions are needed to maximise health outcome. Many of these stressors were identified above.

Having research-based evidence of the health/housing relationship is one thing; dealing with improvements as a front line practitioner is another. Barriers can include inappropriate policy, strategy, legislative frameworks, partnership working and so on. The problem is that there is a great amount of evidence about the relationship of housing to both physical and mental health, but impacts on health are complex and adaptive so direct evidence of effects on health are limited (Cave, 2004; HEA, 2000; Lawrence, 2004; Thomson *et al*, 2002; Wilkinson, 1999). Evidence of the health effects of interventions, including health gain, is lacking and a more holistic approach is necessary to respond to the complex issues in housing, health and deprivation (Thomson *et al*, 2001). There is a need for flexible, innovative interventions as occupiers age, change health status, their housing conditions alter and they have differing needs during the course of their lifetime (Lawrence, 2004). Current policy changes in private sector housing renewal and

public health however offer potential to meet some of these challenges, with new roles and relationships for both local authorities and their communities (Burke *et al*, 2002), within the challenges of a private sector housing market.

Appropriate housing interventions can help to reduce negative health impacts and thereby address health inequalities. However, it is difficult to accurately assess the impact of housing conditions on health, as health can result from wider socio-economic circumstance (HEA, 2000; Lawrence, 2004; Thomson *et al*, 2001; Wilkinson, 1999). Despite this, there is agreement that housing is important in maintaining and improving public health as well as quality of life and well-being (HEA, 2000; Stewart, 1999; Stewart 2001; Stewart, 2005) (Publications 2, 4 and 10). Despite this, even where health gain is implicit, it is not always possible to quantify health gain explicitly, often due to different performance monitoring regimes across partnerships, as seen through my (joint) research on fuel poverty (Stewart and Habgood, in press) (Publication 18).

Two of my joint papers in particular research this theme. Stewart, Ruston and Clayton (2006) (Publication 16) sought to explore the extent to which housing was seen as a health determinant, surely key to jointly deciding where to develop and prioritise (health improvement) interventions across partnerships. Whilst the concept of 'partnerships' as a tool to bring joint solutions has become paramount to the public health agenda, there are clearly barriers in the way. The research showed inconsistencies in how private sector housing is seen as a health determinant, how evidence is used and that it will be some time before those involved will be able to influence the public health agenda effectively.

The second paper, Stewart and Habgood (in press) (Publication 18) explored the current feasibility of assessing health gain arising from a fuel poverty strategy. The research was based around an award winning successful partnership based fuel poverty strategy, which does not currently explicitly measure health gain arising. We applied the principles of a Health Impact Assessment to a local strategy and sought to identify health gain but found that no relevant data was available, partly because there are currently no requirements to report in this area. This illustrates

some of the barriers in partnership working (i.e. joint reporting), even where the partnership itself is otherwise operating well. The government is promoting HIA as an important public health tool, yet the extent to which it is being applied is unclear.

Themes from both papers also illustrate some wider issues in organisation and policy delivery. For example, neither partnerships (at organisational level) nor fuel poverty strategies (at implementation level) are mandatory, and therefore they vary in success locally. Their success or failure is too frequently down to supported, committed individuals in and across organisations, and this situation does not appear sustainable. Successful partnerships take a long time to build and constant organisational and policy change has not been helpful in delivering public health, particularly in areas around housing where health outcomes may take many years of interventions to record positive change. These issues reiterate some of the theories of policy process identified above.

It is ironic that at a time when public health has been high profile in the policy arena, there appear to be discrepancies at local level about what it means in its application to housing interventions. Housing is a key health determinant, yet there is a lack of public health performance indicators, leaving many partnerships unaware of what they might be doing in housing, and why. Additionally, whilst there is some evidence around health and housing interventions, there remains some way to go, and this may not have facilitated partnership interventions in housing. The continued development of appropriately disseminated evidence should assist this process, and help ensure that housing interventions gain further support and resource in the future.

4) CONCLUSION

In the mid-Victorian era, housing was seen as crucial to public health but more recently there has been an emphasis on individual lifestyle in determining health. However many in housing see it as a – if not the – key social health determinant and there is agreement that housing is important in maintaining and improving public health as well as quality of life and well-being. Whilst there is much housing and health research, there is insufficient longitudinal evidence of the relationship and

housing research needs to be seen more comprehensively in its wider context of poverty and deprivation, which are difficult to tease out by empirical evidence. In addition, much of the published literature to date is based on academic rigour, rather than practitioner intervention success, and the latter was a key theme of the research. There remains a notable absence of evidence based practice, although this area is developing.

Housing has therefore had a varied contribution to the public health agenda since its inception, and its position and status here continue to change. The public health agenda – which is primarily situated in the Department of Health – still appears to continue to place an emphasis on medical public health, rather than using a socio-economic model favoured by others involved in health improvement and addressing health inequalities. Indeed, housing policy is under the remit of the Department for Communities and Local Government, and while many themes and objectives are similar, notably community involvement, meeting need and socio-economic regeneration, the agendas appear to fall under different policy banners.

Policy priorities and arrangements to deliver healthier housing have seen a theoretical shift toward new evidence-based policies and strategies at the same time as the government has withdrawn funding in the sector, emphasising the role of personal responsibility in private sector housing renewal. There has been an emphasis on HNA and HIA, although neither remains a statutory requirement and application appears *ad hoc*, and with insufficient guidance or methodology recommendation on what would be helpful in practice.

There has been a political emphasis on expanding the private housing sector, both as owner occupation and private rented accommodation. Low income, lone parent and ethnic minority households occupy the poorest housing and suffer greatest health inequalities in this sector, yet are frequently least well placed to access necessary services and strategies. Dealing with private sector housing is also complicated because there are so many agendas in place. The ethos of owner occupation and 'personal responsibility' does not always knit closely with what government policy is saying in the public health domain and there may be

organisational and individual tensions between the partnership organisations involved.

There is something of a dilemma at the heart of policy, as to whether private sector housing is seen as a personal commercial asset or social determinant of health. This presents a disjointed message, and can complicate health-focused interventions. In this respect, such interventions may not be priority for home owners or landlords. Loss of traditional interventionist grants also heralds a reduction in 'control' by local authorities in what they can require in housing. Whilst local authorities may wish to objectively assess, correct and prevent the impact of housing stressors, home owners may take a more subjective view, based on personal choice, with or without appropriate guidance from the local authority. Local authorities need to develop strategies that respond to a growing number of home owners and private sector landlords and tenants, and a need to repair and maintain existing stock now and in the future in ways that are appropriate, tailored, enabling and sensitive and can meet wider public health objectives of addressing health inequalities where they are most acute.

One benefit of the modern public health agenda is that it allows multiple strategies to be applied and essentially bring an end to silo working. This is important in areas like housing regeneration where wide indicators of health outcome (such as reduced levels of deprivation, social inclusion and neighbourliness), are relevant. However, whilst partnership working is well established organisationally and strategically, many barriers remain. There are differences in agreement on how housing affects health, and indeed very little joint data on existing health status and proposed health gain arising from strategy. Again, HNA and HIA could be used to enhance partnership working in this respect, yet are infrequently applied and it is therefore difficult to measure realistic health outcomes arising from new interventions, also complicated by barriers in partnership working (particularly professional status) and differing performance management regimes across the various partners involved.

Measuring evidence of health gain in housing from practitioner interventions remains challenging and again is carried out on an *ad hoc* basis, too frequently

championed by individuals in organisations, rather than representing a sustainable way forward in improving health and addressing inequalities through targeted and appropriate interventions that really meet need. There are many examples of good practice, and health gain is implicit, but there needs to be more cost-effective, evidence-based verification if resource is to be proactively targeted to the point at which health is determined, not where medical health *care* is delivered.

Ensuring the delivery of healthier housing is complicated by a range of socio-economic and political issues, such as a return to personal responsibility and the dilemma of housing as a health determinant or a commercial asset, which has substantial implications for future housing regeneration policy. The relationship of health and housing is complex and a variety of strategic approaches are necessary. New approaches need to be able to identify evidence-based health need and maximise health gain, but also need to be able to respond to the nature and context of private sector, and the extent to which individuals, communities and the government can form new relationships to improve health through housing in sustainable ways.

My work has brought together different sets of literature and fields of research which link housing and health in the private sector, and also different elements of policy with government emphasis on joined up government, finding that although the strategic public health frameworks are in place, there remains pressure for organisations to revert to core activities. Key recommendations arising are therefore as follows:

- The continued development of an easily accessible housing and health evidence base, with particular reference to the unique nature of the private sector housing sector;
- Wider dissemination of this evidence and new accountability and evaluation mechanisms around the area of health gain, health improvement and health outcomes;
- That health is increasingly considered at all stages of the policy process and that mechanisms such as HNA and HIA become inherent parts of the policy process; and

- That key housing and health strategies such as fuel poverty strategies are promoted to mandatory status with sufficient funding.

5) REFERENCES

Acheson, D. (1988) *Public Health in England: Report of the committee of inquiry into the future of the public health function.* London: HMSO.

Acheson, D. (1998) *Independent Inquiry into Inequalities in Health.* London: HMSO.

Baldwin, R. (1995) 'Rules, discretion, and legitimacy' (pp. 364-368), in M. Hill (ed) (1997) *The Policy Process: A reader*, London: Prentice Hall Harvester Wheatsheaf.

Beattie, A. (1982) cited in Beattie, A. (1991) 'Knowledge and control in health promotion: a test case for social policy and social theory', in J. Gabe, M. Calnan and M. Bury (eds). *The sociology of the health service.* London: Routledge.

Burke, S., Gray, I., Paterson, K., and Meyrick, J. (2002) *Environmental Health 2012: A key partner in delivering the public health agenda.* London: Health Development Agency.

Cave, B., Molyneux, P., and Coutts, A. (2004) *Healthy sustainable communities: What works?* Milton Keynes and South Midlands Health and Social Care Group.

Dahlgren, G. and Whitehead, M. (1991) *Policies and Strategies to Promote Social Equity in Health.* Stockholm: Institute for Futures Studies.

Department of the Environment (DoE). (1996) *DoE Circular 17/96: Private Sector Renewal: A Strategic Approach.* London: HMSO.

Department of the Environment, Transport and the Regions (DETR). (1998) *Housing Research Summary Encouraging Home Owners to Repair and Maintain their Homes: A Review of Initiatives (no. 92, 1998).* London: HMSO. Online. Available HTTP: http://www.housing.dtlr.gov.uk/hrs/hrs092.htm (12 April 2000).

Department of the Environment, Transport and the Regions (DETR) (2000a) *The Housing Green Paper: Quality and Choice: A Decent Home for All.* London: HMSO.

Department of the Environment, Transport and the Regions (DETR). (2000b) *Best Value in Housing Framework.* London: DETR. Online. Available HTTP: http://www.housing.dtlr.gov.uk/information/bvhf/4.htm (3 April 2002).

Department of the Environment, Transport and the Regions (DETR). (2001) *Private Sector Housing Renewal: Reform of the Housing Grants, Construction and Regeneration Act 1997, Local Government and Housing Act 1989 and Housing Act 1985: A Consultation Paper.* London: DETR. Online. Available HTTP: http://www.housing.dtlr.gov.uk/information/consult/pshr/pdf/consult.pdf (12 February 2002).

Department of Health (DoH). (1998) *Green Paper: Our Healthier Nation: A Contract for Health.* London: HMSO.

Department of Health (DoH). (1999a) *White Paper: Saving Lives: Our Healthier Nation.* London: HMSO.

Department of Health (DoH). (1999b) *Health Impact Assessment: Report of a Methodological Seminar,* London: DoH

Department of Health (DoH). (2001) *Strengthening Public Health. Chief Medical Officer's Report.* London: HMSO.

Department of Health (DoH). (2003) *Tackling Health Inequalities: A Programme*

for Action. London. HMSO.

Department of Health (DoH). (2004) *White Paper: Choosing Health? Making healthier choices easier*. London: Department of Health Publications.

Department of Transport, Local Government and the Regions (DTLR). (2002). *Statutory Instrument 2002 No. 1860: The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002*. London: HMSO. Online. Available HTTP: http://www.hmso.gov.uk/si/si2002/20021860.htm (1 October 2002).

Evans, D. (2004) Shifting the balance of power?: UK public health policy and capacity building, *Critical Public Health* 14 (1), pp. 63-75.

Gabbay, J. and Stevens, A. (1994) (Editorial) Towards investing in health gain, *British Medical Journal*, 308 (1117-1118). Online. Available HPPT: http://www.bmj.com/cgi/content/full/308/6937/1117 (17 November 2006).

Harrison, D. (1998) 'Integrating health sector action on the social and economic determinants of health: The UK response under New Labour', *Review of Health Promotion and Education.* Online: Verona Initiative, 1998 URL: http://www.rhpeop.org/ijhp-articles/e-proceedings-verona/1/index.htm (8 October 2003).

Health Development Agency (I). (2004a) *The evidence of effectiveness of public health interventions – and the implications: I Briefing No. 1, June 2004*. London: Health Development Agency.

Health Development Agency (1). (2004b) *The Learning from Effective Practice Standard System (LEPSS): Outline Programme 2004-2007*. London: Health Development Agency.

Health Education Authority (HEA). (2000) *Health Update, Environment and health: housing*. London: Health Education Authority.

Hill, M. (1997) *The Policy Process in the Modern State (3rd edition),* London: Prentice Hall Harvester Wheatsheaf.

HM Treasury and Department of Health (DoH). (2002) *Tackling Health Inequalities: Summary of the 2002 Cross Cutting Review.* London: Department of Health.

Hogwood, B. and Gunn, L. (1984) 'Why perfect implementation is unattainable' (pp. 217-225), in M. Hill (ed) (1997) *The Policy Process: A reader*, London: Prentice Hall Harvester Wheatsheaf.

Howes, F., Doyle, J., Jackson, N., and Waters, E. (2004) Evidence-based public health: the importance of finding 'difficult to locate' public health and health promotion intervention studies for systematic reviews, *Journal of Public Health*, 26 (10): pp.101-104.

Hudson, J. and Lowe, S. (2004) *Understanding the Policy Process: Analysing welfare policy and practice*, Bristol: The Policy Press.

Hunter, D. J. and Sengupta, S. (2004) Editorial: Building multidisciplinary public health, *Critical Public Health*, 14 (1) pp. 1-5.

Jones, B., Kavanagh. D., Moran, M., and Norton, P. (2001) *Politics UK.* Essex: Pearson Education Limited.

Krieger, J. and Higgins, D. (2002) Public Health Matters: Housing and Health: time again for public health action, *American Journal of Public Health*, 92 (5): 758-768.

Lawrence, R. J. (2004) Editorial Introduction: Housing, Health and Well-Being: Moving Forward, *Reviews on Environmental Health*, (Freund Publishing House Ltd) 19 (3-4): 161-176.

Lipsky, M. (1980) 'Street-level bureaucracy: An introduction' (pp. 389-392), in M Hill (ed) (1997) *The Policy Process: A reader*, London: Prentice Hall Harvester Wheatsheaf.

Macintyre, S. (2003) Evidence based policy making: Impact on health inequalities still needs to be assessed, *British Medical Journal*, 326 (7379) pp. 5–6. Online. Available HPPT: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1124938 (17 November 2006).

Mackintosh, S. and Leather, P. (eds.) (1992) *Home Improvement under the New Regime. Occasional Paper 38.* Bristol: School of Advanced Urban Studies.

Muir Gray, J. A. (2000) 'Evidence Based Public Health', in: L Trinder with S Reynolds (eds.) *Evidence-Based Practice: A Critical Appraisal.* Oxford: Blackwell Publishing.

National Institute for Health and Clinical Excellence (NICE). (2006) *HIA Gateway: Demonstrating health gain as added value*, London: NICE. Online. Available HTTP: http://hiagateway.org.uk/page.aspx?o=healthgain (8 December 2006).

Nettleton, S. (1997) 'Governing the risky self: how to become healthy, wealthy, and wise', in A. Petersen and R. Bunton (eds.) *Foucault Health and Medicine*. London: Routledge.

NHS Wales. (Last updated 2006) *Introduction to NHS Wales (from the 1989 Welsh Health Planning Forum 'Strategic Intent and Direction for the NHS in Wales'.* Online. Available HTTP: http://www.wales.nhs.uk/sites3/page.cfm?orgid=452&pid=11597 (17 November 2006).

Office of the Deputy Prime Minister (ODPM). (2003a) *English House Condition Survey 2001*. London: HMSO.

Office of the Deputy Prime Minister (ODPM). (2003b) *Housing Bill – Consultation on draft legislation.* London: HMSO. Online. Available HTTP: http://www.odpmgov.uk/Information/consult/housingbill/01.htm (1 April 2003).

Office of the Deputy Prime Minister (ODPM). (2003c) *Sustainable Communities: Building for the future.* London: HMSO. Online. Available HTTP: http://www.communities.odpm.gov.uk/plan/main/overview.htm (6 March 2003).

Office of the Deputy Prime Minister (ODPM). (2004a) Housing Health and Safety Rating System Guidance (Version 2). London: ODPM. Online. Available HPPT: http://www.odpm.gov.uk/stellent/groups/odpm_housing/documents/page/odpm_house_032782.pdf (18 March 2005).

Office of the Deputy Prime Minister (ODPM). (2004b) *A Decent Home: the definition and guidance.* London: ODPM.

Ormandy, D. (2004) 'Housing Conditions and Health', in W. H. Bassett (ed.) *Clay's Handbook of Environmental Health (19th edition),* Part Five: Housing, Chapter 16: pp. 349-363. London: Spon Press.

Page, R. (2005) 'From democratic socialism to New Labour', in H. Bochel, C. Bochel, C, R. Page and R. Sykes in *Social Policy: Issues and developments*. pp. 268-291, London: Pearson Prentice Hall.

Scott-Samuel, A., Birley, M. and Ardern, K. (2001) *The Merseyside Guidelines for Health Impact Assessment (2nd edition).* International Health Impact Assessment Consortium.

Thomson, H., Petticrew, M., and Morrison, D. (2001) Health effects of housing improvement: systematic review of intervention studies, *British Medical Journal*, 323, pp. 187-190.

Thomson, H., Petticrew, M., and Morrison, D. (2002) *Housing Improvement and Health Gain: A summary and systematic review, Medical Research Council Social and Public Health Sciences Unit, Occasional Paper no 5, January 2002*, Glasgow: MRC Social and Public Health Services Unit, University of Glasgow.

Trinder, L. (2000) 'Introduction: The Context of Evidence Based Practice', in: L. Trinder with S. Reynolds (eds.) *Evidence-Based Practice: A Critical Appraisal.* Oxford: Blackwell Publishing.

US Office of Disease Prevention and Health Promotion. (1996) *Healthy People 2000 Midcourse Review and 1995 Revisions,* US Office of Disease Prevention and Health Promotion.

Walt, G. (1994) *Health Policy: An introduction to process and power*, London: Zed Books Ltd.

Wanless, D. (2004) *Securing Good Health for the Whole Population.* London: H. M. Treasury and HMSO.

Watterson, A. and Watterson, J. (2003) 'Public Health Research Tools', in A. Watterson (ed.) *Public Health in Practice.* Hampshire: Palgrave Macmillan.

Wilkinson, D. (1999) *Poor Housing and Ill Health: A summary of research evidence*. The Scottish Office Central Research Unit.

Wills, J. and Woodhead, D. (2004) 'The glue that binds ...': articulating values in multidisciplinary public health, *Critical Public Health* 14 (1) pp. 7-15.

World Health Organisation (WHO). (1984) *Health Promotion: A discussion document on the concept and principles*. Copenhagen: WHO Regional Office for Europe.

World Health Organisation (WHO). (1986) *Ottowa Charter for Health Promotion.* Ontario: WHO.

6) IMPACTS

6.1 The Health Development Agency Evidence Base (now part of NICE)

At the time I first published in this field, the (then) Health Development Agency Evidence Base did not exist. Three of my papers appeared there, one of which has been included in this submission. The other two are mentioned here, but do not form part of this submission.

Publication 6

Stewart, J. and Bushell, F. (2002) A question of need, *Environmental Health Journal,* 110 (12) pp. 372-374. Online. Available HTTP: http://www.ehj-online.com/archive/2000/december2002/december5.html

Other publications not included in this submission

Stewart, J. (1998) Building up Eire's run-down estates, *Environmental Health,* 106 (11) pp. 326-330.

Stewart, J. and Rhoden, M. (2003) A review of social housing regeneration in the London Borough of Brent, *Journal of the Royal Society for the Promotion of Health*, 123 (1) pp. 23-32.

(Documentation appended for confirmation in Appendix 1)

6.2 Citations of my papers

Below are some examples of where my work has been cited:

Publication 2

Stewart, J. (1999) Healthy housing: the role of the Environmental Health Officer, *Journal of the Royal Society for the Promotion of Health*, 119 (4) pp. 228-234.

Cited by Ann McCarthy MA MCIEH, MCIH, Senior Lecturer, The Nottingham

Trent University, CIEH Congress 2003, 'Home Comforts', Conference paper on the effects of the Housing Bill.

Cited by Instituto Nacional de Hygiene (2003), Epidemiología y Microbiología: Metodología para evaluar indicadores de sostenibilidad pare la vivienda saludable en El Salvador (Methods to evaluate sustainability indicators for good health in El Salvador).

Publication 7

Stewart, J. (2002) Housing Health and Safety Rating: a new method of assessing housing standards reviewed, *Journal of Environmental Health Research*, 1 (2) pp. 35-41.

Cited by Ann McCarthy MA MCIEH, MCIH, Senior Lecturer, The Nottingham Trent University, CIEH Congress 2003, 'Home Comforts', Conference paper on the effects of the Housing Bill.

Cited by Bierre et al, He Kainga Oranga (Health and Housing Research Programme), Wellington School of Medicine and Health Sciences, New Zealand, at the 2nd WHO International Housing and Health Symposium, Vilnius, Lithuania, 2004 and reported in the published Symposium Proceedings under 'A Healthy Housing Index: A collaborative approach to measuring housing condition'.

Publication 8

Stewart, J. (2003) Encouraging home owners to maintain their homes: Initiatives in the Bellenden Renewal Area, Peckham, *Journal of Environmental Health Research*, 2 (1) pp. 10-21.

Cited by Ann McCarthy MA MCIEH, MCIH, Senior Lecturer, The Nottingham Trent University, CIEH Congress 2003, 'Home Comforts', Conference paper on the effects of the Housing Bill.

Cited by Environment and Health International: Magazine of the International

Federation of Environmental Health 5 (2) 2003 pp. 17-18.

Cited in Environmental Health Practitioner (August 2006: pp. 35), as reference source for Continuing Professional Development (CPD) assignment to achieve CIEH 5 hour CPD Equivalence Certificate. Assignment to consider the most common reasons that homeowners fail to carry out necessary repair work to their homes even when grant assistance is available, based on information in my paper.

Publication 10

Stewart, J. (2005) A review of UK housing policy: ideology and public health, *Public Health*, 119 (06), pp. 525-534.

Cited by Croydon Primary Care Trust: Current Awareness list for May 2005 cited under 'Housing Public Health'.

6.5 Book Reviews of Stewart, J. (2001) Environmental Health and Housing (Publication 4).

Hatchett, W. (2002) Housing

> "... The author ... gives a lucid historical overview of the well-recorded links between poor housing and ill health ... her book ... is a source of practical information for enforcement officers ... This book will be an extremely useful reference tool for EHOs and housing officers."

Aston, G. (2002) Journal of the Royal Society for the Promotion of Health

> "As a director of environmental health and housing I only wish that this fine reference source had been available to me when in local government. This ... book ... is good, not least because it deals so clearly with such complex and controversial issues as law and practice relating to housing, statutory fitness, overcrowding, caravan site licencing and the vexed area of multiple occupation ... and energy conservation (is) also dealt with in a clear and concise manner as are the very topical issues of asylum seeks and homelessness ... Jill Stewart ... yet again demonstrates the importance of linking (poor housing to ill health) ... Highly recommended for all students in the widest housing sector."

Simpson, E. (2002) Division of Built and Natural Environment, University of Abertay Dundee

"... This book has several strengths that will make is appealing to a wide readership. It provides a good starting point in many areas that can then be followed up for more in-depth study or work. Another strength includes the use of flow charts – making some of the issues very clear indeed for less informed readers. The case studies demonstrating 'theory into practice' are excellent and combined with the photographs, are particularly helpful to readers. The could provide the basis of excellent discussions for professionals and students alike ..."

In addition, this book is referred to as:

- *A key Learning Material for University of Middlesex Module: 'Dealing with environmental and health stressors';*

- *A required text for University of Derby Module: 'Health & Safety: The Home Environment', which is concerned with physical and social stressors and requires critical knowledge and deep understanding of the impact on health of poor housing, relevant legislation relating to private sector housing and the home environment and appropriate intervention strategies;*

- *Selected by the NHS Scotland e-Library, which aims to empower healthcare practitioners and benefits patient care by providing high quality knowledge support throughout the patient journey. It is the primary vehicle for delivery of NHS Education's national strategy for NHS Scotland Knowledge Services (see http://www.elib.scot.nhs.uk/portal/pfpi/Pages/BookSearchResults.aspx?fl=E); and*

- *Referred to in Ng Hung Fai (2004) 'Hygienic determinants of residential buildings in Hong Kong', dissertation submitted to the Faculty of Architecture in candidacy for the Degree of Bachelor of Science in Surveying, Department of Real Estate and Construction.*

6.4 Conference presentations

Following publication of my work, I have been asked to make the following presentations:

Stewart, J. (2005) *'Changing behaviour: What works?'* Presentation delivered to the North West London Public Health Skills Development Programme, Hammersmith, 8 February 2005.

Stewart, J. (2003) *'Housing and inequality'* presentation delivered at the NHS Eastern Region CPD Training Workshop, Cambridge, 28 November 2003.

Stewart, J. (2003) '*Is Revised Housing Legislation the Answer to Fuel Poverty?*' presentation delivered at the National Energy Agency Annual Conference, University of Derby, 8-10 September 2003.

Stewart, J. (2003) '*Health Needs Assessment and Housing*', presentation delivered at the NHS Eastern Region Spring Training Workshop, Huntingdon, 'Theme: Public Health Partnerships: Aids and Barriers', 9 April 2003.

Stewart, J. (2001) '*Home Safety and the Housing Health and Safety Rating System*', presentation delivered at the RoSPA National Home Safety Congress, 'Safety by Design', Stratford upon Avon, November 2001. [See also 'Home Safety to get £1.5m boost', *RoSPA's Staying Alive*, Winter 2001:8-11. and Stewart, J. (2001) 'Home Safety and the Housing Health and Safety Rating System' in RoSPA Safety by Design: Designing, building and adapting homes for safety; Conference Proceedings for National Home Safety Congress 2001, 12-13 November 2001].

6.5 Funded research

Stewart, J., Ruston, A. and Clayton, J. (2004) *Encouraging and enabling owner-occupiers to maintain their homes in the London Borough of Southwark: a qualitative study.* A report commissioned for and funded by The Private Sector Housing Renewal Team, Bellenden Renewal Area, London Borough of Southwark, Unpublished. (£5000)

Basis of Publications 9, 14 and17.

Stewart, J. Ruston, A. and Clayton, J. (2005) *Housing as a health determinant: Is there consensus from public health partnerships on a way forward?* Research grant funding from the Chartered Institute of Environmental Health. (£750).

Basis of Publication 16.

PART B

CHRONOLOGICAL LIST OF SUBMITTED PUBLICATIONS

Published papers relied upon for this proposal, and included in portfolio:

Publication 1 Stewart, J. and Nunn, G. (1999) A concrete future for concrete houses, *Environmental Health Journal,* 107 (7) pp. 216-7.

Publication 2 Stewart, J. (1999) Healthy housing: the role of the Environmental Health Officer, *Journal of the Royal Society for the Promotion of Health,* 119 (4) pp. 228-234.

Publication 3 Stewart, J. (2001) Home Safety, *Journal of the Royal Society for the Promotion of Health,* March 2001, 121 (1) pp. 16-22.

Publication 4 Stewart, J. (2001) *Environmental Health and Housing,* London: E & F N Spon.

Publication 5 Stewart, J. (2002) A Step in the Right Direction, *Environmental Health Journal,* 110 (04) pp. 104-207. Online. Available HTTP: http://www.ehj-online.com/archive/2000/april2002.april2.html

Publication 6 Stewart, J. and Bushell, F. (2002) A question of need, *Environmental Health Journal,* 110 (12) pp. 372-374. Online. Available HTTP: http://www.ehj-online.com/archive/2000/december2002/december5.html

Publication 7 Stewart, J. (2002) The Housing Health and Safety Rating System: a new method of assessing housing standards reviewed *Journal of Environmental Health Research*, 1 (2) pp. 35-41. Available HTTP: http://www.jehr-online.org.volume1/issue2/5/index.asp

Publication 8 Stewart, J. (2003) Encouraging home owners to maintain their homes: Initiatives in the Bellenden Renewal Area, Peckham,

Journal of Environmental Health Research, 2 (1) pp. 10-21. Online. Available HTTP: http://www.jehr-online.org.volume1/issue2/5/index.asp

Publication 9 Stewart, J., Clayton, J., and Ruston, A. (2004) Maintenance and repairs: an exploratory study into home-owners views on alternatives to grants, *Journal of Environmental Health Research,* 3 (2) pp. 58-65. Available HTTP: http://www.jehr-online.org/volume3/issue2/3/index.asp

Publication 10 Stewart, J. (2005) A review of UK housing policy: ideology and public health, *Public Health*, 119 (06), pp. 525-534.

Publication 11 Stewart, J. (2005) 'Personal responsibility' in private sector housing renewal: Lessons from Scotland and Edinburgh's good practice, *Journal of Environmental Health Research*, 4 (02), pp. 75-83.

Publication 12 Stewart, J. and Gray, I. (2005) Health and Housing, *Environmental Health Journal*, 113 (06) pp. 24-25. Online. Available HTTP: http://www.ehj-online.com/archive/2000/june2005/june6.html

Publication 13 Stewart, J., Bushell, F., and Habgood, V. (2005) *Environmental Health as Public Health*, London: Chadwick House Group Ltd.

Publication 14 Stewart, J., Clayton, J., and Ruston, A. (2006a) Personal responsibility for private sector housing renewal: issues in health improvement, *Health Education Journal*, 65 (01), pp.73-83.

Publication 15 Stewart, J. and Rhoden, M. (2006) Children, housing and health, *International Journal of Sociology and Social Policy*, 26

(7/8), pp. 326-341.

Publication 16 Stewart, J., Ruston, A. and Clayton, J. (2006) Housing as a health determinant: Is there consensus that public health partnerships are a way forward? *Journal of Environmental Health Research*, 5 (02), 87-94.

Publication 17 Stewart, J., Clayton, J., and Ruston, A. (2006) Encouraging and enabling owner-occupiers to maintain their homes: an exploratory study, *Property Management*, 24 (05), pp. 449- 463.

Publication 18 Stewart, J. and Habgood, V. (in press) The Benefits of a Health Impact Assessment in relation to Fuel Poverty: assessing Luton's Affordable Warmth Strategy and the need for a national mandatory strategy, *Journal of the Royal Society for the Promotion of Health*,

PART C

CHRONOLOGICAL LIST OF NON-SUBMITTED PUBLICATIONS

Other papers and books published, but NOT relied upon for this submission or included in portfolio

Papers

Stewart, J. (2006) Current topics and opinions: Housing and health in Havana, Cuba, *Journal of the Royal Society for the Promotion of Health*, 126 (02) pp. 23-25.

Stewart, J. (2004) Rebuilding Cuba, *Environmental Health Journal*, 112 (05) pp. 150-152, Online. Available HTTP: http://www.ehj-online.com/archive/2000/may2004/may4.html

Thomas, S. and Stewart, J. (2005) Optimising health promotion activities, *Journal of Community Nursing*, 19 (01), pp. 9-12.

Cited by Croydon Primary Care Trust: Current Awareness list for January 2005 cited under 'Health Promotion'.

Stewart J and Thomas S (2004) Health Promotion in context, *Environmental Health Journal*, 112 (12) pp. 382-284.

Stewart, J. (2004) Fuel Poverty comes in from the cold, *Environmental Health News,* 19 (46) pp.6. Online. Available HTTP: http://www.ehn-online.com/cgi-bin/news/newsfocus6/EEpEFZAIVpCLaDASxL.html

Stewart, J. (2004) Home Truths, *Cuba Si*, pp.29-30.

Stewart, J. and Brunswic, M. (2004) France faces up to public health, *Environmental Health Journal*, 112 (08) pp. 240-242. Online. Available http://www.ehj-online.com/archive/2000/august2004/august3.html

Stewart, J. and Rhoden, M. (2004) Foyers: a model of success, *Property People,* 6 May 2004, 432: 8-9.

Stewart, J. (2003) Lend them a hand, *Environmental Health Journal*, 110 (04) pp. 212-214. Online. Available HTTP: http://www.ehj-online.com/archive/2000/july2003/july5.html

Stewart, J. and Rhoden, M. (2003) A review of social housing regeneration in the London Borough of Brent, *Journal of the Royal Society for the Promotion of Health*, 123 (1) pp. 23-32.

Cited by the (then) HDA Evidence Base.

Later cited by the National Institute for Health and Clinical Excellence (NICE) Evidence briefing Housing and public health: a review of reviews of interventions for improving health.

Stewart and Rhoden (2003) was one of 62 papers, originally of 1,414, requested or retrieval and subject to critical appraisal for this Briefing, focusing on the research question: what housing interventions are effective at improving health outcomes?

This briefing aims to:

- *Identify all relevant systematic reviews, syntheses, meta-analyses and review-level papers on public health interventions relating to housing*
- *Review these papers and highlight what housing-related interventions work to promote health for all population groups, but with particular reference to disadvantaged and vulnerable groups*
- *Identify cost-effectiveness data for housing-related interventions to promote health for all population groups*
- *Highlight any gaps in the evidence and provide recommendations for future research.*
- *This briefing is intended to inform policy and decision makers, NHS providers, housing officials, public health physicians and other public health practitioners*

in the widest sense.

Taske N, Taylor L, Mulvihill C and Doyle N (2005) Housing and public health: a review of reviews of interventions for improving health - Evidence briefing, London: National Institute for Health and Clinical Excellence.

Stewart, J. (2002) The Housing Health and Safety Rating System: Will the new approach to assessing housing help?, *Housing* December/January 2002 pp. 26-37.

Cited by the South Australian Housing Trust; Paper presented at the Unhealthy Housing: promoting good health conference, Warwick University, Coventry, UK, 19-21 March 2003. Housing Improvement and Rent Control: A Practitioners Perspective. Presented by Mary Yates, Manager, Housing Improvement Branch, South Australian Housing Trust, Adelaide, Australia.

Stewart, J. and Balchin, P. (2002) Community self-help and the homeless poor in Latin America, *Journal of the Royal Society for the Promotion of Health*, 122 (2) pp. 99-107.

Stewart, J. (2002) A Small World, *Environmental Health Journal* 110 (03) pp. 68-70. Online. Available HTTP: http://www.ehj-online.com/archive/2000/march2002.april2.html

Balchin, P. and Stewart, J. (2001) Social housing in Latin America: Opportunities for affordability in a region of housing need, *Journal of Housing and the Built Environment*, 16 (3-4) pp. 333-341.

Stewart, J. and Thompson, N. (1999) Living aboard - as safe as houses?, *Environmental Health Journal* 107 (5) pp. 145-9.

Stewart, J. (1998) Building up Eire's run-down estates, *Environmental Health,* 106 (11) pp. 326-330.

This paper was cited on the (then) HDA Evidence base

Stewart, J. (1996) South Africa's post apartheid housing policy: an exercise in community participation, *Environmental Health* 104 (5) pp. 133-4.

Book chapters and contributions

Stewart, J. (2004) 'Housing: Standards and enforcement' in W H Bassett (ed) *Clay's Handbook of Environmental Health (19th edition),* Part Five: Housing, Chapter 17, pp. 364-408, London: Spon Press, Taylor and Francis Group.

This chapter was written on request from WH Bassett (ed) following publication of Stewart J (2001) Environmental Health and Housing

Contributor to Balchin, P. and Rhoden, M. (2002) *Housing Policy: An Introduction (4th Edition).* London: Routledge.

PART D

ASSESSMENT OF MULTI-AUTHOR CONTRIBUTIONS

Confirmation of breakdown of research and drafting papers

Publication 1

Stewart, J., and Nunn, G. (1999) A concrete future for concrete houses, *Environmental Health Journal,* 107 (7) pp. 216-7.

Breakdown of research contribution: Stewart J, 50%
Breakdown of drafting and editing paper contribution: Stewart J, 80%
See e-mail attached at end of this section

Publication 6

Stewart, J., and Bushell, F. (2002) A question of need, *Environmental Health Journal,* 110 (12) pp. 372-374. Online. Available HTTP: http://www.ehj-online.com/archive/2000/december2002/december5.html

Breakdown of researching, drafting and editing paper contribution: Stewart J, 80%
See e-mail attached at end of this section

Publication 9

Stewart, J., Clayton, J., and Ruston, A. (2004) Maintenance and repairs: an exploratory study into home-owners views on alternatives to grants, *Journal of Environmental Health research,* 3 (2) pp. 58-65. http://www.jehr-online.org/volume3/issue2/3/index.asp

Breakdown of research contribution: Stewart J, 40%
Breakdown of drafting and editing paper contribution: Stewart J, 90%
See e-mail attached at end of this section

Publication 12

Stewart, J. and Gray, I. (2005) Health and Housing, *Environmental Health Journal,* 113 (06) pp. 24-25. Online. Available HTTP: http://www.ehj-online.com/archive/2000/june2005/june6.html

Breakdown of literature review research contribution: Stewart J, 80%
Breakdown of drafting and editing paper contribution: Stewart J, 80%
See e-mail attached at end of this section

Publication 13

Stewart, J., Bushell, F., and Habgood, V. (2005) *Environmental Health as Public Health*, London: Chadwick House Group Ltd.

Breakdown of research, drafting and editing book contribution: Stewart J, 60%
See e-mail attached at end of this section

NB: all the sections included in this submission are Stewart J, 100%

Publication 14

Stewart, J., Clayton, J. and Ruston, A. (2006a) Personal responsibility for private sector housing renewal: issues in health improvement, *Health Education Journal*, 65 (01), pp.73-83.

Breakdown of research contribution: Stewart J, 40%
Breakdown of drafting and editing paper contribution: Stewart J, 90%
See e-mail attached at end of this section

Publication 15

Stewart, J. and Rhoden, M. (2006) Children, housing and health, *International Journal of Sociology and Social Policy*, 26 (7/8), pp. 326-341.

Breakdown of research contribution: Stewart J, 70%
Breakdown of drafting and editing paper contribution: Stewart J, 70%
See e-mail attached at end of this section

Publication 16

Stewart, J., Ruston, A. and Clayton, J. (2006) Housing as a health determinant: Is there consensus that public health partnerships are a way forward? *Journal of*

Environmental Health Research, 5 (02), 87-94.

Application for research grant from CIEH: Stewart J, 100%
Drafting interview schedules, identifying local authorities to be involved and early draft of paper (including background, methods, references): Stewart J, 100%

Carrying out research, analysis and drafting paper for JEHR: Clayton J and Ruston A (100%)
Making minor edits to final draft of paper following peer review: Stewart J and Ruston A

NB – I was unable to participate in actual research, analysis or final drafting of paper due to maternity leave and contract timetable having to be met, see e-mail attached at end of this section

Publication 17

Stewart, J., Clayton, J., and Ruston, A. (2006b) Encouraging and enabling owner-occupiers to maintain their homes: an exploratory study, *Property Management*, 24 (05), pp. 449- 463.

Breakdown of research contribution: Stewart J, 40%
Breakdown of drafting and editing paper contribution: Stewart J, 85%
See e-mail attached at end of this section

Publication 18

Stewart, J. and Habgood, V. (in press) The Benefits of a Health Impact Assessment in relation to Fuel Poverty: assessing Luton's Affordable Warmth Strategy and the need for a national mandatory strategy, *Journal of the Royal Society for the Promotion of Health*,

Breakdown of research contribution: Stewart J, 85%
Breakdown of drafting and editing paper contribution: Stewart J, 95%
See e-mail attached at end of this section

PART E

THE SUBMITTED PUBLICATIONS

Publication 1 Stewart, J. and Nunn, G. (1999) A concrete future for concrete houses, *Environmental Health Journal,* 107 (7) pp. 216-7.

A concrete future f

Solving private sector renovation problems in a way that suits all interested parties is far from easy. ***Jill Stewart*** *and* ***Geoff Nunn*** *explain how Three Rivers DC tackled the problem*

As anyone dealing with private sector housing renovation will know, finding solutions to suit all interested parties is rarely straightforward. This is particularly true where there is mixed tenure – privately-rented and owner-occupied. While owner-occupiers might be pleased to have works done, particularly with the benefit of grant aid, tenants may feel differently if faced with an increase in rent.

NATURE OF THE RENOVATION PROJECT

When we first identified the dwellings, all we knew was that they were of PRC (precast reinforced concrete) type construction and in a poor state of repair. However, they were in a desirable location, next to green belt and a canal, with a strong community spirit. Although properties were falling into disrepair, residents enjoyed the setting, particularly those with families.

It was obvious that all 16 dwellings were statutorily unfit because of disrepair and because the concrete was showing signs of weathe fatigue, becoming potentially dangerous in places. In addition, the poor thermal quality of construction meant condensation and heat loss. Three properties were long-term vacant and difficult to let or sell.

These dwellings were not a common construction type and were not designated under the Housing Defects Act. Step one, therefore, was to employ a structural engineer to identify the type of construction and whether it was feasible to renovate. They were identified as Harnish (similar to Cornish) construction, of which there is only one other example in the country. Because of this, extensive concrete tests had to be carried out. It was found that the properties were structurally sound and could therefore be overclad, to provide a serviceable life of at least 30 years. Knowing the options, we were in a position to meet the landlord who owned most of the properties and discuss the future of the area and of course the occupiers.

We visited all residents to discuss the situation and options for the site. By this stage, we had samples of overcladding material to show residents, and suggested they look at local examples of renovated sites. It was clear that most residents were sceptical about whether the project would take off. However, we were surprised to find that all were keen for works to go ahead, despite the chance of an increase in rent. It was a good opportunity to discuss related issues and what residents would like in the future.

We discussed possible eligibility for grant aid toward the cost of works with the landlord and raised issues discussed with the residents regarding works falling outside the scope of the fitness standard. The tenants had some good ideas, which were taken into the scheme. The landlord was also willing to put tenants in the newly refurbished vacant properties if this was necessary. We were fortunate that the landlord was co-operative and agreed to fund some private works to improve internal standards for residents. This was particularly good for vacant properties which had fallen into greater disrepair and had greater potential for internal redesign. This included moving the bathroom upstairs, creating a modern kitchen/diner downstairs and installing full central heating.

We made efforts to keep residents informed, and arranged with the landlord's representative to be available in one of the vacant properties for a couple of hours. Only one person turned up – but at least we tried. Many residents didn't r ally believe that works would be done, and this was aggravated by delays in the landlord engaging a specialist contractor for the overcladding.

A notice was then served on each property and the landlord made a grant application for each one. We tied this in with the owner-occupied grant applications. For uniformity, we wanted the scheme to be dealt with as one project. Once financial contributions were established, the landlord's site manager was keen to oblige, .

Internal works and external works were kept separate due to the specialist nature of overcladding. Internal works were carried out first. These took longer than anticipated, but were completed to a high specification. Some residents enhanced the upgrade, *eg* by paying the difference for a higher specification front door. Once the internal contractors had left, specialist contractors began the overcladding.

TECHNICAL ASPECTS

Chloride content testing of the concrete was necessary to establish whether renovation was acceptable. The tests put the repair at Category 3 according to building societies who deal with PRC type houses. Category 3 repair involves retaining the existing concrete, fixing insulation to it, and building a new skin around the property. The structural engineer concluded that the properties were generally in

r concrete houses

good condition and robust. There were two options – to overclad in brick, which would have allowed mortgageability but cost three times the second option, which was to overclad in insulating material, then pebbledash. This was agreed by the council and landlord for grant purposes, because it was deemed to meet the fitness standard.

One of the main objectives of the scheme was to enhance the poor thermal standard of the construction. Following treatment with fungicide and biocide, the surfaces were hard wire brushed. All canopies were structurally defective and were replaced with a purpose-made wooden canopy. Exposed, part corroded metal stanchions, were treated with rust inhibitors. The remaining surfaces were prepared to receive the insulating board. This boarding was held in place using drill and drive plastic positive expansion fittings. The boarding had to be cut to allow an even finish ready for rendering. The rendering was carried out in two coats, using a top coat pebbledash finish.

Renovating this type of property is not simply a matter of overcladding. Consideration has to be given to the relative proportions of the property once the works are complete, *eg* extending roof rafters so they overhang the new superstructure, repositioning surface and foul water drainage pipes. The same principle applies to overhangs on windows. Satellite dishes also needed re-siting.

Taking the building as a whole, it was calculated that the typical U Value for a dwelling was 0.4W/M2K. The overcladding works increased this to 0.77W/M2K, taking the thermal insulation above current building regulation requirements. Double-glazing with trickle vents combined with insulation to all loft spaces (with additional ventilation in to the roof) – made an important contribution also to requirements under the Home Energy Conservation Act.

CONCLUSIONS

The scheme met many of the council's private sector housing strategy objectives: meeting housing legislation, bringing vacant properties back into use, aiding anti-poverty and energy efficiency initiatives. Although the scheme did not use brick, and therefore have the benefit of mortgageability, our fundamental objective of bringing unfit properties to a reasonable standard of repair was more than met at a fairly low cost to the council, targeting limited resources to an area of need.

Jill Stewart and Geoff Nunn, Three Rivers District Council

Publication 2 Stewart, J. (1999) Healthy housing: the role of the Environmental Health Officer, *Journal of the Royal Society for the Promotion of Health,* 119 (4) pp. 228-234.

Article

The Journal of The Royal Society for the Promotion of Health; 1999, 119 (4), pp. 228–234

Healthy housing: the role of the Environmental Health Officer

J Stewart

Jill Stewart, BSc Hons, MCIEH, MSc, FRGS, FRSH, Senior Lecturer in Environmental Health and Housing, University of Greenwich (Dartford Campus), Oakfield Lane, Kent DA1 2SZ

Key words

Local government; Environmental Health Officer; health and housing; disadvantage; private sector housing renewal; housing legislation

Abstract

The relationship of health and housing has been well documented. There is less said about action that can be taken to deal with poor housing conditions. Environmental Health Officers in UK Government are key actors enforcing legislation relevant to housing conditions. Despite a century of legislative intervention in private sector housing conditions, the English House Condition Survey continues to report an excessive amount of poor conditions, and a particular decline in quality amongst the most disadvantaged in society who are increasingly accommodated in the private rented sector. This paper examines the role of poor housing in ill health and the difficulties faced in enforcing largely reactive legislative, arguing that wider changes are needed if the link between poor health and housing is to be broken.

Introduction

Environmental Health Officers (EHOs) are the key professionals in Local Government who have legal powers to deal with private sector housing conditions. They are therefore key players in impacting the issue of health and housing. Whilst they routinely ensure that conditions are improved by a mixture of mainly Housing Act enforcement and grant activity, they also have a role to play in health education.

The rapid change in housing tenure from public to private sector, with an increase in homeless figures, has had major implications for EHOs. Despite the move to private rented housing and a recognised decline in standards, there has been reduced capital expenditure in this sector. The 1996 English House Condition Survey illustrated that poor housing is frequently associated with low income (DoE, 1998). The private rented sector proportionally comprises the poorest sector of housing, particularly in houses in multiple occupation (HMOs) yet government ideology during the 1980s and 1990s favoured this sector for housing the homeless. The Audit Commission Report on Health Housing (1991) notes that despite considerable staff resources, only a relatively small proportion of private sector properties in poor condition has been subject to environmental health enforcement powers.

This report considers the relationship of health and housing as a concept that is not fully catered for in current legislation. It then considers why the disadvantaged tend to end up in the poorest housing, aggravating their situation. It makes the link between housing with physical and mental ill health, before moving onto available legislation to deal with poor housing conditions in the private sector. It seeks to explain that whilst some housing conditions might be improved, it is outside the scope of the EHO to be able to deal with the social structure that continues to create disadvantage in society which is then reflected in housing conditions. It looks particularly at the poorest housing stock in the private rented sector because that is where the EHO enforcement role mainly lies.

Whilst it is recognised that many high rise and large scale municipal estates present health and housing issues, these fall outside the scope of an EHO's enforcement role and are not considered here.

The components of healthful housing

The need for healthful housing has been long recognised, but as Ormandy and Burridge (1988) note, few attempts have been made to provide comprehensive guidelines in assessing housing and setting standards. They suggest that the 1939 American Public Health Association's (APHA) *Basic Principles of Healthful Housing*, is still a useful background to housing

assessment. It lists four fundamental categories by which housing standards can be measured. These are physiological needs, psychological needs, protection against contagion and protection against accidents. The PHA, even in 1939, recognised the importance of not just individual physical housing conditions' relationship to health, but the wider issues of housing within its community. The PHA considered that the local environmental quality, noise levels, space for exercise, provision for a normal family and community life and so on, were equally important as, for example, adequate heating or a safe water supply.

More recently, the World Health Organisation (cited in Ransom, 1991), described the complexities of healthful housing both within the house itself and its local environment. It reinforced the view that housing is not just about the avoidance of illness but providing a living environment for betterment of health. It set targets relating to health and housing to be achieved by 2000 within available resources. Although this date is fast approaching, the English House Condition Survey finds no major improvements, and even a worsening of conditions in accommodation housing the most disadvantaged.

There are two main issues as to why this is so. First is that housing renewal policy is based within legislation on already defined standards enforced by EHOs (Ormandy and Burridge, 1993). There is no real scope to embrace all health professionals, GPs, community workers, health visitors and so on to develop the promotion of healthy housing. Secondly, and of increasing importance, is the use of temporary and other unsatisfactory accommodation in the private rented sector to house the homeless and those unable to secure affordable accommodation elsewhere in the housing market.

Housing and disadvantage

The Black Report: Inequalities in Health (Townsend *et al*, 1992) identified several reasons as to why health differentials can be expressed through a person's housing conditions. They suggest that material and structural factors are the main players in housing inequality.

Since housing is one of the main direct determinants of health inequality, if follows that housing policy can be seen as a potential vehicle to alleviate social disadvantage. Finding a suitable definition of social disadvantage is necessary in our attempts to help explain why poor housing and health exist. Disadvantage goes beyond the bounds of poverty, deprivation and inequality, which tend to deal with single aspects and not the combination of people's access to, and remaining in, housing. Clapham *et al* (1990) usefully identify two broad definitions of disadvantage: the market and social democratic models. Advocates of the market model argue that disadvantage has an absolute scale. They see a minimum set of standards required for subsistence, health and welfare and suggest that continuing deprivation is a consequence of an individual's failure or entrapment in a culture of poverty, and it is up to individuals to resolve. Their definition looks only at the economic and fails to address social needs. The social democratic model explains how social disadvantage arises and is maintained as part of the organisation of ecohomic and political processes. They then see disadvantage as relative rather than absolute.

Clapham *et al* (1990) show how social disadvantage, poverty and inequality are expressed in the housing system. They illustrate how housing and its local environment is apportioned by a hierarchy of economic and social power that structures society more widely as a dynamic but interlocking set of markets and institutions. Housing is just part of the markets and institutions whereby disadvantage is structured. It is a variety of social, economic, political and demographic attributes that have a bearing on the housing available and its local environment. Thus housing may facilitate or deny access to wider community and health services. Housing in poor areas is also more likely to have poor local services, preventing disadvantaged individuals from acting fully as citizens. Children born into poor housing environments are less likely to escape either that environment or the behavioural patterns and lifestyle sometimes associated with it, such as frequent moving (see Richardson and Corbishley, 1999). This means that the link between disadvantage and poor housing becomes harder to break.

Who then is disadvantaged in housing? Housing in poor condition is not uniformly distributed, but is associated with social, demographic and economic factors. It is generally low income groups who are unable to have an active choice in the housing market (Rhoden, 1998). They are therefore often marginalised into, or remain in, low cost housing; sometimes reliant on income related benefits to do so. Some examples are as follows. Long term elderly tenants may occupy poorly maintained private rented housing lacking internal amenities, despite security of tenure. Some low income ethnic minorities have been unable to access owner occupation or social housing due to institutional racism. Single people may have less potential to raise a mortgage or secure a market rent without being dependent on benefits and likewise, other low income households tend to be marginalised into the lower end of the private rented sector. The homeless, frequently requiring other social, educational and welfare support suffer further disadvantage when placed in temporary accommodation where poor housing standards and community facilities compound their situation.

Policies during the 1980s and 1990s favoured the private rented sector as housing provider. The simple issue of too much demand and too little supply has resulted in increased low quality housing, increasingly HMO accommodation at the bottom end of the private rented sector, frequently in otherwise undesirable or abandoned areas. With benefits being paid to landlords regardless of conditions, there is little fiscal incentive for landlords to invest in their properties. Deregulation of rents and tenancies has trapped many tenants within the sector long term, becoming increasingly marginalised from mainstream society. This is aggravated by wider economic changes including a general fall in income to the poorest 20% of households due to loss of access to free goods, services and subsidies such as school meals, social fund loans rather than grants and proportional increases in water and local taxation (Townsend *et al*, 1992).

Such issues reinforce the argument that housing regeneration and promoting healthier housing is not just about living accommodation or unemployment. It is also about the complex interrelationship of social exclusion, abandonment of inner city areas and current lifestyles that make up the

bottom end of the private rented sector. The combination effect of these inter-related issues cannot be stressed strongly enough. Housing and health is a two-way street. Access to poor housing generally results from disadvantage and disadvantage frequently results in access to poor housing and therefore poor health.

Housing and Health: the relationship

Whilst the link between poor housing and health is recognised it is difficult to directly link by empirical evidence. It is generally described in terms of negatives rather than in terms of good housing promoting well being. This is because there are many other factors that affect ill health, such as social disadvantage, poverty, inadequate diet, poor working conditions or unemployment, lack of medical care and so on. Attempting to measure the health impact of poor housing is difficult, particularly in cases of mental health. There are few empirical studies available, and a general problem in co-ordinating health and housing information between various organisations such as architects, doctors, EHOs, social workers, policy developers and so on directly relating to poor conditions. However, it is generally regarded that the combination of factors which make up unhealthy housing has an effect on health (Audit Commission, 1991; Ransom, 1991; Townsend *et al*, 1992). Some links between housing and health are now considered.

Cold and damp

Cold and damp are intrinsically linked with poverty. Fuel poverty rose from 5.5m in 1981 to 7m in 1991, particularly amongst people at home all day who require more heating. This is clearly more expensive, so cheaper methods may be used, which aggravate damp, as does drying clothes indoors because there is no where else to do so. The poorest 20% of households spend 12% of their budget on fuel, whereas the wealthiest 20% spend 4%. This disparity has been aggravated by VAT on fuel (Boardman, 1991).

Cold and damp are related to construction type. It is relatively more expensive to heat poor older housing, particularly in the private rented sector where landlords have little legal or financial incentive to invest in energy efficiency. Older people in rented accommodation and people in lower occupational groups are less likely to have central heating and there is less dampness and condensation in centrally heated accommodation. It can also lead to decay of building fabric. Ironically, there has been a rise in complaints of dampness and condensation through improvements being carried out which have reduced ventilation levels, such as by sealing chimney breasts or installing double glazing.

Ill health effects include increased levels of hypothermia, physiological changes in the body, heart attack, stroke, cardiovascular and respiratory disease (especially in children); asthma and mould sensitivity and stress and depression from visual effects of mould growth (Arblaster, 1993; Boardman, 1991; DETR, 1999a; DoE, 1991; Ineichen, 1993; Lowry, 1991; Markus, 1993; Ormandy and Burridge, 1988)

Noise pollution

Noise pollution is closely related to construction. Temporary accommodation can aggravate noise nuisance due to overcrowding and poor noise attenuation due to inadequate building materials, poor design and insulation. Complaints relating to noise have risen about twenty fold in the last twenty years (Ineichen, 1993). Tension from noise, such as loud music or regular arguments, can cause major problems between neighbours and increased stress levels for sufferers. Remedial action falls to the EHO, often with Police support, but enforcement is often extremely difficult.

Space standards

Statutory overcrowding is now uncommon except in temporary accommodation such as HMOs, where conditions are aggravated by a variety of other factors including sharing amenities and means of escape from fire. This can lead to accidental injury and fire. This is particularly so in 'Bed and Breakfast' accommodation where a study has found almost 50% to be statutorily overcrowded, lacking adequate facilities and providing little control over an occupier's personal space, such as in communal areas. (Conway *et al*, 1988). The health effects of overcrowding are related to an increased incidence of infectious disease, both minor ailments and more serious, including Tuberculosis, which is currently rising. Stomach cancer in adults correlates with overcrowding in childhood. Undercrowding can also be a problem, with loneliness, isolation and fear of going outside (Lowry, 1991).

Domestic accidents

There is a significant correlation between accident statistics and social class, unemployment, overcrowding, tenure, education and so on. Accident levels are higher in temporary accommodation, which can be ill-designed, ill-equipped and ill-maintained (Arblaster, 1993; Conway, 1988; Lowry, 1991). These hazards combined with makeshift cooking and heating arrangements, overloaded electrical installations and inadequate means of escape, are particularly pronounced in temporary accommodation where homeless families are regularly placed. HMO residents are ten times more likely to die in fire than residents of other dwellings (Home Office, 1989).

Depression

Whilst depression may not be exclusively caused by poor housing, there is no doubt that living in poor housing conditions can aggravate feelings of isolation and desperation, leading to the development and maintenance of mental ill health (Ineichen, 1993 and Arblaster, 1993). The stress of day to day living in an unfamiliar area, overcrowded conditions and sharing facilities with strangers cannot be understated. Temporary accommodation is disrupting, uncertain and often means the loss of a social support network (Arblaster, 1993). It is not hard to see how a mixture of poor construction and insulation, a lack of space, delays in necessary repairs, dampness, pest invasion and so on combined with wider factors such as crime, harassment and living in a run down area with few services, would effect mental health. Women at home, lacking social interaction, privacy and a leisure time due to child care responsibilities, in poor housing conditions are particularly likely to be depressed (Brown and Harris, 1978).

Although the Audit Commission Report, the key report concerned with the EHO role in healthy housing, notes that poor housing can cause 'stress', it fails to recognise the impact of poor housing on mental ill health, such as depression discussed above. It is largely limited to

physical ill health and is closely allied to the existing standard of statutory fitness, which is discussed later.

Legislation and housing conditions

General background

Edwin Chadwick, the father of the Environmental Health profession, established the legislative link between housing and health in the early Victorian era. Early legislation was based around public health rather than housing and mainly concentrated on physical aspects including drainage and water supply. The Victorian attitude to poverty, and hence to associated matters including housing conditions, was that the state's role was minimal and individuals should improve their own lot. The notion of fitness for human habitation was introduced around the turn of the century, remaining a precedent for local authorities taking remedial action in relation to house conditions (McManus, 1994).

Cross party government support for tackling poor housing conditions increased, particularly with the introduction of the Welfare State after the second world war. However, direct state involvement with area clearance and subsequent mass municipalisation of housing stock by the late 1960's was beginning to lose support for several reasons. Much poor housing had already been destroyed and some large municipal estates were displaying early signs of failure. It was also extremely costly. Many of these municipal estates are now considered 'slums' themselves. In response to much literature (e.g. Coleman, 1986) many such estates are now being redeveloped and redesigned made possible via funding through transfer to a Housing Association or other non-Local Government organisation such as a Housing Action Trust; a form of 're-privatisation'.

Recognising that mass municipal redevelopment could not address poor housing or communities as initially thought, the Housing Acts 1969 and 1974 provided for private sector housing grants. Housing policy since then has favoured general rehabilitation of the private sector, through provision of grant aid to help reverse the cycle of decay. Despite massive public investment, housing conditions have shown little signs of improving overall, particularly in the private rented sector (DoE, 1988). We have already seen that private sector housing renewal policy finds it difficult to address wider issues of disadvantage, which can continually undermine renewal efforts. In addition, there is little information available about grant applicants, other than by crude income determination and location, so it is more difficult to analyse trends which redress the situation where necessary, to ensure best targeting of resources (Leather and Morrison, 1997).

Housing policy, particularly since 1979, has continued to move the onus toward personal responsibility for housing conditions. Clearly this presents problems for tenants who do not have an owner's interest and therefore the ability, or available resources, to affect necessary renovations. The Housing Act 1988 deregulated tenancies to encourage expansion of the private rented sector. The shortage of low cost rented housing has been compounded by sales of council accommodation, leaving less traditional social housing available. The result has been increasing reliance on temporary accommodation for the homeless in the private rented sector, and at a massive social and economic cost. There have been few incentives for the private sector to invest in affordable renting in recent years, and there are no major forthcoming proposals to do so.

Current legal standards

Local Authorities have many duties under the Housing Act 1985 (as amended) in respect of housing conditions. One is to undertake an annual assessment of housing conditions to determine local housing strategy. The manner in which this is carried out is erratic, despite government guidance. DoE Circular 17/96 encouraged a more strategic and uniform approach to deal with poor housing conditions such as establishing Renewal Areas, although very few have been set up. EHOs base assessments of unfitness, and the most satisfactory course of action to deal with it, on their professional opinion and experience of housing conditions, which varies considerably between authorities, and even individual officers. In practice, few authorities have resources to proactively seek out poor housing. Most poor housing is bought to the EHOs attention by tenants and their advisers, although a reactive complaint may lead to proactive renewal of several properties where relevant conditions are met. By its nature this tends to mean that renewal action is low key and pepperpotted and EHOs are frequently under pressure to keep renewal costs to a minimum. The Circular is laudable in theory and draws upon the best of previous policies and legislation but there is generally an acute lack of funding to deal with housing.

There are many legal standards covering housing conditions, but the statutory standard of fitness under the Housing Act 1985 (as amended) section 604, is key. It is a checklist of items to look for and a house is deemed statutorily unfit if it fails to meet one or more of the requirements. The fitness standard requires that houses are structurally stable; free from serious disrepair and dampness; there is adequate provision for lighting, heating and ventilation; that a kitchen and bathroom are provided, with running water and proper drainage. The fitness standard also applies to HMOs, but means of escape from fire and amenities for the number of occupants are also required.

The fitness standard has been criticised since its introduction, mainly because it can be subjective. It fails to address many issues that impact health and housing such as radon exposure, pest infestation and fire safety in non-HMOs and sees failure of one requirement on an equal basis to failure of another, which may in fact have more impact on health. The fitness standard is not dynamic and forward looking; it is finite and static in focus, unable to look beyond basic enforcement. For example, statutory requirements for heating and thermal insulation, key issues in healthy housing, are minimal, and the Home Energy Conservation Act 1996 seems to have made relatively little difference in areas in which it is most needed, despite a variety of agencies actively encouraging Home Energy Efficiency Grants.

The Housing Grants, Construction and Regeneration Act and the Housing Act, both of 1996 amended administration of the system and broke the previous link between unfitness and mandatory grant aid. All House Renovation Grants are now

discretionary and Home Repair Assistance was introduced to deal with small scale repairs for people on income related benefits. Some Local Authorities have taken the decision not to finance some grants such as landlords grants (including HMO grants) at all. Grants can certainly encourage some landlords to carry out works, even to a higher than required standard, without the need for legal redress or works in default. An already disadvantaged tenant who cannot access social housing may be evicted if no grant is available, ending up in worse accommodation. Whilst EHOs and other front line housing professionals are only too well aware of these types of issues, their scope for action is substantially controlled by local councillors and the way in which they use their discretionary powers under housing legislation (Hutter, 1988). The climate of decreasing resources is having a huge effect on front line work.

EHOs can also deal with living conditions under legislation that does not primarily deal with housing, although the Housing Acts are the primary course of action. Other legislation is as follows:

The Environmental Protection Act 1990 provides for action in respect of a statutory nuisance. A statutory nuisance arises if the condition of the premises as a whole is prejudicial to health, either as one defect or an accumulation of defects. It is the effects of the defects which is important, which must be likely to cause injury to health ('prejudicial to health'). Courts have found that the requirement of prejudicial to health is met where conditions would make a well person ill or an ill person worse (Luba, 1991). Health is not specifically defined, but can include physical and mental stress. This action has been successfully used in cases of severe dampness and mould growth. Where statutory nuisance is proven, Local Authorities have a duty to serve an Abatement Notice. A quicker response is provided for in the Building Act 1984, where Local Authorities are able to require works in nine days where a statutory nuisance exists.

Some basic repairs can be dealt with under the Landlord and Tenant Act 1985 section 11. This section implies an obligation on landlords to carry out basic repairs, both to individual dwellings and common parts. This repairing covenant (i.e. active obligation to keep in repair) means that tenants can sue their landlord for breach of contract through the County Court, and advice should be sought from a private solicitor at an early stage. The Defective Premises Act 1972 also provides some legal redress. However, it excludes many private sector dwellings that have been covered on completion by an approved scheme of purchaser protection, but may be applied to those which have been converted or altered later.

Miscellaneous housing conditions also have legal redress. Some pest control can be achieved under the Prevention of Damage by Pests Act 1949. Filthy and verminous conditions are regularly dealt with under the Public Health Act 1936, led by EHOs but generally requiring input from other welfare authorities, and even the police to secure entry. It is not uncommon for such conditions to exist where children are present, requiring ongoing input from social services. EHOs are also able to arrange reconnection of water, gas and electricity supplies where a landlord has failed to pay the bill. Sometimes as much as the EHO, who has been called in too late, can do is sit and listen whilst a desperate and tearful tenant describes how their landlord is going to evict them within the week, deciding who best to refer them on to for help, knowing that sometimes there might not be any.

Development of current standards and proposals for the future

Housing and health has recently made its way back onto the political agenda largely due to the continued efforts of EHOs and pressure groups. Many EHOs and other interested bodies have organised and consolidated in recent years to address the poor housing conditions they witness daily, particularly in temporary accommodation. The Chartered Institute of Environmental Health has consulted and issued documents to promote uniformity of enforcement for standards in HMOs. There has been growing interest and membership of organisations such as the National HMO Network, the Campaign for Bedsit Rights (CBR), the Bed and Breakfast Information Exchange (BABIE), and other Housing Forums, (including landlords and other professionals interested in housing) to help promote standards. The continued pressure from such organisations has led to proposals to introduce a Housing Fitness Risk Assessment and a National Licencing Scheme for HMOs.

The housing fitness rating system involves a review of standards for living accommodation and a change of emphasis in their assessment to replace the statutory standard of fitness (DETR, 1999b). This intends to target the worst dwellings, whether for grant aid or enforcement action by differentiating between serious health and safety hazards and those where the overall risk to occupiers is marginal. It changes the emphasis from listing defects under currently defined standards, toward accounting for the effect of these defects so a 'rating' can be applied. The standard is likely to include fire safety, energy efficiency, internal arrangement, lead piping, sound insulation and air quality (including radon). The rating approach would be a cumulative assessment and evaluation of health risks, informed by relevant scientific standards of the interrelationship of housing and health that could be based within existing local housing strategies. There are currently 22 areas of risk under consideration, with plans for EHOs to check each area of risk, room by room, and apply a score. This would produce an overall hazard rating for each area of risk with recommendations for action, which could then be adjusted according to the vulnerability of the occupier. The sum of final hazard score would be the Dwelling Condition Rating (Toulcher, 1998). The new approach could increase numbers of premises deemed unfit.

In view of the additional risks in multiple-occupancy premises, plans to licence HMOs are also currently under consideration. This seeks to create uniformity between the various departments involved in addressing HMOs. The main purposes is to formally identify and classify HMOs and to simplify the range of enforcement tools currently available under the Housing Act 1985 (as amended), including management, overcrowding, means of escape in case of fire and provision of amenities. A Duty of Care for HMOs is also under consideration (DETR, 1999c). Whatever the eventual outcome of Fitness Rating and the HMO Licencing Scheme, there will be a considerable change from

current standards employed, but this is yet to be seen.

Many local authority EHOs have sought to use legislation available to them in innovative ways, including already locally risk assessing unfit housing and registering, informally or otherwise, HMOs. More pioneering authorities have promoted housing and community issues through Local Agenda 21, an umbrella term for policies encouraging sustainable development. This has required a shift away from thinking on statutory fitness toward suitability for habitation. Forrester (1988) argues that the health and integrity of housing and its environment is crucial to the future human well being. Local Agenda 21 has provided a basis for local authorities to develop and consolidate sustainable indicators to measure performance. These include using sustainable materials for grant-aided works and introducing housing-related statistics such as access to local facilities, homeless, development of Life Housing, as well as domestic carbon dioxide emissions (which contribute to global warming), each of which has at least some impact on the poorest housing. There has been much interest in the government's Social Exclusion Unit, and although we have yet to see what its outcomes will be, sound foundations are already there.

There is also an overlap into planning legislation with new housing development; the EHO's role includes compiling and advising on a Local Register of Contaminated Sites, and liaising with planning colleagues in terms of construction and design processes. Noise from the environment is frequently tackled at design stages through incorporating noise attenuating construction methods as planning requirements. This may apply to new build (e.g. around airports, where Noise Footprinting is already well established and guidelines are set in respect of attenuating noise) but does not normally apply to existing buildings. Although there is little scope to improve noise attenuation in existing dwellings, EHO's are well placed to provide advice and information on acoustics where required

Conclusions

Despite a century of legislative action, poor housing conditions are still far too common. This has led to calls for the introduction of a Fitness Rating System and HMO Licencing scheme at national level. Locally, EHOs have taken stock of the situation and developed policies, strategies and information databases and now encourage uniformity between staff to target resources to the poorest housing stock. They have had to reconsider the priority they can, and are able to, offer private sector housing within resource constraints. More pioneering authorities have been able to use wider policy initiatives, such as Local Agenda 21, to encourage sustainability in housing work.

Crucially, long term structural changes are necessary to deal with housing environments, more in line with the USA 1939 components for healthful housing cited earlier, with close co-operation with other health and welfare professionals. There is a need for a sustainable strategies to improve physical structures of individual dwellings as well as wider social and environmental factors, and the chance to obtain housing in the first place that is safe and affordable. There is clearly a need for more low-cost social housing so that already disadvantaged households do not have to live in poor quality private rented housing in the first place, compounding their situation.

But there is a lot that is being improved upon in dealing with private sector housing by mutual learning and support. There seems more willingness to learn from social housing colleagues through many good examples of how current social housing redevelopment has learned lessons from the past. New developments have involved community participation, they tend to be low rise and have well thought out designs and layouts. There will be no return to the mistakes on mass redevelopment and municipal estates of the past. There is mixed funding and greater scope for sustainable communities and there are lessons EHOs can learn from this. However, as we have seen, the role of the environmental health service is bound by mainly reactive legislation which is not able to address wider issues of disadvantage reflected in the housing system that plays such a key role in poor living conditions. EHOs can only enforce what is currently in legislation, not what is not there.

Despite many restrictions and frustrations, Local Authority EHOs and others concerned with promoting healthy housing have been establishing forums to share knowledge and co-ordinate action: this has been beneficial in promoting standards of enforcement. This has helped some more reluctant officers and authorities to take a greater interest in private sector housing conditions. Many housing forums are working well together to develop best practice and encourage councillors to take a more positive look at the private rented sector, targeting resources to areas of greatest need. Many EHOs are working hard to improve housing conditions within the legislative framework available to them, continuing to have at least some impact in the poorest housing conditions to the most disadvantaged households. Many are now looking forward to the challenge of risk assessment and HMO licencing to provide new impetus in improving living conditions, thus impacting on the issue of health and housing.

References

ARBLASTER L and HAWTIN M (1993). Health, Housing and Social Policy. London: Socialist Health Association

AUDIT COMMISSION LOCAL GOVERNMENT REPORT No. 6 (1991). Healthy Housing: The Role of Environmental Health Services. London: HMSO

BOARDMAN B (1991). Fuel Poverty. London: Belhaven Press

BROWN G W and HARRIS T (1978). Social Origins of Depression: A Study of Psychiatric Disorder in Women. London: Tavistock Publications Ltd

CLAPHAM D, KEMP P and SMITH S J (1990). Housing and Social Policy. London: McMillan Educational Ltd

COLEMAN A (1986). Utopia on Trial. Vision and Reality in Planned Housing London: Hilary Shipman

CONWAY J (ed) (1988). Prescription for Poor Health: The Crisis for Homeless Families London: London Food Commission, Maternity Alliance, SHAC and Shelter

DETR (1999a). Fuel Poverty: The New HEES: a programme for warmer, healthier homes. London: DETR

DETR (1999b). Housing Research Summary: Controlling Minimum Standards in Existing Housing (No. 75, 1998). London: DETR

DETR (1999c). Licensing Houses in Multiple Occupation: England Consultation Paper. London: DETR

DOE (1988). English House Condition Survey: 1986. London: HMSO

DOE (1991). English House Condition Survey: 1986: Supplementary Energy Report. London: HMSO

DOE CIRCULAR 17/96. Private Sector Renewal: A Strategic Approach. London: HMSO

FORRESTER P (1998). Environmental Health and Housing. In: Housing: The Essential Foundations, 209–228 (B Balchin and M Rhoden). London: Routledge

GABE J and WILLIAMS P (1993). Women, crowding and mental health. In: Unhealthy Housing; Research, remedies and reform, 191–203. (R Burridge and D Ormandy). London: E & F N Spon

HOME OFFICE (1989). Fire Statistics: United Kingdom. London: HMSO

HUTTER B M (1988). The Reasonable Arm of the Law? The Enforcement Procedures of Environmental Health Officers. Oxford: Clarendon Press

INEICHEN B (1993). Homes and Health: How Housing and Health Interact. London: E & EN Spon

LOWRY S (1991). Housing and Health. London: British Medical Journal

LUBA J (1991). Repairs: Tenants' Rights (2nd Edition). London: Legal Action Group

MARKUS T A (1993). Cold, condensation and housing poverty. In: Unhealthy Housing; Research, remedies and reform, 141–165. (R Burridge and D Ormandy). London: E & F N Spon

MCMANUS F (1994). Environmental Health Law. London: Blackstone Press Ltd

ORMANDY D and BURRIDGE R (1993). The legal environment of housing conditions. In: Unhealthy Housing; Research, remedies and reform, 401–422. (R Burridge and D Ormandy). London: E & F N Spon

ORMANDY D and BURRIDGE R (1988). Environmental Health Standards in Housing. London: Sweet and Maxwell

RANSOM R (1991). Healthy Housing. London: E & FN Spon

RHODEN M (1998). Equal Opportunities and Housing. In: Housing: The Essential Foundations, 107–119 (B Balchin and M Rhoden). London: Routledge

RICHARDSON K and CORBISHLEY P (1999). The Characteristics of Frequent Movers In: Joseph Rowntree Foundation Findings

TOULCHER P (1998). Boosting the rating system. *Env Health J*; 106(2), 364–365

TOWNSEND P, DAVIDSON N and WHITEHEAD M (1992). Inequalities in Health: The Black Report and the Health Divide. London: Penguin Group

WATSON S (1988). Accommodating Inequality: Gender and Housing. Sydney: Allen and Unwin Australia Pty Ltd

Publication 3 Stewart, J. (2001) Home Safety, *Journal of the Royal Society for the Promotion of Health,* March 2001, 121 (1) pp. 16-22.

The Journal of The Royal Society for the Promotion of Health; March 2001, 121 (1), pp. 16-22

Home safety

J Stewart

Jill Stewart, BSc(Hons), MCIEH, MSc, FRGS, FRSH, Senior Lecturer in Environmental Health and Housing, University of Greenwich (Dartford Campus), Oakfield Lane, Kent DA1 2SZ, England Email: j.l.stewart@greenwich.ac.uk

Received 19 December 2000, revised and accepted 29 January 2001

Key words

Environmental health officers; health and housing; health promotion; home safety; housing legislation; Local Government

Abstract

There are more accidents in the home than many other environments, yet there is no duty on local authorities to promote domestic safety *per se* and the discretionary powers under the Home Safety Act 1961 are rarely used. The local authority remit in safe housing is therefore largely through housing enforcement and grant led activity. The main statutory controls available to local authorities in addressing home safety are found under various Housing Acts, in particular the statutory standard of fitness for habitation, which can provide remedy for some, although not all, potential home accidents.

There are many potential hazards in the home which current legislation fails to address. This is one reason why a new standard of assessing domestic conditions - the Housing Health and Safety Rating System - is currently being considered. This new system seeks to change the current emphasis on a 'materials and construction specification' type approach to a system based on known domestic hazards and their reduction ('performance specification') although there remains much debate around the subject.

This paper considers the current and proposed systems and other opportunities available to local authorities in addressing the major area of home safety.

Introduction

The risk of suffering from domestic accidents can be greatly influenced by the state and condition of one's home. Statistics for home accidents remain high in relation to accidents in other environments. There is however, very little media coverage or home safety promotional activity despite the Home Safety Act 1961. Most local authority activity in respect of home safety is vested in housing legislation, both mandatory and discretionary, and there are currently proposals to link legislative intervention into housing conditions through a new health and safety risk assessed system based on empirical evidence. Some local authorities carry out home safety campaigns, though there is no legal requirement for them to do so.

In the absence of any UK-based duty or strategy, home safety promotion tends to be distributed sporadically and by a variety of organisations, with no consolidated, national programme for delivery in what comprises a major safety issue. Non-statutory organisations have filled this gap. Organisations such as The Royal Society for the Prevention of Accidents (RoSPA) and The Institute of Home Safety (IHS) are working to encourage home safety promotion. They are campaigning for a new Home Safety Act to give local authorities a statutory duty to investigate accidents and provide education and advice as part of an adequately resourced National Home Safety Strategy (NHSS).

This paper is divided into four sections so that the local authority home safety role, normally delivered by environmental health officers, can be considered. It begins with an overview of home safety issues and accident statistics. It then looks at the requirements of housing legislation that can address home safety issues. It then turns to look at current proposals to review the way that housing conditions are legally evaluated and dealt with, through the proposed introduction of a Housing Health and Safety Rating System (HHSRS) and the impact this might have. Finally, it considers a wider local authority role in home safety, tackling issues for which it would be difficult to find a legal response where accidents are related to day-to-day living.

For the purposes of this paper, home safety refers to domestic conditions or behaviours that might give rise to accident or harm. This paper does not seek to address wider issues of housing and health or social disadvantage that can lead people to living in poor housing environments, as this is dealt with in more detail elsewhere (Stewart, 1999).

Safety in the home

According to statistics, the home is not a particularly safe place. The Department of Trade and Industry (DTI), through the Homes Accident Surveillance System (HASS), collates statistics on domestic and leisure accidents recorded at Accident and Emergency (A&E) units in UK hospitals. The data is used as part of a wider government initiative to identify preventable accidents and to make proposals for change (DoH, 1999; DTI, 2000).

HASS statistics include fatal and non-fatal home accidents. Figures for fatal accidents are accurate and relate to England and Wales only and are distinct from the UK-wide approximated A&E figures presented elsewhere in this paper drawn from DTI statis-

tics. Home based deaths for 1998 are presented in Table 1 and show that male deaths tend to exceed female deaths across all age groups and that risk generally increases with age. For 1998, the DTI (2000) recorded 3,946 home deaths resulting from falls (1,650), accidental poisoning (649), drowning, suffocating or choking (356), fire or burn (340), poisonings, other accidents and undetermined events (951).

Non-fatal accidents are collated by HASS on a UK-wide basis from people attending A&E departments. In 1998, the DTI (2000) recorded that accidents at home comprised approximately 1.08 million falls, 650,000 strikes or collisions with other people or objects, 102,000 burns, 41,000 poisonings and 14,000 choking incidents. Table 2 shows a summary of non-fatal home accidents by type from UK A&E statistics from 1998. These are normally related to day-to-day household activities such as cleaning, gardening, eating and drinking, resulting in injuries such as cuts, broken bones and damaged joints and tendons.

The combined cost to society of home accident injuries has been estimated at £25,000 million annually (DTI, 2000). RoSPA (2000a) have expressed concern that despite the high home accident statistics in relation to traffic and work related accidents, there remains very little media interest in the subject of home safety in comparison to other areas. The DTI is beginning to respond - as an example, their burn prevention campaign for pre-school children has resulted in reduced burns in this age group (DTI, 2000).

Categorising accidents

RoSPA (2000b) place home accidents into three main categories: impact accidents, heat accidents and 'through mouth/foreign body' accidents.

Impact accidents

Most impact accidents occur through falls and through injury from falling objects. The young and the elderly are particularly at risk. Falls account for 39% of all children's accidents with around ten dying each year as a result of falls from walls, balconies and stairs (DTI, 1995). Young, inquisitive children are vulnerable to poorly designed architectural features such as sharp corners, and non-toughened window and door glazing (Connelly, 1999). Accidents may result from distraction, inadequate supervision or lack of familiarity with surroundings. Boys are likely to have more accidents than girls. Older children are likely to explore more and further afield, and as a result may suffer injuries from tampering with electrical equipment or tools to which they have access in sheds or outhouses (Ransom, 1999). Older people are likely to suffer from decreased mobility, eyesight and sensory perception, which can render them more vulnerable to suffering domestic accidents. It is estimated that one elderly person dies every five hours from an accidental fall in the home (DTI, 1999). Clearly, many poor design features result from either inadequate regulations in the past, or failure to carry out remedial work up to the current required standards. Some remedial measures can be relatively simple, such as providing non-slip flooring, cupboards at suitable heights, safety catches to windows and grab rails to baths (Ransom, 1999).

Electrical accidents also fall within this category, and affect the young and the elderly the most. Accidents are more likely to occur where appliances are defective or where electrical circuits have not been properly installed. Risk can be reduced by regular inspections and by ensuring that residual circuit breakers are provided to new connections or installations (Ransom, 1999).

Poor housing conditions lead to an increased incidence of accidents (DTI, 1995). There is a significant correlation between domestic accident statistics and social class, unemployment, overcrowding, tenure and education. Accident levels are higher in temporary accommodation, which are often ill-designed, ill-equipped and ill-maintained (Arblaster and Hawtin, 1993; Conway, 1988; Lowry, 1991). These hazards, combined with makeshift cooking and heating arrangements, overloaded electrical installations and inadequate means of escape, are particularly pronounced in temporary accommodation. Childhood injuries are closely linked to social deprivation. Research by the Department of Health (DoH, 1999) illustrates that children from poorer backgrounds are five times more likely to die from an accident than those from more 'well-off' backgrounds. This incidence can be further increased by anxiety, stress and homelessness.

Table 1

Accidental deaths in the home for 1998, England and Wales

Age	Male	Female	Total
0-4	47	29	76
5-9	9	7	16
10-14	18	5	23
15-19	78	34	112
20-24	138	35	173
25-29	192	42	234
30-34	220	65	285
35-39	167	68	235
40-44	143	80	223
45-49	153	78	231
50-54	141	83	224
55-59	96	51	147
60-64	115	58	173
65-69	124	85	209
70-74	140	102	242
75-79	157	156	313
80-84	163	204	367
85+	212	451	663
Total	2,313	1,633	3,946

Note: Accidental deaths caused by poisoning, falls, fire/burns, natural factors, drowning/suffocation/choking, other accidents or undetermined
(Source: Office of National Statistics cited in DTI, 2000)

Table 2

Summary of non-fatal home accidents by type from UK A&E statistics, 1998

Category	Numbers of people
Fall	1.08m
Striking	650,000
Burn	102,000
Poisoning	41,000
Choking	14,000

(Source: DTI, 2000)

Heat accidents

Heat accidents include scalds and burns. Such accidents may result from inadequate or poorly protected heating appliances or cooking equipment, where sometimes simple measures can reduce potential risks, such as by providing fire-guards whenever children are present, ensuring that children are supervised in the kitchen when someone is cooking and that gas-heating appliances are annually serviced.

Gas-heating appliances may pose a particular threat of carbon monoxide poisoning if they are poorly maintained and ventilated. Every year, around 30 people die from carbon monoxide poisoning as a result of inadequately installed or ill-maintained gas appliances and flues (HSE, 1999). The Gas Safety (Installation and Use) Regulations 1998 place duties on gas consumers, installers, suppliers and landlords. Landlords have the responsibility of ensuring that flues are maintained and checked annually, and that these records are made available to the tenants. Anyone working on gas appliances must be CORGI (Council for Registered Gas Installers) registered. It is illegal to use appliances known to be unsafe. The Health and Safety Executive have produced good practice leaflets on gas appliances targeted toward householders and landlords (see the Gas Safety website: http://www.open.gov.uk/hse/gas/index.htm).

Those living in fuel poverty (i.e. those on low income who cannot afford adequate heating and/or who live in poorly insulated conditions) (Boardman, 1991) often have to rely on non-fixed heating facilities, such as bottled gas burners and paraffin heaters, which can be dangerous due to risk of scalding and instability. The young, elderly and those in temporary accommodation are particularly at risk.

Older people in rented accommodation, and people in lower occupational groups, are less likely to have central heating. Houses without central heating suffer more from condensation and dampness. Ill health effects include increased levels of hypothermia, heart attack, stroke, cardiovascular and respiratory disease (especially in children), asthma, stress and depression (Arblaster and Hawtin, 1993; Boardman, 1991; DETR, 1999a; DoE, 1996; Ineichen, 1993; Lowry, 1991; Markus, 1993; Ormandy and Burridge, 1988). Such issues may aggravate the likelihood of home-based accidents through changes in behaviour.

House fires are a common cause of injury and death. Fire may arise as a result of cooking, faulty electrical appliances or smoking, but are often also caused by children playing with matches (DTI, 1995; Home Office, 1996). The risk of fire can be reduced by relatively simple measures such as by installing smoke detectors in suitable positions. House fires account for 46% of all fatal accidents to children (DTI, 1995).

Fire safety is a particular concern in houses in multiple occupation (HMOs) such as bed-sits or shared housing, where residents are ten times more likely to die in a fire than residents in other dwelling types (Home Office, 1989). There is a particular risk in such rented accommodation because the landlord may be unwilling to carry out necessary works to provide adequate means of escape in case of fire and other precautionary measures, and tenants do not have the power, or incentive, to do so. HMO accommodation is unique in that it is the only domestic accommodation where adequate reactive fire safety measures can be enforced, subject to certain provisos.

Ingestion accidents

Through mouth/foreign body accidents include accidental poisoning, suffocation and choking. Young children are especially vulnerable (RoSPA, 2000c). Many accidental poisoning incidents occur each year, many of which involve children with access to medicines, drugs and chemicals. Such poisoning can be relatively easily prevented by securing cupboards containing such items. In spite of this, over 36,000 children each year receive treatment for poisoning, or suspected poisoning (DTI, 1995). Drowning also falls within this category. Children should be under constant supervision whenever there is water.

Many home safety issues can be resolved easily by using common sense and forethought. For example, are smoke detectors installed? If children are present, are stair gates provided? If older people or those with disabilities are present, is a stair lift provided? However, some conditions are more fundamental to the repair, condition, amenities and layout of a house, and some have a remedy in existing, or proposed, legislation concerned with housing standards.

Legislation and housing conditions

Current legal standards

There are many separate pieces of legislation enforced by local authorities and other statutory agencies that have a role to play in home safety, particularly relevant to falls and striking accidents (Table 3).

A standard of housing fitness was introduced around the turn of the twentieth century, but was not enacted until 1957. This standard remained largely unchanged, with the notable exception of incorporating internal amenities under the Local Government and Housing Act 1989. This statutory standard is now contained in the Housing Act 1985 (as amended) section 604 and forms a benchmark for local authority intervention into poor housing conditions. A house is deemed statutorily unfit if it fails to meet one or more of the requirements. The fitness standard requires that houses are structurally stable; free from serious disrepair and dampness; have adequate provision for lighting, heating and ventilation; and are provided with a kitchen and bathroom which have running hot and cold water and proper drainage. The fitness standard also applies to HMOs, but means of escape from fire and amenities for the number of occupants are additionally required.

The statutory standard of fitness, as well as action to take in respect of unfit housing,

is backed up by detailed guidance on its interpretation in the form of Department of the Environment Circular 17/96 *Private Sector Renewal: A Strategic Approach* (DoE, 1996). This circular provides health and safety related information on each aspect of housing fitness such as the health effects of damp and mould, disrepair and inadequate heating. It strives to encourage uniformity in interpretation and application.

The fitness standard has been criticised since its introduction, mainly because it can be subjective. It fails to address many issues that impact health and housing such as domestic radon exposure, inadequate heating, poor internal layout and fire safety. It sees failure of one requirement on an equal basis to failure of another, which may in fact have more of an impact on health and safety. The fitness standard is not dynamic and forward looking; it is finite and static in focus, unable to look beyond basic enforcement. However, it is a standard that is national, has impact and is well recognised, interpreted and enforced.

There is a separate fitness standard for HMOs that incorporates fire safety and additional requirements for amenities. These are specific and respond to the increased likelihood of fire and accident by overcrowding and discomfort caused by inadequate numbers of amenities. There are also regulations governing fire safety of furnishings, which are enforced by Trading Standards Officers and fall outside mainstream housing conditions legislation.

The Housing Grants, Construction and Regeneration Act 1996 provides discretionary powers for local authority intervention on a wider basis than the current fitness standard and offers grant assistance. The extent to which local authorities use and fund such discretionary grant aid is unclear, although this could usefully address many potential domestic hazards that have no legal recourse elsewhere. Such grants can go beyond the statutory standard of fitness and can include putting a property in reasonable repair, providing adequate thermal insulation and adequate facilities for space heating, as well as providing satisfactory internal arrangements, all of which could have a major impact on home safety. Home Repairs Assistance, a small-scale grant available to those on income benefit, is also discretionary, but could be extremely useful in targeting assistance towards more vulnerable groups by granting small-scale assistance to reduce the risk of accidents by providing smoke detectors, small-scale repairs or additional heating installation. However, local authorities would have to be able to resource such strategies in a climate of decreasing capital finance, and would have to meet their mandatory, rather than discretionary, requirements first, which may not always target known home safety issues.

There is legal redress for statutory nui-

Table 3

Legislation for home safety

Act	Features	Enforcing body
Home Safety Act 1961	Discretionary power for local authorities to give home safety education	Local authorities
Fire Precautions Act 1971	In respect of HMOs contains powers to urgently close rooms where serious fire risk exists	Fire Authority
Building Act 1984	Contains accelerated procedures for dealing with statutory nuisance	Local authorities
Housing Act 1985 (as amended)	Consolidating Act containing duty to annually consider local housing conditions and determine local strategy; provides the statutory standards of fitness and overcrowding as well as the mainly discretionary powers for disrepair and controls for HMOs	Local authorities
Local Government and Housing Act 1989	Updates statutory standard of fitness for habitation to include standard amenities	Vested in Housing Act 1985 (as amended) cited above
Environmental Protection Act 1990	Contains statutory nuisance provisions to deal with 'premises'	Local authorities
Home Energy Conservation Act 1995 and Energy Conservation Act 1996	New local authority duty to reduce domestic energy emissions to cut greenhouse gases which impacts the issue of fuel poverty	Local authorities
Housing Act 1996	Provides powers in respect of HMOs, in particular for registration schemes and an anticipated HMO Code of Practice	Local authorities
Housing Grants, Construction and Regeneration Act 1996	Provides for discretionary grant assistance for renovation works and mandatory grant assistance for disabled facilities	Local authorities
Gas Safety (Installation and Use) Regulations 1998	Duties on gas consumers, installers, suppliers and landlords in respect of gas safety. Anyone working on gas appliances to be CORGI registered	Health and Safety Executive
Current Housing Green Paper *Quality and Choice: A Decent Home for All* (DETR, 2000a)	Wide ranging paper; key issues on promoting home safety including introducing a HHSRS to replace the current statutory standard of fitness and a national HMO Licensing Scheme	N/a

sance under the Environmental Protection Act 1990. A statutory nuisance arises if the condition of the premises as a whole is prejudicial to health, either as one defect or an accumulation of defects. It is the effect of the defects that is important, which must be likely to cause injury to health. This legislation can be useful where there is no direct legal remedy under the Housing Acts for addressing conditions likely to give rise to accidents. A quicker response is provided for in the Building Act 1984, where local authorities are able to demand works in nine days where a statutory nuisance exists.

Statutory overcrowding is now relatively uncommon except in temporary accommodation such as HMOs, where conditions are aggravated by a variety of other factors including sharing amenities and poor fire safety measures. This is particularly the case in bed and breakfast accommodation where a study has found almost 50% to be statutorily overcrowded, lacking adequate facilities and providing little personal control over an occupier's personal space, such as in communal areas (Conway, 1988). Clearly this leads to a greater likelihood of home accidents.

There is much legislation specifically targeted towards poor conditions in HMOs where research continues to show that conditions are worse than in other types of housing (DETR, 1998). Most of this legislation remains discretionary and deals with issues such as provision of adequate amenities, fire safety and neglect of management, all of which can lead to domestic accidents. A national HMO licensing scheme, which seeks to improve conditions in this sector, remains under consideration (DETR, 1999a) and may be linked to the HHSRS (Hatchett, 2000a) discussed below.

Proposals for change

Housing Health and Safety Rating System (HHSRS)

In view of some of the issues identified above, a review of the current statutory standard of housing fitness has been underway for some time. Initial consultation focused on whether expanding the standard to incorporate matters such as internal arrangement and energy efficiency, both with important implications for home safety, should be added, or whether a more fundamental review of evaluating housing conditions, based on empirical evidence, was in fact required (Battersby and Ormandy, 1999; DETR, 1999b).

The current proposal is to introduce a HHSRS. This proposal is based on research carried out at Warwick University and based on building regulation, DTI home accident and DETR (Department of the Environment, Transport and the Regions) English House Condition Survey data (DETR, 1998). The research showed that some of the main health and safety risks are not covered comprehensively by current standards. The new HHSRS seeks to be comprehensive, assess the severity and possible effect of health and safety risks and be practical to apply (Hatchett, 2000b; Ormandy *et al*, 2000). The 24 hazards identified by the proposed standard are shown in Table 4.

The HHSRS considers the effect of the defect and provides a rating, which is a substantial move away from the existing standard, which comprises a pass or fail checklist. The ideal standard is established and the actual condition compared with this ideal; conditions falling short of this (faults) are assessed for their potential to cause harm. The assessment is based on the likelihood of occurrence (an event or period of exposure) multiplied by the range of harms or outcomes, which provides a hazard weighting score. The person most vulnerable to the hazard is taken into the equation. The numerical score calculated represents risk, which may be deemed acceptable or unacceptable, and would then trigger appropriate action. The DETR is currently developing further guidance in administering the proposed standard (DETR, 2000a; DETR, 2000b; DETR 2000c) which is now set to apply to HMOs, where each unit or 'dwelling' would be assessed separately.

Whilst many see the proposed system as dynamic and forward thinking, it has not received support from all quarters. Some have disputed the fundamental concept of the system although it initially received support in principle and believe that an updated and revised version of the current fitness standard would be more appropriate, arguing that the new system could be unnecessarily cumbersome to apply (see for example Parkinson and Fairman, 2000). Some are concerned as to how it can relate adequately to HMOs and compares in scope to existing enforcement regimes (Beach, 2000).

Regardless of arguments for and against the proposed system, few would argue that there is a need to ensure that any new standard would more fully address domestic safety more comprehensively.

Local strategies for improving home safety

Accident prevention was a key issue in the Government's *Health of the Nation Strategy* (DoH, 1992), yet the last ten years' home accident statistics reveal fluctuations, rather than general trends, to the reduction of the major injury categories of falls and striking leading to A&E attendance over the period 1989 to 1998 (DTI, 2000). The DTI (2000) statistics reveal that home accidents due to falls fluctuated rather than declined, those being struck or colliding in the home rose fairly steadily from around 400,000 to 650,000, whilst burns, choking and poisoning accidents generally decreased.

The major problem seems to be that no organisation carries responsibility to help prevent, investigate or act upon, in particular, the two largest categories of home based accident. The only current legislation available to local authorities is the now largely disused and, according to some, outmoded, Home Safety Act.

The Home Safety Act 1961 is the only piece of legislation that specifically addresses domestic safety and provides a discretionary power, not a mandatory duty, for local authorities to give home safety education. Many other housing acts have been substantially updated in recent years, but this Act remains untouched. The extent to which its discretionary powers are used remain unclear, and it does carry the same status as other housing acts, such as discretionary grants, which are recognised through DETR resource status. In a climate of decreasing local authority resource, discretionary powers, such as those vested in the Home Safety Act, are normally first to go so that statutory duties can be met. Education and promotion rarely seem to attract the same status as enforcement-led work in many local authority departments, even though they may have a major impact on accident statistics.

There seems to be a gap between the accidents that are known to occur and what happens to help prevent them from happening in the first place, or to investigate and take appropriate remedial action in their

aftermath. Many non-statutory organisations have expressed concern with the lack of statutory and monitoring activity for home safety at local level. RoSPA (2000a and 2000d) argue that home safety education is a much neglected subject and are concerned that organisational change in the public sector might sideline it further, even though it is relevant to everyone. They note that home safety is normally only part of someone's job, so it never attracts adequate training, resources or investment. As a result, RoSPA have developed partnerships with interested organisations, producing an NHSS that sits alongside wider government policies, such as *Saving Lives - Our Healthier Nation* (DoH, 1999). Through this, RoSPA hope to broaden the scope of home safety, by linking it to the wider new public health agenda and the underlying social, economic and physical factors influencing well-being, with local authorities as key players. Their recommendations include developing a new Home Safety Act containing a duty for local authorities to investigate home accidents and to provide good education and advice, founded on empirical evidence and training for those involved.

Outside of the largely reactive legislation discussed above, local authorities have a more promotional role to play. RoSPA (2000c) argue that a combination of factors is required to improve home safety and thus prevent domestic accidents through environment, education, empowerment and enforcement. The local authority response is both proactive and reactive. The main proactive role likely to have most impact is at the design and planning stages of house construction or rehabilitation, where current technologies and building materials can be incorporated to reduce the risk of accidents happening in the first place. Where local authorities cannot legally make requirements, they may be able to produce promotional literature to encourage developers or householders to incorporate preferable materials in areas of potential risk.

In terms of local authority organisation, recent years have seen an increased trend towards partnership (multi-agency) working in many areas, which is increasingly encouraged through policy initiatives. Whilst partnerships have been successful in some areas, they take time as well as personal and organisational commitment to be sustainable and bring about real change. In respect of home safety, there are many statutory and non-statutory organisations that may have a role to play, including local authority environmental health, housing and social service departments, who have regular contact with the public in their homes who are in a position to review home accident data and to develop appropriate strategy. Other organisations, including the health and fire services, and voluntary sector organisations, such as pressure groups encouraging improvements to home safety, also have an important role to play. By working in partnerships, organisations can share and exchange knowledge, as well as preventing duplication, thereby saving resources. Initiatives to help improve home safety might include home safety campaigns, safety audits, information leaflets and advice targeted to higher risk groups.

Another avenue available to local authorities is through working alongside Social Services in respect of child carers, which can be enforceable under the health and safety at work legislation. The local authority role here focuses on child care arrangements and advice to potential child carers on making their homes a safer environment for the children they care for. Such local authority activity may help impart safety information in a more 'acceptable' manner to some members of the public as it would be seen as a necessary business requirement rather than an invasion into one's domestic privacy.

The DTI home accident statistics provide a useful basis for evaluating the nature of domestic accidents, which provides the relevant agencies a ready literature in pushing home safety initiatives forward. It would be helpful if accidents were reported direct to local authorities along the same lines of occupational accidents, so that an immediate investigation could be made and remedial action encouraged, or enforced, as appropriate. However, there is also the issue that those injured in the home may be embarrassed, or resent intrusion by local authority personnel, and it is likely that most people believe their domestic activities to be relatively safe.

There may be scope for home safety information to be exchanged via community networks that already exist, and which are perhaps seen as a less invasive or formal method of delivering education. Community networks include tenants' associations, playgroups, mothers' unions, the Women's Institute, men's clubs, Age Concern groups, religious and church groups, as well as organisations such as the National Childbirth Trust. Relevant information could be cascaded down and shared, so that people have an opportunity to attend courses or learn from others they know and trust. Some local authorities already offer Child Safety Equipment Schemes, which loan items such as stair gates, cupboard catches and so on to lower income households free of charge. Such schemes can substantially reduce the risk of accidents.

Conclusions

Statistics for home accidents remain high in relation to accidents in many other environments as statistics from the DTI's Home Accidents Surveillance System continue to reveal. Accidents may be due to poor hous-

Table 4

HHSRS potential health and safety hazards in the home

Risks from:	
Air pollutants	Hot surfaces of materials
Asbestos	Inadequate facilities for personal hygiene
Contaminated water supply	Inadequate lighting
Crowding and space	Inadequate sanitation or drainage
Damp and mould	Infections from other sources
Electrical hazards	Lead
Entrapment and collision	Noise
Entry by intruders	Poor ergonomics
Excessive temperatures	Poor provision for food safety
Explosions	Radiation
Falls	Structural failure
Fire	Uncombusted fuel gas

(Source: DETR, 2000c)

ing conditions, such as disrepair, multiple-occupancy or overcrowding, or the result of human error. Many potential accidents can be easily prevented and preventative measures need not cost the householder much, if any, money.

Many organisations have a role to play in home safety, yet there is no legal requirement for any agency to promote it. Non-statutory organisations, such as IHS and RoSPA, play a fundamental role in campaigning for improved home safety. Many statutory organisations, particularly those where employees regularly visit people in their home environment, are ideally placed to offer advice and assistance on domestic safety, but may require home safety training. Local authority environmental health departments are particularly involved in respect of enforcing adequate conditions, especially in the private rented sector, where some of the most vulnerable and disadvantaged are resident.

A reworking of resources towards proactive home safety strategies could yield real financial savings to the health service and reduce much stress to individuals and their families as a result of home accidents. Perhaps this can only happen if local authorities are given new statutory powers to promote home safety alongside their powers to control poor housing conditions.

References

ARBLASTER L and HAWTIN M (1993). Health, Housing and Social Policy. London: Socialist Health Association

BATTERSBY S and ORMANDY D (1999). Surveying the system. *Environ Health J*; 107, 357-380

BEACH D (2000) Rating system will not help on HMOs *Environ Health News*; 15(31), 5

BOARDMAN B (1991). Fuel Poverty. London: Bellhaven Press

CONNELLY J (1999). Housing Conditions, Diseases and Injury. In: Clay's Handbook of Environmental Health (18th Edition), pp. 379-383. (Edited by W H Bassett). London: E and F N Spon

CONWAY J (1988). Prescription for Poor Health: The Crisis for Homeless Families. London: London Food Commission, Maternity Alliance, SHAC and Shelter

DETR (DEPARTMENT OF THE ENVIRONMENT, TRANSPORT AND THE REGIONS) (1998). English House Condition Survey 1996. London: HMSO

DETR (DEPARTMENT OF THE ENVIRONMENT, TRANSPORT AND THE REGIONS) (1999a). Licensing Houses in Multiple Occupation - England Consultation Paper. London: DETR

DETR (DEPARTMENT OF THE ENVIRONMENT, TRANSPORT AND THE REGIONS) (1999b). Housing Research Summary - Controlling Minimum Standards in Existing Housing (No. 75, 1998). London: DETR

DETR (DEPARTMENT OF THE ENVIRONMENT, TRANSPORT AND THE REGIONS) (2000a). The Housing Green Paper. Quality and Choice: A Decent Home for All. London: DETR

DETR (DEPARTMENT OF THE ENVIRONMENT, TRANSPORT AND THE REGIONS) (2000b) Housing Research Summary No. 122, 2000. Development of the Housing Health and Safety Rating System. London: DETR

DETR (DEPARTMENT OF THE ENVIRONMENT, TRANSPORT AND THE REGIONS) (2000c). Housing Research Summary No. 123, 2000. Housing Health and Safety Rating System Quick Guide. London: DETR

DOE (DEPARTMENT OF THE ENVIRONMENT) (1996). Private Sector Renewal: A Strategic Approach (Circular 17/96). London: HMSO

DOH (DEPARTMENT OF HEALTH) (1992). Health of the Nation: A Strategy for Health in England. London: HMSO

DOH (DEPARTMENT OF HEALTH) (1999). Saving Lives - Our Healthier Nation (White Paper). London: HMSO

DTI (DEPARTMENT OF TRADE AND INDUSTRY) (1995). Home Accident Surveillance System (HASS) and Housing Accident Death Database (HADD) 1994, 19th Annual Report. London: DTI

DTI (DEPARTMENT OF TRADE AND INDUSTRY) (1999). Dangers that lurk in the home. DTI Government News Online: http://www.building.org.uk/publications/govt-news/dti/p-99-536.asp

DTI (DEPARTMENT OF TRADE AND INDUSTRY) (2000). Home and Leisure Accident Report. Summary of 1998 data. London: DTI

HATCHETT W (2000a). HMO licensing on back burner. *Environ Health News*; 15(41), 1

HATCHETT W (2000b). Radical update due on fitness standard. *Environ Health News*; 15(30), 8

HSE (HEALTH AND SAFETY EXECUTIVE) (1999) Gas Appliances: Get Them Checked, Keep Them Safe. Leaflet available from the Health and Safety Executive, London

HOME OFFICE (1989). Fire Statistics: United Kingdom. London: HMSO

HOME OFFICE (1996). Fire Safety in the Home. Leaflet available from the Home Office Communication Directorate, London

INEICHEN B (1993). Homes and Health: How Housing and Health Interact. London: E and F N Spon

LOWRY S (1991). Repairs: Tenants Rights (Second Edition). London: Legal Action Group

MARKUS T A (1993). Cold, Condensation and Housing Policy. In: Unhealthy Housing: Research, Remedies and Reform, pp. 141-165. (R Burridge and D Ormandy). London: E and F N Spon

ORMANDY D and BURRIDGE R (1998). Environmental Health Standards in Housing. London: Sweet and Maxwell

ORMANDY D, MOORE R and BATTERSBY S (2000). If it's broke, fix it fully. *Environ Health J*; 108(12), 386-389

PARKINSON N and FAIRMAN N (2000). If it ain't broke, don't fix it. *Environ Health J*; 108(10), 330-334

RANSOM R (1999). Health and housing. In: Clay's Handbook of Environmental Health (18th Edition), pp. 384-400. (Edited by W H Bassett) London: E and F N Spon

RoSPA (THE ROYAL SOCIETY FOR THE PREVENTION OF ACCIDENTS) (2000a) Home Safety. Available online from: http://www.rospa.co.uk/homesafe.htm

RoSPA (THE ROYAL SOCIETY FOR THE PREVENTION OF ACCIDENTS) (2000b). Home Safety Project Sheet. Available online from: http://www.rospa.co.uk/hsfacts.htm

RoSPA (THE ROYAL SOCIETY FOR THE PREVENTION OF ACCIDENTS) (2000c). Child Safety in the Home. Available online from: http://www.rospa.co.uk/childsaf.htm

RoSPA (THE ROYAL SOCIETY FOR THE PREVENTION OF ACCIDENTS) (2000d). RoSPA's Home Safety Strategy. Available online from: http://www.rospa.co.uk/hsstratg.htm

STEWART J (1999). Healthy Housing: The Role of the Environmental Health Officer. *J Roy Soc Health*; 119(4), 228-234

Publication 4 Stewart, J. (2001) *Environmental Health and Housing*, London: E & F N Spon.

Clay's Library of Health and the Environment

Jill Stewart

ENVIRONMENTAL HEALTH AND HOUSING

Chapter 2

Background to legal conditions

2.1 History of private sector housing renewal

Outline

A background knowledge in the development of private sector housing renewal policies is important in informing an understanding of current housing conditions, law and practice. It is also useful to overview which policies were successful and why, and, conversely, which policies were not so successful, and why. A comprehensive, honest and sensitive overview is useful in developing sustainable new policies. This section, which can only offer a summary of key features and dates, traces the history of private sector housing renewal to its roots in the Victorian public health movement, changes in policy since then, to where it is at now. It seeks to show how much housing policy relates to wider social change and political ideology, and briefly considers the development of social housing, and is summarised in Table 2.1.

Table 2.1 History of housing law

Key dates and features	*Committees and legislation*	*Comments*
1840s – Industrial Revolution and urbanisation, aggravating poor housing. *Laissez-faire* ideology. Birth of public health and philanthropic activity in housing.	Public Health Act 1848 Common Lodging Houses Act 1851 Labouring Classes Lodging Houses Act 1851 (Lord Shaftesbury) Torrens Acts 1868 and 1879	Introduction of legislation empowering local authorities to deal with poor housing conditions
Late 1800s	Artisans and Labourers Dwellings Act 1868 Artisans and Labourers Dwellings Improvement Act 1875 (Cross Acts) Public Health Act 1875 Royal Commission on Housing of the Working Classes Cl[illegible] Act 1890 Town and Country Planning Act 1909	Provided for local authority intervention in housing conditions and allowed for rates for local authority building Local authority powers to make building by-laws Provided a formal structure to *ad hoc* housing schemes and encouraged further schemes
1914–1918 – Predominantly privately rented housing, low incomes, rent strikes, massive social change	Tudor Walters Committee Rent and Mortgage Restriction Act 1915 Housing (Additional Powers) Act 1919 The Housing and Town Planning Act 1919 (Addison Act) Housing Act 1923 (Chamberlain Act)	Rent controls introduced 'Homes Fit for Heroes' to standards determined by Tudor Walters Committee with a subsidy for new houses, extended in 1923 with Trade Union support. New duty to survey district's housing needs.
1920–1930 – Growth of Building Societies, development of suburbia, increasing owner occupation and decline of private rented sector, self-help schemes, etc., alongside growing depression and poverty; national debt, and socio-political unrest, worsening of housing conditions housing conditions, e.g. overcrowding and lack of renewal. Health Minister Sir Hilton Young promised £95million on	Housing (Financial Provisions) Act 1924 (Wheatley Act) Housing Act 1930 (Greenwood Act) Housing Act 1935	Long-term house building programme Power to grant rent rebate Definition of overcrowding

Table 2.1 continued

Key dates and features	*Committees and legislation*	*Comments*
slum clearance and rehousing in 1933, combining employing with social provision		
1939–1945 – 3.5 million homes damaged in air-raids, 173,500 slum houses from the 1930s' programmes still lived in; use of unfit housing to meet need; poor housing still common	1944 – Dudley Committee	Recommended standards for local authority housing
Post-1945 – talk of a 'New Jerusalem' and introduction of the Welfare State. Development of New Towns, but not until 1955 that housing renewal was in full swing	New Towns Act 1946 Town and Country Planning Act 1947 Housing Act 1949	New Town Development Corporations Development rights consolidated Grants for standard amenities introduced
1950s–1960s – Continued decline in private rented sector, increase in owner occupation. Welfare State remained a priority with full employment. Growth of pressure groups together with Packman legacy and *Cathy Come Home* had a huge impact on social attitudes on housing and homelessness. Rent officers established and birth of Housing Corporation. Tale ends of mass clearance and area municipalisation	Housing Act 1952 Housing Repairs and Rents Act 1954 Housing Subsidies Act 1956 Rent Act 1957 Housing Act 1957 Housing Act 1961 1961 – Parker Morris Committee Housing Act 1964 Protection from Eviction Act 1964 1965 – Milner Holland Report (Housing in Greater London) Rent Act 1965 Housing Subsidies Act 1967 Housing Act 1969	Housing subsidy increased Slum clearance High-rise building encouraged Fitness standard consolidated Controls for HMOs introduced. Subsidy costs based on Parker Morris standards New power to repair where substantial disrepair. GIAs introduced
1970s – Social unrest, influence of Europe on domestic policy. Ombudsman service introduced in 1974. Recognition of early failure of some municipal estates	Housing Act 1974 Local Government Act 1974 Housing (Homeless Persons) Act 1977	HAAs introduced. More interventionist local authority role through grants and CPO Right to permanent housing for the priority homeless
Recent – recognition of social exclusion, emphasis on partnerships and	Housing Act 1980 Housing Act 1985 Housing Act 1988	Right to Buy, tenants charter, amendments to finance Consolidating Act.

Table 2.1 continued

Key dates and features	*Committees and legislation*	*Comments*
commissioning, sustainability. Increased emphasis on local housing strategy. Rise of the 'New Left'		Introduction of deregulated tenancies (Assured), Housing Action Trusts, Tenants Choice, mixed funding
	Local Government and Housing Act 1989	Mandatory means tested grants linked to fitness standard; ring-fenced housing revenue account
	Leasehold Reform, Housing and Urban Development Act 1993	CCT in local authority housing All grants discretionary, except DFGs
	Housing Grants, Construction and Regeneration Act 1996	Changes to homeless, enforcement processes etc.
	Housing Act 1996	
	Housing Green Paper 2000	See tables 1.2 and 1.3

Public health pioneers

The Industrial Revolution had seen thousands of people move away from rural life and into the emerging polluted and overcrowded cities to find work. The massive influx from town to country put huge pressure on urban areas. Edwin Chadwick, the father of the environmental health profession in the Victorian era, first made the link between health and housing (Figure 2.1). In 1842 he presented a report on the Sanitary Conditions of the Labouring Population of Great Britain to Parliament (cited in Brown and Savage 1998, Hibbert 1988). It was the first time anyone had linked living conditions to health and revealed a desperate picture of overcrowded, damp, unventilated houses lacking adequate drainage and proper water supplies. Chadwick believed that such conditions caused and aggravated ill health among the working classes, resulting in an average life expectancy of an urban working class person of 12–15 years. Engels' 1844 Condition of the Working Classes (cited in Briggs 1987, Hibbert 1988) painted a similar picture.

Pioneered by Chadwick, the Public Health Act 1848 had attracted much criticism, but by now there was no turning back and the General Board of Health was borne. This early legislation focused around public health rather than housing conditions, mainly concentrating on issues such as drainage and water supply, possibly because recent cholera outbreaks had affected all social classes, not just the poor. The Victorian attitude was very much *laissez-faire*; the poor were seen to be responsible for

Figure 2.1 Edwin Chadwick in 1848

their own lot, and it was up to them to take steps to counteract their housing conditions, where overcrowding, disrepair, lack of facilities and so on were rife. Providing the poor with decent housing was seen as nothing short of revolutionary, and certainly not a government function.

Chadwick was not the only one changing attitudes in the Victorian era. Octavia Hill, pioneering in her time for being both a philanthropist and a woman set on social change, established the first social housing at Paradise Place, Marylebone in London. Other wealthy families committed to social change also became involved. Joseph Rowntree (1805–59) for example, of a Quaker family, believed that social change was possible and he began to challenge the Victorian notion that poverty was a natural, and therefore acceptable, state of affairs – the Joseph Rowntree Foundation is still a key institute for housing and social research. Charles Booth's Life and Labour of the People of London from 1899 to 1903

developed a new attitude toward poverty, which was increasingly seen as a social phenomeneon rather than as a fact of life (cited in Briggs 1987, Hibbert 1988).

Many low-income households had to share accommodation, so common lodging houses became popular. Lord Shaftesbury (previously known as Lord Ashley) pioneered two Acts to tackle such poor conditions. The Common Lodging Houses Act 1851 introduced some controls to such accommodation and the Labouring Classes Lodging Houses Act 1851 enabled local authorities to create lodging houses to reduce homelessness, although these Acts had little impact on housing conditions due to a lack of associated resources.

However, the continued pressure for legal improvements had gained momentum. The Torrens Acts 1868 and 1879 enabled local authorities to deal with individual insanitary houses, although not areas of bad housing. The first legal powers for area action were introduced in private legislation in Manchester in 1867. With little security of tenure, tenants were readily evicted when an owner wished to sell the property for commercial interests. This changed with the Cross Acts (Artisans and Labourers Dwellings Improvement Acts) 1875 and 1879, which allowed local authorities to intervene in unfit housing, to clear and redevelop land for the purpose of improvement, through designated schemes, for the working classes, with provision for Compulsory Purchase. The simultaneous Public Health Act 1875 enabled proactive local authorities to adopt by-laws to control building standards.

One problem for local authorities with these new Acts was that of cost. Local authorities were reluctant to spend funds on tackling working-class housing conditions but public pressure continued, leading to the Artisans Dwelling Act 1882, which provided closely controlled financial assistance from central government. Progress remained slow and a Royal Commission was established in 1884 to consider housing for the working classes. It was made up of respected public figures such as Lord Shaftesbury and Chadwick, who was by then President for the Association of Sanitary Inspectors. The Commission's work led to the Housing of the Working Classes Act 1885, which required local authorities to achieve proper sanitary conditions of housing in their areas through an implied condition that houses would be fit at the commencement of the holding, provided for by-laws to deal with houses let as lodgings and required the supervision of tents and vans used for dwellings (Foskett 1999). Simultaneously, philanthropic charitable trusts were providing some working class housing and were developing new forms of housing management. Hill, in particular, pioneered early tenant involvement in housing management, largely through attempting to encourage certain behaviour .

The Housing of the Working Classes Act 1890 drew together the

miscellaneous *ad hoc* housing schemes in an attempt to consolidate best policy and to encourage housing where none currently existed. The Act provided for dealing with unhealthy areas and improvement schemes, unfit dwelling houses and powers to provide lodging houses, which provided the administrative framework for later housing measures. However, it came with no funding and local authorities were expected to raise the money themselves. The Housing and Town Planning Act 1909 enabled local authorities powers to control development and it introduced some controls on housing development and design, such as prohibiting back-to-back houses, and it recognised the role of building societies in housing. As a result, prior to the First World War, less than 1 per cent of housing stock had been provided by municipal and philanthropic activity.

Regional differences remained in both legislation and policy. Generally, large northern industrial towns were developing long-term plans for housing redevelopment. By 1894, the London Building Act had legislated for the first building code and building standards requiring minimum standards of sanitation and layout. The idea of the garden city and the new town was borne at the turn of the century, together with the notion of fitness for human habitation, remaining a precedent for local authorities planning and control powers in respect of housing conditions.

Into the twentieth century

Although the Victorians had introduced and pioneered then radical legislation, the prevailing society of extreme wealth existing alongside extreme poverty had changed little, but the First World War was to bring social change on an unprecedented scale. Throughout the world, societies were changing as the horrors of the war began to emerge. The revolution in Russia had overthrown its ruling class; Trade Unions in the UK were gaining considerable standing; men were returning to England physically injured and mentally disturbed; women had been employed in the previous male preserves and were not prepared to lose their emerging equality. There was a lot of pressure on government to act on ill-health issues such as tuberculosis and the still high rate of infant mortality. The emphasis was moving toward creating healthier housing and a better standard of living. In 1911, 9.1 per cent of the population lived at a density of more than two per room, and by 1921 this had risen to 9.9 per cent (Foskett 1999). The first rent controls had been introduced in 1915, and some vehemently argued that this was interference in the housing market and was responsible for the sector's decline, although wider changes were having a greater impact.

The Government had promised 'Homes fit for Heroes' after the War

and some 176,000 council houses were built under the Housing Act 1919 (Foskett 1999) to standards determined by the Tudor Walters Committee. This Act also provided a new duty for local authorities to survey the housing in their district. The house building programmes had several objectives, including the recruitment of post-war male unemployed workers and professional classes into house building to help quell growing domestic social unrest, as well as to respond to the very real need for decent and affordable housing. There were criticisms of some of these new programmes, including allegations of financial mismanagement in some areas, but, in general, large numbers of new homes were constructed to a good standard and, in general, house-building rates mirrored the Exchequer subsidy available. The Housing Acts 1923 and 1924 sought further to stimulate house building through new subsidy and, by 1927, more than 270,000 dwellings were constructed annually (Foskett 1999). The Labour Minister of Health, Wheatley, instigated a local authority house-building subsidy with trade union support. The majority of existing legislation concerning housing developments and general conditions was consolidated into the Housing Act 1925, by which time building for sale rather than for rent had become more profitable.

The interwar years saw a re-emergence of poverty with the decline in industry, a General Strike and the Wall Street Crash leading to the Depression in the 1930s. Public health worsened correspondingly, particularly in industrial areas. The problem of poor housing became so acute that the government was forced to act, introducing the Housing Act 1930 to instigate slum clearance and area improvement programmes, with accommodation provided for those to be re-housed. The Act gave local authorities powers to demolish or repair unfit dwellings leaving land for new development. In 1933, the Health Minister Sir Hilton Young promised £95 million for slum clearance to generate employment as well as to tackle poor housing. The 1930 Act also introduced new powers for overcrowding, which were built upon in the Housing Act 1935 by introducing a definition, guidance and powers to deal with overcrowding. It was envisaged that mass building programmes would both help reverse unemployment figures and replace slums with new local authority housing. Because conditions were so bad, it was relatively easy to equate improved health with improved living accommodation and the Housing Act 1936 added impetus to the recent legislation.

In the aftermath of the Second World War, housing took its place alongside the new National Health Service (NHS) as part of the Welfare State and was increasingly important politically. The 1944, the Dudley Committee recommended further standards for council housing. New towns were constructed in green-field areas, with many re-housed in new areas some distance from their previous lives in cities. The government pledged itself to regional regeneration, particularly since some half

a million houses had been demolished by bombing raids. The 1930s' slum clearance programmes had been put on hold because of the War and about 173,500 houses included in slum clearance schemes had been disbanded. Additionally, unfitness had risen because routine maintenance had not been carried out. People's expectations had changed, and households were growing in number and changing in structure.

The first private sector housing grants were introduced under the Housing Act 1949, but with little overall impact on conditions. This was followed by the Housing Act 1954, which required local authorities to survey local housing – this revealed massive levels of unfitness. In Birmingham, 16 per cent of houses were unfit, in Manchester 33 per cent and in Liverpool 43 per cent (Foskett 1999). Post-war clearance programmes started again in 1954, but existing housing conditions tended to lag behind the general improvements in the standard of living envisaged through the Welfare State. The Joseph Rowntree Memorial Trust estimated that in the early 1960s, 29 per cent of households still had no bath, 28 per cent no hot water supply, 6 per cent no flushing lavatory and 10 per cent had to share a toilet. Immigrant communities were also growing but they faced much discrimination in housing and social opportunity. Many faced overcrowding and poor living conditions, particularly in inner city areas.

Housing law took a new direction and the Housing Act 1957 introduced the statutory standard of fitness and directed action to take in respect of unfit houses. Based largely on standards around 1919, it still did not include internal amenities (bath, hand basin, toilet), but housing had a new legal basis on which to move forward. Discretionary grants for rehabilitation and conversion were introduced in 1959.

Much happened during the 1960s that had an impact on attitudes toward poor housing and homelessness. The Parker Morris design standard, covering matters such as heating, floor and storage space, was introduced in 1961 and it remained mandatory until 1981. The government established the Milner Holland Committee in 1963 particularly to investigate private rented accommodation in Greater London, which drew attention to poor conditions in this sector. The first national House Condition Survey followed in 1967. The Rachman legacy and film *Cathy Come Home* in this period had changed many public perceptions of housing, homelessness and poverty. Housing pressure groups such as the Public Health Inspectors London Action Group (PHILAG), but more notably Shelter, were gaining momentum. The combined effect gathered support for an increase in local authority house building.

Meanwhile, local authority house-building programmes were shifting in emphasis from quality to quantity with the introduction of high-rise rapid build, concrete developments taking place on a massive scale during the 1960s and 1970s. Poor private housing was replaced with a

new form of largely high-rise municipal estate, considered at the time to be an answer to the nation's housing problems.

Whilst there was, of course, a need for ending poor housing conditions, the policy response was not always beneficial. Many communities were broken up and have never recovered. Some clearance was unnecessary, and whilst the number of unfits may have reduced, this did not mean that the replacement municipalised housing was socially more desirable. Some thought that the housing crisis was over, and high-rises had answered the nation's housing problems, but new problems came to light, such as untested construction methods and inherent problems in design, as illustrated with the 1968 explosion at Ronan Point. Additionally, social problems were already starting to emerge with the new large-scale municipal schemes and emerging concentrations of welfare-dependant communities.

The Dennington Committee pointed to a new way to improve housing and its environment. It was also seen as more economical to provide some funding to poor housing before it required demolition and, in any event, most of the unfit housing had by now already been cleared, but much unsatisfactory housing remained, so a new power was introduced to tackle substantial disrepair. As a result, the Housing Act 1969 introduced General Improvement Areas in an attempt to target grants more effectively to areas of poorer housing and complement clearance programmes through area renewal. Even so, grant uptake was generally by better off people, and funding was not reaching the poorest sectors of private housing, in the owner-occupied or privately rented sector. This had resulted in gentrification and local people finding it harder to afford local housing. There were also allegations of 'winkling' whereby some landlords sought to displace tenants with a one-off financial payment following housing grant assistance and a subsequent rise in house-price (Balchin 1995).

The Housing Act 1974 introduced Repair Grants and sought to address how grant assistance was allocated, providing a more interventionist role and incorporating compulsory purchase. The Act introduced Housing Action Areas so that funds could be targeted into the poorest sector of private sector housing, preventing the need for clearance. Such legislation sought to use a mixture of public and private funds to arrest the decay in private sector stock so that it would not require early clearance. This was seen to be both more cost-effective and socially desirable. The problem of pepper-potted resources – grants being scattered across a local authority area – with some houses being improved and others not tended to undermine attempts at area improvement. As a result, enveloping schemes were introduced around 1979 so that local authorities could improve the external fabric of an entire block of houses, including windows roofs and walls, to encourage confidence in an area and owners to invest in internal works to their properties.

The Housing (Homeless Persons) Act 1977 for the first time acknowledged a growing issue of homelessness, and it provided a new duty for local authority to meet the needs of the statutorily homeless. This remained so until the Housing Act 1996 controversially redefined homelessness and the 'right' to local authority housing accommodation.

Into the twenty-first century

Private sector renewal policies have favoured general rehabilitation over renewal of the private sector through grant assistance to owners to arrest housing decay. Despite massive public investment, housing conditions overall have remained relatively stable, although the age profile of the stock continues to rise (DETR 1998). Most local authorities have had to prioritise action in respect of poor housing and have had to make difficult decisions in respect of private sector stock. Some enforcement powers concerned with housing repair and HMOs, as well as all-renovation grants remain discretionary, and the climate of decreasing resources is likely to build up a greater backlog of houses requiring rehabilitation. In addition, there is little information available about grant applicants, other than by crude income determination and location, so it is more difficult to analyse trends to help ensure best targeting of available resources. Private sector housing renewal policy finds it difficult to address wider issues of disadvantage, which can continually undermine on-going renewal efforts, a key issue in policy sustainability.

The 1980s saw the rapid emergence of 'New Right' policies, with a withdrawal of the Welfare State, a growth in unemployment and poverty and a shift from the housing budget to the social security budget. In line with the ideology of deregulation, the Parker Morris standard was disbanded in 1981, allowing each local authority to decide its own housing standards. A form of 'privatisation' of social housing by schemes such as Large Scale Voluntary Transfer (from local government to housing associations) and Housing Action Trusts gained momentum. The Housing Act 1988 deregulated tenancies, and in addition temporary accommodation became increasingly important to house the homeless. The move from public to private sector housing was not without financial cost (e.g. Balchin 1995). There have been few long-term incentives for the private sector to invest in affordable renting in recent years, and there are no major forthcoming proposals to do so.

The ideology of the New Right from 1979 was to have a radical and substantial impact on housing policy. The Housing Act 1980 introduced the Right to Buy for local authority tenants, and the Housing Act 1985 consolidated legislation before the Housing Act 1988 introduced powers for new contractors to take over the local authority housing function with a range of new powers not available to local authorities. Grants

were seen as increasingly ineffective, and a review of policy with wide consultation from 1985 to 1987 led to a fundamental change to the grants system and the development of home improvement agencies.

The resulting Local Government and Housing Act 1989 was designed to simplify grant procedures, linking means-tested mandatory grants to a new statutory standard of fitness (under the Housing Act 1985 as amended). It also introduced the concept of renewal areas to consolidating and adding to the best of previous area based schemes, although relatively few have been declared. Group repair schemes were introduced to encourage enveloping, grant assistance to improve the exterior of properties with a assumption that owners would be encouraged to invest in internal works, through a renewal confidence in the area. Examples of selective clearance, rehabilitation and new-build arising from local authority housing grant and enforcement activity are illustrated in Figures 2.2 and 2.3.

The mandatory link between fitness and grant was broken by the Housing Grants, Construction and Regeneration Act 1996, largely due to acute funding problems, leaving local authorities to use their discretion in delivering local private sector housing renewal. There are current proposals to finance public and private sector housing from one budget, combining private sector renewal grants with the main capital budget. There is a risk that the private sector will lose out on funding as local authorities use available resources to regenerate their own housing stock.

Figure 2.2 Selective clearance. This illustrates how selective small-scale clearance can remove redundant housing stock and create space for a new street layout

Figure 2.3 Infill development. This illustrates how new build, following selective clearance, can complement an existing area without too much community disruption. The new build properties are set back from the road to allow for parking, a general improvement to accommodate changing needs in older terraced housing stock

Moving forward – housing and sustainability

Gro Harlem Brundtland, former Chair of the World Commission on Environment and Development, defined sustainability in 1987 as follows: 'Humanity has the ability to make development sustainable – to ensure that it meets the needs of the present generation without compromising the ability of future generations to meet their own needs' (cited in Sustainability 2000). The ability to sustain ourselves, our housing and our communities requires some basic changes and local authorities can move in the right direction through the way in which they deliver their housing functions. Cyberus (1999) suggests that activities are sustainable when they:

- use materials in continuous cycles;
- use continuously reliable sources if energy; and
- come mainly from the qualities of being human (including creativity, communication, coordination, appreciation, and spiritual and intellectual development).

Conversely, activities are not sustainable when they:

- require continual inputs of non-renewable resources;
- use renewable resources faster than rates of renewal;
- cause cumulative environmental degredation and extinction of species; and
- undermine other's well-being.

It therefore follows that sustainable development would be based on the four principles of sustainability: futurity, environment, equity and participation. In terms of housing, there are wide-ranging implications.

Sustainable housing requires a community based and multi-agency approach to be successful and, in effect, to be self-regulating in the longer term. It requires input from all those involved in housing, planning, the environment and community services at local level. Some local authorities have maximised the potential of Local Agenda 21 as a framework to deliver sustainable and locally developed housing policies (LGMB 1995). This process requires that local authorities develop sustainable indicators, many of which can be drawn from lessons from past private sector renewal policies – what has proven sustainable in the longer term, and, conversely, what has not. Forrester (1998) argues that the planning function is key as the number of households continues to grow, and the demand for both brown- and green-field sites requires close control. Construction and design processes are also key, so that new house building and rehabilitation of existing housing both uses renewable resources where possible, and that maximum energy is conserved during the property's lifetime.

Sustainability also incorporates lifestyle issues. House design needs to cater for an ageing population and changing households needs; to be located to minimise travel; to incorporate renewable materials and to conserve energy and to be located sensibly to promote health and housing issues; and to have an optimum density with a good infrastructure (Forrester 1998, Conway 2000).

Such issues pose a huge challenge to a local authority housing function, particularly in the private sector, where much work is a response to existing housing conditions, rather than the development of new. There is however an increased potential to incorporate sustainability issues into some areas of housing, which are covered throughout this book. Renewal action will almost always lead to some improvement in the lifetime of the property; the Home Energy Conservation Acts 1995 and 1996 require local authorities to reduce carbon dioxide emissions; renewal areas can provide the impetus for wider socio-economic change; and so on.

The government's recent document *Regeneration that Lasts* (DETR

2000) refers to elements of sustainability in social housing rehabilitation and notes the importance of well-thought-through exit strategy that happens at the right time to enable project sustainability. This strategy, which also has implications for private sector renewal areas, includes the on-going ability to:

- preserve the results of capital works, including environmental works;
- sustain improvements in housing management; and
- sustain the 'Housing Plus' agenda.

In terms of private sector renewal, the equivalent would be for the local authority to exit a renewal area at the point at which the community was displaying the ability to sustain itself locally through new community initiatives, employment and local services, with a marked improvement in housing conditions and infrastructure.

Summary

- Edwin Chadwick first linked housing conditions and poor health around 150 years ago.
- Legislation addressing poor housing conditions received much government support after the First World War.
- Housing policy has followed political ideology and changed markedly since the Second World War.
- Recent years have seen a gradual withdrawal of the welfare state, moves away from municipal housing stock, a targeted grants system encouraging area action with public–private partnerships, and moves toward sustainability through multi-agency approaches.

2.2 Housing and health

Outline

Housing and health is a wide-ranging subject covering all issues of physical and mental health that might arise from poor living accommodation, or conversely well-being that might be promoted by decent accommodation. This section reviews issues of housing and health and introduces the potential for positive action in dealing with private sector housing.

General background

The World Health Organisation (WHO) defines health as being 'a state of complete physical, mental and social well-being, and not merely the

absence of disease or infirmity', an optimistic and all embracing statement (WHO 2000). A healthy body needs to be in a state of equilibrium and the Greek term 'homeostasis' means 'staying the same', so that it can cope with changes to its external environment. Illness, then, is the body's response to harmful environmental forces such as poor housing and a poor local environment. A person's housing conditions plays a crucial role in their physical and mental well-being; the better the housing, the better the health. Conversely, the worse the housing, the worse the health is likely to be.

The Greeks first established a link between housing and health, but it was not until the early sanitary reformers such as Chadwick made a link in the UK, when the term 'slum' was introduced to describe poor housing conditions. The Victorians began to keep statistics that illustrated a profound link between premature death and impoverished conditions, but linked poor housing and ill-health with smells. They, however, took a broad view of health – including relating overcrowding to potential harm to mental and moral health by inadequate separation of the sexes, but their responses nevertheless began to reduce housing-related disease such as tuberculosis.

Linking housing and health

Whilst the link between poor housing and health continues to be recognised it is difficult directly to link by empirical evidence. It is generally described in terms of negatives rather than in terms of good housing promoting well-being. This is because there are many other factors that affect ill-health, such as social disadvantage, poverty, inadequate diet, poor working conditions or unemployment, lack of medical care, and so on. Attempting to measure the health impact of poor of housing is difficult, particularly in cases of mental health. There are few empirical studies available, and a general problem in coordinating health and housing information between various organisations such as architects, housing officers, doctors, EHOs, social workers, policy developers, and so on directly relating to poor conditions. However, it is generally regarded that the combination of factors that make up unhealthy housing has an effect on health (Audit Commission 1991, Ransom 1991, Townsend *et al.* 1992).

The English House Condition Survey (DETR 1998) continues to point to the fact that though most of the worst condition housing is in the owner-occupied sector (because this is the predominant tenure), as a percentage, the private rented sector suffers the worst housing, particularly to the most disadvantaged groups, such as the homeless in temporary accommodation and those otherwise unable to secure decent accommodation in the housing market. The Audit Commission Report on Healthy

Housing (Audit Commission 1991) only comments on physical aspects on ill-health – and makes no mention of mental ill-health such as depression. The government tends to focus on a medical rather than social model of health. Measurement of health is usually based around occupational class, which excludes a lot of groups, such as people with a disability, who have special housing needs. There are also different class perceptions of health and how articulate people are in visiting their doctor and so on. Such a focus tends to be individual and looks at cures for health, not social and environmental factors that may prevent ill-health and promote well-being. Dependence on mass social housing is politically no longer seen to be the answer as it was in the heyday of the Welfare State and the health debate in terms of private sector housing is invariably reactive. Some links between health and housing are now considered.

Homelessness and temporary accommodation

Many current issues on housing and health focus on an increase in the use of temporary accommodation, which aggravates many of the issues discussed below. Some local authorities make extensive use of accommodation rented from private landlords, mostly to offer temporary housing to those accepted as unintentionally homeless and in priority need (see the definitions in Section 2.5), for whom there was no suitable accommodation available in the social rented sector. Temporary accommodation can be provided either direct by private landlords to nominated households, or through an intermediary such as a housing association as leaseholder or manager. Temporary accommodation comprises many types of accommodation, normally financed through housing benefit, which the DETR (1997) categorises as follows:

- Private sector leasing.
- Housing association leasing.
- Housing association as managing agents.
- Assured shorthold tenancies.
- Discharge of duty.
- Bed and breakfast.

Of the above categories, bed and breakfast accommodation is frequently in poor condition, and dependence on this sector for temporary accommodation has fallen in recent years in favour of other types. However, a substantial number of households are still housed in bed and breakfast establishments, and it is this sector that is mainly considered here to illustrate health and housing issues.

The London Research Centre (LRC) established the Bed and Breakfast

Information Exchange (BABIE) in 1988 as a response to poor conditions in hotels being used by London Boroughs for temporary accommodation. At this time there were about 20,000 households in temporary accommodation, some 7,000 of which were placed in bed and breakfast accommodation, although the figure has now dropped to around 3,000 (LRC 2000). Owing to increasing pressure on accommodation, as well as increasing costs, many were housed outside of their own boroughs, so housing conditions became another local authority's responsibility. BABIE was formed to coordinate action and agree recommended prices for rooms across local authorities and it has prepared a common grading system for hotels, which EHOs inspect. The details are of location and condition, including amenities, etc., and are centrally collated by BABIE. This has led to a gradual improvement in such temporary accommodation, and disuse of accommodation that remains unsatisfactory. However, there is still some way to go.

The effect on health from living in bed and breakfast-type temporary accommodation has been well documented. Day-to-day living in overcrowded conditions and sharing insufficient facilities with strangers has some impact on ill-health. Such lifestyles frequently result in accidents, small babies, less immunisation of children, poor nutrition and depression arising from uncertainty and poor conditions (Conway 1988). Providing comprehensive health services to temporary accommodation residents is difficult; because it is temporary, many find it difficult to register with a GP and so do not; some GPs do not wish to take them on for financial reasons. They may end up as no one's responsibility in the hospital system. Closure of many specialist hospitals has left many people living in the community with inadequate support in temporary accommodation.

Many fall outside of the statutorily homeless definition and self-place themselves in temporary accommodation, which can aggravate their health, housing and social needs. They may have less support, but similar health and support needs, to those deemed statutorily homeless. Many asylum seekers fall into this category (see Section 2.6), and may already be disadvantaged because of accessing low-cost unsatisfactory private rented accommodation with inadequate local facilities, often compounded by language and cultural differences, a general lack of resources and simply having nowhere else to go. Here, housing need and conditions can be at their most acute and multiple disadvantage needs to be addressed.

Being accepted as homeless and in 'defined' temporary accommodation or otherwise housed in the private rented sector is only one side of the story. The deregulated assured shorthold tenancies introduced by the Housing Act 1988 place considerable pressures on private sector tenants and their families. There is without doubt some impact on tenant's emo-

tional well-being, and the constant pressure of a possible end of tenancy and having to move after 6 months is, at the very least, stressful.

Rooflessness

Homeless is not the same as roofless. The number of people sleeping rough is unknown and it is difficult accurately to quantify those with nowhere at all to live, but the figure may be up to 96,000. Many are discharged mental health patients, some of whom struggle to cope in 'formal' housing. It is difficult for GPs to take on, and keep track of, homeless people who may go to a specialist clinic, but follow up is difficult unless the patient self-presents. Crisis, the national charity supporting single homeless people with no legal rights to accommodation, seeks to help individuals to rebuild their lives and to move into sustainable housing. Crisis's Health Action for Homeless People initiative seeks to improve homeless people's access to a range of quality health and social care services (Crisis 2000). It estimates that 65 per cent of premature deaths were probably preventable given proper housing and good health care. The sector displays high, and growing, levels of tuberculosis.

Cold and damp

Cold and damp is perhaps the most familiar aspect of health and housing to the majority of people. Cold and damp are intrinsically linked with poverty. Numbers in fuel poverty (see the definition in Section 2.7) rose from 5.5 million in 1981 to 7 million in 1991, particularly among people at home all day who require more heating. This is clearly more expensive, so cheaper methods may be used, which aggravate damp, as does drying clothes indoors because there is no where else to do so. The poorest 20 per cent of households spend 12 per cent of their budget on fuel, whereas the wealthiest 20 per cent spend 4 per cent. VAT on fuel has aggravated this fuel poverty (Boardman 1991).

Cold and damp can be closely related to construction type. It is relatively more expensive to heat poor older housing, particularly in the private rented sector where landlords have little legal or financial incentive to invest in energy efficiency. Older people in rented accommodation those in lower occupational groups are less likely to have central heating and there is less dampness and condensation in centrally heated accommodation. It can also lead to decay of building fabric. Ironically, there has been a rise in complaints of dampness and condensation through improvements being carried out which have reduced ventilation levels, such as by sealing chimneybreasts or installing double-glazing.

Ill-health effects include increased levels of hypothermia, physiological changes in the body, heart attack, stroke, cardiovascular and respiratory

disease (especially in children); asthma and mould sensitivity and stress and depression from visual effects of mould growth (Ormandy and Burridge 1988, Boardman 1991, Lowry 1991, Arblaster and Hawtin 1993, Ineichen 1993, Markus 1993, DoE 1996, DETR 1999)

Legal standards for heating and insulation in existing dwellings are minimal, as discussed further in Sections 2.7 and 4.2. Normally all that can be required is a fixed heater in the main living room and provision for heating (sockets) in other rooms, with minimum loft insulation. EHOs regularly find that even this requirement is not met in many premises. Figure 2.4 illustrates the only heating source in a privately rented premise – clearly insufficient to provide adequate heat and extremely expensive to operate. The condensation dampness shown in Figure 2.5 illustrates the condensation mould growth that was a direct result of inadequate heating, ventilation and loft insulation in this instance. Possible legal remedies for such a situation are explored in Chapter 4.

Noise pollution

Noise pollution is closely related to construction. Temporary accommodation can aggravate noise nuisance due to overcrowding and poor noise

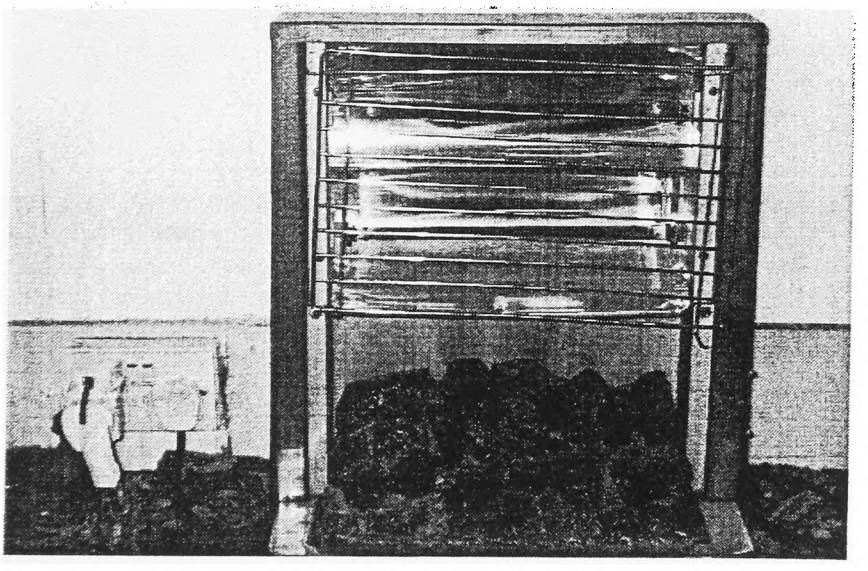


Figure 2.4 Inadequate heating source. This electric bar heating source was the only heater in the dwelling – it was incapable of providing adequate background heat for the room and was expensive to operate. Its short-term use would be likely to aggravate temperature differentials and cause condensation

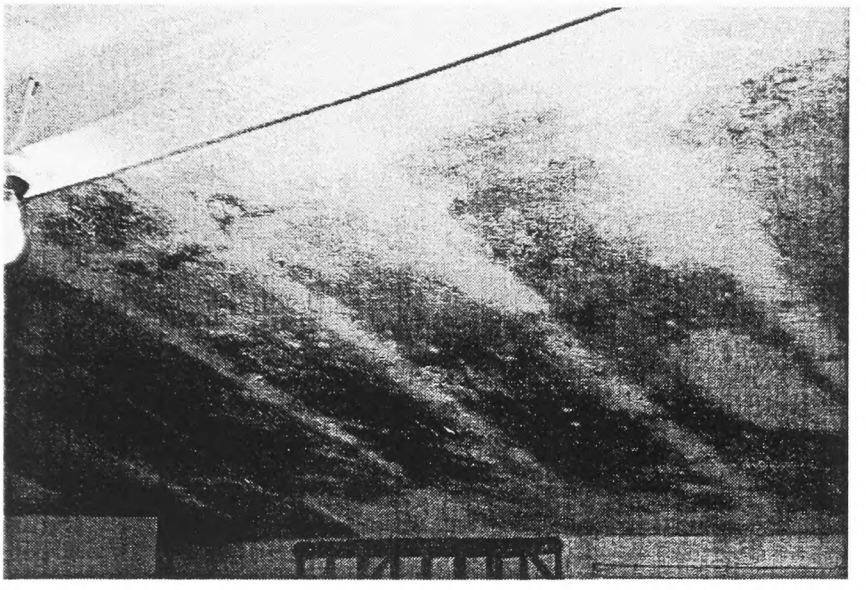


Figure 2.5 Condensation and mould growth. The condensation and mould growth result from the poor heating supply in the living room as well as inadequate insulation and ventilation to this room (the bathroom). The mould growth clearly indicates how it is less likely to proliferate where insulation is provided, and there is no mould growth where the roof joists provide some insulation. In such cases, requiring the landlord to provide an adequate fixed heating source in the main living room and loft insulation, combined with advice to the tenants, would help resolve the situation

attenuation due to inadequate building materials, poor design and insulation. Complaints relating to noise have risen about twenty-fold in the past 20 years (Ineichen 1993). Tension from noise, such as loud music or regular arguments, can cause major problems between neighbours and increased stress levels for sufferers. Remedial action falls to the EHO, often with police support, but enforcement is often extremely difficult.

Space standards

Statutory overcrowding is now uncommon except accommodation such as HMOs, where conditions are aggravated by a variety of other factors including sharing amenities and the means of escape from fire, which can lead to accidental injury as well as to increase the risk of fire. This is particularly so in bed and breakfast accommodation where a study has found almost 50 per cent to be statutorily overcrowded, lacking adequate facilities and providing little personal of control over occupier's personal space, such as in communal areas (Conway 1988). The health effects of

overcrowding are related to an increased incidence of infectious disease, both minor ailments and more serious, including tuberculosis, which is currently rising. Stomach cancer in adults correlates with overcrowding in childhood. Under-crowding can also be a problem, with loneliness, isolation and fear of going outside (Lowry 1991).

Domestic accidents

There are about 5,500 fatal accidents per year in British homes, and another 2.2 million non-fatal accidents requiring hospital treatment, another 900,000 requiring GP treatment which cost the NHS some £300 million annually. Domestic accidents are the commonest cause of death among children. Childhood accidents, including those leading to permanent disability, show a significant correlation with social class and a further association with unemployment, overcrowding tenure, education, etc. Older people show an increased likelihood of accidents, such as from poor mobility and vision, and open fires rather than central heating. Internal layout and design such as awkward stairs, widely opening windows and so on can contribute to an increased accident rate.

Many features are introduced during domestic planning phases, but others can be incorporated into existing homes such as good lighting, fire guards, grab rails and stair gates to stairs, safety glass, and smoke detectors. Many of these features could be incorporated at relatively little cost at the design phase.

Accident levels are higher in temporary accommodation, which is ill-designed, ill-equipped and ill-maintained (Conway 1988, Lowry 1991, Arblaster 1993). These hazards combined with makeshift cooking and heating arrangements, overloaded electrical installations and inadequate means of escape are particularly pronounced in temporary accommodation where homeless families are regularly placed. HMO residents are ten times more likely to die in a fire than residents of other dwellings (Home Office 1989).

Increased reliance on artificial lighting due to changes in the Building Regulations might cause physical damage and an increase the possibility of accidents. There is an increased risk of accidents (especially to older people) in poorly lit accommodation, which might be improved by better light bulbs and decoration to increase illumination.

Depression

Whilst depression is not exclusively caused by poor housing, there is no doubt that living in poor housing conditions can aggravate feelings of isolation and desperation, leading to the development and maintenance of mental ill health (Arblaster 1993, Ineichen 1993). The stress of day-to-

day living in an unfamiliar area, overcrowded conditions and sharing facilities with strangers cannot be understated. Temporary accommodation is disrupting, uncertain and often means the loss of a social support network (Arblaster 1993). It is not hard to see how a mixture of poor construction and insulation, a lack of space, delays in necessary repairs, dampness, pest invasion and so on combined with wider factors such as crime, harassment and living in a run down area with few services would effect mental health. Women at home, lacking social interaction, privacy and a leisure time due to child care responsibilities and in poor housing conditions are particularly likely to become depressed (Brown and Harris 1978).

Air quality and indoor pollutants

People spend 80 per cent of their time indoors, or far more if a vulnerable group, such as older people, the disabled, the young or unemployed. Ironically, air quality has decreased with energy efficiency measures. The effect of different pollutants varies with time as well as individual susceptibility. Carbon monoxide poisoning has attracted much publicity due to recent fatalities caused by faulty heating appliances. Radon exposure (in granite areas) is long-term and can lead to lung cancer, asbestos exposure is only a problem if it is friable or if renovation works are going on, formaldehyde can result from cavity wall insulation, nitrogen dioxide from burning fossil fuels and gas cookers. Legionnaires disease and domestic smoking also fall into this category.

The quality of indoor air can always be improved by increasing ventilation, removing or modifying the source of pollution, filtration or changing the occupant's behaviour. Ventilation helps to maintain or improve indoor environmental conditions so that heating and cooking appliances operate effectively, humidity levels are kept below critical levels associated with house dust mites ability to breed, and so on. Problems frequently occur where accommodation is shared and maintenance of equipment is the responsibility of another person, such as a landlord. Those living in flats, hostels, bedsits, and bed and breakfast accommodation are most vulnerable, often because dangerous appliances have been reconnected or where owner-occupiers cannot afford to maintain or replace faulty equipment.

The increase in asthma, particularly to children, has been heavily publicised in recent years. Asthma is a respiratory condition and symptoms include wheezing, coughing, shortness of breath and tightening of the chest. It is not possible to identify what is responsible for the increase in asthma, which seems to vary between individuals, and may be a result of antibiotics weakening the immune system, eating processed foods, lack of exercise, smoking during pregnancy, and so on, and the UK has amongst the highest rates of asthma in the world (BBC 2000). Whilst not

the sole trigger for asthma, there is little doubt that symptoms are at least worsened, if not caused, by poor internal environments, where house dust mites and their waste products as well as condensation and associated mould spores can aggravate asthma.

Sanitation

Legally speaking, drinking water should be 'wholesome'. The European Union's Directive on drinking water quality came in into force in 1985, when some domestic water failed the 100 per cent pass standard required. The water authority's responsibility is as far as the stopcock in the house, when it becomes the householder's responsibility. This is why pipework can be a source of contamination, such as lead pipes in soft water areas. Local authorities sometimes carry out checks on water supplies, especially private water supplies and home treatment plants where known about.

Waste disposal tends not to be an issue in the UK except where problems arise with individual pipework, cesspits and so on, where public health risks are obvious. The English House Condition Survey (DETR 1998) illustrated that some households still lack basic amenities such as an internal toilet, especially in the private rented sector. Many amenities have to be shared in HMOs which can present problems of hygiene where management standards are low, possibly leading to diarrhoea, particularly to high-risk groups such as children.

Waste disposal

If allowed to build up, such as in communal areas where no one takes overall responsibility, domestic waste can lead to secondary problems of vermin. Rat and cockroach populations are increasing and can be vectors of disease, especially where design factors encourage their multiplication. Refuse can also present problems of accidents, fire and stress.

High-rise flats and municipal design

As a mass, low-cost response to housing need in the 1960s, many high-rise flats, though providing a decent internal living space with internal amenities, were poorly designed, developed and constructed to provide an unsatisfactory outside environment. Many had inherent problems of the low structural and insulation properties of concrete and metal supports, with asbestos insulation. Poor thermal qualities and cold bridging from supporting beams is linked to high heating costs, compounded by cheaply installed heating that is inefficient to run. Besides inherent design faults, they can be difficult to manage, leading to problems with

refuse chutes, lifts, vandalism, lack of operable lighting and crime (Coleman 1990). Many of these issues would be difficult to address because they are 'designed in'. There are few places for children to play outside because of safety. Again there is the issue of who is responsible for communal areas.

Health problems also include feelings of isolation; lack of choice and control in housing allocation with a loss of family and friends network; lack of community, facilities and shops; mental ill-health has been found to increase with the number of floors and women are particularly affected. Poor construction, use of materials and design also lead to damp housing. The Child Accident Prevention Trust suggested that architectural design would substantially reduce the number of child hospital cases (currently 250,000 annually). Social exclusion has become an issue in many such estates, although local authority (and ex-local authority) estates are by no means the sole location of exclusion.

Special needs housing

Housing for older people should not be thought of on mass, but for individuals who may have special needs increasing with their increasing vulnerability, such as maintaining body temperature, poor eyesight, restricted mobility and deteriorating memory in some case. 'Lifetime Housing', incorporating, for example, wider doors, designing kitchen for later adaptation, installing lever taps, is finding it hard to enter design processes. Older people may have increased heating requirements due to reduced mobility, but some struggle to afford this. Severe weather payments are usually too little too late and insulation grants are inadequate. Isolation may delay help arriving in case of accidents. People may not wish to admit they are elderly and their family may pressurise them into decisions about their housing, or having an alarm system to call for help. Violent crime against older people has increased in recent years. With an increasingly elderly population, there is more choice than ever for housing possibilities, but people's needs are continually changing and the resultant financial implications can be considerable. Often older people are forced to move suddenly due to illness. Many older people are well off and in good health and some suggest that they are given unfair advantage over more needy groups.

Housing and disability

There is little housing choice available to people with learning and physical disabilities, particularly for young people. Many live in the community relying on carers for support, but they may wish to have homes designed to live more independently. People with disabilities do not

wish to be labelled or stigmatised, but often, for economic reasons, small estates have been developed to cater exclusively for them, which can be isolated from the wider community. There is tremendous inequality between those with disabilities, because there is so little purpose-built accommodation. Accommodation often requires adaptation to meet specific needs, rather than some simple features being designed-in at planning stages (see Section 4.7).

Housing and health – breaking the link

Ormandy and Burridge (1988) suggest that the 1939 American Public Health Association's (PHA) 'Basic Principles of Healthful Housing' is still a useful background to housing assessment. It lists four fundamental categories by which housing standards can be measured: physiological needs, psychological needs, protection against contagion, and protection against accidents. The PHA, even in 1939, recognised the importance of not just individual housing conditions and their relationship to health, but the wider issues of housing within its community. The PHA considered that the local environmental quality, noise levels, space for exercise, provision for a normal family and community life, and so on, were equally important as, for example, adequate heating or a safe water supply.

The World Health Organisation (cited in Ransom 1991) described the complexities of healthful housing both within the house itself and its local environment. It reinforced the view that housing is not just about the avoidance of illness but it provides a living environment for betterment of health. It set targets relating to health and housing to be achieved by 2000 within available resources. Unfortunately, poor housing, particularly to lower-income groups in the private sector, remains at unacceptably high levels.

There are two main issues as to why this is so. First is that housing renewal policy is based within legislation on already defined standards enforced by EHOs (Ormandy and Burridge 1993). There is no real scope to embrace all health professionals, GPs, community workers, health visitors and so on to develop the promotion of healthy housing. Second, and of increasing importance, is the use of temporary and other unsatisfactory accommodation in the private rented sector to house the homeless and those unable to secure affordable accommodation elsewhere.

EHOs are the key professionals involved in delivering legislation to promote housing conditions in terms of housing fitness, nuisance, pest control and public health in the private sector through a range of measures described in Chapter 4. There is also scope for campaigning for improvements on housing and community. Much poor public sector housing is currently being renovated or redeveloped, with a move away from tower blocks to more traditional designs. In improving housing and

health, it is important to target resources to the worst housing identified, which will inevitably include HMOs and the bottom end of the private rented sector as well as housing meeting the specific needs of the occupiers. There is also a clear need for increased liaison between health professionals and multi-agency working. Particularly relevant to private sector housing, the government is currently considering a housing fitness rating scheme that seeks directly to relate health and housing issues, and to introduce a national licencing scheme for HMOs. These are discussed further in Chapter 4.

Also encouraging are moves toward a reworking of public health issues since the late 1980s (Ashton and Seymore 1988). This revision of pubic health – the New Public Health – seeks to draw together partnerships (see Section 5.6) of those involved to develop new and innovative ways forward in promoting well-being. This represents a substantial move away from traditional static organisations delivering predefined and segregated services. The new public health combines health promotion, healthy alliances, issues of equality and empowerment through new styles of management and service delivery in a corporate approach. The success of such approaches can be seen in the many examples of well-attended Healthy Living Centres, which offer a new approach to, and interest in, community health in its holistic context.

The recent White Paper, Saving Lives: Our Healthier Nation (DoH 1999) has sought to consolidate and develop such initiatives in order to tackle the complex causes of ill-health (personal, social, economic and environmental). Partnerships and joined up government action are seen as key in order to extend and encourage healthier lives by tackling and reducing health inequalities. Housing quality is recognised in impacting health across all tenures, and the government's current policy initiatives to address poor private sector housing include extending Home Improvement Agencies and the proposed housing health and safety rating system, as discussed further in chapter 4.

Summary

- Health and housing issues are wide ranging and can be aggravated or resolved by a variety of issues.
- People with special needs, such as the elderly and those with disabilities, sometimes require particular adaptations to enable them to make use of their existing accommodation.
- Some health and housing issues can be resolved relatively easily and inexpensively, but others are far more difficult to address and can be reinforced by a complex matrix of inequality.
- Existing legislation tends to be reactive and cannot address wider issues of disadvantage.

- New legislation is set to focus more directly on the health and housing relationship rather than concentrating on physical standards as at present.

5.5 Urban regeneration

Outline

A history of private sector housing renewal was reviewed in Section 2.1 and it is this history that has flavoured current activity in this sector. What generally emerges is a separation of renewal across tenures, due largely to funding opportunities and ownership differences. Much social housing has had specific programmes for resource allocation, such as estates action, housing action trusts and, more recently, the estates renewal challenge fund.

Until the Local Government and Housing Act 1989, private sector housing renewal was based on small-scale housing schemes with no legislative scope for wider area regeneration. This Act introduced the concept of renewal areas to take on board wider regeneration issues, essential to sustainable renewal programmes. These were developed further through the Housing Grants, Construction and Regeneration Act 1996, with government guidance in the form of Department of the Environment Circular 17/96, *Private Sector Renewal: A Strategic Approach* (DoE 1996), which for the first time provided detailed guidance on area-based action, incorporating issues wider than just housing rehabilitation.

There is currently other potential resources in the form of single regeneration budget, which has to be competitively bid for. Current regeneration strategies have to take on board this process of bidding for a declining base of funds, and accessing resources elsewhere, such as the European Union as well as becoming increasingly innovative in new initiatives in urban regeneration.

This section looks at the process of urban decline, how this is understood, and subsequent policy development in terms of political ideology to intervene and reverse that decline. It looks at legislation and funding available to local authorities to deal with urban regeneration and how this is evolving.

Urban regeneration – the policies, legislation and resources

What is regeneration?

Regeneration is wider than just housing rehabilitation. In its urban context, regeneration is about the improvement of a distinct geographical area by tackling a wide range of factors causing disadvantage and decline. Regeneration activities range in scope from small-scale community development projects to large-scale regeneration with substantial capital investment (Hooton 1996). The nature and extent of regeneration is frequently determined by funding and other resource

opportunities. Urban regeneration is largely governed by the extent to which the State chooses, or is able to involve itself in a market-based system that has ultimately failed to be sustainable. This State involvement is mainly subject to resource availability, particularly financial.

Whilst it would be encouraging to claim that regeneration schemes are always successful and sustainable, this is not always so. Even the government's own publication (DoE 1994) points to the facts that some schemes have not been successful in the longer term and their research illustrates the need for sustainable renewal programmes based on a sound and guaranteed financial footing, which allows for flexibility and partnership approaches, including clearly defined local authority and community roles combined with programme coherence across and within government departments. The report also suggests the possible development of an urban budget administered at regional level to improve coordination across programmes and departments. This is clearly in line with European Union thinking and resource allocation. The key objectives to include in effective urban regeneration policy are illustrated in Table 5.3.

What then emerges is a need for honest appraisal of the current urban situation before embarking on a regeneration programme and the following questions become key:

- How is the area of decay defined? By whom?
- What policy will be put in place, and is this actually likely to be effective?
- What is its goal? How will this fit in with prevailing market forces in the area?

Table 5.3 Key objectives to include in urban regeneration policy

- Economic revitalisation to promote industry and commerce as well as creation of employment in the building sector
- Decentralisation of power to local government and local community involvement in the renewal process
- Involvement of public–private partnerships
- Improvement in use of infrastructure
- Improved quality of life and environment, including social renewal initiatives and energy conservation
- Rehabilitation of historic buildings and districts to maintain character
- General residential improvements with a guarantee for residents to stay after improvements; maintenance of low-cost housing; transfer of rented dwellings to owner occupation or cooperatives; better special needs housing, particularly for the elderly and disabled

Source: based on Skifter Andersen (1999)

Process of urban decline

There is not scope here to analyse fully the economic process involved in urban decline, but to provide a brief overview of the changing nature of the urban arena. Balchin *et al.* (1995) argue that urban regeneration is a reaction to changing requirements and demands placed on large conurbations and the inevitable process of obsolescence and reconstruction. They add that redevelopment, rehabilitation and relocation of services are all part of the urban growth and renewal process. Such change essentially relocates urban activities, spontaneously regenerating some areas, but causing stagnation and decline in others, and inevitably affecting wider issues such as transport and infrastructure. Areas in decline may fall into further decline as market investment withdraws due to risk, causing local decay. The process tends to be a downward spiral, with a blighting effect on neighbouring areas, with depressed property values and little incentive for improvement.

The effect is similar for housing, as older dwellings are vacated by higher-income groups and re-occupied by lower income, or benefit-dependent groups experiencing high levels of unemployment, with a possible shift to multiple-occupation, serving as an inexpensive form of residential accommodation. Such rented accommodation, where heavily subsidised by housing benefit, can also serve to support low wages and temporary labour, and, of course, the poverty trap. The urban environment has therefore become increasingly temporary and there is little market incentive to invest in rehabilitation. Some see this as a key feature in intervening in private housing, which is already more difficult to address than social housing because of dispersed ownership and low property prices (Simpson 2000). The combination of low demand and decay inevitably effects land values.

Whatever their ideology, governments have involved themselves in some form of subsidised urban regeneration, and associated intervention in the market in the form of local taxation, for example, for around a century. Such intervention has taken many forms, but became particularly prevalent in the 1960s and 1970s in whole-scale clearance and redevelopment. Such intervention and municipalisation is no longer seen as politically desirable or indeed sustainable. The emphasis is now on partnerships approaches, with communities themselves taking a key role, and mixed funding opportunities – a mixture of the market and the State working together in urban regeneration schemes. Regeneration also requires some process of getting people involved – whether by persuasion, assistance (such as through grant-aid) or compulsion (such as through enforcement notices), and it is up to each local authority to determine a suitable way forward.

Cities are a primary source of economic progress and wealth creation,

but at the same time suffer many social costs brought about by urban change including industrial decline, poor housing, unemployment, crime, social exclusion and so on (Oatley 1998a). Cities therefore contain both opportunities, and issues arising from a combination of economic, social, political and ideological changes over time. There is pressure to retain a competitive edge in a global economy, and a simultaneous need to address urban deprivation. Recent years have seen major economic shifts toward high unemployment, short-term contract working, etc., which has been in part responsible for an increase in inequality, welfare dependency and social exclusion. Political responses have included increased partnership working, centralisation of government and new management practices, brought about largely by New Right ideology, a rolling back of the Welfare State and principles of competition and privatisation (Oately 1998a). Both the nature and history of the urban environment influence urban regeneration policies, but political ideology also plays a key role.

Land prices, and consequently land use, play an important role in any urban regeneration programme, and invariably has some effect on the commercial–residential pressures in an area. The nature of local government, and the financial, political and community power it is allowed to have in relation to central government, can help influence planning and land use patterns and how much of a role housing can play in the regeneration process, rather than being a peripheral issue in urban regeneration. Skifter Andersen (1999) points to the following justification for the State to intervene in improving poor housing conditions:

- Provision of decent housing conditions for all.
- Long-term preservation of housing stock.
- Prevention of health problems caused by substandard housing.
- Provision of savings to social care services.
- Making a contribution to broader regeneration programmes.

Clearly, these all have different implications in terms of strategies and resources required to achieve them and the role that the State takes in meeting required objectives.

Urban regeneration – the local authority role

In terms of regeneration, the government has developed and administered complex systems directed to meeting specific objectives across different housing tenures. As far as private sector housing is concerned, the first real area-based schemes were introduced in the form of General Improvement Areas and Housing Action Areas by the Housing Acts 1969 and 1974 respectively. Although theses schemes had some success,

there were criticisms that resources were not targeted to the worst properties and the most in need, but that some landlords were exploiting the grant system and that the grants caused gentrification in some areas. Enveloping schemes followed, whereby grants were targeted to whole blocks of houses for external renovation which was seen as more cost-effective, and had the objective of improving confidence in an area and encouraging owners to invest in further works. Such schemes were housing-based, and largely overseen by environmental health officers within a local authority. Such schemes had little scope to bring wider issues, such as poverty, deprivation, exclusion, employment and capacity building opportunities into the equation.

It was not until the Local Government and Housing Act 1989 (where grants for fitness were means tested and mandatory), and more recently the Housing Grants, Construction and Regeneration Act 1996 (where such grants became discretionary), that legislation provided for renewal areas as a new means of pioneering urban regeneration. Renewal areas provide the administrative framework to deal with social, economic, environmental and housing problems in an area of mainly private sector housing, which involves a range of strategies to encourage sustainable renewal. There is no dedicated funding, so local authorities have to identify their own resources as part of establishing a renewal area. There are currently one hundred renewal areas in England (DETR 1999a). Such area-based approaches have many benefits over other types of strategy, including:

- tackling both poor housing and its social environment;
- developing long-term sustainable partnerships;
- the possibilities of bidding for other funding, such as the Single Regeneration Budget;
- the stimulation of private investment through developing confidence in the area; and
- providing a local strategic framework for group repair, renewal, clearance or targeted renovation.

Renewal Areas superseded GIAs and HAAs and provided a new framework for a comprehensive approach to improve housing as well as the local socio-economic environment through developing partnerships, extensive regeneration and mixed-use funding and to provide maximum impact by increasing community and market confidence to help reverse decline. A renewal area would contain from 300 to 5,000 dwellings, of which 75 per cent would be privately owned and 75 per cent of which would be in poor condition. In addition, 30 per cent of households would be in receipt of income-related benefit. Establishing a renewal area is based upon a comprehensive area appraisal prior to declaration,

using Neighbourhood Renewal Assessment as detailed in Department of the Environment Circular 17/96 (DoE 1996). This provides the framework for 10-year resource identification, publicity and consultation required, before seeking Secretary of State approval. After declaration, local authorities need to ensure a flow of information, an implementation plan, mechanisms for monitoring and review, a strategy to suitably end the scheme and importantly give consideration as to coordination of action with other local authority schemes. This is summarised in Table 5.4.

For a flow chart on the procedure, see Bassett (1998: FC118).

Group repair and clearance can be used within renewal areas to help achieve required objectives. The aim of a group repair scheme is to renovate blocks or terraces with mixed funding, within or outside of a renewal area. The objectives are to improve the external appearance of dwellings and target resources on area basis. This is thought to encourage owners to then invest their own finance in carrying out further necessary repairs and on-going maintenance, although the extent to which this actually happens is unknown. Clearance areas (as outlined in Section 4.3) seek to replace worn out housing and can be an important dimension of housing strategies when considered alongside possible renovation as the most satisfactory course of action. The issues to be addressed through clearance are sensitive ones concerning the local community, since compulsory purchase orders can result in blighting the area.

Impact of regeneration

To be successful, regeneration schemes need to be able to tackle broader urban problems and the extent to which poor housing conditions are part of a general social and economic process in a geographically defined

Table 5.4 Establishing a renewal area

Before declaration	*After declaration*
• Comprehensive area appraisal • Use NRA process • Identify resources for 10-year programme • Carry out publicity and consultation • Prepare a report • Seek Secretary of State approval	• Provide adequate information and advice • Prepare an implementation plan • Monitor and review activity • Prepare an 'exit' strategy for the end of the programme • Coordinate renewal area action with other local authority schemes

Source: based on DoE (1996)

urban area. It can be difficult to find a way forward in some areas where traditional industries have disappeared, leading to an ageing population and lack of young inflow, causing long-term decline which can cause changes to local housing markets due to low demand for owner occupation and an increase in private renting, with less funding for private sector renewal. There is a need for investment that some regeneration programmes are not meeting (Brooks 2000). Administrators need to decide the feasibility of rehabilitation (of existing stock) versus renewal (providing new housing stock, which is likely to have a greater impact on residents) and how social and economic issues can be realistically addressed (Skifter Andersen 1999).

The impact of housing renewal legislation from the 1989 Act has been mixed. One major difficulty in area-based schemes has been the means testing element, and encouraging wide take up to improve an area. One of the difficulties in declaring renewal areas has been the lack of long-term funding guarantees (Leather and Mackintosh 1993, Leather 1999, Skifter Andersen 1999). This has resulted from a shortage of capital resources, inadequate local authority funds to meet other forms of grants and the inability of the means testing system to take account of an applicant's out-goings and the lack of grants to the private rented sector, where conditions are poorest (Leather *et al.* 1994). The legislation has had some impact on preventing further decline in housing conditions, but has made little overall impact on stock improvement. There were also problems with grant distribution nationally, with some areas of housing stress receiving proportionally less than elsewhere (Balchin 1995).

Competition in funding opportunity

Urban policy has altered radically since the 1979 election of a government with a New Right philosophy and ideology. The focus of the New Right shifted away from local management toward contracting and competition in the urban regeneration arena, and this has been largely retained by the New Left. Part of this change has been a move away from traditional property-led regeneration, toward exclusion and economic competitiveness. The philosophy is manifested and characterised through funding opportunities, new forms of local authority management and partnership working (Oately 1998b).

The ideas of competition and challenge were introduced into private sector housing (and wider urban) regeneration in the 1980s and has become a key political tool in resource allocation. The City Challenge initiative was introduced in 1991 to fund 5-year programmes of comprehensive urban regeneration. To be successful in achieving funding, local authorities would have to illustrate how their proposals were comprehensive and ambitious, contained partnership proposals with the private

sector, provided for local community participation and that they had arrangements in place for implementation and delivery (Balchin 1995). Through the bidding process, thirty-one winners each received £7.5 million over a 5-year period (Oatley 1998b). This amounted to additional potential funding toward urban regeneration strategies. Renewal initiatives since 1989 are summarised in Table 5.5.

City challenge was incorporated into, and superseded by, the single regeneration budget (SRB), along with other funding initiatives from other government departments, such as estate action, development corporations and housing action trusts, in 1994. The introduction of SRB was the most significant re-organisation of urban policy since the 1978 Inner Urban Areas Act and a proportion of SRB was made available for new regeneration schemes designated under the challenge fund, delivered by regional offices to be more comprehensive and accessible (Oately 1998c, DETR 1999b). The fund sought to recognise problems of poverty,

Table 5.5 Initiatives in private sector housing and urban regeneration

Date	*Initiative*	*Key regeneration purpose*
1989	Local Government and Housing Act 1989	Introduced mandatory means-tested grants based on fitness; introduced home repair assistance; introduced renewal areas and group repair schemes; redefined clearance areas and action for individual dwellings
1991	City Challenge	Programme to rehabilitate housing and commercial areas and at the same time to provide training for employment
1994	Single Regeneration Budget	Combination of some twenty previous urban aid budgets administered through regional offices to improve economic and industrial competitiveness, employment, social, and physical environment and quality of life. Bidding, competitive process. Initiatives to be comprehensive and part of a wider strategy incorporating partnerships, providing added value and value for money
1994	Lottery Funding	Added value-type funding to support urban regeneration initiatives
1995	Regional Challenge	Resource derived from EU Structural Fund for competitive bidding for public–private partnership projects, to stimulate innovative regional developments and maximise private sector contributions
1996	Housing Grants, Construction and Regeneration Act 1996	Discretionary grant-aid for renovation; further proposals for renewal areas and group repair schemes; home repair assistance extended
1997	Social Exclusion Unit	Established to coordinate policies to tackle social exclusion

Source: based on Oatley (1998)

isolation, community breakdown and industrial decline and associated issues by targeting some areas, based on need, not previously receiving priority for assistance.

SRB provides resources to support regeneration initiatives undertaken by local regeneration partnerships. SRB is very much about local regeneration and capacity building through relevant partnership support. It seeks to reduce inequalities and areas and groups, and encourages best practice as well as value for money. SRB allocation varies according to local circumstance, but needs to include some or all of the following as identified by the DETR (1999b):

- Improvement of education, skill and employment prospects locally.
- Addressing social exclusion and improving opportunities.
- Promotion of sustainable regeneration through improving and protecting environment and infrastructure, including housing, commerce and industry, and social problems such as crime, drugs and community safety.

SRB is administered through regional development agencies, except in London where the London development agency has this function. Bidding in rounds one to five led to the approval of 750 schemes amounting to £4.4 billion for up to 7 years. This is likely to attract over £8.6 billion of private sector investment, and make funding from the European Union more likely. Such partnerships are likely to create or retain 790,000 jobs, complete or rehabilitate 296,000 homes, support over 103,000 community organisations and 94,000 new business ventures (DETR 1999b).

Such competition in accessing funding has radically altered the way in which policies tackling urban decline and social disadvantage are formulated, funded and administered. Urban and rural locations alike can bid for the same budget – a shift away from an urban regeneration fund. Competitive bidding and funding has altered the way in which local governance, management, local representation and leadership have had to develop and operate, particularly in terms of new partnership (Oatley 1998a). The shift has been from local governance toward central control over funding allocation and altered previous methods of allocation and at the same time seen reduced government funding (Balchin 1995). There remain many arguments about the nature, extent and accountability of SRB funding.

The EU has had a growing influence on domestic policy, with some £10 billion allocated to the UK through the European structural fund between 1994 and 1999 (Oately 1998a). As government resources have declined, local authorities are having to look elsewhere for funding, and the EU offers some potential for urban regeneration projects. Funding has

been available from the EU in the form of regional challenge – launched in 1995 – modelled largely on city challenge. This resource is allocated from the domestic allocation of the EU structural fund and must be competitively bid for by public–private partnerships. A total of £160 million was allocated in 1995, and repeated in 1997. This accounts for 12 per cent of the domestic fund allocation from the EU. The EU is seeking to develop the role of cities in the global economic context, and the current Labour Government is supportive of this policy.

The philosophy of competition and bidding for funds has to a large extent been retained by the current Labour Government, with a general trend in emphasis away from pure economic efficiency concerns toward cooperation and best use of resources (Oately 1998b). However, there has been a greater emphasis on issues of social exclusion, and interest shown in the social and economic consequences of long-term unemployment (Oatley 1999a), but delays in the government's urban White Paper and adequate strategies, funding and freedom in place to pioneer urban change (Hatchett 2000). The current approach is social democratic, and resources remain severely constrained. It is difficult to see how effective such an approach will be where a radical, if not revolutionary, approach is required to deal with if some of the root causes of urban decline, such as disadvantage, are to be turned around by regeneration process, and sustainable in the longer term.

Resourcing future regeneration

A major problem in regeneration policies has been a reduction in capital expenditure and a shift toward competitive bidding for available funds. Meanwhile, the nation's housing stock is ageing and clearly requires investment. Grant expenditure has declined even though renovation of existing stock is favoured over redevelopment.

There is a need to address other potential sources of funding, particularly in the private rented sector, many of which are explored by Leather and Younge (1998). Options for investment might include a decreased capital grant with loan charges for remaining costs, providing equity sharing loans, limiting of a grant to renewal areas, subsidised interest rate loans, an increased role for building societies, education, information, advice and practical help and reform of the building industry. This would need to be combined with an awareness of true costs of ownership and maintenance, a reduction in initial costs for first-time buyers, a change in attitude to borrowing, saving and insurance in the long-term, houses seen as liabilities as well as assets; use of housing equity for renovation works, a reduction in prices in run down areas, so releasing money for renovation, and targeting of grants to areas where there is no potential for private investment and other relevant assistance.

It remains to be seen what the local authority role will be longer-term in housing regeneration.

Summary

- The State has taken an active involvement in housing, and more recently wider urban regeneration, for many years, but particularly since the late 1960s in terms of private sector housing.
- More recent trends have been toward recognising the role of the wider environment in housing decline and a reflection of this in policy, made particularly explicit in Department of the Environment Circular 17/96: *Private Sector Renewal: A Strategic Approach* (DETR 1996).
- There has been a general shift from local to central government in decision-making on urban renewal seen through the funding opportunities and local authorities now bidding competitively for funding to preset criteria, resulting in new forms of management and local partnerships developing.
- Current policy seeks to take on board wider urban issues, to turn around problems such as social exclusion, so that regeneration can be sustainable in the longer-term, which is in line with academic research in the area.
- There is a need for local authorities constantly to appraise what they are doing and to be imaginative in how new organisations can become involved in the regeneration process, particularly in respect of securing increased resources.

Publication 5 Stewart, J. (2002) A Step in the Right Direction, *Environmental Health Journal*, 110 (04) pp. 104-207. Online. Available HTTP: http://www.ehj-online.com/archive/2000/april2002.april2.html

step in the right direction

Jill Stewart takes an academic look at the benefits of landlord accreditation schemes

As numbers of those accepted by local authorities as statutorily homeless continue to rise, and with growing concern about the availability of social housing to meet this trend, local authorities are having to work increasingly with the private housing sector to meet local need.

Although many local authorities are ideologically opposed to this and have valid concerns about its condition and suitability, they are increasingly finding that the use of the private sector meets wider governmental policy and local strategic objectives. This includes at least some ability to meet growing housing need at the same time as offering the potential for self-regulation, freeing up time to concentrate on housing enforcement elsewhere. However, there remains little systematic information about the extent to which local authorities are working with the private rented sector with many authorities having to do so for lack of alternative accommodation in the social sector.[1]

This article considers the changing role, function and potential of the private rented sector (PRS) before turning to the practicalities and opportunities of establishing a landlord accreditation scheme.

Who lets, who rents, and why?

Landlords let for a variety of reasons, but it is suggested that general confidence in letting has increased since the 1980s.[2] Much of this increased confidence derives from the deregulated tenancies introduced under the Housing Act 1996 – assured shorthold tenancies (AST). The Government believed that such tenancies would increase the supply side of the sector, making it a more attractive opportunity for landlords, thus unleashing an untapped housing supply for rent. Indeed it did, and ASTs now account for around two-fifths of private lettings.[2]

The private rented sector is able to cater well for those able to afford market rents, and those who require flexibility in housing location. But there is a flip side to the coin – those who are not able to afford market rents. Increasingly, those on low income that are not able to access social housing have nowhere to turn but the private rented sector, which can be both expensive and insecure.

It has been suggested that the sector has acted primarily as temporary accommodation for the young and/or mobile, who are not able to access social housing.[3] Those in receipt of housing benefit are more likely to occupy poor condition dwellings let by investment orientated landlords.[4]

Assessed at 1998/1999 prices, the housing benefit bill for 1978 to 1979 was £2.3bn. By 1998/1999 it had risen to £11.1bn.[5] Clearly, the new ASTs had substantial impact on government expenditure as expenditure shifted from bricks and mortar subsidy to personal subsidy during the period. For housing expenditure in 1979, 84 per cent was bricks and mortar subsidy with 16 per cent personal subsidy, and by 1998/1999, 27 per cent bricks and mortar subsidy with 73 per cent personal subsidy.[5] Housing benefit expenditure is still expected to rise, even though unemployment is decreasing. Serious questions need to be raised about the economic efficiency of such expenditure, particularly when most

The private rented sector can be expensive and insecure for those on low incomes.

homeless households would prefer social housing than the private rented sector.[1]

Government research into the private rented sector[2,6] shows that 50 per cent of private sector tenants receive housing benefit, illustrating the considerable demand from lower income households, but around 40 per cent of landlords do not wish to let to people on housing benefit. Many on low income are forced into the sector through lack of choice, leaving them trapped into high rents and low security with few opportunities to access other tenures, trapped in a cycle of poverty.[5]

One key criticism is that despite high levels of housing benefit paid, the private rented sector remains in poor condition relative to other tenures and housing benefit is paid regardless of condition. Most privately rented housing is pre-1919 stock – one of the reasons for its generally poor condition – and the English House Condition Survey continues to report poor conditions in the sector which is increasingly occupied by ethnic minorities and low income groups.[7]

Around 20 per cent of private rented housing is unfit, compared with 6 per cent owner-occupation, 7 per cent local authority and 5 per cent of registered social landlord housing stock.[5] Research continues to show that there is not a consistent relationship within deregulated tenancies between dwelling condition and rent charged. Although some landlords had a more responsible attitude toward proactive maintenance, this did not include investment orientated landlords[4] so tenants may be unwilling – or unable – to pay more for better accommodation. This leaves landlords with little financial incentive to improve condition.

Meeting local need

Recent research published by the Department of the Environment, Transport and the Regions (2001) found a vast range of different landlord accreditation schemes (defined as schemes whereby landlords submit their properties for assessment against a range of condition and management criteria) being developed and implemented by local authorities (see table 1).[8] Some local authorities see such schemes, which vary in consistency of conditions, facilities, management and tenancy considerations, as a way to influence standards in the private rented sector. Others, however, view them only as a possibility for more responsible landlords.

A key finding of this and related research is that landlords are more inclined to join such a scheme where there is a surplus of accommodation, than in areas of high demand.[9]

Local authorities are faced with trying to house an increasing number of those accepted as statutorily homeless in decent accommodation with a general decrease in social housing stock. But they also have other responsibilities relating to the private rented sector which landlord accreditation schemes may also help to address.

Accreditation schemes can also help fulfil a local authority's multiple aims in wider strategic housing objectives, normally related to increasing supply and improving the quality of stock, including: promoting standards in the private rented sector; bringing vacant properties back to use; addressing anti-poverty strategies; encouraging wider regeneration; and finding viable options for homeless households. Many authorities have made innovative use of wider government initiatives to help finance local strategies.[1]

Despite the many anomalies of the private rented sector, there is cross-party governmental consensus on the role of the private rented sector, although those involved day-to-day in trying to regulate the sector may hold an understandably different perspective. Research continues to recognise problems in the sector, especially conditions and management, and how these might be tackled.[10]

There remains a lack of consensus on how to tackle the private rented sector, but the general trend is to focus enforcement attention on the bottom end of the sector, offering assistance to where it currently works well.[5] There is agreement that the private rented sector is performing below its potential in both quality and quantity – hardly surprising considering some of the fundamental dilemmas in terms of affordability for tenants, and expectation of return from landlord. The social housing sector simply does not operate in this way.

Many local authorities have found landlord accreditation schemes a more acceptable and viable option than using bed and breakfast hotels for temporary accommodation. While local authorities have tried many schemes in working with the private rented sector – including private sector leasing, housing association leasing, housing associations as managing agents and discharge of duty – direct provision has tended to prove more cost effective. This is because the landlord bears the cost of management, voids, arrears and dilapidation – with most of the cost as housing benefit from central government.[6]

A workable landlord accreditation scheme

Landlord accreditation schemes administered by local authorities attempt to secure a supply of decent quality privately rented properties for those in housing need. They are also seen to establish a competitive market position for members and encourage others to improve by setting and monitoring standards.[5,9]

Setting up an accreditation scheme requires considerable strategic development and implementation, but authorities already have many organisational systems, personnel, knowledge and information in place to champion them. Successful schemes involve landlords from an early stage – utilising a landlords forum – and are likely to take some twelve months to develop and a further six months to launch (see tables 2 and 3).[8]

If landlord accreditation schemes are to stand any chance of success, the landlord's objectives need to be met. Incentives are therefore crucial, particularly as landlords will wish to see a market advantage in joining a scheme. However, the DETR has reported that only 45 per cent of authorities were monitoring the success of their schemes and that, generally, numbers of accredited properties remained small.[8] This raises some questions about the viability of schemes, particularly where the outcomes; including security for tenants and financial and resource cost to local authorities, are considered.

The constant battle to house a growing list of households may lead to standards being cut, as any willing landlord may be seen as preferable to a bed and breakfast alternative. Equally, there may be pressure to let to a tenant before inspection by the environmental health department when standards are not legally acceptable.

There has been concern as to the cost of such schemes, and it has even been suggested that poor scheme management can lead to housing benefit fraud. There is also the very real problems of locating decent accommodation on an adequate scale in respect of the local authority resources put into setting up such a scheme.

In order to overcome potential problems before they emerge, it is essential that the interested parties – including local authority officers (housing allocations and advice, environmental health and so on) as well as potential landlords and tenants meet to determine the aims and objectives of such a scheme.

An important issue is who would ultimately be held liable on accident where a local authority placed a tenant in accommodation that it later emerged were defective. In particular, concerns about rent payment need to be met. Local authorities already have considerable expertise and existing administrative systems that can be developed to help administer the deposit and rent promptly to make belonging to the scheme an attractive option to the landlord.

Table 1: Features of accreditation schemes

Accreditation to include management practices and letting of suitable standard, which may be recognised by "hallmarked" symbol.
Self-certification on the production of current gas safety certificate; compliance with fire regulations (where appropriate); inspection certificate from professional agency; tenancy agreement signed by manager and tenant (for each letting); property details *eg* building type, amenities, number of residents, and notices served by the local authority (or other recognised accrediting agency).
Retention of local authority enforcement powers in case of breach of standards.
Annual re-accreditation may be less incentive to landlords than "one-off" accreditation.
Benefits to landlord of joining accreditation scheme *eg* preferential access to grant assistance, fast track housing benefit, support and training, and negotiated cheaper insurance.

(Based on Rugg and Rhodes, 2001)

Table 2: Key features of a partnership approach

- Development of "internal" partnership approaches that are workable and provide support and guidance on rights, including local authority environmental health and housing departments, and housing advice services (benefit, tenancy advice *etc*).
- Development of existing and new "external" partnership approaches including private sector tenants groups, landlord forums, and local authority personnel *etc*.
- Working groups of field staff to meet regularly to ensure a flow of information and co-ordinate action to develop best practice; to regularly and honestly appraise the scheme's success and necessary amendments.
- Planned, proactive inspections based on good practice guidelines to avoid loss of lettings.
- Joint meetings to establish areas of overlapping responsibility and training needs.
- Establishing a database of landlords and lettings – as well as other local accreditation agencies – so that the most appropriate accommodation can be selected and allocated to meet need rapidly and effectively.
- Opportunities to look to potentially longer-term housing supply; *eg* leasing, housing association nominations, and private rented housing accommodation that meets minimum standards.

Table 3: Making voluntary accreditation work

Clear objectives set within overall private sector housing strategy with political support.

Appreciation of the local housing market's operation

Thorough development of accreditation scheme with agreement from landlords to ensure that the scheme's incentives are adequate.

Adequate staffing resource and support from partnership organisations.

On-going publicity and promotion, supported by clear documentation of the scheme.

(Based on DETR, 2001)

It is apparent that landlord accreditation schemes are only likely to attract the better landlords, but there is still a huge way to go on promoting standards and security elsewhere in the private rented sector. The establishment of landlord accreditation schemes requires considerable local authority resource, with no guarantee of increasing privately rented supply. But costs to local authorities are decreasing as lessons are being learned and schemes are slowly becoming more accountable and more attractive to landlords and authorities alike.

Accreditation may be one step closer toward licensing the private rented sector, although there is clearly a long way to go. There remain many different perspectives behind the theory and practicalities of establishing an accreditation scheme, but at the very least it may help promote conditions and self-regulation more widely – and more acceptably – to landlords, tenants and local authorities alike.

Further information about private sector housing, its purpose, condition and necessary remedy can be found in Jill Stewart (2001) *Environmental Health and Housing*, London: Clay's Library of Health and the Environment Volume 1: Spon Press. ISBN 0-415-25129-X

References

1 DETR (1998c) Housing Research Summary. "How local authorities used the private rented sector prior to the Housing Act 1996" (No. 86, 1998), London: DETR. Available online at: www.housing.detr.gov.uk/hrs/hrs086.htm (14/02/2002).
2 DETR (1996) Housing Research Summary. "Private landlords in England" (No. 54, 1996), London: DETR. Available online at: www.housing.detr.gov.uk/hrs/hrs054 htm (03/08/2000).
3 Cowan D. (1999) *Housing Law and Policy*, London: Macmillan.
4 DETR (2000b) Housing Research Summary. "Repair and maintenance by private landlords" (No. 138, 2000), London: DETR. Available online at: www.housing.detr.gov.uk/hrs/hrs138.htm (14/02/2002).
5 DETR (2000a) The Housing Green Paper. *Quality and choice: A decent home for all*, London: Joint publication from the Department of the Environment, Transport and the Regions and the Department of Social Securit. Available online at: www.housing.detr.gov.uk/information/consult/homes/index.htm (20 August 2000).
6 DETR (1997) Housing Research Summary. "Financing temporary accommodation in the private rented sector: An economic analysis" (No. 56, 1997), London: DETR. Available online at: www.housing.detr.gov.uk/hrs/hrs056.htm (14/02/2002).
7 DETR (1998a) The English House Condition Survey 1996, London: HMSO Available online at: www.housing.detr.gov.uk/research/ehcs96/tables/index.htm (30 August 2000).
8 DETR (2001) Housing Research Summary "Voluntary accreditation for private landlords" (No. 144, 2001), London: DETR. Available online at: www.housing.detr.gov.uk/hrs/hrs144.htm (14/02/2002).
DoE (Department of the Environment) (1996) Circular 17/96. "Private sector renewal: A strategic approach". London: HMSO.
9 Rugg J, Rhodes D and Jones A (2000) "Students and the private rented market", York: Joseph Rowntree. Available online at: www jrf.org.uk/knowledge/findings/housing/d60.asp (11/02/2002)
10 Rugg J and Rhodes D (2001) *Chains or Challenges. The prospects for better regulation of the private rented sector*. London: British Property Federation and Coventry. The Chartered Institute of Housing

Forum question:

What are you views on landlord accreditation schemes – do they work, are they economically viable and can they improve poor housing conditions? To discuss the issues raised in this article visit: **www.ehj-online.com**

Publication 6 Stewart, J. and Bushell, F. (2002) A question of need, *Environmental Health Journal,* 110 (12) pp. 372-374. Online. Available HTTP: http://www.ehj-online.com/archive/2000/december2002/december5.html

A question **of**

Health needs assessment sets health priorities for a given population according to need and identifies changes and action needed. **Jill Stewart** and **Fiona Bushell** investigate its relevance to environmental health

A health needs assessment (HNA) researches the current status of health and need within a community – *ie* a geographical area or social group of people – as a basis for decision-making. Fundamentally, HNA is about profiling a community to determine which health issues should be tackled and how.[1]

Both existing and new organisations charged with delivering public health through partnership arrangements – notably to inform health improvement plans (HIMPs), community strategies and local strategic partnerships – have to take a needs-assessed approach, with an emphasis on ensuring that identified, evidence-based health inequalities are addressed. Further, in an increasingly competitive funding environment, that requires almost constant justification as to value for money, HNA is becoming increasingly important in attracting resources to an area or community.

HNA, which involves looking at the health problems that have a major impact on the population and the recurring factors so that better services can be provided locally[1], helps to provide accurate information on:

- baseline or supporting evidence in developing innovative, partnership-based strategies that are comparable over time;
- current and potential health-based activity based on resource allocation, bidding, or prioritisation, or to influence, justify or review policy, service or practice;
- acceptability and feasibility of policy changes;
- impact maximisation in relation to resource used;
- community participation and involvement in health activity;
- organisational and individual activity in health delivery and its impact on a community's health; and,
- local health issues to raise consciousness, or in advocacy work.

Unravelling the definitions

Before getting started on a HNA, it is important to achieve consensus from partnership organisations (statutory, voluntary, community *etc*) as to what is understood by the concepts of "health" and "need", as these terms can mean different things to different people. It is also necessary to determine the "community" that is subject to assessment, which could be either geographically based or a dispersed social group. Methods of research and analysis selected need to be valid, reliable, objective and rigorous enough to withstand scrutiny.[2] At the earliest stage, the organisations commissioning the HNA research must decide its purpose so that it can be appropriately directed and managed.

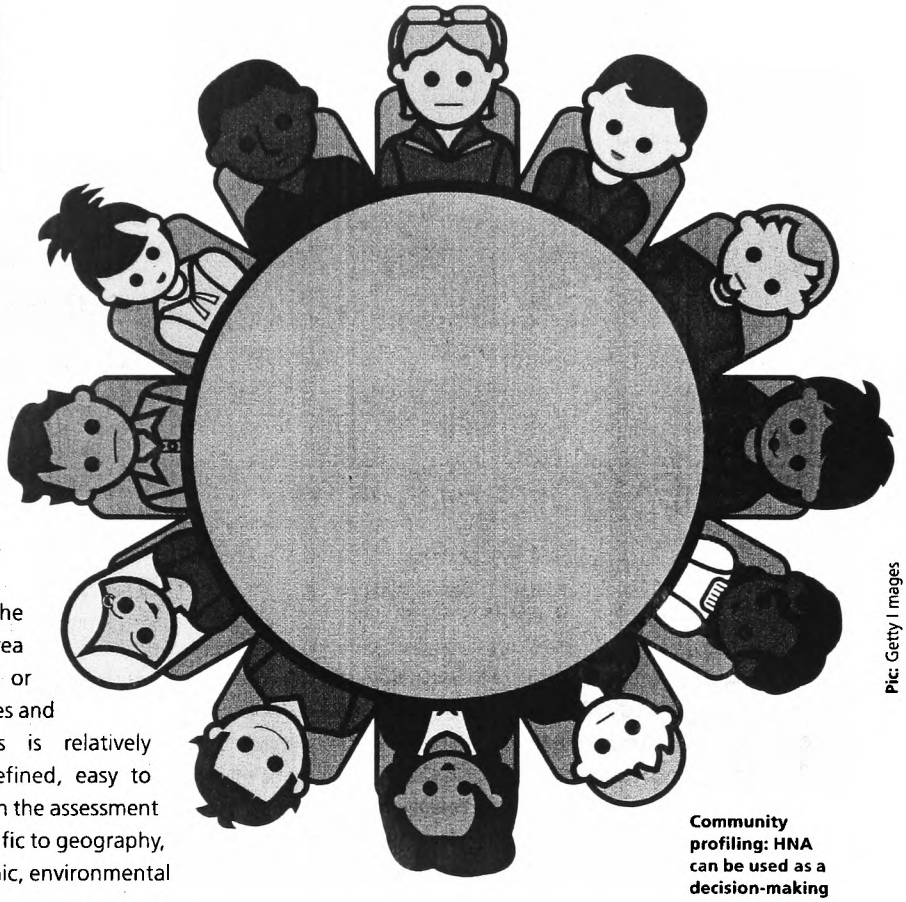
Health, need and community

A HNA seeks to identify, measure and source health information in its widest sense, unravel the causes, and find out what action to take to best address the issues. Although much of the literature on HNA is placed firmly in the remit of the NHS, it is clear that improvements need to reach far beyond the NHS to those charged with delivering positive change to address the underlying causes of ill-health – notably environmental and public health specialists. But this must be centred around communities that need support – many of whom have already filled the gaps in state provision and begun to find their own health solutions. HNA and resulting policy is not about public sector organisations domineering grass roots organisations, but looking at why and how they work, and providing appropriate support.

A health need can be seen as a subjective, relative concept, identified by a professional or community. However, needs defined by the former reflect a professional judgement and may be very different to those identified by the community. Thus, it is essential that those most in need of information, support or services are able to express their needs and have them taken into account. While community profiling can result in a wish list, limited resources means that not all needs can be met.

Whether subjective or objective, the purpose of identifying health needs is to assist in prioritising action to secure health improvements and to reduce inequalities. Action must be based on qualitative and quantitative data and medical, environmental and social data should be layered on top. Information on health status, the community itself and on the determinants of health, *ie* lifestyles, quality of housing, levels of employment and access to health services, is needed.

need



Pic: Getty Images

Community profiling: HNA can be used as a decision-making tool.

Invariably, much HNA is related to the population or "community" in a geographical area – such as a local authority, a neighbourhood, or ward – as this normally relates to funding regimes and initiatives. HNA on a geographical basis is relatively straightforward – the boundary is clearly defined, easy to understand and a community is either included in the assessment or it is not. Most population information is specific to geography, and it is relatively easy to compile socio-economic, environmental and health information about an area.

However, there are some difficulties in a geographically specific approach. Not all vulnerable people live in deprived areas, and not everyone living in a deprived area is vulnerable. The impact of globalisation, personal mobility, cultural evolution and evolving class differentials means that lifestyle has become increasingly important in health determination. The fact that health status in an area has changed may be more to do with gentrification than actual improvements in the health of existing residents. Recorded trends in health – as well as individual perceptions about health – may not provide an accurate picture of what is really occurring as data may be skewed or distorted.

A more accurate and thorough understanding of a community's health also needs to consider individual groups of people, such as ethnic minorities, female-headed households in bed and breakfast accommodation, gypsies, or those sharing some similarities in health status and experience, such as those with a particular disability, AIDS, or older people leaving hospital and returning to their homes alone. However, although professionals may group those with similar perceived "needs" for their own purposes, it does not follow that the same group will recognises itself as a community with common interests or features (figure 1)

Compiling the data

HNA is essentially a research project, carried out on multiple levels, for the assessment and planning of how to improve the health of a community (figure 2). Besides regionally and nationally collated data sources, organisations like local authorities and primary care trusts (PCTs) already collate and map many sources of data that can provide the information needed in the initial stages of a HNA. Since health and social care delivery organisations do not always share coterminous boundaries, consideration needs to be given to possible duplication or distortion of compiled statistics. Statistics and communities may or may not overlap, are not always comparable and are not necessarily mutually exclusive.

Initial profiling involves asking a broad range of people and professionals what they consider to be the key health problems, as well as collecting data on an area. The information obtained will contain interrelated issues to show how medical, environmental, social and economic factors influencing health are linked and how an integrated approach is needed to tackle them.[1] This can help map medical, environmental and socio-economic data across boundaries to identify common patterns and to obtain an integrated, partnership-based approach to identifying the gaps and links, and solving problems.

The HNA focus on both quantitative and qualitative data reflects the wider shift in thinking in public health away from the traditional medical model and toward a socio-economic model that recognises the underlying causes of ill-health that environmental and associated health specialists deliver on a daily basis.

Qualitative data is the "why" in social research and provides valuable understanding and insight into why a situation is as it is

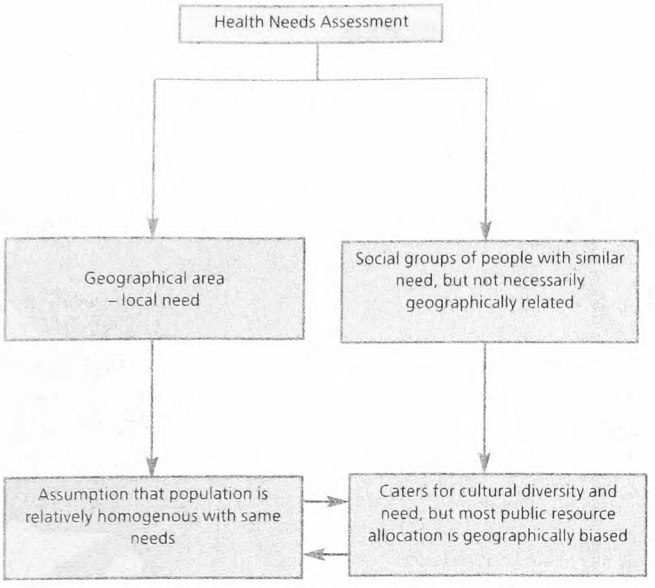


Figure 1: Geographical or social group framework for HNA?

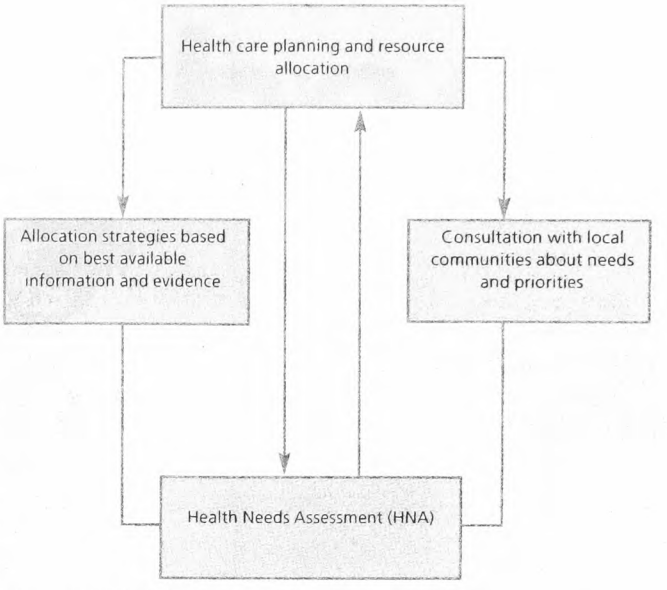


Figure 2: Principles in planning and resourcing health care.

and enables patterns of interrelated issues to be made clearer. It can be complied by questionnaires, focus groups, and community networks. It provides personal and community perceptions which give valuable insight into the impact of a policy that may not be fully revealed by statistical data alone, rather than just concentrating on what that overall statistics are (apparently) saying about an area.

This is becoming increasingly important to the social agenda as communities are engaging with policy makers in local decision making – a fundamental part of developing inclusive and bottom up partnerships so that communities themselves can self-identify need and how it can be met. It provides decision-makers with the data to support or refute policy and implementation processes.

Social capital

HNA is not just about finding out what is not adequate, or suitably sufficient in a community, it is also about recognising the potential of what is already there in the form of social capital – relationships and networks in civil society that help formulate collective community action[3,4] – and its importance to the community resolving its own issues.

A HNA needs to be local and contribute toward this as part of problem solving and democratic participation.[3] However, communities may be experiencing "survey fatigue" or have had bad experiences of governmental organisations in the past, leading to some disinterest in current health research activity. Thus, HNA needs to be approached with sensitivity and tact, valuing the contribution than many communities already provide themselves.

Uses and presentation

HNA needs to be presented – orally or in written form – in such a way that something positive will actually come from it. It is important to consider the key message of the research and to communicate this in the right way to the right audience. What was the research for? Is it accurate and contemporary? Has it been successful and useful? Has it confirmed or refuted earlier perceptions? Who is going to read it and in what format? Why? What is its current and future use in policy change or advocacy? Do we recognise the issues and move forward?

The final document may take several drafts before it is acceptable for public scrutiny and it may be appropriate to publish interim findings to help maintain momentum and interest, particularly if a very long time delay is anticipated between collating and analysing the data. The expected audience needs to be able to understand what is being said and to be sure that what is being said is factual and accurate.

There is no point in pouring resources into a HNA that goes nowhere or that is so complex or secretive that no one can make sense of it. It may be that the results need to be reported in a variety of formats suited to recipient and a summary report is extremely useful. Sufficient resources should be set aside so that that the final document can be professionally prepared. It should be a document that provides evidence-based data that is comparable over time.

Contact Jill Stewart at: J.L.Stewart@greenwich.ac.uk or Dr Fiona Bushell at: F.L.Bushell@greenwich.ac.uk

References:
1 Lock K (1999) "Meeting the need", *Community Practitioner.* Vol 72 /6: 157-8.
2 Payne J (1999) *Researching health needs: A community based approach,* London: SAGE Publications.
3 Sirianni C and Friedland L (undated) "Social capital", Civic Practices Network Online. Available HTTP: http://www.cpn.org.sections/tools/models/social_capital.html (6 September 2002)
4 Social Capital Formation (2001) What is social capital?, Online. Available HPPT: http://www.lks.net/~cdc/scapital/WhatIsIt.html (6 September 2002)
5 Ashton, J and Seymour, H (1988) The New Public Health. Milton Keynes: Open University Press.

This is an edited version of a chapter of the book *Environmental health as public health*, by Jill Stewart and Fiona Bushell, to be published by Chadwick House Publishing next year. For further details e-mail: s.mcguire@chgl.com

Forum question:

How relevant to environmental health do you think health needs assessment is? To discuss visit: **www.ehj-online.com**

Publication 7 Stewart, J. (2002) The Housing Health and Safety Rating System: a new method of assessing housing standards reviewed *Journal of Environmental Health Research*, 1 (2) pp. 35-41. Available HTTP: http://www.jehr-online.org.volume1/issue2/5/index.asp

PROFESSIONAL EVALUATION

The Housing Health and Safety Rating System – a new method of assessing housing standards reviewed

Jill Stewart[1]

[1] **Senior Lecturer, School of Health, University of Greenwich**
Correspondence: Telephone: +44 (0)20 8331 8218
Email: j.l.stewart@greenwich.ac.uk

Abstract

The statutory standard of fitness was first introduced as a concept around 1919 and remains the key legal (Housing Act 1985, as amended) standard in assessing housing conditions and determining action to take, notably in the private sector. It has been criticised for failing to address many known hazards likely to give rise to harm in dwelling-houses, such as poor fire safety, domestic energy efficiency and ergonomics. There has also been criticism that the current standard is not dynamic and forward looking, and as such is not able to respond to changing needs and aspirations, and there have been calls for a 'system' of assessing conditions, rather than a fixed standard. Concern has also been expressed about how tenure-neutral the standard is and questions raised about how comparisons are made between public and private housing. There have therefore been moves in recent years to completely review the way in which housing conditions are assessed and a new approach has been under development for several years. This new approach is set to take into account known domestic accident-related data as well as to accord with current building regulation requirements and relevant research data concerning the effect of housing conditions on health and accidents. The proposed system – the Housing Health and Safety Rating System (HHSRS)– incorporates known hazards and is able to relate these to the likelihood of harm in all dwellings. Primary legislation will be required to introduce the system. Such a 'risk based' approach is set to bring determining housing conditions into line with wider environmental health approaches and activity relating to food and health and safety. This paper reviews the current statutory standard of fitness, its strengths and weaknesses, before turning to consider the development and likely implementation of the HHSRS. Whilst many welcome the new standard, others have concerns as to its practical application and its relationship to wider housing and renewal programmes within the new public health agenda.

Key words: Accident statistics, home safety, housing fitness, housing health and safety rating, statutory fitness.

Introduction

The debate about how housing conditions across tenures are assessed, monitored and regulated by local authority strategies and whether what is achieved really makes in roads into improving the nation's health has been evolving for many years within a climate of rapidly shifting tenure patterns. The current statutory standard of fitness has tended to be seen as a regulatory tool for the private sector, whilst social housing has been subject to its own protocol. Recent years have seen the rapid development of local housing strategies that more rigorously assess and respond to 'community need' with a renewed public health focus. Such changes have led to calls to review whether a new, comprehensive approach is necessary as part of a wider social agenda in assessing and responding to poor housing conditions (DETR, 2000a).

This paper reviews the current statutory standard of fitness, why it sometimes fails to provide a sufficient resolution for poor housing conditions in relation to maintaining and promoting health and how a new hazard based approach – the Housing Health and Safety Rating System (HHSRS) seeks to remedy this. It considers how the HHSRS may fit into wider housing and area renewal strategies in a climate of rapidly evolving policy.

The HHSRS and steps toward its future implementation are still evolving and local authorities are developing appropriate strategies to implement the proposed system. The author is aware of continually being overtaken by events and this paper therefore seeks to provide a review of the standard at this stage. It is hoped that research will be carried out to assess the impact of the HHSRS in relation to the current fitness standard at a later date.

The current statutory standards of fitness and nuisance

The concept of housing fitness was first introduced by the Ministry of Health in 1919, and some eighty years on, the standard remains broadly similar.

Statutory fitness is the key legal standard by which housing conditions are measured and appropriate action is taken. It represents a bricks and mortar type approach which does not take occupancy into account. Local authorities have an annual duty to survey their district for unfitness and determine a strategy to address it, with a further duty to take action to deal with every unfit dwelling-house identified. The standard is therefore crucial to local authority activity across housing tenures.

The current statutory standard of fitness (the fitness standard) is found under the Housing Act 1985 (as amended) section 604. A dwelling-house is deemed fit for habitation unless it fails to meet one or more specified criteria, and for that reason is not suitable for occupation. The criteria include structural stability, serious disrepair, dampness prejudicial to health, adequate provision for lighting, heating and ventilation, a wholesome water supply, facilities for preparation of food – including a sink with hot and cold water, provision of a WC (internal), bath or shower with hot and cold water, foul and surface water drainage. The fitness standard also applies to houses in multiple occupation (HMO), where an extended standard includes means of escape from fire and amenities for the number of occupants, responding to the increased likelihood of fire and accident by overcrowding and discomfort caused by an inadequate numbers of amenities.

The fitness standard was most recently amended by the Local Government and Housing Act 1989, when it was also made an integral part of the private sector housing grant regime. It added items that previously formed part of the Compulsory Improvement criteria (internal amenities) and aimed to provide a more objective basis for intervention into housing conditions, based on health and safety and reduced State intervention, with a change in emphasis from 'unfitness' to 'fitness'. Interpretation and application of the fitness standard was initially supported by Department of the Environment Circular (DoE) 6/90, and more recently upgraded to DoE Circular 17/96 (DoE, 1996) that provides ministerial advice to encourage uniformity in application. The Circular also delivers protocol on action to take in respect of individual and area based unfit dwelling-houses in the private sector.

However, almost as soon as the new standard was introduced, it was criticised and a Private Members Bill called for amendments. Some saw it to be subjective and limited in scope, excluding many domestic health and safety issues likely to cause harm, such as poor or even absent requirements for fire safety, internal arrangement, energy efficiency and indoor air quality. The standard is static, finite and non-progressive, being enforcement-based rather than progressive. It is not able to distinguish between degrees of unfitness, for example, lack of a wash hand basin is currently considered equal to major condensation dampness. Meanwhile, many other public and environmental health standards have moved on to forms of risk assessment, which can help provide a more dynamic approach. This said however, the current fitness standard is one that is national, has impact, is well recognised and interpreted and fits neatly into existing enforcement and grant-assisted regimes.

Statutory Nuisance provisions under the Environmental Protection Act 1990 also provide legal resolution for poor housing conditions, where the effect of the defect on health, rather than just the presence of the defect is important. Statutory Nuisance legislation may be a better course of action in some instances where the fitness standard is not sufficiently extensive. An advantage of this legislation is that it is enforceable across tenures and enables social housing tenants to take action against their landlords in seeking necessary repairs and improvements with increasing success, but such actions have caused resource problems to many local authorities. Any new approach assessing and responding to housing conditions across tenures would need to consolidate the advantages of both statutory fitness and nuisance to help provide an increasingly 'tenure-neutral' approach.

Relevant research

Concern with the fitness standard focused largely on the extent to which it was really able to help improve (recorded) health and safety housing data. By 1993, academics at Warwick University published a report on monitoring the new housing fitness standard and identified areas of concern. By 1995, the Building Regulations increasingly focused on safety and health issues, incorporating risk assessment techniques. The 1996 English House Condition Survey (DETR, 1998) reported that fitness standards remained similar to the previous survey, suggesting a general lack of progress in improving housing conditions nationally. In addition, the Home Accident Surveillance System (HASS) (DTI, 1995 and 2000) published evidence that suggested existing housing legislation was failing to tackle many domestic conditions likely to give rise to harm.

In view of some of the issues identified above, a review of the current statutory standard of housing fitness has been underway for some time. Initial consultation focused on whether expanding the standard to incorporate items such as internal arrangement and energy efficiency, both with important implications for home safety, or whether a more fundamental review of evaluating housing conditions, based on empirical evidence, was in fact required (see Battersby and Ormandy, 1999; Battersby et al, 2000; DETR, 1999).

Table I: Accidental deaths in the home for 1998 (England and Wales)

Age	Male	Female	Total
0-4	47	29	76
5-9	9	7	16
10-14	18	5	23
15-19	78	34	112
20-24	138	35	173
25-29	192	42	234
30-34	220	65	285
35-39	167	68	235
40-44	143	80	223
45-49	153	78	231
50-54	141	83	224
55-59	96	51	147
60-64	115	58	173
65-69	124	85	209
70-74	140	102	242
75-79	157	156	313
80-84	163	204	367
85+	212	451	663
Total	2,313	1,633	3,946

Note: Accidental deaths caused by drug poisoning, other poisoning, falls, fire/burns, natural factors, drowning/suffocations/choking, other accidents, or undetermined.
Source: based on ONS statistics cited in DTI (2000)

The government issued a Consultation Paper in February 1998 (DETR, 1998) seeking comments on how the standard might develop in the future. It fundamentally sought comment on whether to retain the current fitness standard, or to introduce an alternate approach, then called 'Fitness Rating'. This new rating approach would be a substantial move from the existing standard in that it would; target resources to the worst properties, include hazards known to present the most serious health and safety risks, allow more items to be considered without increasing the number of 'unfit' properties, and provide a more flexible approach for local authorities.

More recently, the DTI (2000) reported that there were almost 4,000 deaths at home in 1988, resulting from falls, poisonings, fire, suffocating/choking, and miscellaneous events (see Table I), these figures being higher than equivalents for road or workplace accidents. Many of these cannot be addressed by existing legislation. The government has increasingly favoured a risk assessment approach (DETR, 2001) so that the most serious health and safety hazards in housing stock could be addressed – notably cold, slip, trip, fall, fire and radon gas hazards (related to the accident data shown in Table II). Additionally, the need to relate health outcome of accident or harm occurrence to severity was identified to help allocate a risk rating based on the likelihood of, for example, death, pneumonia, serious injury, chronic stress, accident or infection. Any new approach would need to comprehensively address 20,000 excess winter deaths due to cold homes; 230,000 injuries and 500 deaths annually on stair falls; 15,000 non-fatal injuries and 600 fire deaths. Many of these could be barely (if at all) tackled by the existing standard, but could be by a new risk based system a completely new approach to assessing housing conditions.

The Housing Health and Safety Rating System – a new approach

Current proposals are to introduce a comprehensive health and safety based system – the Housing Health and Safety Rating System (HHSRS) – applicable to all types of 'dwelling'. This would measure and rank the severity of risk by considering the effect of a defect, not just the presence of a defect. It would be medically and scientifically valid, practical and modern in application and legislatively based. It would protect the most vulnerable occupant (by age banding) to a particular defect. Fundamentally the new system would be based on 24 health and safety hazards in housing known to give rise to injury, with each being individually assessed – these are listed in Table III.

The proposed definition of 'dwelling' would be enlarged from the existing 'dwelling-house' definition to include the structure, the means of access, and associated outbuildings and garden, yard and /or other amenity space should provide a safe and healthy environment for the occupants and any visitors, enabling a wider domestic area to be addressed, again incorporating known areas of risk.

Table II: Summary of (non-fatal) home accidents by type from UK A&E statistics 1998

Category	Numbers of people
Fall	1.08m
Striking	650,000
Burn	102,000
Poisoning	41,000
Choking	14,000

(Source: DTI, 2000)

Table III: HHSRS hazards in the home

1.	**Excessive temperatures**
2.	Falls
3.	**Fire**
4.	Hot surfaces of materials
5.	**Damp, mould etc.**
6.	Air pollutants
7.	**Radiation**
8.	Electrical hazards
9.	**Noise**
10.	Lead
11.	**Asbestos**
12.	Entry by intruders
13.	**Crowding and space**
14.	Explosions
15.	**Infections from other sources**
16.	Poor provision for food safety
17.	**Inadequate facilities for personal hygiene**
18.	Inadequate sanitation or drainage
19.	**Contaminated water supply**
20.	Structural failure
21.	**Inadequate lighting**
22.	Uncombusted fuel gas
23.	**Entrapment and collision**
24.	Poor ergonomics

(Source: DETR, 2000)

The HHSRS considers the effect of the defect and provides a rating for this, which is a substantial move away from the existing standard, which comprises a pass or fail type checklist. The 'ideal standard' is established and the actual condition compared with this ideal; conditions falling short of this (faults) are assessed for their potential to cause harm. The assessment is based on the likelihood of occurrence (an event or period of exposure) multiplied by the range of harms or outcomes, which provides a hazard weighting score. The person most vulnerable to the hazard is taken into the equation. The numerical score calculated represents risk, which may be deemed acceptable or unacceptable, and would then trigger appropriate action. Risk assessment is to be based on the likelihood of occurrence multiplied by the range of harms resulting, to equal a hazard score ranging from 0 (safe) to 5,000 or more (unsafe) (see Table IV). The Office of the Deputy Prime Minister (ODPM) (previously DETR, then DTLR) is currently developing further guidance in administering the proposed standard (DETR, 2000a and b) which is now set to apply to HMO's, where each unit or 'dwelling' would be assessed separately, although there is some concern as to whether the HMO as a whole can be assessed holistically under the proposals, and this is considered later (CIEH, 2001; CIH, 2001).

The HHSRS is capable of comparing different types of hazard, taking into account the likelihood of occurrence and severity of occurrence and providing a numerical score for each hazard. This allows for improvements on architectural features that can give rise to an accident, such as design of stairs, windows, kitchen and so on. Fundamentally the HHSRS is a system, or an approach – not a standard, which enables it to be progressive in terms of housing conditions.

Application of the HHSRS

In practice, applying the standard involves identification of the 24 hazard categories (see Table III), to be assessed and recorded individually. This involves a two-stage assessment, considering the likelihood of occurrence and the range of probable harm outcomes that may result. The combination

Table IV: Ranges of possible hazard scores

Band	Score	Equivalent annual risk of death	Local Authority action
A	**5,000 or more**	**1 in 200 or more**	**Mandatory**
B	2,000 - 4,000	1 in 200 - 1 in 500	Mandatory
C	**1,000 - 1,999**	**1 in 500 - 1 in 1,000**	**Mandatory**
D	500 - 999	1 in 1,000 - 1 in 2,000	Discretionary
E	**200 - 400**	**1 in 2,000 - 1 in 5,000**	**Discretionary**
F	100 - 199	1 in 5,000 - 1 in 10,000	Discretionary
G	**50 - 99**	**1 in 10,000 - 1 in 20,000**	**Discretionary**
H	20 - 49	1 in 20,000 - 1 in 50,000	Discretionary
I	**10 - 19**	**1 in 50,000 - 1 in 100,000**	**Discretionary**
J	Less than 10	Less than 1 in 100,000	Ideal

(Source: DETR, 2001)

gives hazard score, directly related to equivalent annual risk of death. The assessment is based on the occupant most vulnerable to risk (by age banding), or it can be interpreted for the current occupant. The most appropriate action can then be determined from ranges of possible hazard scores (DETR, 2001).

The issue of enforcement is still the subject of consultation, but a local authority is likely to have a duty to take the 'Most Appropriate Action' based on the HHSRS hazards score and the local authority judgement as to acceptability. The most appropriate action options include Hazard Awareness Advice, an Improvement Notice, a Prohibition Notice or suspended action. The regulatory situation for local authority housing stock is less clear at this stage, but it is difficult to see how an entirely tenure neutral approach is possible here.

Although primary legislation is required before the system can be implemented, local authorities and other interested organisations have been making preparations to introduce the HHSRS. Officers are already familiar with the statutory standard of fitness, its scope and limitations, but are now getting to grips with application of the new HHSRS. In practice, this normally involves using a hand held computer which lists the 24 hazards enshrined in the system and an sub-menu for each hazard identified, to extend it further and offer a more accurate risk assessment. Once each hazard in each part of the dwelling has been identified, the computer generates a hazard rating for the dwelling that enables a decision to be made of acceptability at a given threshold (see Table IV). The new system will also require new computer software, compatible with existing data collation regimes.

The government continue to produce guidance as the system is tested and refined, including worked examples, which show how the standard applies to all dwellings. These examples range from system built tower blocks, to addressing major condensation and mould growth, to individual hazards arising from steps to an owner occupied 1930's dwelling (see DTLR, 2001). This is particularly important so that all tenures of housing stock within a local authority area can be considered and compared, with resources increasingly allocated according to risk.

Criticisms of the HHSRS proposal

Whilst many see the proposed system as dynamic and forward thinking, it has not received support from all quarters. Some have disputed the fundamental concept of the system – although it initially received support in principle – and believe that an updated and revised version of the current fitness standard would be more appropriate, arguing that the new system could be unnecessarily cumbersome to apply (see Parkinson and Fairman, 2000). Such an approach is understandable as the current standard is widely understood, easy to apply and fits well with existing enforcement and grant protocol. It also allows for professional judgement and some flexibility.

Ironically, the HHSRS may be seen to be too 'scientific' in its approach and as such may make it difficult to tackle some of the wider holistic health issues inherent in the current public health agenda. As with any approach based on reliance on data and statistics, there is a risk that other health-related issues many be missed or excluded in a risk assessment because they cannot be clearly rated. The home and its environment may cause, or contribute to ill-health in the form of stress and depression in some instances, but it is unclear whether, and how, the HHSRS might cater for this. Stress and depression are notoriously difficult to rate directly by empirical evidence, but may cause extreme harm outcomes in some cases. This is of increasing importance to the new public health agenda that seeks to reduce inequality and so promote health, seeing health in its wider context of building sustainable communities where housing, health and safety also need to be seen and responded to in it socio-economic context.

Now that the HHSRS is being tested, there is some concern with the practicalities of applying it. In their response to the DETR Consultation Paper (DETR, 2001), the CIEH (2001) and CIH (2001) raise concerns about its workability and how 'tenure-neutral' it really is. For example, they question the number of hazards currently listed, suggesting a simplified hazard grouping; how hazard ratings might be aggregated and compared and how resulting activity should be delivered; how consistent the standard can be; and the suitability of IT systems in its application. The CIEH (2001) also comments on the HHSRS's relationship to wider government policies, such as Best Value Performance Indicators and the Better Regulation and Modernising Local Government.

There are concerns, too, as to how the HHSRS could fit into wider housing renewal regimes and the impact it could have on renewal strategies. In this respect, it remains largely untested at this stage. It is unclear as to whether all hazards should be addressed, or just the more serious above threshold level, and if so, what should happen about lesser hazards. Existing case law suggests that repair is dealt with at the early stages so that dwellings do not fall into unfitness, but the guidance for HHSRS does not provide answers as to lower rated hazards, or about the general incentive under HHRSR to carry out general maintenance to dwellings. There is also a need for enforcement to be

able to address urgent hazards identified requiring immediate remedy, that is not able to be unreasonably delayed by appeal processes.

It is difficult to assess how the HHSRS relates to HMO's. There are currently additional legal controls governing HMO's, notably in respect of fire safety and amenity provision, but also for management and overcrowding. It is unclear whether the HHSRS will be able to address HMO's holistically, as the current approach seems to concentrate on individual dwellings rather than the HMO in its entirety.

Fitness, HHSRS and wider strategy

The Office of the Deputy Prime Minister – the new Office for regional and local government, housing, planning, regeneration, social inclusion and neighbourhood renewal – recently issued further housing renewal guidance, confirming its commitment to replacing the fitness standard with the HHSRS but not offering a timetable for reform (ODPM, 2002a). They seek to ensure that everyone has the opportunity of a 'decent home' and to help promote social cohesion, well-being and self-dependence. A decent home is defined as one that is statutorily fit, is in reasonable repair, has reasonably modern facilities and services, and provides a reasonable degree of thermal comfort (ODPM, 2002b). The government has announced increased resources for social housing to meet the decency standard by 2010 (ODPM, 2002c) but reiterated personal responsibility for the necessary works in the private sector (ODPM, 2002a). At this stage, it is unclear how and why the HHSRS might dovetail into these new arrangements.

As local authorities continue to acquire discretion in developing and delivering local strategy that sits within the wider government agenda of area regeneration, social inclusion and so on, they are simultaneously having to incorporate the fitness standard allied to HHSRS proposals as well as forging new partnerships that address the new public health's emphasis on inequality. There is a risk that local authorities will be pulled in different directions of new discretion and duties, and this needs to be carefully considered at the early stages. With local authority housing functions under increasing pressure it is important that they are able to retain flexibility in their approach. It is important for example that implementation of the HHSRS will not skew local authority housing activity wholly toward evidence based data and statistical returns at a time when community empowerment and social inclusion are also seen as crucial to promoting housing and health, and has a fundamental role to play in more non-quantifiable health improvements inherent in area regeneration.

As part of the wider public health movement, partnerships are seen as key to address health inequalities in service provision. The government's current approach to fuel poverty (DEFRA and DTI, 2001) is one example of where local authorities – largely due to earlier inadequate legislation and resources – have failed to make adequate in-roads, particularly in the private housing sector and partnerships are now seen as key in delivering change. Whilst the HHSRS system may be able to tackle the whole issue of domestic energy efficiency more comprehensively, there seems no reason why energy efficiency could not be inherent to an expanded standard of fitness. However, it remains too early to comment on this in respect of both the new Fuel Poverty Strategy and the HHSRS. Again, it is difficult at this stage to see how partnership based strategy and an enforcement led HHSRS may co-exist without duplication or unnecessary bureaucracy.

Summary

Many organisations, notably the CIEH and CIH, urge more government guidance which will take their concerns about the HHSRS into account. However, regardless of arguments for and against the proposed HHSRS, few would argue that there is a need to ensure that any new standard addresses domestic safety more comprehensively.

The HHSRS is likely to replace the fitness standard in the near future, but will require primary legislation. Once in place, local authorities will have a duty to apply the standard across tenures. It remains too early to assess how successful such a new approach to assessing and regulating housing conditions might be, and this will become clearer in the fullness of time. There is much benchmarking evidence available already to measure progress increases in the health and safety of the nation's housing stock for its residents, but improvements in reported statistics are only part of the story – particularly if reporting becomes skewed and fails to recognise wider health improvements in housing and communities. The new public health agenda, with its focus on tackling health inequalities through a range of local community partnerships, are also crucial in improving the nation's housing stock.

The HHSRS has many potential benefits in enabling local authorities to tackle many of the issues that are fundamental in the housing, health and safety interrelationship and the fact that a new approach is imminent is to be welcomed. It should help provide an evidence based response to addressing housing conditions, but any concerns need to be fully addressed now – including how and why it fits within emerging local housing strategies – before the new system is implemented.

References

CIEH (Chartered Institute of Environmental Health) (2001) Health and Safety in Housing. Replacement of the Housing Fitness Standard by the Housing Health and Safety Rating System. Response to the Department of the Environment, Transport and the Regions Consultation Paper (May 2001) (London, CIEH). Online. Available at web site: http://www.cieh.org.uk/about/policy/response/HHSRS.pdf [13 November 2001]

CIH (Chartered Institute of Housing). (2001) Health and Safety in Housing. Replacement of the Housing Fitness Standard by the Housing Health and Safety Rating System. A Consultation Paper. Views of the Chartered Institute of Housing (June 2001) (Coventry, CIH). Online. Available at web site: http://www.cih.org/cgi-bin/display.pl?db=policies&id=168 [accessed 13 November 2001]

DETR. (Department of the Environment, Transport and the Regions). (1998) Housing Fitness Standards Consultation Paper , London.

Battersby, S. and Ormandy, D. (1999) Surveying the system, Environmental Health Journal, 107, 11, 357-380

DEFRA and DTI (2001) UK Fuel Poverty Strategy. Available at web site http://www.dti.gov.uk/energy/fuelpoverty/fuelpeng.html [accessed 12 January 2002]

DETR. (Department of the Environment, Transport and the Regions). (1998) English House Condition Survey 1996 (London, HMSO)

DETR. (Department of the Environment, Transport and the Regions). (1999) Housing Research Summary No. 75, 1998 – Controlling Minimum Standards in Existing, London.

DETR. (Department of the Environment, Transport and the Regions). (2000a). The Housing Green Paper. Quality and Choice: A Decent Home for All, London.

DETR. (Department of the Environment, Transport and the Regions). (2000b). Housing Research Summary No. 122, 2000. Development of the Housing Health and Safety Rating System (London, DETR). Available at web site: http://www.housing.detr.gov.uk/hrs/hrs122/htm [6 October 2000]

DETR. (Department of the Environment, Transport and the Regions) (2000c). Housing Research Summary No. 123, 2000. Housing Health and Safety Rating System Quick Guide, London. Available at web site: http://www.housing.detr.gov.uk/hrs/hrs123/htm [6 October 2000].

DETR. (Department of the Environment, Transport and the Regions). (2001) Health and Safety in Housing: Replacement of the Housing Fitness Standards by the Housing Health and Safety Rating System: A Consultation Paper (London, DETR). Available at web site: http://www.housing.dtlr.gov.uk/information/consult/hhsrs/pdf/housinghealth.pdf [13 November 2001].

DTLR. (Department of Transport, Local Government and the Regions). (2001) Housing Research Summary No. 142, 2001. Worked examples to support the Housing Health and Safety Rating System, London. Available at web site: http://www.housing.dtlr.gov.uk/hrs/hrs142/pdf/hous142.pdf [1 November 2001].

DTI. (Department of Trade and Industry). (1995) Home Accident Surveillance System (HASS) and Housing Accident Death Database (HADD) 1994, 19th Annual Report , London.

DTI (Department of Trade and Industry). (2000) Home and Leisure Accident Report. Summary of 1998 data , London.

DoE. (Department of the Environment). (1996) Circular17/96. Private Sector Renewal: A Strategic Approach, London, HMSO.

ODPM. (Office of the Deputy Prime Minister). (2000a). Housing Renewal Guidance (Consultative Document) Housing Research Summary 103, 2002, London. Available at web site http://www.housing.odpm.gov.uk/hrs/hrs163/index.htm [28 August 2002].

ODPM (Office of the Deputy Prime Minister) (2000b) A Decent Home: the revised definition and guidance from implementation. Section 2, London. Available at web site http://www.housing.odpm.gov.uk/information/dhg/definition/02.htm [28 August 2002].

ODPM (Office of the Deputy Prime Minister) (2000c) A Decent Home: the revised definition and guidance from implementation, Section 1, London. Available at web site: http://www.housing.odpm.gov.uk/information/dhg/definition/01.htm [28 August 2002].

Ormandy, D. Moore, R. and Battersby, S. (2000) If it's broke, fix it fully, Environmental Health Journal, 108, 12, 386-389.

Parkinson, N. and Fairman, N. (2000) If it ain't broke, don't fix it, Environmental Health Journal, 108, 10, 330-334.

Publication 8 Stewart, J. (2003) Encouraging home owners to maintain their homes: Initiatives in the Bellenden Renewal Area, Peckham, *Journal of Environmental Health Research*, 2 (1) pp. 10-21. Online. Available HTTP: http://www.jehr-online.org.volume1/issue2/5/index.asp

Encouraging home-owners to maintain their homes: Initiatives in the Bellenden Renewal Area, Peckham

Jill Stewart[1]

[1] **Senior Lecturer in Environmental Health and Housing, School of Health and Social Care, University of Greenwich**
Correspondence: Avery Hill Campus, Mansion Site, Avery Hill Road, Eltham, London SE9 2UG, UK.
Tel: +44 (0)20 8331 8218, Email: j.l.stewart@greenwich.ac.uk

Abstract

With declining capital grant expenditure and ageing and deteriorating UK private sector housing conditions, policy makers at national and local level are charged with finding new ways forward in encouraging home-owners to maintain their homes before they fall into disrepair. This is more economical to both home-owners and the state. However, the situation is complicated by a culture that seems to lack initiative to invest in home maintenance. This is for a variety of reasons, which include rapidly rising house-prices, often regardless of condition in some areas, and the inability of low income home-owners to be able to afford, or in some cases, to understand, the importance of regular maintenance. This paper explores literature relating to the history of housing grants, existing home maintenance initiatives and new requirements under The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 and supporting Renewal Guidance (ODPM, 2002). It then turns to overview how officers in the Bellenden Renewal Area are and will be seeking innovative new ways of encouraging home-owners themselves to sustainably invest in their homes as housing expenditure moves away from public provision.

Key words: Home maintenance, local authority housing grants, private sector housing renewal

Introduction

The UK's private sector housing stock – defined here to include owner-occupied and privately rented housing, but excluding housing association dwellings – is ageing and deteriorating. Whilst the owner occupied sector comprises the predominant tenure requiring the majority of resource available in its renovation, the privately rented sector contains proportionately more unfit homes. Figures on the cost of private sector renovation vary considerably, but if early maintenance and repairs are not carried out, the cost will rise substantially. There seems to be a culture which lacks initiative to carry out regular maintenance, possibly in part due to dependence on housing grants, which needs to be reversed if conditions in private sector housing stock can realistically be sustainably addressed.

With declining capital expenditure and a return of personal responsibility for home repair and maintenance to owners, local authorities are having to increasingly seek new and innovative ways to inject private finance into existing housing regeneration strategies, rather than continue with various housing grants as a main thrust of their private sector housing renewal strategy (DTLR, 2002). English and Welsh local authorities currently invest almost £400 million on improving conditions for 100,000 households per year and provide support to Home Improvement Agencies (HIA) (DETR, 2001).

Local authorities have traditionally held an invasive role in the privately owned sector, particularly since the Housing Act 1969 in financing various grants (see also Table 1.0). Some argue that this expenditure has partially created a culture of dependency on grants (DETR, 2001; Mackintosh and Leather, 1992) and may, to some extent, be responsible for reduced likelihood of home-owners themselves maintaining their homes. Grants are essentially a one-off injection of funds to enable dwelling fitness and repair, but do not in themselves encourage regular maintenance as they are mainly concerned with an owner's deemed ability to afford works. There has been little progress in marrying grant policy to adequate resource in tackling private sector housing conditions and policies to assist low income home-owners tend to lack direction (Leather, 2000).

The Housing Green Paper (DETR, 2000a) and Consultation Paper on the future of grants (DETR, 2001) raised several key issues in seeking to provide a broad power to provide financial and other assistance for home repair and improvement including:

- More discretion for authorities to address the specific needs of their area;
- More opportunity to target help effectively to those at risk from poor housing;
- More effective use of resources;

- Less dependency on grants and reinforcement of homeowners' responsibilities toward their properties; and
- More choice for homeowners between grants or loans.

As a result, many local authorities have already been actively seeking new ways of encouraging and enabling home owners to routinely invest their own resource in their homes before they fall into substantial disrepair, rather than continuing to rely on public sector funding through housing grants.

The resulting Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (DTLR, 2002; ODPM, 2002) subsumed earlier grant provisions relating to repair and improvement (see Table 1.0). It also provided a new power for local authorities to provide assistance for the repair of living accommodation (as well as other matters outside the scope of this paper). Local authorities are required to take into account a person's ability to repay this assistance before enforcing it (such as through a charge on the property) and to provide a written policy

Table 1.0: Initiatives (legislation) in private sector housing regeneration

Act/Policy/Consultation	Key regeneration purpose
Housing Act 1969	New powers for repair; General Improvement Areas introduced
Housing Act 1974	**Housing Action Areas introduced**
Local Government and Housing Act 1989	Previous grant provisions superceded; Act introduced mandatory means tested house renovation grants based on revised fitness standard; introduced home repair assistance; introduced renewal areas and group repairs schemes; redefined clearance areas and action for individual dwellings. Greater emphasis placed on role of Home Improvement Agencies.
Housing Grants, Construction ~~aid for~~ and Regeneration Act 1996	**Switch from mandatory to discretionary grant renovation; further proposals for renewal areas and group repair schemes; home repair assistance extended.**
DoE Circular 17/96 (DoE, 1996)	Provided detailed guidance on private sector renewal activity, emphasis on relevant local housing strategies and home-owners responsibilities for repair and maintenance.
Consultation Paper 2001 (DETR, 2001)	**Consultation Paper on Private Sector Housing Renewal reviewing the role of housing grants etc.**
The Regulatory Reform (Housing Assistance) England and Wales) Order 2002 (DTLR, 2002)	Repealed existing grant legislation (except DFG's) into new local authority power to provide assistance for housing renewal, requiring that local authorities publish their policy.
Housing Renewal Guidance (consultative document) (ODPM, 2002)	**Explains above, encourages increasingly strategic context and approach aligning with other corporate objectives**

Source: Based on Stewart (2001)

statement. This needs to be set within a wider policy framework which encourages personal responsibility for housing conditions if it is to be successful.

This paper considers the many opportunities available to encourage – and indeed enable – owners to invest in home maintenance and repair. It focuses in particular on the way in which officers at the Bellenden Renewal Area, Peckham, in the London Borough of Southwark are currently promoting home maintenance, through a variety of initiatives, to help arrest inevitable decline in older housing stock. It considers the advantages and disadvantages of such an approach, in particular, how likely it is to harness private sector funding as local authorities adopt a more enabling approach to private sector housing renewal. Such policy has never previously been adopted nationally, and there is currently very little evidence to assess how successful such policy – allied to a wider expectation that home-owners will maintain their own homes – might be in respect of housing stock condition. A key purpose of this paper is therefore to draw together available literature and practice for later evaluation.

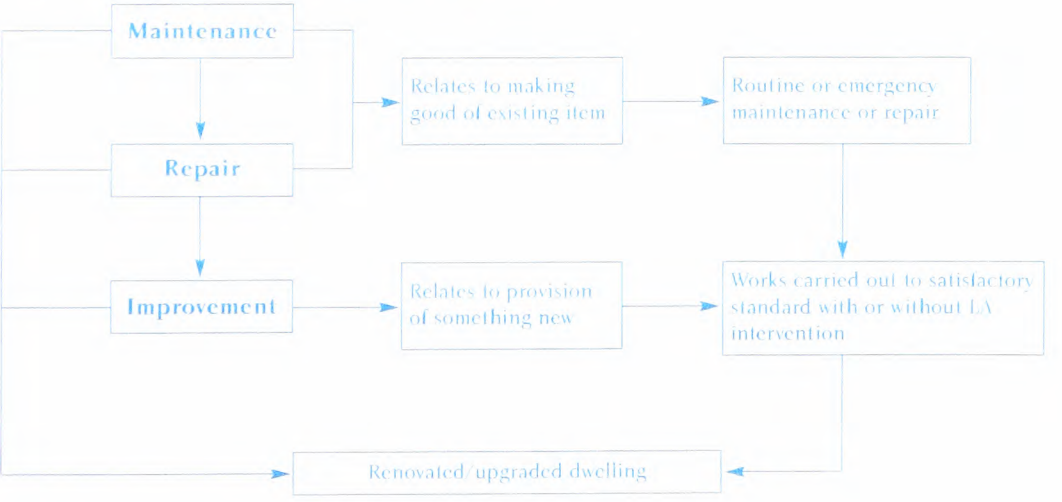
Additionally, at the time of writing, there are two other major – and parallel – issues to consider in respect of (private) sector housing conditions. The first is the government's introduction of the Decent Housing Standard (DETR, 2000b), and the second is the replacement the current statutory standard of fitness with the housing health and safety rating system which are considered in more detail in Stewart (2002). It is not the purpose of this paper to overview these new proposals for assessing housing standards, but to explore the direction and focus of future housing assistance intervention and ways in which home owners are able to address issues in home maintenance and repair.

Maintenance, repair and improvement – whose job is it?

The day a house is built it starts to decline. Regular maintenance, which need not require major financial investment, can help arrest that decline. If maintenance is not carried out, or something simply gets worn out, repair (i.e. making something good) will be required which by its nature requires some degree of financial investment and possibly a specialist contractor. (See fig. 1). Financial investment may come from the owner – as owner-occupier or landlord or in the form of local authority assistance. Improvement is not the same as repair, normally referring to the provision of something new, such as central heating, an enhanced kitchen, or provision of an internal W.C. where none currently exists. Many owners seem prepared to invest in improvements, commonly at the expense of a repair such as a new roof, which may be more cost effective in the longer term.

Government has been withdrawing capital grant expenditure for some time. (Table 2.0). There was a boom in spending in 1983/4, but it has since declined – notably since the Local Government and Housing Act 1989 as a new system of mandatory grants became both means tested and related to statutory fitness. These grants became discretionary under the Housing Grants, Construction and

Figure 1.0: Maintenance, repair and improvement



Regeneration Act 1996, with an increase in expenditure for 1999/2000 (Revell and Leather, 2000; Wilcox, 2001). Since then, government has increasingly questioned state investment in the private housing sector, proposing an increasingly enabling role with grants as a 'safety net' (DETR, 2000c; DETR, 2001). It advocated further local authority discretion but no firm spending commitment, even though three fifths of low income households live in poor private sector housing (Wilcox, 2001).

There are many reasons why homeowners fail to inadequately invest in their homes. In the owner occupied sector, many simply cannot afford to, despite owning a major capital asset. Older and younger people, and some minority ethnic groups, are the most likely to live in poor housing conditions (Macintosh and Leather, 1993; Revell and Leather, 2000). Older people – frequently occupying some of the worst stock – may not wish to have the upheaval or stress associated with major repair, or may hold valid concerns about trusting some builders. Many have such high outgoings, including mortgage repayments, that they may not be in a position to afford necessary repairs. Younger home-owners, in a position to afford repairs, may simply prefer to spend their income elsewhere, on something frankly more interesting than home repair. Additionally, regional house prices may be a disincentive for a mobile population to invest substantially in repairs, as house prices may increase, regardless of an owner's investment level (Leather and Reid, 1989).

There is little accurate information available on the extent to which individual householders use their own resource for maintenance and repair. Home-owners tend to spend more than other tenures, although the figure shows regional variation. The amount spent rises with income (Leather and Reid, 1989; Revell and Leather, 2000). The English House Condition Survey (EHCS) (DETR, 1998b) probably provides the most accurate estimate of expenditure, estimating an aggregate £31.5 billion spend by householders, some 28 billion of this (89 per cent of total) by owner-occupiers. During the 1987-91 period, 86 per cent of owners completed major works, but estimates for landlords are not available for improvement, repair or internal decoration (Revell and Leather, 2000). Homeowners tended to spend more on improvements (53 per cent) than repairs (30 per cent). Do-it-Yourself (DIY) represents an important contribution in influencing the state of stock repair – normally for minor rather than major repairs, and generally carried out by younger, higher income home-owners. It is estimated that since there is no labour cost involved, four times the work is possible at the same price, although it is difficult to accurately asses either the quality or quantity of works undertaken (Davidson et al, 1997).

The private rented sector is even more complex. The English House Condition Survey (DETR, 1998b) continues to show that this sector has proportionally more unfit properties than other tenures, with 19 per cent unfitness as compared to 6 per cent unfitness in the owner occupied sector. Landlords of the poorest stock are commonly unwilling to invest in their properties, particularly investment landlords (DETR, 1998c; DETR, 2000b), who lack financial incentive to invest when return from market rent financed by tenant or housing benefit is forthcoming regardless of condition. With inadequate incentive for maintenance, there is certainly little incentive for repair, and practically none for improvement. The situation is further complicated with complex tenancy and rental situations of houses in multiple occupation (HMO), which are in the poorest condition of all (DETR, 1998b). Landlords are frequently compelled into carrying out essential works following service of legal notice by local authorities. What is clear is that a source of money, advice, support and sometimes compulsion, is required, which local authorities are already well placed to deliver and/or support. This sector warrants further specific research.

Table 2.0: Private sector renovation grants (£ million)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
England	316.7	281.6	439.9	361.3	385.6	336.7	316.5	232.1	172.5	237.1
Total *	**581.9**	**482.1**	**599.0**	**613.1**	**605.5**	**559.9**	**525.3**	**409.6**	**326.2**	**356.6**

Notes:
*Total * refers to England, Wales and Scotland*
Includes grants under 1985, 1989 and 1996 Acts, excludes disabled facilities grants

Based on Wilcox (2001:47)

Stock Condition and Grant Expenditure

Not all private sector housing investment comes in the form of grant assistance. Many owners are financially able and willing to maintain their homes, but some are not interested and others not able to afford – or perhaps cope the upheaval of – necessary works. In a complex South East housing market, home-owners are not always 'rewarded' for regular maintenance and repair and their properties would increase in capital value regardless of condition. Many potential grant recipients are excluded from all local authority assistance, and are deemed eligible to afford works as a result of the 'means test', although on practical terms this may not be so. Others regularly maintain and improve their homes and these groups are not normally offered any form of assistance from the local authority.

Home-owners and local authorities may have differing objectives about where housing investment is best spent. Home owners already secure their own repairs and improvements outside of the grant regime, such as through saving schemes, loans, insurance, social fund loans and so on. However, owners and local authority's strategic housing duties and objectives do not always coincide. Home owners, for example, may invest in improvements such as central heating, re-decoration or a new kitchen, which may not affect fitness, whilst local authorities may prefer to concentrate resource on a strategic enveloping scheme to help prevent further stock decline.

Stock condition

Government policy continues to favour the private sector as housing provider, with almost 70 per cent UK home ownership in 1999 (Wilcox, 2001), but the increase in this sector has not been matched by a parallel increase in renovation funding. Renovation is generally promoted as a lower cost alternative to demolition (Macintosh and Leather, 1993). In addition, the stock is ageing, requiring continued investment as poor housing is closely related to age of stock as well as household income.

The 1996 English House Condition Survey (EHCS) (DETR, 1998b) reported that 45 per cent of housing was more than fifty years old, with 7.5 per cent of housing stock (1,552,000 dwellings) being unfit, the majority being pre-1919 and converted into flats. Terraced housing tends to be in greater disrepair in comparison to semi-detached housing (Revell and Leather, 2000). Almost 80 per cent of dwellings had some form of defect. 1 per cent of housing stock (200,000 dwellings) lacked basic amenities, almost half of these being vacant, a reduction since the previous EHCS, and grant intervention has been closely linked to major steps forward in such improvements (Wilcox, 2001). There has also been some stock improvements, with 60 per cent of dwellings with double-glazing, which normally falls outside of the grant-assisted regime.

Despite considerable expenditure, recorded disrepair has remained relatively static, and is still a key cause of unfitness. Problems remain even in areas where substantial grant expenditure has been paid (Leather and Reid, 1989; Wilcox, 2001). Disrepair is particularly crucial as nearly a third of all dwellings require urgent repair and swift works are required to arrest further decline. There are two considerations here; either owners cannot afford to, or owners do not appreciate the importance of, regular maintenance to prevent further disrepair. There is a significant correlation between household income,

Table 3.0: English housing conditions: mean average costs for repair and unfitness 1996

Tenure	Estimated cost of remedial repairs (£)			Average cost (£) of remedying unfitness	Number of unfit dwellings (000s)
	Urgent repairs	Repairs and improvement	Comprehensive repairs		
Owner-occupied	1,250	1,850	3,620	5,498	829
Private rented	2,370	3,250	5,030	5,972	393
Total stock *	**1,280**	**1,830**	**3,420**	**3,301**	**1,522**

Note:
*Total stock * includes LA and HA dwellings*

Source: EHCS (1996) and Wilcox (2001)

unemployment and poor housing conditions (DETR, 1998b; Macintosh and Leather, 1993; Revell and Leather, 2000). In England, 1 in 10 households where income was less than £4000 per annum, lived in unfit dwellings, compared to 1 in 25 who had an income of £24,000. As recorded levels of disrepair have remained relatively static over subsequent house conditions surveys, despite grant expenditure over the period, it is reasonable to assume that a viable, cost effective culture of home-maintenance is somewhat lacking.

Likely costs of renewal are an important consideration in developing appropriate strategy. Analysis of the EHCS estimated that 8.5 per cent of unfit dwellings could be made fit at £500 or less (DETR, 1998a), as 69 per cent of English dwellings are unfit in respect of only 1 criterion, and 18 per cent fail for 2 criteria (Revell and Leather, 2000). Mean average costs of renewal per dwelling for 1996 are shown in Table 3.0. It should be noted that these figures are averaged, and vacant dwellings would cost substantially more. Additionally, the median cost is different as the average figures are skewed, with most dwellings having nil cost. This means that urgent repairs would cost £397, for 46 per cent of dwellings the cost would be more than £5000, with only 20 per cent of dwellings requiring urgent works at around £1,800 (Revell and Leather, 2000).

Grants and renovation

Repair and improvement provisions of the Housing Grants, Construction and Regeneration Act 1996 (see Table 1.0) have now been subsumed into The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (DTLR, 2002; ODPM, 2002). This brings an end to House Renovation Grants and Home Repair Assistance (HRA) for smaller scale works. HRA increased as local authorities attempted to spread grant expenditure more widely (Wilcox, 2001), and although this was not the government's intention (DETR, 2001) it led to further residualisation of larger grants as a policy tool (Leather, 2000).

Additionally, local authorities – with government encouragement – have sought to concentrate resource in area activity in an attempt to stimulate private sector investment. There is little local data analysing the impact of grant investment over time or the profile of householders receiving assistance. For example, Group Repair Schemes – introduced to enhance the external envelope of dwellings – were encouraged on the assumption that owners would then be prepared to invest further, but there was no real evidence to support this. Information tends to be property based with, for example, 75 per cent of approvals for pre-1919 stock (Revell and Leather, 2000).

Conversely, the focus on means testing means that grants are based essentially on applicants rather than property. Although research shows that lack of resource is the commonest reason for owners' lack on investment in housing (Revell and Leather, 2000), many low income households fall just above the grant threshold, and others have substantial outgoings (such as mortgage repayments which are not taken into account) and there is no help for them. By 1990-96, demand for grant had exceeded available government resource in England (Revell and Leather, 2000). Limiting grant availability by means testing and subsequent management mechanisms in this way theoretically targets grant assistance toward the worst housing and the lower-income households. Means testing can have an impact on area renewal schemes, resulting in pepper-potting of repairs and improvements since one neighbour may be eligible for assistance, and another not, even though both dwellings require similar works. The person not in receipt of grant assistance may have other financial outgoings or personal circumstances preventing participation in a renewal scheme.

Households typically respond to, rather than anticipate, repair requirements, and tend to favour low cost solutions that may fail to tackle underlying problems (Leather and Reid, 1989). The grant regime has to a large extent reflected this, essentially being a one-off injection of funds with no conditions attached requiring the owner to take a more proactive role in future maintenance. Some see this as a fundamental flaw in the grant system, which essentially 'rewards' those who have failed to invest – either deliberately or through lack of resource, and does not assist those outside of the grant system at all. A fundamental shift in culture is required to encourage – and to enable – owners to regularly maintain their homes before they fall into substantial, and expensive, disrepair. The private housing sector needs to become essentially self-regulating, with local authorities financially or otherwise assisting those in need. A new proactive and reactive approach is required to prevent the need for grant expenditure in the first place, and also to preserve diminishing funds for the worst stock. The question to local authorities is how can costs and resource requirements be minimised for all?

Can home-owners be encouraged to invest?

Government emphasis is increasingly about home-owners taking responsibility for their own homes (DoE, 1996; DETR, 2001; DTLR, 2002). It is fundamental that local authorities develop realistic strategies based on local circumstance that draw together a range of in-house services and external providers (DETR, 1998d) that provide the right things to enable home owners to maintain their homes. Many local authorities already have strategies in place that incorporate several initiatives.

Table 4.0: Initiatives in encouraging personal responsibility in home maintenance, repair and improvement

Initiative	Comments	Organisation responsible
* LA Home Improvement Loan e.g.	Currently permitted in legislation, but effectiveness could be improved to enable preferential LA rates and terms of interest	LA (private sector would expect preferential interest rate return)
*** Equity release scheme (as form of loan cited above)**	Use of capital rather than income to repay loan; avoid the need for borrower to make repayment from income, so access capital without affecting income	Private sector
Handy person services	Free or low cost service (available on request or referral) for minor repairs – may have limited contribution to stock condition, but early intervention many help prevent more serious problems. Increase in such services, but likely to remain specialist for vulnerable groups.	Scheme facilitated by local authorities, housing associations, HIA's, voluntary sector etc.
Subscription based Emergency repair services	Nationally available, for provision of accredited builders and available 24 hours. Seen to offer the greatest potential for developing wider demand as already has a growing membership and high satisfaction with service provided; encouraging more work through awareness	Private companies, funded by charging client
Subscription based maintenance service	Includes exterior survey and maintenance plan, with free emergency call out and fees charged. Little interest currently – tends to be for more affluent householders and related to age. 40% scheme members use it for works.	Local building companies – local authorities may initiate such a private sector scheme with appropriate personnel
Money advice	Owners – particularly those on low income – may require advice concerning increased spending on loans, benefits, savings etc.	Local authority, citizens advice, voluntary sector etc
Advice and information	Verbal, visual and literature advice and guidance on repair and maintenance issues and wider issues e.g. energy efficiency – e.g. leaflets, videos, exhibitions, demonstrations. Many schemes exist. E.g. may give schedule for necessary works to someone not eligible for grant	Local authorities, HA's and HIA's, particularly associated with applications for, or completed grants, community associations, residents groups
Home maintenance surveys	Written or verbal survey plus report on short and long term repair and maintenance requirements, how to tackle the problem, likely costs – may help with owner prioritising works required and employing suitably priced builder with LA inspector checking quality of works. May from part of home maintenance strategy, encouraging and enabling works owner would not other wise tackle.	Local authorities, HA's and HIA's – either free of charge, or fee to cover costs
Tool loans	Including loan of specialist or expensive items e.g. cement mixers, scaffolding, ladders, power tools – saving owner money in enabling them to carry out works	Local authority or community based organisations

Initiative (cont.)	Comments (cont.)	Organisation responsible (cont.)
Home maintenance training	Training focus on maintenance awareness of specific maintenance skills; surgeries to discuss common problems, DIY, targeted focus. Could be tied to capacity building through project based employment – not common at present	Local authorities as well as possible funding from DFEE, NDC etc
Volunteering schemes	Encouraging residents to assist with vulnerable persons e.g. older people etc	Local authority and/or existing community groups
Builders list	Assurance of trustworthy and competent builder	LA or community group
Maintenance strategy	Useful to help protect LA's investment and encourage people to do works to reasonable standard that they might not otherwise tackle. Draws together several above initiatives for all or part of LA area; funding and staffing considerations	LA
Do-it-Yourself (DIY)	Basic maintenance/repair/improvement work by home-owner and unpaid help (mainly cosmetic).	Private sector

* *denotes government favoured options*

Based on Mackintosh and Leather (1992); DoE (1996); Davidson et al (1997); DETR (1998c) and Davidson and Leather (2000).

From several years experience working in the sector the author believes that home- owners fail to carry out necessary works for, a variety reasons, even where they are eligible for grant assistance. These include: Lack of trust in builders; bad publicity for them in the media recently; problems in past of shoddy building work;

- Inability to find suitable builder to carry out small-scale maintenance/repair at viable cost;
- Could do work themselves, but lack time or wrong time of year;
- Do not want the upheaval involved;
- Concern about the cost of initial works, unforeseen works and redecoration and/or necessary relocation;
- Thinking about moving house anyway, so not worth the bother;
- Would rather spend money elsewhere (e.g. new car, holiday);
- Lack initiative or confidence to be proactive.

The government has also identified wider community concerns responsible for lack of maintenance and repair by owners such as high crime in the area, poor environment and a low level of community activity (DoE, 1996). It is essential local authorities that address such concerns in strategic development and implementation.

Financial investment aside, local authorities already have substantial house renovation expertise, experience, organisational arrangements and systems in place which could be readily adapted to encourage and enable home owners to arrange for, and fund, necessary works outside of local authority expenditure to protect their grant investment. Authorities increasingly operate Home Agency Services, in-house or via a partnership arrangement with another organisation, which operate to a variety of levels and suitability. Whilst these services are established to support 'vulnerable' groups such as older people, their role and expertise could be increased to cater for the needs of others. Similarly, existing Direct Service Organisations (DSO) or suitable local building companies, could take on a new role to carry out repairs at more cost effective price, possibly on a self-financing basis.

Several existing schemes have been identified which are of increasing interest to local authorities in acquiring private sector finance (Mackintosh and Leather, 1992; DoE, 1996 and DETR 1998d). These include targeting grants more effectively, home improvement loans and an increasing emphasis on equity release schemes (see summary in Table 4.0). The government is keen to promote interest in effective use of these relatively new schemes. It does,

however, recognise some of the problems of working with the private sector, including possible repossessions and the impact on borrower's benefit entitlement – although the market has been slow to develop, it can be localised and expensive (DETR, 1998d). The government has asked local authorities to take a fresh look at such initiatives in partnership with the private sector (DETR, 2001). Few new initiatives have been proffered since, and few have made major leaps forward in the intervening period, although a combination of such initiatives may help reduce pressure on local authority capital expenditure.

What certainly needs to change dramatically is the culture of maintenance, repair and improvement. The question is how, and with what degree of success, particularly in the context of area regeneration? Fundamental to this, of course, is whether home owners are able to afford works – either directly, or indirectly by releasing capital they already, or by participating in a local scheme whereby maintenance and repair become both affordable and feasible. It is here that local authorities need to increasingly operate realistic strategies.

Local stock condition surveys are fundamental in deciding how best to administer available resource. Local authorities increasingly need to spend the money they have available efficiently, effectively and on dwellings that most require investment as part of a wider strategy. Successful strategic development requires honest appraisal of housing stock and the profile of local residents so that maintenance strategies can be sensitively and appropriately targeted, possibly by development of existing schemes in the area, or the development of new partnership based schemes with advice from operational schemes elsewhere. The DoE (1996) suggest that those least aware of problems with their homes are older people, those with mental health problems, those on low incomes and minority ethnic groups, so maintenance schemes need to be developed and targeted accordingly. Local strategies also need to recognise that often older, low income households are less able to participate in DIY than their younger, often wealthier counterparts (Table 5.0), and may have to finance both materials and labour, substantially increasing the overall cost (Davidson et al, 1997; Davidson and Leather, 2000). This has important implications for home maintenance schemes.

The recent Audit Commission report on social housing repair and maintenance services (cited in Kemmner 2002) provides some useful lessons. It argued that local authorities need to challenge and improve performance so business plans, planned and capital programmes and responsive repairs contribute to better targets across all areas. Relevant staff need to be fully trained and working toward the required objectives. The strategy needs to be delivered by staff with good project and budget management skills, tied to effective systems based on housing need and decency standards. Involving residents is crucial in setting standards and monitoring repairs and maintenance services and there is a need for greater education in respect of technical issues. Planned works are more cost effective than reactive and emergency works, so they should be prioritised so that budgets can be more easily managed. Close sustainable, interdependent partnership working between public and private sectors is fundamental, operating in a climate of respect and building mutual trust.

Case Study: The Bellenden Renewal Area, Peckham

Bellenden Renewal area is a low-income area within the London Borough of Southwark with a wide ethnic mix and age profile. To date, strategy to repair and improve housing within the Renewal Area has concentrated mainly on existing group repair and

Table 5.0: Householders most likely to use DIY and contractors for major work

Most likely to use DIY	Most likely to use contractor
Young head aged less than 40 years	Retired, especially if head aged over 74
Resident for less than 5 years	Retired for at least 5 years
Head is or was skilled manual worker	Head is female
Within top half of income distribution	Within bottom half of income distribution
New dwelling, post-1980	Old dwelling, pre-1919

Source: Davidson et al (1997)

individual grant regimes as well as partnership based work with other organisations.

Uncertainty about future funding and projected legislative changes led to the Renewal Area Team re-thinking strategy and how to encourage and enable an ethnically and age diverse profile of low-income home-owners to maintain and repair their own homes. As local housing stock continues to age and decline, new investment needs to come increasingly from owners themselves, and officers are actively seeking culturally viable ways forward in close consultation with local residents.

The Renewal Team's recent survey sought to profile housing grant recipients by age, income and ethnicity. It obtained data on approaches to home maintenance, including works carried out following grant completion – its cost, regularity, who carried/s it out and difficulties encountered. The survey also collated early information on interest in potential council services that may help home-owners with home maintenance, including DIY training, free home maintenance surveys, information video and leaflets, approved builders lists and contracting/instruction arrangements, loans, tool hire and discounted building materials.

The Renewal Team – working closely with residents – has therefore been able to develop some of these ideas into practice, and has produced educational and training literature and an award winning video that provides useful advice on basic construction methods and remedial works. The emphasis of much of this training and advisory information is to encourage low-income residents to be able to carry out maintenance and repair works themselves. However, this aside, the practicalities of affordability of remedial work for low-income households – within a climate of declining capital grant expenditure – remains key.

In view of the issues identified, a Home Maintenance Strategy has been developed for the Bellenden Renewal Area. This approach recognises that some homes require works now, but is also able to cater for properties 'at risk' of falling into disrepair. A primary emphasis is to inform and educate residents of the importance of early home maintenance. A further major objective is to help low-income groups to spend income they have more effectively by considering where their money is currently spent – and how – and what the council can do to help reduce some of the costs. The council are looking at skills and services they already provide that may be adapted to meet the needs of the Renewal Area.

An understanding of the nature of expenditure for low-income groups – with particular reference to cultural difference in approaches to home maintenance due to ethnicity and age – is fundamental in determining best local strategy to assist home owners in being able to helping fund works themselves. The total costs of remedial works can be broken down to assess where savings could be made to low-income groups and these include:

- Costs of labour. Low-income groups tend to contract labour rather than carry out works themselves, so are already cost-disadvantaged. The cost is proportionately significantly higher for small-scale works where a contractor needs to charge a day's labour to cover travelling time, sourcing materials etc, leaving the overall cost out of proportion to the minor repair required.
- Necessity of works identified by 'builder'. Are the works really necessary?
- Cost and type of materials – both immediate and longer-term (e.g. will new windows need painting in two year's time; can the home owner afford on-going maintenance cost?).
- Quality of work undertaken. Do the works represent value for money, or will they need re-doing due to shoddy workmanship?

The council's emerging strategy seeks to respond to the issues raised by residents. Many are anxious when seeking to have work carried out due to bad publicity about builders; others may have unwittingly instructed a poor quality contractor. To help overcome this, the council is keen to promote a list of suitably qualified, skilled and trustworthy contractors so that residents receive a quality service that represents value for money. The council could also assist in reducing labour costs by developing an area-based approach. This would enable low-income households to 'share' overheads such as travelling costs of an appointed contractor who operates on particular days on a diary basis. Additionally, some contractors specify and carry out works that are unnecessary. The council is considering introducing a 'Home Survey Package' whereby suitably qualified local authority staff could fully survey individual houses and offer advice on what actually needs doing, the priority that should be afforded and advice on best use of a low-income for maintenance and repairs necessary. Either scheme would help householders achieve only necessary works that have been carried out to an acceptable standard.

The Home Maintenance Strategy is being further refined and the council are eager to ensure that services offered reflect what residents actually need and want. In taking this forward, the council is considering commissioning research to identify what home owners feel would be of assistance to them in ensuring effective home maintenance. This partnership approach – developed through focus groups – will help to reveal problems and possible solutions from the perspective of residents and will feed into the council's policy-making process. This is still in early stages, but will be evaluated in the fullness of time.

Conclusions

Most sub-standard housing is in a poor condition because owners cannot afford repairs. The English House Condition Survey continues to report that low income groups – particularly ethnic minorities – are the most likely to occupy poor housing. There is no doubt that properly targeted and funded grant system can have a substantial impact on stock condition in the private housing sector. However, local authorities are faced with reducing capital and increasing disrepair in an ageing housing stock and need to find new and realistic ways to move forward.

The government now requires that home-owners – both owner-occupiers and private landlords – take on greater responsibility for maintaining, repairing and improving their properties. Some may be able to afford to, but do not. Some may not be able to afford to, so do not. Others may simply lack the will, or interest, or knowledge, or have insufficient knowledge, skills or equipment to instigate their own repairs, or confidence to locate and instruct a suitable contractor. Local authorities are well placed to be able to develop strategy that responds to local needs and is able to provide new and viable ways forward in encouraging and enabling home maintenance, but its remains too early to assess the success of new initiatives.

Alternatives to existing grant funded regimes need to incorporate new approaches in initiative and attitude of both home-owners and local authorities in delivering their strategic housing responsibilities. Fundamentally, local authorities need to develop a variety of resource and support initiatives to encourage and enable home-owners to maintain their homes for the future. Regardless of arguments for and against such initiatives, there is little doubt that local authorities need to find new ways of encouraging home-owners to sustainably invest in maintaining their homes. The Bellenden Renewal Team are eager to continue to work toward finding a realistic way forward through a Home Maintenance Strategy that is really able to respond to the needs of low-income groups.

Acknowledgement

The author is extremely grateful to staff at the Bellenden Renewal Area, London Borough of Southwark – in particular Roger Young and Keith Murphy – for their on-going time and assistance in compiling this paper.

References

Davidson, M. and Leather, P. (2000) Choice or necessity? A review of the role of DIY in tackling housing repair and maintenance. Construction Management and Economics. (18) pp. 747-756.

Davidson. M, Redshaw, J. and Mooney, M. (1997) The role of DIY in maintaining owner occupied stock. Bristol, The Policy Press Housing Repair and Maintenance Series.

DoE. (1996) DoE Circular 17/96: Private Sector Renewal: A Strategic Approach. London, DoE.

DETR (1998a) The Housing Green Paper, London, DETR

DETR. (1998b) The English House Condition Survey 1996. (London, HMSO). Online. Available at www.housing.detr.gov.uk/research/ehcs96/tables/index.htm [Accessed 30 August 2002].

DETR. (1998c) Housing Research Summary: Repairs and Improvements to Private Rented Dwellings in the 1990s (no. 79, 1998). London, DETR. Online. Available at www.housing.dtlr.gov.uk/hrs/hrs079.htm [Accessed 14 February 2002].

DETR. (1998d) Housing Research Summary Encouraging Home Owners to Repair and Maintain their Homes: A Review of Initiatives (no. 92, 1998). London, DETR. Online. Available at www.housing.dtlr.gov.uk/hrs/hrs092.htm [accessed 12 April 2002].

DETR. (2000a) The Housing Green Paper: Quality and Choice: A Decent Home for All. London, DETR.

DETR. (2000b) A decent home: the revised definitions and guidance for implementation. London, DETR.

DETR. (2000c) Housing Research Summary: Repair and Maintenance by Private Landlords (no. 138, 1000). London, DETR. Online. Available at www.housing.dtlr.gov.uk/hrs/hrs138.htm [Accessed 14 February 2002).

DETR. (2001) Private Sector Housing Renewal: Reform of the Housing Grants, Construction and Regeneration Act 1997, Local Government and Housing Act 1989 and Housing Act 1985: A Consultation Paper. London, **DETR.** Online. Available at www.housing.dtlr.gov.uk/information/consult/pshr/pdf/consult.pdf [Accessed 12 February 2002].

DTLR (2002) Statutory Instrument 2002 No. 1860: The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002, London: HMSO. Online. Available at www.hmso.gov.uk/si/si2002/20021860.htm [Accessed 1 October 2002].

Kemmner, M. (2002) The art of maintenance, Inside Housing, 18 January 2002. pp.16-17.

Leather, P. (2000) Grants to Home Owners: A Policy in Search of Objectives, Housing Studies (15, 2) pp. 149-168.

Leather, P. and Reid, M. (1989) Investing in Older Housing: A study of housing improvement in Bristol. Bristol, SAUS.

Mackintosh, S. and Leather, P. (eds.) (1992) Home Improvement under the New Regime. Occasional Paper 38. Bristol, SAUS.

Mackintosh, S. and Leather, P. (1993) Renovation File: A profile of housing conditions and housing renewal policies in the United Kingdom. Oxford, Anchor Housing Trust.

ODPM (2002) Housing Renewal Guidance (consultative document). Housing Research Summary 163, 2002. London: ODPM. Online. Available at www.housing,odpm.gov.uk/hrs/hrs163/index.htm [Accessed 28 August 2002]

Revell, K. and Leather, P. (2000) The State of UK Housing: A factfile of housing conditions and housing renewal policies in the UK (2nd edition). Bristol, The Policy Press.

Stewart, J. (2001) Environmental Health and Housing. London, E and F N Spon.

Stewart J (2002) 'Housing Health and Safety Rating - a new method of assessing housing conditions reviewed' in Journal of Environmental Health Research, vol.1, issue 2, November 2002.

Wilcox, S. (2001) Housing Finance Review 2001/2002. York, Joseph Rowntree Foundation.

Publication 9 Stewart, J., Clayton, J., and Ruston, A. (2004) Maintenance and repairs: an exploratory study into home-owners views on alternatives to grants, *Journal of Environmental Health Research,* 3 (2) pp. 58-65. Available HTTP: http://www.jehr-online.org/volume3/issue2/3/index.asp

Maintenance and repairs: an exploratory study into homeowners views on alternatives to grants

Jill Stewart[1], Julie Clayton[2] and Dr Annmarie Ruston[3]

[1]Senior Lecturer, School of Health and Social Care, University of Greenwich
[2]Research Fellow, School of Health and Social Care, University of Greenwich
[3]Director of Research, School of Health and Social Care and Director of the Centre for Health Research and Evaluation (CHRE)

Correspondence: Jill Stewart, School of Health and Social Care, University of Greenwich, Avery Hill Campus, Bexley Road, Eltham, London SE9 2PQ. Tel. + 44 (0) 20 8331 8218. email: j.l.stewart@greenwich.ac.uk

Abstract

The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 subsumed earlier private sector housing grant legislation and provided local housing authorities with a new power to provide assistance. This heralded a major change in emphasis from provider to enabler, with new opportunities for interventions. Local authorities need to see this as part of a wider change encouraging homeowners to take more responsibility for their properties, which presents opportunities as well as threats, particularly as increasing numbers are becoming homeowners.

Although some options to assist homeowners have been put forward, they have not been rigorously tested. For this research, focus groups were convened to explore what homeowners might find helpful in supporting them to maintain, repair and improve their homes in the context of options already put forward by the government and against a background of declining capital grant expenditure as the state shifts further from provider to enabler.

This research suggests that government driven options of more closely targeted grants, equity release and loans were not necessarily what homeowners would find helpful. Respondents appeared to centre their choice of option around what would give them the most flexible approaches to maintaining their homes, whether or not this might fit into what a local authority may require under housing legislation and policy. Respondents tended to favour options which focused around their individual needs and aspirations, rather than wider housing and community regeneration. They did, however, indicate that they would like more assistance to empower them to make better choices, particularly through training in home maintenance to enable DIY and/or an understanding of works needed to confidently instruct reliable and competent builders to carry out necessary (and not unnecessary) works. However, there was still something of a gap in the approach of those unable to afford any works themselves, as equity release and local authority loans were not generally favoured, possibly because these schemes are still in the very early stages and such attitudes may change longer term.

In addition, the current move toward personal responsibility must be seen in the context of the public health agenda, particularly where health inequalities are at their most acute. It was unclear from this research whether the Regulatory Reform Order may be able to make real inroads into improving housing and health (physically and emotionally) both on an individual and area level and further appropriately timed research will be necessary to explore this further.

Key words: Environmental health; home owners; home maintenance and repair; housing grants; personal responsibility and housing; private sector housing renewal.

Introduction

The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) (DTLR, 2002) brought the most fundamental and sweeping change to what had been an interventionist grant policy in the private housing sector over a period of decades to help preserve the nation's housing stock. Despite this fundamental change, there has been very little written about what alternatives to housing grants might help owner-occupiers to maintain, repair and improve their homes, what they might find helpful from local authorities in enabling them to do this, and indeed how successful such new approaches might be.

The RRO is part of a wider change in encouraging a new approach to housing and community regeneration in line with the Labour government's vision of a return to personal responsibility, wider community involvement and new partnership relationships between the statutory and voluntary sectors. Such partnership based approaches – with communities at the centre of regeneration – are now

politically favoured as a new way forward and may be seen to end some of the culture of dependency on grants that has arguably played some role in preventing homeowners themselves from investing in their own homes (DETR, 2001: Mackintosh and Leather 1992).

However, there are some problems in making assumptions that homeowners are willing and able to carry out maintenance, repairs and improvements to their own homes and, indeed, in assuming that homeowners will wish to spend their income on housing issues that meet statutory requirements and therefore a local authority's objectives. For example, homeowners may choose to spend their money on largely cosmetic features such as a new paved front garden that may have a higher "feel good" factor, as opposed to a new (or overhauled) roof, which would be in keeping with a local authority's housing renewal objectives. The withdrawal of grants – and grant conditions – also removes some level of local authority control over what they are able to require in the nation's private sector housing stock.

In addition, the English House Condition Survey (ODPM, 2003) continues to report that it is low-income households (commonly lone parent and ethnic minority) who occupy the worst housing, and this is a very important point. It is also of course such households who are likely to find most difficulty in accessing alternative financial or resource options in being able to carry out works to their homes. This is particularly important at a time when homeownership continues to be politically favoured. Clearly, options need to be found to assist such homeowners, who are likely to suffer multiple stresses of poverty and inequality in all aspects of their lives, not just their housing.

Although grants have been able to help maintain housing stock over a period of decades, it has been suggested that grant policy for homeowners has increasingly lost its way (Leather, 2000). Whilst many welcome the potential for change and shift of strategic emphasis potentially provided by the RRO, others regret the potential loss of grants as an interventionist option. It remains for local authorities to develop and implement strategies that are appropriately tailored and able to offer homeowners realistic options to assist them in maintaining, repairing and improving their properties.

This paper reports on recent research in a low income renewal area in South London, which investigated ways of encouraging and enabling owner-occupiers to maintain their homes within a rapidly changing policy environment. It particularly extends the earlier reviews of policy options and their context (Stewart, 2003a; Stewart 2003b). It further seeks to present evidence based options that homeowners may find helpful as part of state expenditure withdrawal from private sector housing renewal and a renewed emphasis on homeowners themselves taking more responsibility through an innovative range of options, with or without the support of local authorities.

It is emphasised that this paper is an exploratory study using focus groups to investigate what low-income homeowners would find helpful in maintaining and repairing their homes. It does not seek to offer options to replace grants, but an indication of possible ways forward as provided by respondents in this particular study.

Research objectives and methods

Many local authorities have been investigating alternatives to an interventionist grant approach to help preserve private sector housing stock for some time, although very few options have been rigorously tested. There is a risk that assumptions may be made around untested options unless they remain under regular scrutiny and review. Many local authorities have been promoting home maintenance through a variety of initiatives to help arrest inevitable decline in older housing stock. However, there are advantages and disadvantages to such an approach and it is important to consider how likely it is to harness private sector funding as local authorities adopt a more enabling approach to private sector housing renewal, addressing this issue in a systematic manner based on the needs of local residents. A South London Renewal Area's team therefore commissioned the Centre for Health Research and Evaluation (CHRE) at the University of Greenwich to carry out an exploratory study to ascertain the most effective means of assisting people to maintain their houses adequately and to develop new approaches to tackling the problem of disrepair.

The overall aim of the exploratory study was to support the development of new policies for helping homeowners to take more responsibility in achieving effective home maintenance. Objectives were to:

- Ascertain homeowners' perceptions of the problems they encounter in maintaining their properties in a good state of repair;
- Investigate which support mechanisms homeowners would find useful in facilitating effective home maintenance;
- Identify practical methods / solutions that the local authority are able to incorporate into their private sector housing renewal strategy; and to
- Ascertain whether homeowners can take a more proactive role in maintenance and repair of their homes.

Focus groups were considered the most appropriate way to conduct this study in order to ensure data collection from a group of people more quickly than individual interviews; to enable the researcher to

interact directly with the respondents to probe and clarify responses; and an open response forum to obtain large and rich amounts of data from the perspective and needs of the respondents in their own words. Although a disadvantage of focus groups is that they cannot provide a generalised response relative to a wider population, they nevertheless help to reveal the respondent's problems and solutions and thereby facilitate the development of policies that are able to meet the needs of homeowners.

Options selected for consideration by the focus groups were drawn from a review of the literature (in particular Leather and Younge 1998; Mackintosh and Leather 1992; DoE., 1996; Davidson et al, 1997; DETR, 1998; Davidson and Leather, 2000) and included:

- Council Home Improvement Loan
- Equity release scheme
- Handy person services
- Subscription based Emergency repair services
- Subscription based maintenance service
- Money advice
- Advice and information
- Home maintenance surveys
- Tool loans
- Home maintenance training
- Volunteering schemes
- Builders list
- Maintenance strategy
- Do-it-Yourself (DIY)

Results

Each focus group engaged in a group discussion around key issues followed by individual consideration of what respondents felt would be helpful to them in carrying out work to their homes. Discussion centred around perceptions of, and the value placed on, home maintenance and disrepair in a "real life" scenario of competing priorities on homeowners financial and other resources. It particularly focused on homeowners' perceptions of what would be of value in supporting them to prevent their property getting into a state of disrepair and/or putting it back in order and their views on a range of possible solutions.

The table of options for future home maintenance, repairs and improvements they were asked to consider was based on those that had already been established in the literature. These were placed into three categories of 1) financial; 2) subscription; and 3) services from the local authority, for clarity. Respondents in the focus groups were each asked to individually and without discussion select which they felt were the five highest and five lowest useful options for them. The focus group also allowed time for further discussion around each of the options where appropriate. Relevant comments are included.

Results – presented in the relevant three categories below – tended to be very individual, although some stood out as having very high or very low priority for the majority of respondents. Interestingly, the list appeared to be fairly exhaustive as no one suggested any other options.

1) Financial

The following illustrates what the focus groups as a whole ranked as most useful (high priority) and least useful (low priority) financially to them in carrying out works to their properties. Respondents were asked to rank the following financial options:

- Home Improvement Loan from the council at reasonable rate of interest
- Using capital (equity) from home as a type of loan toward works without affecting your income
- Money advice to help make better use of your income toward maintenance and repairs.

Although several rated home improvement loans highly, more rated this as a low priority. It should be noted here that this is a key option put forward by the government, alongside more closely targeted grants (which the groups generally seemed to accept, although reasons behind this were not clear) and equity release.

Generally, equity release was not favoured by respondents, possibly because of bad publicity in the past about such schemes, and newer schemes such as HouseProud (to which many local authorities have signed-up) have not perhaps had enough time to run to re-build confidence. It is difficult at this stage to see any reasoning from the respondents behind this, and comments varied from those who thought that with equity release:

"You can't go wrong."

To those who were suspicious of the nature of equity release:

"No. I don't like the sound of it."

And those who felt that it was not a sensible option at their age:

"Yes, well, at the moment, at this age which I have now reached, I wouldn't agree to take out nothing."

There were some concerns about commercial equity release schemes, whether people would lose their homes and the issue of 'inheritance' after interest and administration had been charged on the costs of equity release.

There tended to be more discussion in the groups about very individually based alternatives that were appropriate to meeting particular needs, and generally the groups reported a willingness to carry out maintenance and repair to their homes, as the following quote illustrates:

"Because you have got to live somewhere and to keep up the house the right and proper way that is ... you should concentrate on the house and make sure that the house has everything which it needs anyway."

However, the question of what a "house needs" is subjective and depends on the perspective of the owner's needs, and the local authority's legal, policy and strategic objectives which may not be the same.

A lot of disagreement, and misunderstanding was expressed around schemes on offer, and a lot of mind changing went on as the respondents discussed issues and found out more from each another. However there was general agreement that low-income homeowners would have problems in being able to afford home maintenance and repairs. The following commentary illustrates what the group were thinking:

"...And low income people can't afford to do that regular maintenance I think that is one of the problems so they tend to put it off until they can afford it but then ..."

"...Its worse".

"...Yes that's right."

Money advice and how to manage budgets was equally divided as being high and low priority. There was no specific commentary from respondents to explore this further, despite it being a key issue concerning personal responsibility.

2) Subscribing to schemes

The following summarises what the focus groups as a whole ranked as most useful (high priority) and least useful (low priority) through subscription to schemes to them in carrying out works to their properties. Respondents were asked to rank the following subscription schemes:

- Subscription to emergency repair services, with works done by recommended builders
- Subscription to a maintenance service – cover includes exterior survey and maintenance plan, with free emergency call out
- Handy person services – free or low cost service for minor works / repairs only
- Sharing builders costs – council arranges for a builder to visit an agreed area on a set day, to reduce the builder's overheads, making costs less to all
- Volunteering schemes – voluntary help from other local residents, mutual co-operation.

Subscription to emergency repair services was divided between being seen as high priority and low priority and issues were raised in discussion. This was possibly because there was already a culture of subscribing to schemes and enabled closer budgeting, seen by many in the group as offering a good service when *"things went wrong"*, particularly in things needing a regular service and some provision for repairs, such as gas boilers.

Interestingly, subscribing to a maintenance based service generally received far higher priority than emergency based schemes and the following quote illustrates the general feeling of the groups:

"Well because you are likely to need repairs"

The group generally suggested that they would pay a *"reasonable"* annual cost, although there was no agreement as to what this amount might be, possibly around *"£20 per month"*.

Having access to a handy person service stood out as rating highest priority of all during the study. This is possibly because it could help alleviate some of the earlier concerns raised around trust, cost and quality of works *etc.* The following comment illustrates the general feeling of the group:

"If you know you can get hold of someone fairly quick, especially for anybody who can't do it for themselves."

And this service was seen as having the potential to offer a range of works, including plumbing, electrical works, which many were anxious about trying themselves, and even very minor issues (but high priority to some individuals) such as changing a plug.

Sharing builders costs was also favoured overall. It was explained to the group that the local authority could arrange for a builder to visit on a pre-arranged day and reduce the builder's overheads, making costs less to all, although there was no specific commentary on this to support why people held this view.

Volunteering schemes were not favoured overall, with most people saying that they would not mind helping neighbours out for a favour, but would not expect any payment, and would not relish the idea of it becoming a more "formalised" scheme.

3) Services from the local authority

The following illustrates what the focus groups as a whole ranked as most useful (high priority) and least useful (low priority) as services from the local authority to them in carrying out works to their properties. Respondents were asked to rank the following potential services from the local authority:

- Home maintenance training – groups to discuss common problems, DIY, *etc*
- Inexpensive tool loans - including loan of specialist or expensive items *e.g.* cement mixers, scaffolding, ladders, power tools – helping to save money on overall cost
- Builders list – to help ensure a trustworthy and competent builder for a quality, value for money service
- Advice and guidance on repair and maintenance issues and wider issues e.g. on basic construction
- Reduced cost building materials (with free delivery where necessary)
- Home maintenance surveys (free from the council);

written or verbal survey plus report on short and long term repair and maintenance requirements.
Home maintenance training was generally positively viewed so that people could learn and share knowledge. The group generally favoured some form of home maintenance training both to be able to do works themselves, but also to check on what builders were saying needed doing, whether it actually did, and the quality of their work (women found this particularly relevant and important). The following quote illustrates this point:

"...I have often thought it would have been so useful to have had a kind of home maintenance course just to sort of prepare you for how to do simple things like electrics."

This tied in closely to providing advice and guidance on repair and maintenance issues, and was seen as being more proactive and akin to a 'health check'.

"...in a way we are talking about home maintenance rather than repairs, its more that you don't know need doing and I suppose. Ideally its just like yourself, you know you ... ideally you'd sort of go off and have a health check every 5 years or whatever and I suppose you should do the same thing with you home but I mean you don't..."

Generally, the issues discussed were about empowerment for homeowners to be able to confidently make their own decisions based on sound technical knowledge, anticipate and proactively carry out routine, appropriate home maintenance and ensure that works done were both necessary and represented value for money.

This was both in terms of accurately anticipating necessary works in a more proactive way and ensuring that builders did a good job. The following comments show the general thinking of the groups towards home maintenance training:

"It's a good idea because a lot of people don't realise something has gone wrong until it happens."

"...And also that someone with more experience may have picked up maintenance needs earlier, but..."

"...that is the drawback, would it be someone who was very thorough and would it be someone very experienced..."

"...When you need anything doing and then if you are not sure you can ask someone."

Several members of the group stated that they had done works themselves in the past (DIY) but this had become more difficult as they got older. Several reported that they would try most things themselves, and ask for technical assistance where necessary, or find things out for themselves from the library. Internet and other information sources. Some reported that they would rather do the works themselves than have a builder doing it badly, and having to pay for poor work. However, most respondents suggested that they would not attempt to do electrical or plumbing works, because they lacked the skills and were concerned about safety.

The issue of contracting decent and trustworthy builders raised several issues. The following quote supports some of the group's feelings around why they may or may not get works done based on their experiences of builders, which showed a regional bias:

"Could I just mention my experience of being an owner occupier because the first house that I owned was in an Oxfordshire village and the thing there was that if you needed jobs done whether it was electrical or plastering or whatever, there was somebody there who knew who would do that. They wouldn't always do it terribly well but at least you knew who they were."

"...And you know that you could get hold of them again."

"...When I moved to London I mean that doesn't exist. I think that is one of the difficulties."

This point was reiterated several times, largely related to increasingly dispersed communities and not having so much contact with neighbours, particularly as people tend to move house more regularly now. The groups clearly favoured personal recommendation for builders.

Although local authorities have tried to respond to this by providing a 'Builders List', this received a mixed response in this study. Most people saw it as high priority, yet concerns were expressed about how builders actually got onto this list, and whether the list could be trusted, even where the local authority had compiled it. Those ranking builders list as a high priority made comments such as:

"I think that it is very important when you want something done unless you know a builder."
and
"Well it's not something you really look forward to even though you might need it at times, if the occasion arise then you say 'Oh, let's try this one'."

Generally the group's comments suggested that they would be prepared to wait for someone who was reliable, even if this would take some time.

Inexpensive tool loans and reduced cost materials (with free delivery) were seen as low priority.

Discussion

Three major themes emerged from the research – the changing policy environment; personal empowerment (and 'withdrawal' of the state from grant-led housing intervention); and familiarity with the schemes (invariably this study represents snapshot in time only in relation to grants and maintenance issues).

Changing policy environment

The shift from the state as provider to the state as enabler has been evolving for around the last two decades. It is only really since the Local Government and Housing Act 1989 that legislation heralded a shift toward personal responsibility (and therefore a withdrawal of state expenditure), furthered by increased local authority discretion in grant expenditure in the Housing Grants, Construction and Regeneration Act 1996. By 2002, the Regulatory Reform Order had subsumed earlier grant legislation and provided a new power for "assistance", set within a personal responsibility context for homeowners. Grant expenditure will continue to decrease, and local authorities will need to look to owners themselves investing more of their own funds and other resources into their homes.

A fundamental question to ask is whether the new approach can help. In the past grants have been able to help ensure that homeowners have been able to repair and improve their homes, yet grants have acted in a similar way to homeowners, in that they responded to disrepair, rather than help prevent more expensive disrepair in the first place. The new approach could arguably help promote a new ethos in home maintenance and encourage owners to take a more proactive role in home maintenance, which would be more economic for all.

However, this is not as straightforward as it might seem. The focus groups clearly showed that people do not generally make provision for maintaining their homes, individuals have their own priorities regardless of any perceived "community need", older people are less able to participate in DIY, younger people are more able and willing to, but may or may not have the required skills. In addition, house prices in some parts of the country rise so rapidly that some may see it as a "false economy" to invest time and resources in their homes if they are thinking of moving. Lifestyle issues (*e.g.* a foreign holiday or new car) can be far more appealing than overhauling the roof, particularly when it is the middle of summer. Also, even where available money was spent on housing, the focus groups suggested that people may prefer to spend their money on, for example, an extension, which might not meet the local authority's strategic renewal objectives.

Another factor is that many homeowners simply cannot afford to carry out any works at all to their homes if they have a low income, or even a reasonable income, but high mortgage repayments or other financial commitments. Eligibility to participate in options offered by local authorities needs to be able to take this on board to help ensure maximum options for homeowners. This research was carried out within an established Renewal Area, and there may be different findings where there is not such intensive local authority renewal activity.

Additionally, just because local authorities may be interested and motivated by Home Maintenance Strategies, it does not follow that local homeowners will be. There appear to be some assumptions being made by government, that are not necessarily supported by this research.

Personal empowerment

Much of the rhetoric surrounding the proposed changes hinges on homeowners being given more choice in respect of how they resource maintenance and repairs to their homes. This research generally backed up the idea that homeowners would like more say, but the reality of this is that it leads to less "local authority control" over what can be delivered in housing strategy, and indeed whether the needs of the individual home owner mirror the local authority's objectives to ensure that legal housing standards are met. Loss of grants as an interventionist policy option also leads to some loss of influence.

In addition, while personal and community empowerment may be key to the social side of the public health agenda (which in itself has importance housing/health relationships) physical housing conditions remain key to health. Local authorities need to ask serious questions about whether the options they promote under the Regulatory Reform Order are really able to make inroads into housing conditions, particularly where they are at their most acute.

Many respondents favoured having more advice, training, skills and knowledge in helping them to help themselves in maintaining their own homes and making their own decisions. It is perhaps here that local authorities can be much more pioneering and innovative in encouraging a more proactive approach to home maintenance, repair and indeed improvement, in ways that are more sustainable. Most local authorities already have qualified staff (legal, technical, practical) who would/could be able to offer courses, seminars etc which could help homeowners to understand more about the physical side of their homes, and what to do about conditions.

Although not the subject of this particular research, the issue of the decline in social capital was reported overall as having a negative impact on trust locally, and therefore on the extent to which neighbours and communities might help each other with building works. However, as a result of intense regeneration activity from the local authority in this Renewal Area, plus the focus groups for this research, respondents reported that they had been able to develop new relationships with their neighbours, possibly to mutual advantage in the context of housing renewal.

Familiarity with the schemes and favoured options

There was surprisingly little resistance from the focus groups to grants being withdrawn as a policy option, and reasons for this were not clear. It may have been because respondents were selected from an existing Renewal Areas and therefore more familiar with legislation and policy than others might have been.

Equity release was not favoured, even following some explanation of what it entailed. However, this is possibly because it is a relatively new concept for many homeowners and there has been much bad publicity about some commercial equity release schemes. It would be useful to carry out further research here into some of the newer not-for-profit type equity release schemes that are now starting to operate elsewhere and assess homeowners' views on how they felt after participating in such options.

However, several issues were raised where local authorities may be able to take more innovative approaches to encouraging and enabling homeowners to be able to carry out works themselves, either by instructing a builder, or by DIY. In respect of DIY, most people would be willing to try works, yet this is clearly limited by age, disability and so on. This would help homeowners to understand more about the structure of their homes and what to do about repair and maintenance.

The results generally showed that respondents favoured assistance from the local authority in some areas but not others. It is here that local authorities can develop and implement strategies around what homeowners would find helpful. For example, many respondents reported that one reason they did not instigate works was because of lack of trust and faith in builders. Local authorities could do more to help homeowners find decent, reliable and cost effective builders through a regularly updated builders list operating on the recommendation of the community, including local businesses where possible.

Additionally, local authorities may be able to extend their own in-house local authority housing maintenance contractors and/or role of their local Home Improvement Agency to offer builders for large and small scale works, including a handy person service, to help build trust and encourage further works and tied into other strategies on offer. Although it is hard to know at this stage how effective this might be, it is another option.

Conclusions

Local authorities are freer than they ever have been to make local decisions about how to help address conditions in their private sector housing stock. However, they still have to be able to make their decision in the context of what will help make inroads into poor housing conditions. Most importantly, they have to ensure that whatever their new strategies they deliver realistic solutions to ensure that low-income homeowners of poor housing.

The research showed homeowner's responses varied as regards interest and ability to carry out works themselves or to be able to knowledgeably instruct a builder to ensure a value for money and quality service.

It seems that there is a place to build on what is culturally acceptable already, such as more insurance-based subscription schemes, in which there is some level of confidence. It may take more time until there is confidence in non-commercial type equity release schemes, but these certainly provide an option for higher cost works. Otherwise, this research suggests that there is a need for more ad-hoc type schemes that suit individuals and communities.

Despite major policy changes, local authorities still retain the fundamental duty to ensure that legal housing standards in their area are met. This needs to align to strategies in the wider public health agenda, particularly addressing health inequalities where they are at their most acute. It is certainly a key policy area to continue to develop new and innovative ways of working, but local authorities need to ensure that their strategies actually deliver what they set out to do.

Acknowledgements

This research was commissioned and funded by the Bellenden Renewal Area, London Borough of Southwark. The views contained in this paper are those of the authors and do not necessarily respresent those of the London Borough of Southwark.

References

Davidson, M. and Leather, P. (2000) Choice or necessity? A review of the role of DIY in tackling housing repair and maintenance. Construction Management and Economics, 18. 747-756.

Davidson. M, Redshaw, J. and Mooney, M. (1997) The role of DIY in maintaining owner-occupied stock. The Policy Press Housing Repair and Maintenance Series: Bristol.

Department of the Environment (DoE). (1996) DoE Circular 17/96: Private Sector Renewal: A Strategic Approach. HMSO: London.

Department of the Environment, Local Government and the Regions (DETR). (1998) Housing Research Summary Encouraging Homeowners to Repair and Maintain their Homes: A Review of Initiatives (no. 92, 1998). HMSO: London.

Department of Transport, Local Government and the Regions (DTLR). (2002) Statutory Instrument 2002 No. 1860: The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002, HMSO: London. Online, available at http://www.hmso.gov.uk/si/si2002/20021860.htm (accessed 26/07/04).

DETR. (2001) Private Sector Housing Renewal: Reform of the Housing Grants, Construction and Regeneration Act 1997, Local Government and Housing Act 1989 and Housing Act 1985: A Consultation Paper. (London, DETR).

Leather, P. (2000) Grants to Homeowners: A Policy in Search of Objectives, Housing Studies, 15 (2), 149-168.

Leather, P. and Younge, S. (1998) Repair and Maintenance in the Owner Occupied Sector, Centre for Urban and Regional Studies: Birmingham.

Mackintosh, S. and Leather, P. (eds.) (1992) Home Improvement under the New Regime. Occasional Paper 38. School of Advanced Urban Studies: Bristol.

Mackintosh, S. and Leather, P. (1993) Renovation File: A profile of housing conditions and housing renewal policies in the United Kingdom. Anchor Housing Trust: Oxford.

Office of the Deputy Prime Minister (ODPM). (2003) English House Condition Survey 2001:Key facts. HMSO: London.

Revell, K. and Leather, P. (2000) The State of UK Housing: A factfile of housing conditions and housing renewal policies in the UK (2nd edition). The Policy Press: Bristol.

Stewart J (2003a) Home maintenance: Initiatives in the Bellenden Renewal Area, Peckham, Journal of Environmental Health Research, 2 (1), 10-21. Online, available at http://www.jehr-online.org/volume2/issue1/2/index.asp (accessed 26/07/04).

Stewart J (2003b) 'Lend them a hand' in Environmental Health Journal July 2003, 110 (04), 212-214. Online, available at http://www.chj-online.com/archive/2000/july2003/july5.html (accessed 26/07/04).

Publication 10 Stewart, J. (2005) A review of UK housing policy: ideology and public health, *Public Health*, 119 (06), pp. 525-534.

Public Health (2005) 119, 525-534

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

A review of UK housing policy: ideology and public health

J. Stewart*

School of Health and Social Care, University of Greenwich, Avery Hill Campus, Mansion Site, Bexley Road, Eltham, London SE9 2PQ, UK

Received 16 January 2004; received in revised form 24 May 2004; accepted 17 July 2004
Available online 21 January 2005

KEYWORDS
UK public health policy;
Public health and housing;
UK housing policy;
New public health

Summary *Objectives*. The aim of this paper is to review UK public health policy, with a specific reference to housing as a key health determinant, since its inception in the Victorian era to contemporary times.

Review. This paper reviews the role of social and private housing policy in the development of the UK public health movement, tracing its initial medical routes through to the current socio-economic model of public health. The paper establishes five distinct ideologically and philosophically driven eras, placing public health and housing within liberal (Victorian era), state interventionist (post World War 1; post World War 2), neoliberal (post 1979) and 'Third Way' (post 1997) models, showing the political perspective of policy interventions and overviewing their impact on public health. The paper particularly focuses on the contemporary model of public health since the Acheson Report, and how its recommendations have found their way into policy, also the impact on housing practice.

Conclusions. Public health is closely related to political ideology, whether driven by the State, individual or partnership arrangements. The current political system, the Third Way, seeks to promote a sustainable 'social contract' between citizens and the State, public, private and voluntary organizations in delivering community-based change in areas where health inequalities can be most progressively and successfully addressed.

What is public health?

The UK public health movement originally developed as a response to the poor working and living conditions arising from rapid urbanization of the industrial revolution, and has traditionally had a medically biased focus. The concept of 'new public health' has moved away from a medical, reactive model of health to one that focuses on the social aspects of health determination with appropriate health promotion. Public health is increasingly concerned with sociopsychological and physical environments, life styles, and prevention services, and holds addressing health inequalities at its core.[1,2]

The Acheson Report in 1988[3,4] defined public health as 'the science and art of preventing disease, prolonging life and promoting health through organized efforts of society', and argued that life

* Tel.: +44 20 8331 8218; fax: +44 20 8331 9926.
E-mail address: j.l.stewart@greenwich.ac.uk.

0033-3506/$ - see front matter © 2004 Published by Elsevier Ltd on behalf of The Royal Institute of Public Health.
doi:10.1016/j.puhe.2004.07.006

Table 1 Traditions in ideology.

Liberalism	Marxism	Social reformism	Conservatism
Freedom of individual, not rights of groups—favour individual equality not group equality	Role of State in capitalist society preserves status quo and class privilege	Society needs reforming, State policy to reform positive freedom for people to allow equality of disadvantaged	Inequality is natural and fundamental and functional in society, necessary to maintain status quo and those with true ability will better themselves
No group given favourable treatment—would undermine equal access	Some groups will always face inequality under a capitalist system, equal-opportunity policies pointless	Possibility of progress through government intervention, e.g. equal-opportunity policies as policy is effective in itself	Government should not intervene, other than paternalism for disadvantaged
Laissez faire, not state interference	Revolution and classless society to remove inequality		

Adapted from Ref. 5.

style was as important as environmental hygiene in the prevention and promotion of health. It called for closer working and cooperation both within and between organizations, and for joint partnerships with public health practitioners in the socio-economic (environmental and non-lifestyle issues) and medical (biological and lifestyle issues) domains; a distinct move away from the traditional public health movement.

The development of public health can be largely categorized into five key policy eras where relatively distinct ideologies can be identified (see Tables 1 and 2) to help provide a means of understanding policy direction and change. This paper traces the development of public health from its inception in the Victorian era to the new public health underpinning much current policy, placing it into its ideological and philosophical context and drawing material from original government documentation. It particularly focuses on housing as a key health determinant. The health/housing interface is difficult to distinguish from socio-economic status by empirical evidence, but there is wide recognition that decent housing can help maintain and promote health, whilst poor housing has a negative health impact; the relationship between housing and health is summarized in Table 3.[6-10]

Victorian era until 1914

The prevailing ideology of the Victorian era was one of 'laissez faire', and the view was largely held that poverty was a natural state of affairs, and that the poor—who frequently lived and worked

Table 2 Ideology in practice in the UK.

Date	Themes
Victorian era and until 1914 Early 19th century	Liberalism; laissez faire; anticollectivism, values of freedom, individualism, equality—an anti-State ideology, State's role is control and deterrence, minimal intervention
Interwar era (1918-1939) Post World War 1	State as provider
Post World War 2 (1945-1979) Post World War 2	Welfare State introduced; State as top-down provider; nationalization—values of equality, collectivism, collective ownership
1950s-1979	Critiques of Welfare State, but no overall change to status quo; shift towards less inequality, some collectivism, mixed economy
Post 1979: the New Right 1979-1997	New Right (neoliberal)—redefinition of Welfare State; State as enabler; privatization—freedom, individualism, free enterprise
Post 1997: the New Left 1997 until present	New Left (Third Way); State as provider of umbrella socio-economic framework; new responsibilities to individuals and communities in a 'social contract'; social reform/democracy proposed

Table 3 Health and housing: the relationship.

Health/safety issue	Comments
Poor domestic conditions	Disrepair, insufficient facilities and sanitation (e.g. external toilet) can have detrimental health impact
Home accidents/fire	More accidents (including fatalities) than other environments; closely correlates to housing standards and vulnerability of occupant; fire safety, etc.
Security of tenure/high cost of housing (rent or mortgage)/homelessness	Can lead to feelings of insecurity, stress, instability, etc.
Asylum seekers/cultural needs	Anomie, alienation
Special needs housing	Suitability of housing for actual/future needs, e.g. age, disability, ill health
Temporary accommodation	High numbers in 'bed and breakfasts'; socio-economic impact, detrimental impact on children's and adults' physical and emotional health
Cold and damp/fuel poverty	Low income, poor housing, poor heating leading to respiratory disease, accident, discomfort, hypothermia, etc.
Indoor air quality/pollutants	Poor quality can cause ill health or death, e.g. carbon monoxide poisoning, radon, etc.
Community	Integration with local community; support networks; access to health and welfare services; empowerment
High-rise municipal flats	Poor design and architecture; socio-economic exclusion; polarized communities
Emotional health/depression	Poor housing environments (e.g. some temporary accommodation) can exacerbate poor emotional health
Overcrowding	Mainly found in multiply occupied premises (bed and breakfasts); increases risk of infectious diseases, e.g. tuberculosis. Opposite is loneliness and isolation
Noise pollution	Can cause tension, stress
Pest invasion	May result from lack of refuse disposal provision/architecture, etc. rat and cockroach infestations increasingly common

Adapted from Refs. 6-9,11.

in conditions resulting from the industrial revolution—were responsible for their own lot. Victorian philanthropists and some politicians with counter-ideologies started to challenge the socio-economic status quo and argue for a new role for government in improving health.

Calls for public health reform stemmed from differing philosophies based on capitalist, religious, scientific or philanthropic beliefs. Pressure for reforms continued to slowly improve poverty and living conditions, but not in a systematic way.[11]

Edwin Chadwick followed Jeremy Bentham's utilitarian school of philosophy and became a major influence in environmental health thinking, although his theories on disease spread were based on miasma rather than contagion, as later proposed by John Snow.[11] In 1842, Edwin Chadwick's 'Report on the Sanitary Conditions of the Labouring Population of Great Britain' (cited in Ref. 10) painted a picture of poor living conditions and amenities that aggravated disease. Although, he was strongly criticized and opposed by many with vested or religious interests, it led to the first ever Public Health Act in 1848. Chadwick had recognized that non-medics were important in sanitary environments.[11]

Engels' 'Condition of the Working Classes in 1844' (cited in Ref. 11) provided similar information on living conditions—overcrowding, people living in cellars, low income leading to common lodgings, etc.—leading to pressure for legislation to address conditions in lodging houses (see Table 4), although the Acts had little practical support. Later Victorian legislation enabled local authorities to address individual insanitary housing, but there was no security of tenure or alternate accommodation other than in some more progressive local authority areas.

Others focused on the nature of industrialization and poverty. For example, John Ruskin criticized political, social and environmental issues, and other public health pioneers such as Charles Booth and Seebohm Rowntree (whose legacy is the Joseph Rowntree Foundation) challenged the prevailing

Table 4 Victorian era and interwar era until 1939: overview of housing and public health policy.

Date	Event
1848-1900	First Public Health Act, followed by various Public Health and Housing Acts until early 1900s, that empowered local authorities to deal with poor housing conditions with increasingly formalized structures, e.g. Common Lodging Houses Act 1851, Labouring Classes Lodging Houses Act 1851 (Lord Shaftesbury), Torrens Acts 1868 and 1879, Artisans and Labourers Dwellings Act 1868, Artisans and Labourers Dwellings Improvement Act 1875 (Cross Acts), Town and Country Planning Act 1909; A Royal Commission on Housing of the Working Classes led to the Housing of the Working Classes Act 1890; Growth of Garden Cities movement developed by Ebenezer Howard
World War 1	Tudor Walters Committee, Homes for Heroes
Interwar era	Growth of building societies, increasing owner occupation, declining conditions, especially private rented sector, slum clearance, overcrowding legislation introduced, some council house building but building houses for sale was more profitable than building for rent; steady stream of new housing legislation, e.g. Rent and Mortgage Restriction Act 1915, Housing (Additional Powers) Act 1919, The Housing and Town Planning Act 1919 (Addison Act), Housing Act 1923 (Chamberlain Act), Housing (Financial Provisions) Act 1924 (Wheatley Act), Housing Act 1930 (Greenwood Act), Housing Act 1935
World War 2	Bombing destroyed 200 000 houses and damaged more than 3 million; Dudley Committee (1944) recommended standards for council housing

Adapted from Refs. 8-13.

ideology that poverty was part of the natural order, and argued that it was in fact socially and economically constructed. Both painted a desperate picture of poverty at the dawn of the 20th century.[12]

Several Housing Acts were passed during this era, but these had little practical support. Octavia Hill and John Ruskin established the first social housing project in London in 1864, but it was some time before the State itself was to take a more formal role in housing the working classes. Around this time, new legislation introduced powers to deal with unfit housing, but little changed.[11] In 1884, a Royal Commission was appointed to investigate housing conditions for the working classes, which consolidated and strengthened earlier legislative powers but did not provide sufficient resources for local authorities to tackle poor housing.

The combination of improved living (and working) environments had some impact on reducing some of the endemic public health communicable diseases towards the end of the era.

Interwar era (1918-1939)

The sociopolitical era prior to and during the war had been one of increasingly powerful trade unions, a rise in women's rights, a growth of local community health movements, and an increasing pressure on the government to provide 'Homes fit for Heroes' when soldiers returned from World War 1; 176,000 new homes were built under the Housing Act 1919. This was allied to create post-war employment in the construction and architectural industries. Aldridge[14] highlighted the national commitment to addressing housing need:

> 'A new spirit of desire to take resolute constructive action is now animating the members of all political parties in the State. Henceforth, the housing movement will march forward to success whatever Government is in power. No clearer proof of the national desire to regard the achievement of great housing schemes as part of the national duty toward the poor of this country could be found than that given in the unanimous declarations made relative to housing in the Election Addresses of all Candidates for Parliament at the General Election of November, 1924.'

However, building could not keep pace with demand and by 1933, the Health Minister stated that 200,000 slum dwellings would be demolished and 285,000 people would be re-housed.[12]

The Ministry of Health was established in 1919 and was responsible for most social services. Interestingly, its first Minister was Dr Christopher Addison who promoted housing legislation. During the era, health generally improved because living standards and health care improved. Better housing and local welfare services helped reduce the rate of communicable diseases.[11] However, the depression left many in poverty and trapped in poor housing, and efforts to improve housing were largely suspended at the outbreak of World War 2. A new and integrated National Health Service (NHS) to

replace existing localized healthcare provision was yet to be realized.

Post world war 2 (1945-1979): mixed economy and the welfare state

Housing was the biggest public health (and indeed sociological) challenge of this era because—during the War—area redevelopment had been put on hold, unsuitable housing was temporarily licensed and spending on housing was minimized as a wartime measure, whilst many additional homes had been bomb damaged. The post-war labour government introduced the welfare state, pioneering the NHS and subsidised council house building on a major scale (Table 5). The role of the government became one of provider in a mixed economy, and the 'post-war consensus'[15] went largely unchallenged until 1979 (Table 2).

The 'State as Provider' was a top-down approach. Housing management was seen as a task of planners, architects, clerks, treasurers and the medical officers, with no mention of tenants, and called for clear separation between housing and other welfare organizations. Estates were seen as self-contained, supported by their own community venues.[16]

There remained cross-party consensus for council housing building and management, which ironically led to new forms of yet untested architecture as house building shifted from quality to quantity. Competition for house completions between successive governments led to the construction of thousands of modernist-inspired tower blocks for social housing through the 1960s, with little regard to the psychosocial impact of architecture, relocation of residents (often some way from their original communities, such as on a peripheral estate) or wider issues of exclusion, or indeed views and needs of communities.[8,9] The Ronan Point disaster in London, early problems with condensation, communal facilities and pest invasion also contributed to the end of the utopic vision of the tower block as the answer to the nation's housing problems.

Even by the 1970s, such housing needed major regeneration investment, but local authorities did not have the capital resource available for such major works. In addition, compulsory purchase for the purposes of area regeneration was increasingly

Table 5 Post World War 2 (1945-1979): overview of housing and public health policy.

Post 1945	Labour election victory; introduction of Welfare State, new organizational structure, responsibilities to housing and National Health Service; development of New Towns
1952	Census shows 1 million more households than dwellings
1954	Housing Repairs and Rents Act—local authorities could take over slum areas for site value; new private rents removed from rent control
1956	Extra height subsidy introduced for high-rise blocks
1957	Rent Act decontrols rents; legislation protects sitting tenants; Rachman era
1960	Park Hill Estate (Sheffield) becomes UK's first deck access block
1961	Parker Morris Report establishes minimum space standards for council housing
1964	Labour election victory; Wilson adopts target of 400,000 new homes/year
1964	Housing Act established Housing Corporation in England
1965	Milner Holland Report on housing and race in Greater London
1965	Rent controls and rent officers introduced
1966	Labour re-elected, pledging 500,000 houses/year
1966	'Cathy Come Home' film released, highlighting the plight of homeless families
1967	Erno Goldfinger designs 32-storey tower block
1968	Housing White Paper calls for renovation, not redevelopment
1968	Gas explosion at Ronan Point, kills five
1969	Housing Act introduces General Improvement Areas and Home Improvement Grants
1970	Conservative victory; Department of the Environment created to oversee housing, planning, local government and transport; councils set up social service departments, combining children's mental health and welfare services
1972	Housing Finance Act encourages slum clearance; boost to Home Improvement Grants
1974	Local authority/National Health Service split
1974	Housing Action Areas introduced
1974	More than 100,000 council house completions; Rent Act extends security of tenure to most furnished lettings
1977	Homeless Persons Act; new duty for councils to house certain homeless people

Adapted from Refs. 8-13.

seen to be unjust, and frequently failed to acknowledge the views of those affected,[17] although some attempts were made to assess the experiences and attitudes of households displaced by redevelopment of 'slum' areas, which began to recognize the importance of combining physical with social planning.[18]

By the end of the era, the UK's housing stock tended to be owner occupied or council housing. Dissatisfaction was growing with many of the new tower block estates, which were beginning to present a new range of housing and health issues, particularly emotional and behavioural, and then unnamed and largely unrecognized concepts: social exclusion and a growing welfare-benefit-dependent underclass,[8,9] which are now key public health issues.

Post 1979: the new right

Headed by Margaret Thatcher, the conservative government was elected with a mandate to transform the role of the State in favour of the individual within a quasimarket system (Table 6). The New Right was a substantial move away from traditional conservatism (Table 1), through a reworking of liberalism with values of freedom, personal responsibility and enterprise, illustrated through policies of rolling back the welfare state, privatizing public utilities and assets, and favouring the market sector as provider, so that tenants and patients became 'customers' with a notional choice in their provider.

Housing was one of the key areas where the New Right's vision—ideologically rather than health based—was most apparent. Housing shifted from the state to the individual, most notably through the 'Right to Buy' policy. Additionally, the poor condition of much council housing—notably the tower blocks that local authorities had neither the resource nor technical knowledge to regenerate—enabled the government to point to the failure of councils as housing managers, and argue in favour of alternate providers of social housing in a form of 'quasiprivatization'.

During the era, unemployment increased, inner city areas declined, social problems and health differentials were on the increase, and marginal social housing estates became increasingly polarized.[19] Although, the 1980s saw a revival in interest in public health domestically and internationally, the movement was unable to gain a political foothold in the UK as there was no space for recognition that ill health—frequently determined by poverty and deprivation—was often beyond the realm of the individual.

Many argued that increasing numbers of households were socially and economically excluded by

Table 6 Post 1979: the New Right: overview of housing and public health policy.

1979	Conservative election victory; 1979 Priority Estates Project (HIP funded) to rescue unpopular estates; Urban Programme established
1980	'Right to Buy' introduced, urban development corporations, competitive tendering
1981	Development Corporations begin, EHCS survey shows 1.1 million unfit houses; post-rioting enquiries identify socio-economic and policing problems in rundown estates
1985	Estate Action targets capital at rundown estates where management is localized and tenants are consulted. Voluntary transfer, estate management boards, etc.
1986	Unemployment reaches 3.5 million
1988	Housing Act introduces assured tenancies and promotes stock transfer; UK housing market collapses; Housing Action Trusts and Tenants Choice further break up council housing
1989 onward	Housing Associations become the major developers of new social housing, using private finance for the first time. Needs-based lettings led to polarization. Increased funding for tenant-led initiatives
1989	Local Government and Housing Act introduces mandatory Renovation Grants linked to statutory fitness; Home Improvement Agencies encouraged
1991	City Challenge—new competitive, quasibusiness public-private partnerships for inner city areas in decline
1991	Health of the Nation launched (following the Black Report)
1992	Compulsory competitive tendering—housing management to 'improve' performance; private finance initiative increases private sector role
1993	Single Regeneration Budget introduced, consolidating social, economic, training and housing budgets
1996	Housing Act creates registered social landlords and local housing companies; restriction on homeless people's rights; end of mandatory Renovation Grants

Adapted from Refs. 8–13.

poverty or powerlessness, and questioned the nature and extent of social policy—including housing, diet, employment, antipoverty, etc.—to tackle a background of growing health inequalities. In particular, the Black Report re-reiterated that the persistent inequalities in health caused by poor housing, material deprivation and poverty were fundamental health determinants lying outside the scope of the NHS.[20] Of relevance to housing, the report recommended antipoverty strategies and better coordination of housing policies, but this found little political support during the era.

Post 1997: the new left—a social contract for health

The new labour government consolidated their values and ideological basis for their 'Third Way', which was to be neither left nor right in the traditional sense, but a re-alignment of policy in a new 'social contract'[21] based on a new relationship and responsibilities for government, communities and individuals. The Third Way's values of social justice and modernization is aligned to European 'social democracy' and the USA Clinton administration's 'communitarianism',[22] and absorbs ideas from the Thatcherite agenda including privatization[15] (see Table 7).

This is a distinct departure from traditional labour ideology favouring the state as provider towards a State that is concerned with providing an umbrella framework for policy (including establishing a Minister for Public Health, the Health Development Agency, the Social Exclusion Unit, policies such as the New Deal for Communities and Sure Start) with new responsibilities for communities to help themselves. This is illustrated by the emergence of new organizational structures, with a move from local government to local governance, and a new role for the not-for-profit (voluntary) sector. This is concerned with organizations mobilizing around community need, and not the other way around, and is seen as a more sustainable health-promoting-policy environment.

Much current policy is derived from the Acheson Report[23] that confirmed an overall increase in prosperity and reductions in mortality for people in England, but a widened gap in health between those at the top and those at the bottom of the social scale. Acheson called for fundamental political involvement across government departments to sustainably tackle socio-economic determinants of health and inequalities, with an emphasis on addressing income levels and improving living standards, particularly for families with children.

Most ill health is now environmental and lifestyle determined, both physical and psychosocial, and is increasingly based on consumerism, culture and globalization.[24,25] As a result, the White

Table 7 Post 1997: the New Left: overview of housing and public health policy.

1997	Labour election victory; first Public Health Minister appointed; Social Exclusion Unit established
1997	One in five families headed by single parent; nearly one-third of children live in households where no one is in full-time unemployment
1998	New Deal for Communities introduced
1999	Best value introduced, requiring continual improvement of council and RSL services
1999	White Papers: 'A Better Quality of Life' (150 sustainability indicators) and 'Saving Lives' as responses to criticisms that UK has some of unhealthiest children in the developed world
1999 and 2000	Local Government Acts promoted modernization and social justice agendas; required preparation of community strategy to promote the economic, social and environmental wellbeing; also to contribute to UK sustainable development; partnership approach required
2000	Health Development Agency introduced to raise quality of public health in England; National Health Service plan re-inforced the need for local authorities and health authorities to work in partnership
2000	The Joseph Rowntree Foundation published results of the first national study to attempt to measure social exclusion, confirming rise in poverty rates
2002	Homeless Act to encourage development of local strategies to help prevent homelessness and deliver partnership working
2002	Regulatory Reform Order subsumed all earlier grant legislation, replaced with power to provide assistance
2003	National Health Service Priorities and Planning Framework introduces local delivery planning
2003	Community Plan to create sustainable communities in all regions
2003	Housing Bill provisions seek to more closely re-integrate housing and health

Adapted from Refs. 7-12.

Paper 'Saving Lives—Our Healthier Nation'[26] argued for a comprehensive programme of action to tackle the complex causes of ill health (personal, social, economic and environmental); partnerships between individuals, communities and the government, and more activity on addressing the determinants of health in the most deprived communities. The emphasis is concerned with assessing evidence-based need (health needs assessment) and developing strategic responses that sustainably address this need with maximum health-promoting impact (health impact assessment).[27]

What is the current public health workforce? Where is housing placed in the public health agenda?

Public health is about the organizations and policies that seek to promote health, but who makes up this workforce, and with what interventionist powers and outcomes to sustainably address key health determinants?

The majority of the public health agenda has been concerned with organizational change to the NHS to deliver public health through the new primary care trusts (PCT) in partnership arrangements with other organizations, notably local authorities. Some public health doctors see themselves as best placed to promote public health,[28] but others refute this, arguing in favour of those dealing more directly with health determinants, such as housing officers, environmental health officers, etc. to adopt a higher profile role in the public health agenda to sustainably address health inequalities at community level.[1,29] It is important that community-based partnerships take a lead, as if medics alone take control of strategy, there is a risk that it will mobilize around quantifiable health risk only—such as home accidents, fuel poverty, etc. and wider socio-economic issues in regeneration may fail to be sustainably addressed.

The Environmental Health Commission[30] recognized the need for: health inequalities and health determinants to be sustainably addressed; policy and its organizational delivery to be more closely aligned to need through community development and bottom-up participation mechanisms; a new focus and re-integration of environment and health policies; and a renewed emphasis on addressing the needs of the most deprived communities through active citizenship and partnership working. Much of this is happening in social housing (although housing officers may not see themselves as part of the public health workforce), although the extent to which it is happening in private sector housing is notoriously more difficult to implement and assess, except in area renewal schemes which are gaining increasing political favour.

Partnership approaches in health improvement have moved apace.[27,31] Local Delivery Planning (previously Health Improvement Programme (HImP), then Health Improvement and Modernisation (HIMP) is now concerned with identifying local-needs and turning national contracts into local action with a focus on schools, workplaces and neighbourhoods. It has placed particular emphasis on health inequality. The aim is to tackle poverty, poor housing, pollution, low educational standards, joblessness and low pay. This is to be allied with other partnerships, including local strategic partnerships (LSP) that align public, private, business, voluntary and community initiatives and services, and seek to operate at the right level for strategic decisions that are close to communities. LSPs are seen as pivotal to finding joined-up solutions to help tackle priority areas for local people, notably in crime, jobs, health and housing.

In addition, local authorities—who oversee local social and private sector housing, conditions and need—have new duties for community strategies under the Local Government Act 2000 and are required to prepare a strategy for promoting or improving the economic, social and environmental wellbeing of their area and contributing to sustainable development across housing tenures. The purpose is to enhance the quality of life locally based on community need and participation, with a long-term vision focusing on health improvement outcomes. This is closely aligned to local authorities 'best value' obligations, to ensure continued service improvements. Public service agreements (PSA) also offer opportunity for additional resource that can be used to help address national and local priority issues such as social exclusion, improving education, housing and employment, and reducing crime and health inequalities.

However, despite these major policy shifts, the extent to which partnerships are being developed and implemented as perceived—so that they have an actual and sustained impact on health improvement where it is most acute—is difficult to gauge. The plethora of policy change leaves little time for evaluation, aggravated by the fact that meaningful improvements in housing and health status need to be measured over a period of years, not months. Meanwhile, however, there are many examples of innovative practices being delivered by local authorities and their partners in promoting public health.

One example is that of the London Borough of Newham's approach to tackling tuberculosis.[9] Newham had one of the highest rates of

tuberculosis in the UK, and this has been tackled through partnership with the PCT, environmental health practitioners, social services and others through a PSA receiving some £100k/year which established patients' targets and decided on action to be taken. This has led to further training, health-promotion activities, tuberculosis screening, outreach work, vitamin D deficiency research, and quantitative and qualitative research into new solutions, leading to innovative increased concentration on socio-economic and housing conditions. Such projects are having an impact in other areas of public health, largely because traditional, medical and socio-economic barriers between organizations are being broken down, but they are only funded in the short term. This needs to be redressed by government to maintain the achievements made.

Additionally, many local authorities have used their best value reviews as an exercise in working towards issues such as improved home safety, where their traditional 'top-down' legal powers have been inadequate. Home safety has become an increasingly recognized public health issue, perhaps because it is easier to monitor by empirical evidence than most housing and health issue.[7] Best value performance reviews have enabled such issues to be adopted on wider partnership bases, and have helped to raise the profile nationally, although there is no national home safety strategy per se.

Housing policy and contemporary public health

The most recent English House Condition Survey[32] demonstrated a continued close correlation between low income, ethnicity, lone parents and poor housing.

Government is seeking to address health-promoting housing through its 'Community Plan'[33] and to create thriving, sustainable communities in all regions, ensuring that socio-economic and environmental community needs are met alongside housing delivery as part of the public health agenda. Key to this is the concept of 'decent homes' and neighbourhoods across tenures, which is defined to be: fit (imminently to be replaced by the housing health and safety rating system[34]); in reasonable repair with reasonably modern amenities; adequate noise and thermal insulation; and adequate size and layout of common areas in flats.[35,36] The priority is to address poor social housing in the most deprived local authority areas, although it also covers private sector housing, but it is unlikely that this target will be met.

In addition, the Housing Bill[34] seeks to: re-integrate living environments and health with a new evidence-based housing health and safety rating system; introduce mandatory Health Maintenance Organisation (HMO) licensing (but only for those HMOs deemed 'higher risk'); introduce discretionary licensing of the private rented sector; modernize the Right to Buy provisions; and to improve the process of house selling and buying. All this, of course, sits within a wider package of public health reform aligned with national policy and local-needs-based strategic partnerships to promote health where inequalities are most acute. Partnerships alone cannot guarantee this, and there is a real need for enough suitable accommodation within health-promoting environments where housing—whether owner occupied or rented—is available, secure, of a decent standard and affordable.

However, despite these major steps forward, it is the author's view that many of those involved in housing still do not see themselves as public health workers. Environmental health practitioners, who mainly work in private sector housing, are trained in public health, and therefore tend to recognize the role they play in the public health agenda. Conversely, social housing practitioners—whilst dealing with housing and health—do not normally regard themselves as public health practitioners (although they clearly are), despite the current government agenda. There still remains a divide in terminology in social and private sector housing, which is not helpful. Such issues could be more comprehensively addressed so that housing and health policies are more closely integrated and the new partnerships could offer a more 'tenure neutral' approach.

Conclusion

The public health movement has made enormous progress since its inception in the mid Victorian era. The post-war welfare state sought to ensure equality, and remained in its largely top-down structure for some 30 years. The post-1979 conservative government adopted a neoliberal agenda, with a focus on ideology and health seen as a commodity rather than a complex result of a complex socio-economic society. The current labour government has absorbed many political systems into its Third Way, promoting public health as a core policy, arguing for a new relationship between individuals, communities and the government, and seeking to align policy with health-promoting outcomes. Turning around a legacy of health inequality is a large task and it will be some years before the fruits of the current public health

agenda—and, in particular, moves in health-promoting housing and communities—can be realized.

References

1. Burke S, Gray I, Paterson K, Meyrick J. *Environmental health 2012: a key partner in delivering the public health agenda.* London: Health Development Agency; 2002.
2. Naidoo J, Wills J. *Health promotion: foundations for practice,* 2nd ed. London: Balliere Tindall in association with the Royal College of Nursing; 2000.
3. Acheson D. *Public Health in England. Report of the committee of inquiry into the future of the public health function.* London: HMSO; 1988.
4. Wanless D. *Securing good health for the whole population: Final Report.* H.M Treasury on behalf of HMSO.
5. Open University. *Politics and Power.* Milton Keynes: Open University Press; 1995.
6. Stewart J. Healthy housing—the role of the Environmental Health Officer. *J R Soc Promot Health* 1999;**119**:228-34.
7. Stewart J. Home safety. *J R Soc Promot Health* 2001;**121**: 16-22.
8. Stewart J. *Environmental health and housing.* London: E and F N Spon; 2001.
9. Stewart J, Rhoden M. A review of social housing regeneration in the London Borough of Brent. *J R Soc Promot Health* 2003; **123**:23-32.
10. Stewart J, Bushell F, Habgood V. *Environmental health as public health.* London: Chadwick House Group Ltd; 2004 [in press].
11. Foskett EW. Historical development of environmental health in the UK. In: Bassett WH, editor. *Clay's handbook of environmental health.* 18th ed. London: E and FN Spon; 1999. p. 24-59.
12. Brown C, Savage C. *For the common good: 150 years of public health.* London: Chartered Institute of Environmental Health; 1998.
13. Anon. From strength to strength: half a century of environmental health under the reign of Her Majesty the Queen. *Environ Health J* 2002; **110**: 171-8.
14. Aldridge HR. *Guide to the Administration of the Housing Acts, 1923 and 1924 (being a supplement to the National Housing Manual).* London: The National Housing and Town Planning Council; 1924.
15. Jones B, Kavanagh D, Moran M, Norton P. *Politics UK.* Essex: Pearson Education Limited; 2001.
16. Ministry of Housing and Local Government. *Councils and their houses: management of estates.* London: HMSO; 1959.
17. Kay J, editor. *Housing in the Seventies.* Warrington: Association of Public Health Inspectors, undated, possibly 1969.
18. Ministry of Housing and Local Government. *Moving out of a slum: a study of people moving from St. Mary's Oldham.* London: HMSO; 1970.
19. Power A. *Estates on the edge. The social consequences of mass housing in Europe.* London: Macmillan Press Ltd; 1999.
20. Townsend P, Davidson N, Whitehead N. *inequalities in health; the Black report and the health divide.* Harmondsworth: Penguin; 1988.
21. Department of Health. *Green paper: our healthier nation: a contract for health.* London: HMSO; 1998.
22. Harrison D. *Integrating health sector action on the social and economic determinants of health: the UK response under new labour Review of health promotion and education. Verona initiative.*; 1998. *http//www.rhpeop.org/ijhp-articles/e-proceedings-verona/1/index.htm* [8 October 2003].
23. MacArthur ID. Introduction to environmental health. In: Bassett WH, editor. *Clay's handbook of environmental health.* 18th ed. London: E and FN Spon; 1999. p. 1-22.
24. MacArthur I. Making a world of difference. *Environ Health J* 2003;**111**:68-70.
25. Department of Health. *White paper: saving lives: our healthier nation.* London: HMSO; 1999.
26. Health Development Agency. *Draft paper: evidence-based public health and local delivery plans: a briefing for the HDAs regional Associate Directors.* London: Health Development Agency; 2003.
27. Taylor S, Coyle E. *Education and debate: public health does not need to be led by doctors: against. BMJ.* 2003; **322**:1593-6 [6 November 2003].
28. McPherson K. *Education and debate: public health does not need to be led by doctors: for. BMJ.* 2001;**322**:1593-6. *http://bmj.bmjjournals.com/cgi/content/full/322/7302/1593?eaf* [6 November 2003].
29. Environmental Health Commission. *Agendas for Change.* London: Chadwick House Group Ltd; 1997.
30. Department of Health. *Improvement, expansion and reform: the next 3 years priorities and planning framework 2003-2006.* London: HMSO; 2003.
31. Office of the Deputy Prime Minister. *English house condition survey 2001: key facts.* London: HMSO; 2003.
32. Office of the Deputy Prime Minister. *Sustainable communities: building for the future.* London, Office of the Deputy Prime Minister *http://www.communities.odpm.gov.uk/plan/main/overview.htm* [6 March 2003].
33. Office of the Deputy Prime Minister. *Housing bill—consultation on draft legislation.* London: HMSO; http://www.odpm.gov.uk/information/consult/housingbill/01.htm [1 April 2003].
34. Department of Environment, Transport and the Regions. *The Housing Green paper. Quality and choice: a decent home for all.* London: Department of the Environment, Transport and the Regions and the Department of Social Security; 2000.
35. Department of Environment, Transport and the Regions. *A decent home: the revised definition and guidance for implementation, sections 1 and 2.* London: Office of the Deputy Prime Minister; 2000.
36. Acheson D. *Independent inquiry into inequalities in health.* London: HMSO; 1988.

Publication 11 Stewart, J. (2005) 'Personal responsibility' in private sector housing renewal: Lessons from Scotland and Edinburgh's good practice, *Journal of Environmental Health Research*, 4 (02), pp. 75-83.

'Personal responsibility' in funding private sector housing renewal: Lessons from Edinburgh's good practice

Jill Stewart[1] MSc BSc (Hons) MCIEH FRSH PGCE ACIH

[1] **Senior Lecturer, School of Health and Social Care, University of Greenwich**

Correspondence: Avery Hill Campus, Bexley Road, Eltham, London SE9 2PQ.
Telephone: + 44 (0) 20 8331 8218, Email: j.l.stewart@greenwich.ac.uk

Abstract

England and Scotland are at different stages of their private sector housing renewal policies. Scotland has devolved powers in housing and public health, and legislation and practice is quite distinct from other parts of the UK. English policy documents tend to emphasise needs and area-based interventions set within a wider range of other public health policies, while Scotland's approach tends to mobilise around property management and maintenance.

As grants are in decline, there is a renewed emphasis on personal responsibility for private sector housing condition. The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 subsumed earlier grant legislation and provided a new power for assistance, requiring increased private sector funds to be levered into the sector. Research into how this is being implemented at local level and examples of good practice are continually being evaluated. At the time of writing, the Scottish Housing Improvement Task Force is still considering how to best implement personal responsibility and the forms of assistance that will be necessary. There is a growing evidence base of good practice (i.e. at practitioner/implementation level), in private sector funding opportunities that may help promote housing conditions. It is becoming increasingly important to demonstrate accountability and increased use of private funding in private sector housing renewal.

This paper reports on issues around personal responsibility in Scottish and English private sector housing renewal policy. Its content is based on a literature review and interviews with the Scottish Executive, the Scottish Federation of Housing Association and the City of Edinburgh Council's Private Sector Services, where innovative local approaches have – and continue to be – developed. Notably, the Edinburgh Stair Partnership, launched in 1991, offers residents technical and administrative support as a form of Property Management Service Scheme. It seeks to motivate owners to maintain their homes cost effectively, using decent, guaranteed builders. All targets have been exceeded without having to fund any grant assistance. Such evidence-based practice offers useful lessons at implementation level that can be appropriately adapted elsewhere.

Key Words: Evidence and housing, Edinburgh Stair Partnership, Housing and public health, Housing Improvement Task Force, Regulatory Reform, Private sector housing renewal.

Introduction

As levels of home ownership continue to rise, both England and Scotland are currently undergoing sweeping changes in policy development and implementation in respect of private sector housing stock. Following decades of interventionist housing grant policy funded by the state, home owners are now required to take more personal responsibility for funding maintenance, repairs and improvements in their own houses. The drive toward personal responsibility for private sector housing has been made explicit in key documents about private sector housing in both England (DoE, 1996; DETR, 2000; ODPM, 2003a; ODPM, 2003b) and Scotland (HITF, 2003). This process really began with the New Right from 1979 as the role of the state became one of enabler rather than provider of services delivered through a range of new organisations such as Home Improvement Agencies (HIAs). The New Left since 1997 has continued to favour home ownership and personal responsibility for the sector's condition. This seeks to empower individuals to make choices in meeting their needs by accessing appropriate goods and services based on information from professional experts (Nettleton, 1997; Petersen, 1997).

Scotland already had its own housing powers prior to devolution, and different intervention standards, enforcement protocol and grants regimes. However, there is now a shared emphasis on personal responsibility for private sector housing conditions in the form of private finance rather than grants for housing renewal. The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 subsumed earlier grant legislation and encouraged greater use of private funding opportunities. At the time of this study, the Scottish Housing Improvement Task Force (HITF) was considering how to develop and implement similar proposals locally in providing 'Schemes of Assistance' to owners.

Most households in England and Scotland are home-owners. Many are in a position to take responsibility to

maintain, repair and improve their homes. However, many low-income home owners are not. Indeed, most occupying poor housing in England are low-income groups, particularly lone parent and ethnic minorities (ODPM, 2003b). The Scottish House Condition Survey (Scottish Executive, 2003) reports that it is mainly households on low incomes who suffer substantially higher incidences of dampness and condensation in their housing (across tenures). Herein lies the problem of personal responsibility for housing conditions: how can lower-income groups, who are already disproportionately represented in poor housing and suffering health inequality, afford necessary works?

Despite the sweeping changes currently underway in private sector housing renewal, there remains little published literature about evidence-based practitioner involvement in implementing private sector housing renewal policy. Historically, success in private sector housing renewal has been measured quantitatively (e.g. number of houses with internal amenities or meeting the fitness standards of tolerable standard following grant or enforcement activity etc, – see for example Leather and Morrison, 1997; ODPM, 2003c; Scottish Executive, 2003. While this provides valid indicators of housing quality, it does little to illustrate the qualitative benefits of policy intervention, or indeed to attempt to 'measure' whether, and to what extent, wider health benefits have been achieved.

Sharing practitioner knowledge of what works well, within a sound strategic process that is routinely monitored and evaluated, is becoming more important. Many working at practitioner level already share innovative, good practice routinely, yet often this 'expert knowledge' – based on research – is disseminated informally and the current calls for evidence-based practice represent an opportunity to ensure that such practice is disseminated through nationally recognised structures. One purpose in writing this paper is to present Edinburgh's good practice – which responds to ideals of personal responsibility – within its wider context as a basis for learning lessons intra UK. Such good practice is set to become more important in the context of evidence-based practice within a rapidly evolving public health agenda in England (see for example Health Development Agency, 2004).

New strategies in England and Wales

The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 required local authorities to provide new means of assistance to address local needs and priorities through enhanced access to private funding opportunities and to publish their policy by July 2003. ODPM Circular 5/2003, *'Housing Renewal'* (ODPM, 2003b) reiterated the Government's view that home maintenance remains the owners' responsibility. However, the Circular also pointed to the impact of poor housing and health and local quality of life and that appropriately targeted local authority strategic, partnership-based approaches were essential. The Order is therefore also seen as an opportunity to contribute to wider housing and public health government objectives of poverty, social exclusion, health inequalities and neighbourhood decline based on local needs assessment and other policy priorities.

There has been more of a focus on client based group approaches to improving energy efficiency, health etc, emphasis on Renewal Areas and continued use of HIAs. The policy tools put forward to encourage personal responsibility include grant assistance; loan assistance (interest bearing repayment loans, interest-only loans, and zero-interest loans); Income Support for loan interest payment; Equity Release Schemes; providing loan finance with others; packages of grants and loans; and other forms of non-financial, technical and social assistance. It also raised the training and culture change necessary for authorities in administering loans. The Circular set out requirements for drafting, adopting and monitoring the new policies (including drawing from good practice) and ensuring public consultation.

Results from a recent postal questionnaire (ODPM, 2003d) suggests that this has proven more challenging than anticipated, but some examples of good practice are now emerging from local authorities and their partners (ODPM, 2003e). The Centre for Urban and Regional Studies at the University of Birmingham undertook research into the success of this Order (see www.curs.bham.ac.uk). The report of the initial survey found variation in how the new strategies have been researched and developed. Some have consulted with other housing and health organisations, although less so with potential lenders to supplement public resource, or with residents or builders. Of the responses received, some 92 per cent were considering a new policy, and 8 per cent intended to retain their existing policy. Overall there has been more of an emphasis on preventative interventions and a more client-centred approach (OPDM, 2003e).

Although the 2002 Order has been in place for some time, there is still a lot to be done to develop new and innovative policies, targeted to greatest need and to maximise private investment. The research also investigated innovative developments emerging from the Order, with 78% of local authorities planning to develop new packages and 65% of these (mainly London Boroughs and Metropolitan Districts) intending to fund another organisation to assist in delivering this. Results indicate considerable diversity in local implementation, but mainly a mixture of grants and loans. An increasing number of local authorities were working with the Home Improvement Trust (HIT) to access the Houseproud scheme. However, the main emphasis was found to be a modified grants system rather than other assistance, particularly in Wales (OPDM, 2003e).

In addition, a recent Briefing Note overviews some good practice adopted to date, offers lessons to other

Table 1.0: Summary of private funding initiatives

Organisation(s)	Brief overview of scheme
The Home Improvement Trust (HIT), Nottingham. *(At time of writing, the only national home loans service for repair, adaptations and maintenance)*	Established in 1997 and operates nationally to provide advice and access to affordable home repair and improvement for equity rich home-owners, normally aged over 60, except where the applicant is disabled. HIT and Houseproud work with lenders, LAs and HIAs, offering a range of products and loan types. Some 80 LAs work with Houseproud in England and Wales, at a fee.
ART (Aston Reinvestment Trust) Homes Ltd, Birmingham (not for profit, subsidiary of RSL)	Established in 2000 to provide affordable loans to meet the needs of low income home-owners, working in close cooperation with LAs. Costs are spread across LAs and helps bring in private sector finance to assist in wider private sector regeneration. By January 2004 ART home had given £200,000 in loans and had approved some £850 in further lending, with a view to expanding its range of products longer term in the West Midland area. Now exploring new possibilities on national basis, as its Property Appreciation Loan (PAL) could be made available to all adults, not just those over 60.
The 'HomeImprove' initiative, Rochdale and Oldham Borough Council, in partnership with West Pennine Housing Association (Not for profit, partnership between RSL and LAs)	Established in 2001 to enable loans via the SRB5 scheme, further amended via Best Value review, leading to consideration of equity release schemes and grant assistance where eligible. Equity based on valuation after improvement. Implications for staff training and funds are recycled. Situation still under review as progress on uptake is monitored, and scheme could expand.
The Derby Loans Group (not for profit)	Established in 2002 to assist those without access to credit, enabling access to loans, privately funded from shareholders' equity, loans and grants. Pilot scheme for housing loans was set to begin in April 2004. Loans restricted to geographical area to complement LA scheme for RTB owners – £3,000 over 4 years maximum – secured by a land charge.
Wigan Borough Council Housing Finance Assistance (direct lending)	Established following RRO, a grant and loan package – 'capital appreciation loan' – secured against equity in the property. Grant element enabled LA to exercise some control, and flexibility built into system. Generally successful, possibly because of high grant to loan ratio at present, but still a need for more private finance. Other regional LAs interested in adopting similar approach.

Key: LA = local authority; RSL = registered social landlord; RTB = right to buy; SRB = single regeneration budget. Source: Summarised from ODPM et al (2004)

local authorities (ODPM *et al*, 2004). Five case studies from this are summarised in Table 1.0.

Key lessons from the ODPM research (ODPM, 2003e; ODPM *et al*, 2004) include:

- fundamental cultural change is required in delivering new packages of financial assistance;
- sustained funding and resourcing for new initiatives can be challenging;
- the lack of national requirements, loan products and government guidance may lead to substantial strategic development time locally; but local variations may bring advantages to communities;
- early decisions need to determine what assistance packages will be available for, e.g. healthier housing or simple repairs/maintenance etc;
- mechanisms are needed for the dissemination of good practice and to convey more widely to communities information on the types of assistance available, and
- monitoring and evaluation remain fundamental.

This paper is concerned with the extent to which current Scottish policy development aligns with personal responsibility for private sector housing conditions in a market environment, and what evidence base exists to help measure progress and maximise policy output. There is a particular emphasis on Edinburgh City Council's approaches to private sector housing renewal, which can offer lessons in good practice, increasingly recognised as part of the need for a growing evidence-base in private sector housing renewal. Comparisons are drawn with England's approach as appropriate. Other parts of the UK are not specifically considered (except where

otherwise stated) as they do not share completely similar housing and/or public health policies.

Methods

Following a literature review, a series of initial telephone discussions helped identify relevant personnel with responsibility for private sector housing conditions, at policy making level (Scottish Executive) and implementation level (City of Edinburgh Council). The Scottish Federation of Housing Associations was also included due to the challenges they face in maintaining mixed tenure blocks where they hold overall responsibility. The telephone discussions also helped identify relevant policy documents at local level. Semi-structured interviews were then held with representatives of each of the following organisations in Edinburgh: Scottish Executive (the devolved government of the Scottish Parliament); City of Edinburgh Council (who have their own unique legislation, and have been innovative in their private sector housing renewal policies and strategies); and the Scottish Federation of Housing Associations (SFHA) (Scotland has a high concentration of tenements (flats) and the SFHA's interest extends to private sector housing renewal to facilitate joint renewal programmes in mixed tenure blocks that have arisen from the Right to Buy policy) (see also SFHA, 2003; SFHA, 2004).

Interviews were used to enable some adaptability to probe ideas and responses as well as to explore some of the motives behind policy changes from the perspective of each organisation. Interviews were based around key themed areas. This sought to explore the nature of current housing policy and strategic changes, differences identified and why, and the extent to which an emerging evidence-base was underpinning these changes. Policy and practice issues and the wider health agenda were also investigated. Particular attention was paid to encouraging 'personal responsibility' in Edinburgh's City Council's good practice in private sector housing renewal and the extent to which the new proposals might underpin this.

Results and discussion

The starting point for this study was to explore how Scotland – which already had different housing and public health policy approaches to England – was addressing a wider policy of personal responsibility for private sector housing conditions, and find out what evidence-base exists to help measure progress and maximise policy output.

Juggling personal responsibility with better housing: proposals for assistance and property management in Scotland

Since most Scots now own their own home, the Housing Improvement Task Force (HITF) was commissioned to explore issues in improving the quality of this sector and bring together evidence on which to develop new legislation, polices, improved working practices and better information to those in, or aspiring to, this sector. Its report and recommendations were published in *'Stewardship and Responsibility: A Policy Framework for Private Housing in Scotland'* (HITF, 2003). Of particular relevance to this paper, the report proposed consideration of the level and nature of local support necessary for delivering maintenance, repair and improvement of private sector housing, with recommendations on disseminating good practice, such as in property management at local level (e.g. City of Edinburgh Council's approaches), in successfully delivering Schemes of Assistance to owners. This is part of a wider approach concerned with personal responsibility for homeowners.

The report provided the HITF's recommendations for the sector, including provision of Schemes of Assistance to owners. While much was similar to contemporary changes in England and Wales, there were also some differences, mainly due to the nature of Scottish housing stock and earlier (and continuing) differences in its legal and intervention standards. Scottish policy is seeking to achieve a balance between public policy objectives and owners' rights and responsibilities. In respect of maintaining and repairing the private sector, financial assistance is to be targeted toward those in greatest need, with other forms of support being made available, including advice, assistance with accessing finance and equity based loans. In addition, a new system of area-based powers are proposed, with new enforcement powers available (although enforcement powers are not within the scope of this paper) (HITF, 2003). It seeks to deliver a wider approach to housing and health within a market-led system, whereby home owners make rational decisions about their property (Scottish Executive, Personal Communications, 2004).

The HITF proposed that Scottish local authorities should consider how to make the following forms of assistance available in their areas:

- General advice and guidance – leaflets, websites, general advice, Communities Scotland HomePoint Services for accreditation system built on national standards and good practice;
- Practical assistance, where homeowners can afford works, such as handyperson services, Care and Repair etc, assistance with neighbours;
- Loans provided by local authorities, as conventional or equity based;
- Subsidised loans; and
- Subsidy through grant.

Whilse most dwellings in Scotland are houses, the proportion of tenements (flats) in Scotland is significantly higher than in other parts of the UK (HITF, 2003; Scottish Executive, 2003). This clearly has important policy implications for maintenance, which is primarily technical, but also organisational, social and financial. Where there are common parts

home-owners also have responsibility to others for carrying out and funding works. For this reason, the technical and administrative practicalities about enabling maintenance and repair – i.e. property management – become key issues (Scottish Executive, Personal Communications, 2004; City of Edinburgh Council, Personal Communications, 2004).

Property management arrangements (including mediation on disputes etc) are seen as paramount to ensure that works are carried out uniformly and that everyone acts fairly towards one another in the tenement. The SFHA are keenly interested in ensuring that new proposals for personal responsibility are able to dovetail into their own capital renovation programmes in mixed-tenure tenements (Scottish Federation of Housing Associations, Personal Communications, 2004; SFHA, 2003; SFHA, 2004). This is also backed up by (proposed) statutory powers for maintenance plans by giving local authorities the power to require owners to establish arrangements for property management and a maintenance plan, including a professional property manager (HITF, 2003). There are many lessons here that may prove good practice elsewhere for group repair/enveloping type schemes.

Funding private sector housing renewal: the home-owners' responsibility in Scotland

Currently, grants are still being administered in Scotland under the Housing (Scotland) Acts 1987 and 2001. Various grants are available, including Improvement Grant and Repairs Grant, which are means tested. Issue-based grants are also available, including for adaptations for people with disabilities, replacement of lead pipes and works to reduce radon gas. Housing grants are seen to have been effective as a policy instrument, in as much as there are now fewer properties failing the Tolerable Standard where grants have been targeted here, including in area based schemes (City of Edinburgh Council, Personal Communications, 2004). However, within the new local strategies, there is a shift of emphasis from grants to other forms of assistance as it is increasingly felt that home owners should factor in costs when buying and managing their property (Scottish Executive, Personal Communications, 2004). The Scottish Executive are keen to 'recycle' finance through loans rather than grants, and are seeking to leave grants wholly to local authority discretion (Scottish Executive, Personal Communications, 2004).

Following the HITF's recommendations, funding for Private Sector Housing Grants (PSHG) paid to local authorities will total more than £140 million in the next two years, a more than 40 per cent increase since the previous year (Scottish Executive, 2004). PSHG is delivered according to need and circumstances based on agreements between local authorities and Communities Scotland, which governs the grant. Priorities for assistance are proposed to be – houses failing the tolerable standard and adaptation of houses for specific needs (HITF, 2003). PSHG is specifically ring fenced, applicable to capital costs of providing assistance, but also to revenue costs including initially piloting and establishing new schemes (City of Edinburgh Council, Personal Communications, 2004; Scottish Executive, 2004). Examples of how the City of Edinburgh have maximised this grant are included later in this paper.

Scottish Local Housing Strategies (managed by Communities Scotland) are set to be strengthened. The HIFT (2003) argue that strategic planning should include a comprehensive scope; clear purpose and objectives; have established and appropriate targets nationally and locally; be responsive to local needs, conditions and priorities; and be linked to effective delivery mechanisms. In addition, the Scottish Executive (Personal Communication, 2004) advise that local housing strategies should be set in a community planning context, engaging with health agencies. For example, they would like to see Care and Repair Agencies operating in all local authority areas.

In England, this process is already well established, and indeed it is an annual requirement of all local authorities. In addition, it has become linked to the wider public health agenda through partnership based working. There has also been an increased emphasis – although not a statutory requirement - for Health Needs Assessment and Health Impact Assessment in England, but this is not currently the case in Scotland (Scottish Executive, Personal Communications, 2004). Indeed, from discussions with each of the three Scottish organisations in this study, there was no apparent integration with a wider public health agenda identified, as successful property management in itself appears to be priority.

City of Edinburgh Council: Good practice in private sector housing renewal

Discussions were held with Edinburgh City Council to assess how national policy is being interpreted and delivered locally. Edinburgh has several unique features and innovative approaches to private sector housing renewal (see City of Edinburgh Council, 2002). Edinburgh has 222,813 properties of which 5,500 are traditional pre-1919 tenements. For the City of Edinburgh as a whole, 153,724 (69 per cent) are owner-occupiers. There are significant repair problems in the private sector, particularly among pre-1919 tenements, which can require works costing up to £200,000. Edinburgh overall has 80 per cent private sector tenements (City of Edinburgh Council, Personal Communications, 2004) and therefore a history of property management.

The Edinburgh Stair Partnership (ESP) was launched in 1991. It responds to tenements already in disrepair (i.e. outside of the Tolerable Standard) and provides technical and administrative support as a form of Property Management Service Scheme. It seeks to motivate owners to address maintenance issues

through a participative approach using decent, guaranteed builders. For £50 per annum, participating homeowners are able to have an annual inspection, a comprehensive report on condition (including photographs), and a meeting convened to discuss joint decisions and agreements on costed repairs.

The owners pay the local authority their proportion (and factor-in costs) and the local authority then arrange for the works and pay the builders, representing a win-win situation for all. Edinburgh City Council has found that it has exceeded all targets for progress without having to fund any grant assistance. In 2003-4 for example, £0.5 million works were achieved at no capital cost to the council, with £1 million since the start of the ESP. The ESP is now in its 'service testing' stage, so is not recovering full revenue costs and will need to be self-funding in the future, but is nevertheless already cited as evidence-based good practice (City of Edinburgh Council, Personal Communications, 2004). It has the advantage of being able to respond to levels of disrepair in a proactive and cost-effective manner. A key emphasis of the ESP is on property management and making home-owners meet their obligations to others.

In addition, the City of Edinburgh has been able to access funding from the PSHG to investigate other opportunities to assist home-owners in arranging and funding PSHR. These approaches seek to be an increasingly proactive approach to addressing maintenance and for necessary repairs, and have been successful in securing PSHG. For example, the proposed Home Works scheme seeks to offer a variety of proactive techniques to require owner-occupiers to repair their properties. This is based around the Scottish Housing Quality Standard, so that houses are wind and watertight and increasingly energy efficient. Leaflets and brochures have been produced and a website established (see www.edinburgh.gov.uk/yourhome). This website offers guidance and advice on how to get joint agreement and make progress on joint works, suggestions on funding and links to relevant organisations such as property managers (who will soon have an accreditation scheme in Scotland). The Council is now looking to bolster secondary services that can also be successful, such as Building Maintenance Log Books.

The City of Edinburgh Council has some unique features that affect private sector housing renewal. Edinburgh is a World Heritage Site, although there are no real mechanisms to ensure that owners spend the available resource on housing (City of Edinburgh Council, Personal Communications, 2004). However, the City Council has its own special powers for private sector housing for property conservation, the City of Edinburgh District Council Order Confirmation Act 1991 and the Civic Government (Scotland) Act 1982. This enables the Council to issue statutory notices for (serious) disrepair, including in mixed tenure tenements, where other routes taken by the Council's housing managers have been unsuccessful. It is the owners' responsibility to do the works, although City of Edinburgh Council can on formal request. This is cited by HITF as good practice, although it is reactive rather than proactive as the property would already have to be in disrepair. While this would ensure the works were done, the Council may end up with a long-term debt before all monies were repaid.

There is a variety of other strategic approaches. For example, the Lothian Educational Environmental Partnership (LEEP) encourages solar panels and is jointly funded by the council and utilities. For fuel poverty, the Warm Tenements Project fits neatly with those already in the Stair arrangements, with no charge to owners, and the Energy Action Grant Agency support domestic energy improvements. Many Listed Buildings have undergone Energy Audits. In addition, Care and Repair help target resources more closely (City of Edinburgh Council, Personal Communications, 2004).

City of Edinburgh's strategy to establish a culture of personal responsibility

Following the HITF Report (2003), the City of Edinburgh Council has been able to successfully use the Strategic and Development Programme PSHG Baseline and Bid Element to support the development of new initiatives for home-owners within their private sector housing strategy. This has included, for example, assisting further owners in Property Management Services through the ESP, as well as assistance through Core Housing Grants, Lead Replacement Grants, Adaptation for Special Needs (City of Edinburgh Council, Personal Communications, 2004; City of Edinburgh Council, 2004). For 2004/5-2005/6, the Council will seek further resource to:

- Develop advice and information on financial options for owners for those not currently eligible for grants, including loans, factoring services etc;
- Further develop the ESP (e.g. an interactive website); and
- Commission other research into new initiatives and projects.

The City of Edinburgh Council Private Sector Services have held public meetings with joint owners in exploring what they would find helpful as grants are reduced in favour of other schemes of assistance. The Council is working with groups of owners on pilot projects to help firm up ideas about proposed schemes, including personal responsibility for funding. Some of these would need to be arranged by individual owners, some by an independent financial adviser and some may need to be initially developed from scratch. As the system moves from grant-assisted to increasingly market led 'Schemes of Assistance', options presented to home-owners to help them arrange and fund repairs and improvements would include:

- Use of savings;
- Borrowing from within the family;
- Extending mortgage, borrowing from existing lender;
- Borrow from new lender;
- Low interest repayment;
- Equity release; and
- Property appreciation loan.

Commissioned research has included investigating Subsidised Loan Schemes to help owners afford works to their homes. Much of the focus is on mixed tenure properties for common repairs and improvements and research has helped explore preferred routes for schemes of assistance. The City of Edinburgh Council has looked at the experience of subsidised loans in England, such as ART Homes and the HIT (see Table 1.0); how effective a range of loan products might be; potential for local lenders; options for delivering loans; comparison of loans versus grants in delivering better housing; potential of local property market to deliver; extent of investment required; longer term advantages and disadvantages of proposals; and establishing appropriate time scales. Researchers have looked at a range of loan products available for home repair and improvement, how this may streamline into the ESP, issues around Edinburgh's housing market and housing stock and options available (see DTZ, 2004a; DTZ, 2004b).

At the time of this study, analysis, consultation and strategic development remains ongoing in an attempt to address the very complex nature of private sector housing renewal as part of a long-term strategy, maximising resource use, ensuring organisation and cultural change, and offering fairness in the system (see for example City of Edinburgh Council, 2003). It is too early to evaluate this.

Disseminating evidence-based good practice

An emphasis on personal responsibility and private financing raises fundamental questions on how private sector housing stock will be maintained, repaired and improved in the future. Even with grants, it has not been possible to 'get ahead' of housing conditions, or always to correlate grants to health issues. Although they have been successful in ensuring provision of standard amenities etc, the need for regular maintenance and necessary repairs continues to provide major challenges to private sector housing renewal strategies. Both countries are seeking to involve their communities more in what they are doing, and proposing to do, although the extent to which this happens varies locally.

With the withdrawal of mainstream grants as an interventionist policy option, there are differences in the Scottish and English approaches. The change of grants legislation to assist home-owners to carry out repairs, emphasis on 'personal responsibility' is well underway in both countries. In England, a range of financial, technical and social initiatives is under consideration, while in Scotland, the focus is mainly on financial initiatives (replacing grants with forms of loans). Both also deliver more specific grants that are targeted toward health issues, such as disabled facilities grants, grants to address fuel poverty, or otherwise determined by local strategy.

There are also differences in the approaches to area renewal/regeneration. England's approach sits within a wider socio-economic model of regeneration within an established public health agenda through partnership working and wider forms of accessing and utilising resource. Scotland's approach appears to have less area emphasis, and a closer focus on property management, with technical aspects and practicalities of renovating tenements as 'joint ventures' through the ESP. Lessons can be learnt from each approach. Indeed, it could still be argued that sufficient connections are still not being made with communities in England through partnership arrangements (Hunter and Sengupta, 2004), and that Scotland's approach through the ESP is providing a valuable, evidence-based way forward in individuals themselves working together to get the job of maintenance done, with appropriate support from the Council.

Some form of nationally recognised evidence-base is essential to disseminate and share good practice intra-UK to help respond to and evaluate the sweeping changes currently underway in private sector housing renewal. Although there is currently no such formal outlet, the emerging (English) *'Learning for Effective Practice Standard System'* (LEPSS) (Health Development Agency, 2004) sets out new proposals for collection, review and synthesis of effective health improvement practice. This seeks to develop and establish national standards in England to plan, evaluate, record and retrieve effective practice that links research and practice in a new way. This would help develop the evidence base further by establishing national templates to enable planning and evaluation of health impact of increasingly effective interventions. The LEPSS system would essentially comprise a good strategic process about planning for change within a given policy context, identifying and overcoming barriers (organisational, community, partnership, resource, training, communication, aims and objectives, commitment, monitoring protocol etc) and ensuring that the strategy achieved what it set out to do in the first place. The system seeks to combine research and practice within the context of the public health agenda to maximise health gain. Practitioners are seen as fundamental to understanding what works effectively at implementation level, and why in a way that can adapt according to local need. Much of this type of evidence already exists in the research base and the practitioner input of the ESP, which can offer many useful lessons. It has already proven to provide a cost effective approach to ensuring that jointly owned properties, including those of mixed tenure, can be maintained and repaired at minimum cost the Council, with a potential longer term scope for assessing health gain arising.

Conclusion

England and Scotland have different approaches to many aspects of their private sector housing renewal policies. They do, however, share a model favouring 'personal responsibility' for housing conditions, although the Scottish system gives more emphasis to

responsibilities as well as rights of home owners, largely stemming from the nature of its housing stock as tenements. The ESP provides lessons in good practice that can help reduce costs to the public sector while simultaneously transferring them to the private sector in a viable way. Such good practice is set to become part of evidence-based protocol in helping to deliver healthier housing in the longer term. The focus on reintegrating health and housing, however, seems to be more implicit than explicit in Scotland's approach, as the technical side of housing management becomes paramount; nevertheless the ESP provides a realistic response to housing renewal.

Grants continue to be an important policy tool but new forms of financial initiatives are being developed and delivered locally. Strategies arising from the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 are now in place, and subject to early evaluation, but there remains a long way to go in implementing such a major culture change to both the organisations delivering assistance and the communities receiving it. The process is in the earlier stages in Scotland, yet the City of Edinburgh Council is already taking major steps forward to maximise its activities and outputs in this sector.

There are no easy answers in attempting to juggle personal responsibility for housing conditions with better housing stock, but examples of evidence-based good practice can be adapted locally and lessons learnt intra-UK. Whatever strategies are developed and implemented, they must be able to ensure that low-income groups are appropriately supported. There needs to be effective and accessible mechanisms to ensure that homeowners are able to afford and manage the necessary works. In England and Scotland the challenge for the future will be assisting a growing number of home-owners of varying income levels to maintain and repair their homes.

Acknowledgement

The author is extremely grateful to representatives from the City of Edinburgh Council, Scottish Executive and Scottish Federation of Housing Associations for their time, information and hospitality. The views expressed, though, are those of the author and not necessarily those of the interviewees.

References

1) Literature review

City of Edinburgh Council. (2002) 'City Housing Strategy 2002-2007' (City of Edinburgh Council). Online. Available at http://www.edinburgh.gov.uk/housing/policyandplanning/Policy_and_Planning.html (accessed 16/06/05).

City of Edinburgh Council. (2003) Draft discussion paper. 'Private Sector Housing Strategy: Towards a Scheme of Assistance', Unpublished.

City of Edinburgh Council. (2004a) Draft Research Brief: 'Financial Assistance to Homeowners for Improvement and Repair, Scheme of Assistance – development of loan products for homeowners', Unpublished.

City of Edinburgh Council. (2004b) 'Proposals for Private Sector Housing Grant Funding', Unpublished.

Department of the Environment (DoE). (1996) DoE Circular 17/96: 'Private Sector Renewal: A Strategic Approach', London: HMSO.

Department of the Environment, Transport and the Regions (DETR). (2000) The Housing Green Paper: 'Quality and Choice: A Decent Home for All', London: HMSO.

Department of Transport, Local Government and the Regions (DTLR). (2002) Statutory Instrument 2002 No. 1860: The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002, London: HMSO. Online. Available http://www.hmso.gov.uk/si/si2002/20021860.htm (accessed 16/06/05).

DTZ Pieda Consulting for City of Edinburgh Council. (2004a) 'Loan Scheme Option Appraisal', Unpublished.

DTZ Pieda Consulting for City of Edinburgh Council. (2004b) 'Subsidised Loans Schemes – Stage One Research Findings (draft)', Unpublished.

Health Development Agency. (2004) 'Learning from Effective Practice Standards System (LEPSS): Outline Programme 2004-2007', London: HDA.

Hunter, D. J. and Sengupta, S. Editorial: 'Building multidisciplinary public health', Critical Public Health, 14 (1): 1-5.

Housing Improvement Task Force. (HITF). (2003) 'Stewardship and Responsibility: A Policy Framework for Private Housing in Scotland: The Final Report and Recommendations of the Housing Improvement Task Force', Edinburgh: Scottish Executive.

Leather, P. and Morrison, T. (1997) 'The State of UK Housing: Housing Research 209', York: Joseph Rowntree Foundation. Online, Available on line at www.jrf.org.uk/knowledge/findings/housing/H209.asp (accessed 16/06/05).

Nettleton, S. (1997) 'Governing the risky self: how to become healthy, wealthy and wise', in A. Petersen and R. Bunton (Eds) Foucault Health and Medicine, London: Routledge.

Office of the Deputy Prime Minister (ODPM). (2002) 'A Decent Home: the revised definition and

guidance for implementation, sections 1 and 2', London: HMSO. Online. Available on-line at www.housing.odpm.gov.uk/information/dhg/definitio n/02.htm (accessed 16/06/05).

Office of the Deputy Prime Minister (ODPM). (2003a) Housing Bill – Consultation on draft legislation, London: HMSO. Online. Available HTTP: www.odpm.gov.uk/Information/consult/housingbill/0 1.htm (accessed 16/06/05).

Office of the Deputy Prime Minister (ODPM). (2003b) ODPM Circular 05/2003 17 June 2003 Housing Renewal, London: HMSO.

Office of the Deputy Prime Minister (ODPM). (2003c) English House Condition Survey 2001, London: HMSO.

Office of the Deputy Prime Minister (ODPM) (with Welsh Assembly Government, Joseph Rowntree Foundation, The University of Birmingham, Chartered Institute of Environmental Health and Local Government Association). (2003d) Implementing new powers for private sector housing renewal. Initial survey questionnaire to local authorities, Issued January 2003, London: ODPM. Available on-line at: www.odpm.gov.uk/stellent/groups/odpm_housing/do cuments/downloadable/odpm_house_025525.pdf (accessed 16/06/05).

Office of the Deputy Prime Minister (ODPM) (with Welsh Assembly Government, Joseph Rowntree Foundation, The University of Birmingham, Chartered Institute of Environmental Health and Local Government Association). (2003e) Housing Research Summary Number 203, 2003: 'Implementing new powers for private sector housing renewal. Report of the initial survey November 2003', London: HMSO. Online. Available on-line at: www.odpm.gov.uk/ stellent/groups/odpm_housing/documents/download able/odpm_house_025523.pdf (accessed 16/06/05).

Office of the Deputy Prime Minister (ODPM), The University of Birmingham and the Joseph Rowntree Foundation. (2004) Briefing Note No. 1 March 2004: 'Developments in Private Finance for Private Sector Housing Renewal', Online. Available on-line at www.curs.bham.ac.uk/ (accessed 25/05/05)

Petersen, A., (1997) 'Risk, governance and the new public health', in A. Petersen and R. Bunton (Eds) Foucault Health and Medicine, London: Routledge.

Scottish Executive. (2003) Scottish House Condition Survey 2002, Edinburgh: Scottish Executive. Online Available on-line at: www.Scotland.gov.uk/pages/ news/2003/11/Senw1032.aspx (accessed 16/06/05).

Scottish Executive. (2004) Private Sector Housing Grants, News Release, Edinburgh: Scottish Executive. Available on-line at: www.scotland.gov.uk/pages/news/ 2004/04/SENW4896.aspx (accessed 16/06/05).

Scottish Federation of Housing Associations (SFHA). (2003) Scottish Federation of Housing Associations response to 'Stewardship and Responsibility: a policy framework for private housing in Scotland', Glasgow: SFHA.

Scottish Federation of Housing Associations (SFHA). (2004) Submission to Justice 2 Committee on the Tenements (Scotland) Bill, Glasgow: SFHA.

2) Personal Communications (Semi-structured interviews)

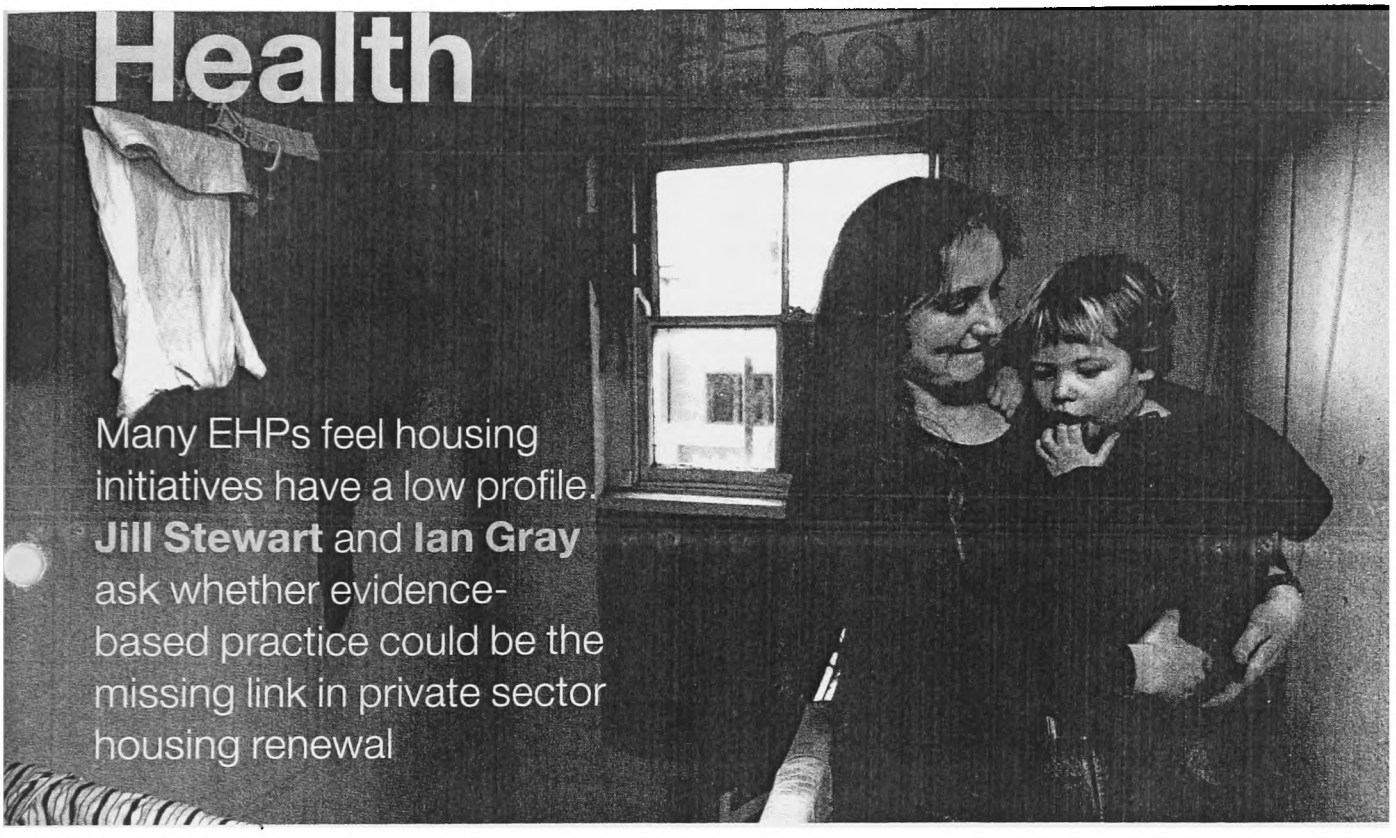
City of Edinburgh Council. (2004) Semi-structured interview with representative from the City of Edinburgh Council, Private Sector Services (July 2004).

Scottish Executive. (2004) Semi-structured interview with representatives from the Scottish Executive (July 2004).

Scottish Federation of Housing Associations. (2004) Semi-structured interview with representative from the Scottish Federation of Housing Associations (July 2004).

Publication 12 Stewart, J. and Gray, I. (2005) Health and Housing, *Environmental Health Journal*, 113 (06) pp. 24-25. Online. Available HTTP: http://www.ehj-online.com/archive/2000/june2005/june6.html

Health



Many EHPs feel housing initiatives have a low profile. **Jill Stewart** and **Ian Gray** ask whether evidence-based practice could be the missing link in private sector housing renewal

Pic: Third Ave

Front line housing EHPs tasked with delivering healthier housing and communities are deluged with scientific data that links housing and health. Which is all very well. But what EHPs really require is evidence to show what is needed and what works in such a complex physical, social and emotional health relationship. While this is a regrettable gap, it is one in which EHPs are well placed to make a difference.

Evidence-based practice is about focusing on health determinants and asking what the most effective interventions are to protect and improve people's lives. *Environmental Health 2012* sets out the case for EHPs to move away from a rigid, enforcement-led approach and ensure that their work tackles health inequalities. Barriers need to be challenged so that EHPs can improve lives using evidence-based activities. Having said that, there is an increasing need for EHPs to display and demonstrate the effectiveness of interventions. This is a problem. While EHPs across the UK are responsible for delivering health improvements, there is currently a lack of accepted evidence on these activities being pursued in the right places.

Our fundamental role should be about improving health and wellbeing and focusing our attention on reducing health inequalities. In environmental health, activities should mobilise around the social, psychosocial, economic, environmental, biological, chemical and physical determinants of health and wellbeing and enable people and communities to increase control over their own health and wellbeing. In order to do this, it is first necessary to understand the evidence (with research and evaluation) to develop effective strategies.

What is "evidence" in environmental health?

Evidence-based practice really began in the medical health sector in the 1990s. More recently, it has become associated with the nation's need to maximise health gain as part of the public health agenda. That means delivering best practice that focuses on audit, efficiency, value for money and accountability.

Evidence can comprise both quantitative and qualitative data. It should be contemporary, valid and reliable, based on sound research and good practice that should help deliver quality assured, effective approaches in the longer term. It is not an end product in itself, but part of a developing process, which should be accessible and regularly evaluated, but not over-simplified.

Evidence-based practice also sits within a wider political agenda in a modernised approach to governance. It is to some extent based on the concepts of "risk" and "personal responsibility". These are themes running through the 2004 *Choosing health* white paper, which largely focuses on lifestyle issues. Most agree that risk reduction can be achieved by making more public health information available, which in turn, it is argued, fosters a more rational approach to decision making.

The Wanless report and health improvement

Securing good health for the whole population argues that although there is a great deal of public health information, there remains little assessment of the long-term impact on health of key policies, especially in disadvantaged communities where inequalities are most acute. The paucity of information is compounded by a lack of funding for research and the continuing low evidence base about the cost-effectiveness of public health and preventative policies. There needs to be more of a focus on health, not just on health care, accommodating wider targeting.

Health Needs Assessment (HNA) and Health Impact Assessment (HIA) are becoming increasingly important tools to assess a community's need and to develop strategies that are able to maximise positive health impact and outcomes. Both HNA and HIA entail partnership working, participation, equity and efficiency, use of evidence-based quantitative and qualitative data and – importantly – ensuring that the needs of marginalised communities are met fully.

HNA is important to identify the health needs, as well as health assets, of the community and to inform strategic decisions so that health is improved and health inequalities are reduced. Need might be normative (*ie* determined by the professional) or comparative (*ie* the situation is better or worse than another area or community). Joint needs assessments are essential to assess where inequalities are greatest and partnership strategies can be developed that are founded on overlaps where they are at their most acute. This may challenge what has gone before. Setting up a baseline of data is essential to dynamically and longitudinally map progress in reducing health inequalities.

HIA, on the other hand, is an important tool to help maximise the health gains from policy and to inject a health focus back into policy and strategy, so that adverse health impacts are minimised. HIA focuses around health determinants so that inequalities can be tackled in a sustainable way. HIA methodologies and processes are still at an early stage and there is a need for more work in this area.

Nevertheless, despite the obvious place for HNA and HIA in public health, neither is a statutory requirement. There are also no national methodologies or templates for action. The extent to which either is routinely applied remains unclear although their use is advocated in *Choosing health*.

So which way now for EHPs and evidence?

The Health Development Agency's evidence base (*see website address at the end*) is a relatively new resource to support, build and disseminate both research and good practice in public health, and focuses on reducing inequalities. At the moment, most of the resources on the HDA website are academic papers. These are now being consolidated into evidence briefing papers across a range of subjects to help identify available evidence and gaps, with recommendations for future research, which includes discussion on the implications of the evidence for policy and practice.

What is currently missing – particularly for EHPs – is how to deliver their front line work in a way that effectively tackles and reduces health inequalities. The Learning from Effective Practice Standard System (LEPSS) is currently within the NHS remit, but should in time be introduced across all government departments in England. LEPSS is about learning lessons from practitioners to identify, assess and collate evidence and learning from examples of effective practice that might not normally be published or disseminated. In this five-year project, there is an increased emphasis on developing and establishing national standards for planning, evaluating, recording and retrieving effective practice.

The combination of evidence briefings and effective practice briefings would feed into HDA recommendations for action, guidance etc to help promote practitioner operations – and good practice – more effectively. This would expand the evidence base to inform public health action. EHPs might now want to start to collate more evidence around work they are doing, based on the HDA's draft national standards framework for effective health improvement. These include a focus on intervention, intervention aims and objectives, intervention methodology and the cost of intervention. Such activities could help to develop the evidence basis for EHPs ■

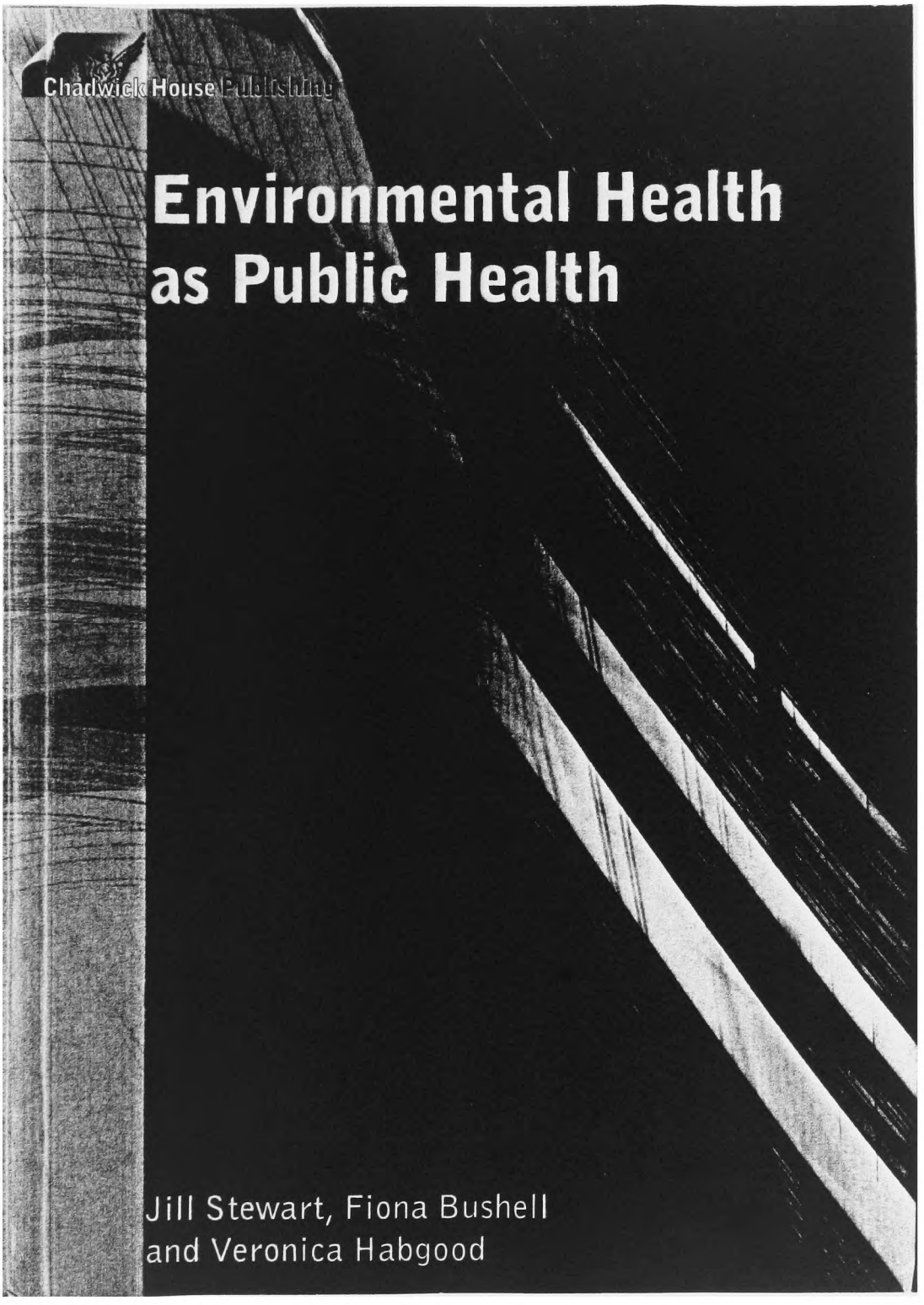
For the HDA's evidence base, visit: www.hda online.org.uk/evidence

References

1 Burke, S, Gray, I, Paterson, K, Meyrick, J (2002) *Environmental health 2012 – A key partner in delivering the public health agenda* (London, HDA).
2 Department of Health (2004) *Choosing health? Making healthier choices easier*. (London, Department of Health Publications)
3 Health Development Agency (2004) Learning from Effective Practice Standards System (LEPSS): outline programme 2004-2007, (London, HDA)
4 Muir Gray, J A (2000) Evidence-based public health in L Trinder with S Reynolds (Eds) Evidence-based practice a critical appraisal (Oxford, Blackwell Publishing).
5 Trinder, L (2000) Introduction: the context of evidence based practice in L Trinder with S Reynolds (Eds) *Evidence-based practice: a critical appraisal* (Oxford, Blackwell Publishing).
6 Wanless D (2004) *Securing good health for the whole population*. HM Treasury.
7 Watterson, A and Watterson, J (2003) Public health research tools in A Watterson (Ed) *Public health in practice* (Hampshire, Palgrave Macmillan)

Jill Stewart is senior lecturer at the School of Health and Social Care at Greenwich University. Ian Gray is a policy officer for health development at the CIEH.

Publication 13 Stewart, J., Bushell, F., and Habgood, V. (2005) *Environmental Health as Public Health*, London: Chadwick House Group Ltd.


Chadwick House Publishing
Environmental Health as Public Health
Jill Stewart, Fiona Bushell and Veronica Habgood

Partnership working in public health: statutory organisations and local communities

Hutchinson and Campbell (1998: 2) suggest that partnerships are valuable to:

- bring together a range of interests from more than one sector;
- seek to develop common aims and a strategy to achieve them;
- share risks, resources and skills;
- seek to achieve mutual benefit and synergy.

In addition, good management and sustained resourcing is necessary for partnerships to be successful and able to perform to their full potential.

The partnership process has become pivotal to strategic development in the government's modernisation agenda, its implementation and accountability in recent years to address a wide range of social and economic issues. Organisations increasingly have to show that they are offering comprehensive, partnership-based strategies to attract government funding. The DETR (2000i) described local authority partnership as a 'process in which a local authority works together with partners to achieve better outcomes for the local community, as measured by the needs of the local stakeholders, and involves bringing together or making better use of resources [requiring] the development of a commitment to a shared agenda, effective leadership, a respect for the needs of the partners, and a plan for the contributions and benefits of all the partners.' The process requires specific goals to be identified and performance to be evaluated and a reassessment of the link between activities and needs or priorities.

By its nature, environmental health is multi-disciplinary. Informal and formal partnerships have existed for many years, although the momentum has recently shifted as a result of reports such as *Agendas for Change* (Environmental Health Commission, 1997) which called for new co-operative, partnership-based activity to nurture sustainable change by recognising the many existing positive aspects of environmental health work and the need to reintegrate public and environmental health with clearer local accountability. This new approach took a holistic perspective to encourage interdependence and inter-collectiveness to help broaden concerns and perceptions of new links through a revision of traditional professionalisms able to respond to rapidly evolving public and organisational expectations. Such an approach was seen as flexible, inclusive and task orientated – to help find sensible solutions to overlapping problems. (see Table 3.5).

- Problems tackled are common ones in which all participants have a stake
- Not only government agencies but all organisations with an interest are involved
- Policy-makers, technical and service staff and volunteers at national and local level have functions to perform
- Various participants play leading or peripheral roles
- Co-operation in defining proposals, issues, prioritising need, information, considering alternatives, building capabilities for implementation
- Stable co-operative mechanisms are established, nurtured and revised

Table 3.5
Issues in partnership working

(Source: MacArthur 1999: 5)

Partners come in many shapes and forms and consultation arrangements need to address the timing and purpose of joint working to maximise partnership potential. Partnerships may operate within or outside of organisations, and be on a statutory or non-statutory footing. Those involved include:

- councillors – eg by workshops or seminars;
- corporate board or management team – for consensus and support for action, replanning of resources;
- strategy, commissioning and service staff across various departments – eg may incorporate social services officers for joint commissioning purposes, planning and housing staff in respect of using of brownfield sites, land release and transport policies, tenure diversification, economic development, rural area etc;
- other neighbouring local authorities or county councils where not a unitary authority;
- PCTs;
- potential partners in other statutory, non-governmental, voluntary and private sectors as well as community-based organisations;
- community representatives, residents, etc – eg consult via post, focus groups, special meetings, exhibitions, village appraisals, community profiling, listening surveys, etc.

How successful can partnerships be expected to be?

Establishing and maintaining partnerships is not always as straightforward as it might seem and outcomes are not automatic (Hutchinson and Campbell, 1998). Professions and organisations have different roots, objectives and priorities and may see intersectoral collaboration as a threat to their own roles and funding regimes. There may be discrepancies in priorities, legislative requirements and joint assessments, as well as in the ideologies and values of different organisations. There may be difficulties in deciding who holds – or who thinks that they hold – the ultimate responsibility, rather than finding viable joint solutions to joined-up problems or even none (Cowan, 1999). There may be increasing bureaucratic hierarchies, leading to confusion and duplication of functions as individual organisations risk becoming less certain of their evolving role, particularly with so many short term public health projects seeming to take precedence over longer-term strategies. Crucially, will they really be able to achieve what more traditional organisations could not apparently

achieve? There can be no guarantee that they will actually work, timescales may be limited and constant appraisal is required to ensure that resources invested are used wisely.

Effective partnerships need to operate on a variety of levels to 'add value' to what is already there (Hutchinson and Campbell, 1998). The organisational level – such as the local authority or PCT – is only one stage of the process. What is really important is how professionals work together in overcoming barriers and delivering change. There are invariably power struggles and tensions involved (Hudson, 2002; Hutchinson and Campbell, 1998; University of the West of England, Bristol and the Office for Public Management, 1999) as different professions vie for their own status and boundaries, particularly at a time of such change and where so many are involved in delivering public health objectives. Allied to this is the extent to which professionals – particularly at the local authority level – are willing to dynamically share power with local communities, crucial to establishing democratic and accountable policy processes. (see Table 3.6).

Table 3.6 Establishing partnerships: overcoming barriers

Barriers to partnerships
• Existing government legislation (focus on national initiatives may divert resources from local priorities) • Financial constraints • Cultural factors (resistance to change, lack of willingness or clarity) • Insufficient resources – including time and staffing for co-ordination, • Difficulties in selecting measures that could be attributed to the partnership alone • Lack of clear criteria that are appropriate and quantifiable against which to measure success • Lack of recognition of the importance of evaluation
Overcoming barriers to partnership
• Shared vision and commitment (supported by shared data, agreed priorities, joint service planning and review) • Good leadership • Clear objectives, roles and responsibilities (clear purpose and evaluation, benefits for all, identification of each partners aims) • Using member resources more effectively • Changing organisational structure • Commitment, honesty and trust, understanding limitations and culture of partners, willingness to share advantages and disadvantages • Skills of partner representative (decision-makers, enthusiastic, professional, efficient, innovative and open-minded) • Well trained and motivated staff to deliver high-quality services

Based on Goss and Blackaby (1998), DETR (2000j)

Despite some emerging concerns about partnership working, the drive for partnerships is legislatively and resource based as the government has sought to maintain momentum as part of the modernisation agenda. Currently, the key issues within environmental health departments – working in partnership with other organisations – need to be able to address are inequality and sustainability, paramount to the government's health and inclusion agendas. Partnership working includes working with other allied health and social care organisations to help ensure long-term, sustainable change.

IDeA has developed 'Beacon Scheme' status for the operation of local health strategies, together with the key features and critical success factors required. These are summarised in Tables 3.7 and 3.8.

Table 3.7
IDeA's 'Beacon Scheme' for local health strategies

- Excellent grasp of health and commitment to the health agenda
- Addressing health inequalities (including health poverty profiling) and improving health by creatively targeting disadvantage
- demonstration of strong and wide-ranging consultation, esp. hard to reach groups
- Clear vision, aims, targets, processes and outcomes for health improvement strategy, approach clearly documented and presented, active monitoring of outcomes and ability to demonstrate where change has occurred
- Good partnership working across cross-agency planning and pooled budgets; strong links to other strategies (eg HIMPs (now LDPs), community regeneration)

Tables 3.8
Key features and success criteria of 'Beacon' councils' local health strategies

Key features
- Recognition of wider determinants of health and the role of mainstream council services in tackling them
- Effective interagency partnerships focusing on heath, leading the development and implementation of plans and strategies
- Effective officer implementation group in place to deliver the health agenda and the use of jointly funded posts and units to support implementation
- Effective analysis of health issues; specific programmes, initiatives and targets set for reducing health inequalities
- Well developed integrated planning and services delivery across health and social care services
- Training and development support to members engaging in the health agenda

Critical success factors
- Using relevant policy documents in modernisation, health inequalities and social exclusion
- Development of a shared vision and clear strategy
- Member commitment
- Recognition of the importance of the public health function
- Willingness to take risks and learn
- An effective process for developing and supporting partnerships through and commitment to inclusiveness and resourcing partnership development

Source: IDeA (2000), in Hamer and Easton (2002)

Partnerships with communities

Local authorities and PCTs exist to serve communities, though until recently communities have had few opportunities to be able to participate in decisions being made about them and for them. The emphasis has tended to be about the local authority or PCT determining its community's health and need and making remote decisions about making improvements. It may be that an organisation's understanding of the concepts of health and need are quite removed from the community's, a key issue in seeking to develop sensitive and appropriate policy. The community voice has become increasingly important to policy-making, implementation and accountability in recent years, but neglect of participation in the past means that much work will be needed to start to engender new forms of local participation where communities lie at the heart of decision-making processes.

Community empowerment is crucial to establishing democratic and accountable policy processes. Empowering communities requires developing new participatory frameworks to take a wide overview of activities undertaken on behalf of that community, resulting in better decisions being made, enabling influence – or even control – over decision making (Arnstein, cited in Gaster and Taylor, 1993; Taylor et al, 1992; Taylor, 1995). This is figuratively represented by the 'Ladder of Participation' where at the bottom

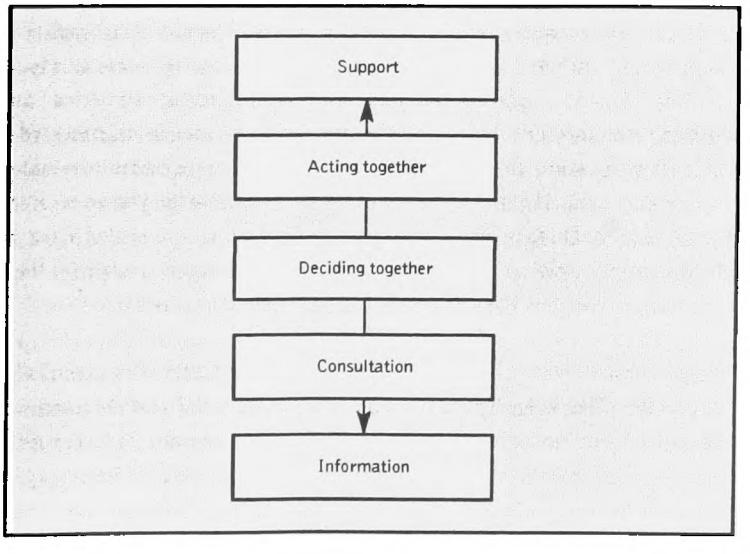


Figure 3.3
Communities at the heart of decision-making: the Ladder of Participation – based on Arnstein, cited in Taylor (1995)

stage, state organisations simply provide information about what they are doing, to the top stage of participation where communities and the state share power, with local authority and PCTs supporting self-identified community development initiatives. (see Figure 3.3).

Communities and professionals need to learn from each other as both have much to offer policy development. Communities have the grassroots knowledge of how they operate and which direction they might like to take. Professionals have knowledge of policy processes. Professionals may need to develop skills to facilitate citizen empowerment and question their own (perhaps unknown) prejudices and judgements about people's lives. This may not be popular, and may be seen as a challenge to 'professional' status. In this way policies can be developed that are relevant to the very people they seek to serve, and are able to tackle each situation uniquely without imposing a standardised solution. Government organisations need this 'expert knowledge' from communities.

Community partnerships are fundamental to social inclusion and finding joined-up solutions to joined-up problems. Community partnership processes can help yield more accountable, democratically based services that respond to local needs, especially where the voluntary sector and existing social capital can realistically operate to fill in gaps in state provision where appropriate. Forging community partnerships is part of bottom-up, rather than top-down, policy-making to increase local confidence and capacity in delivering sustainable, sensitive and appropriate services. This is a fundamental part of moving toward a process of social inclusion rather than a defined end product. Developing community capacity and capital in this way is key to a long-term strategy to address exclusion and finding what support communities need to instigate their own solutions. State organisations needs to support local capacity, not assume they know best what the community needs.

Involving the community is not always straightforward. The community may have preconceptions about local authorities that relate to earlier negative experiences, or have their own agenda – and the early stages of developing a relationship and mutual trust are crucial. It is important to consider at what stage, why, who should be consulted and how – and indeed about what. Many communities are exhausted with constant consultation

that seems to lead nowhere. Such attitudes may need to be turned around which can be done – and with dramatic effect. Methods include surveys, telephone surveys, focus groups, citizens juries and community conferences. What is the balance of different needs in the community? There needs to be negotiation and consensus building. It is important to consider and to be prepared for a realistic amount of feedback in relation to the groups(s) selected and how they are asked for their views – there may be a better way of doing it. Such an approach must be ongoing.

Communities are increasingly seen as crucial to informing the policy process to redress inequalities at a very local level (Naidoo and Wills, 2000) and to driving change where its need is really felt. This is because those in greatest need of health services often have least access to them. Poor physical and mental health, age and ethnic groups can prevent social and economic participation. This must be recognised and taken on board in the policy process.

Current health improvement policy favours community participation as a pivotal force in bringing positive change for the following reasons (cited in Campbell and Mclean, 2002):

- The participation of grassroots community representatives in decisions regarding designs and delivery of health services is vital to address differential access, cultural differences, racism, language, etc as barriers to socially excluded groups.
- Local people should participate in health promotion projects designed to promote healthy behaviour – people are more likely to change if they see their peers changing their behaviour.
- There is growing recognition of the influence of neighbourhood conditions on health and that participation in local community networks has a positive impact on health.

This chapter reviews some current issues in housing, health and community. It particurlarly refers to emotional health, temporary accomodation, fuel poverty, home safety and public health issues for gypsies.

Poor housing environments: the impact on anxiety, stress and depression

The exact link between poor housing and health is difficult to make by empirical evidence. A poor housing environment is frequently the result of low income, and low income frequently results in a poor housing environment through a lack of choice. The cycle of inequality is difficult to break. It can be difficult to directly relate health conditions to poor housing, as other aspects of inequality – such as unemployment, poor diet, insufficient health and social care – may be equally responsible for the physical or emotional poor health experienced. However, there is general agreement that poor housing and living environments can and do affect health status (Audit Commission, 1991; DETR, 2000a; Ranson, 1991; Townsend et al, 1992).

For too many, decent housing is little more than a pipe dream as high numbers are housed in marginal social housing estates or temporary accommodation that is frequently inadequate to meet need. It is difficult to know which of these options is less attractive. Social housing in a marginal estate can have inherent problems of poor architecture, design and management with little prospect of further suitable rehousing. Those housed in temporary private rented accommodation face inherent problems of uncertainty, overcrowding and over-occupation with generally poor conditions in the longer term. Neither option offers a particularly viable route into a socially inclusive lifestyle.

Unsatisfactory living accommodation lies at the heart of excluded communities since a poor internal and external housing environment can have a significant impact on physical and mental health and there is concensus that there is simply insufficient decent quality, locally available and affordable housing stock in many areas, which is essential if some of the health issues discussed in this section are to be alleviated. Far too many have little – if any – active housing choices (Bogard et al, 1999; Cumella et al, 1998; Vostanis et al, 1998). The situation is summarised in figure 5.1.

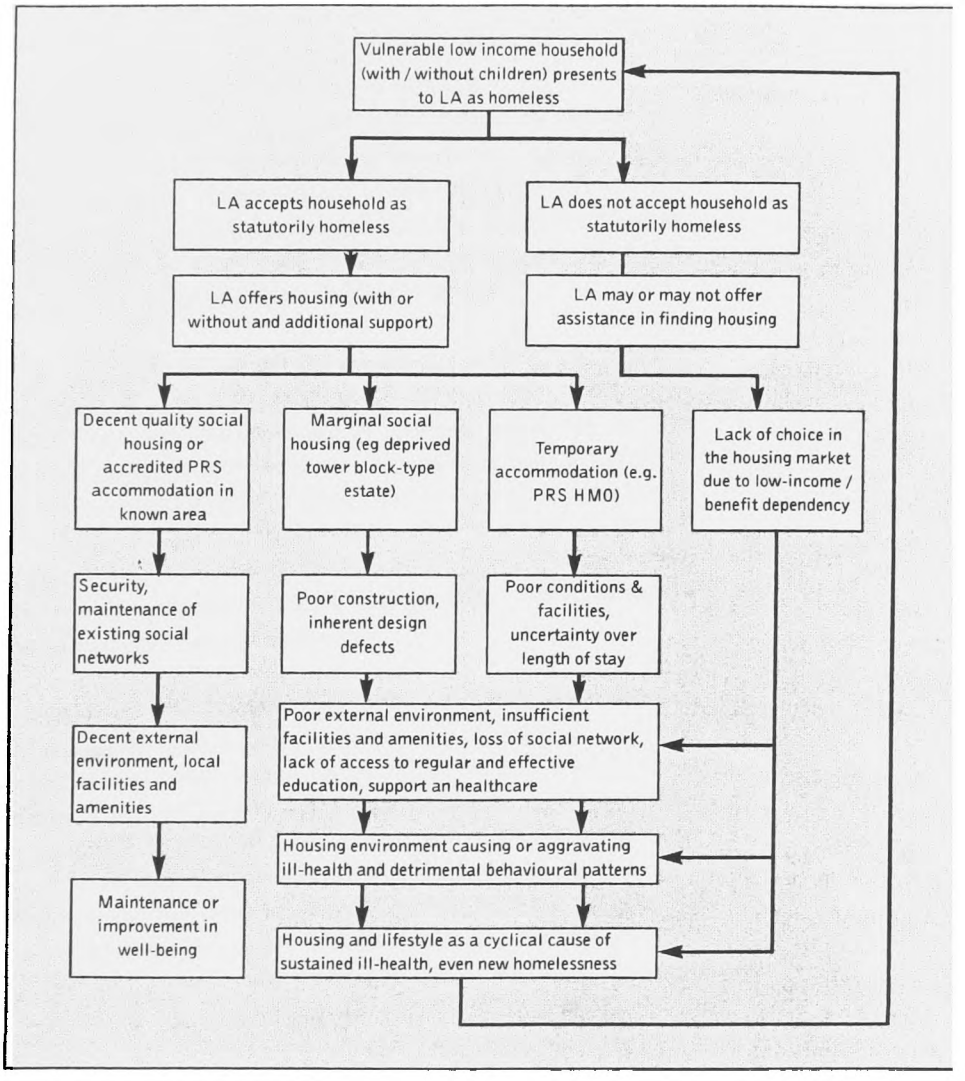


Figure 5.1
Possible fate(s) of the homeless seeking assistance: Implications for public health

Finding solutions to anxiety, stress and depression

Housing policy has its roots in traditional public health and responds to a medical model of physical ill health rather than a wider socio-economic model and policy can invariably miss out on other important issues. While individual housing standards are of course essential, addressing access to affordable housing as well as the wider environment and community development are also fundamental in tackling inequality.

From an environmental health perspective, housing activity has traditionally been about positive change in remedying individual housing conditions – poor conditions include, for example, inadequate heating, external WC, dampness and mould growth and shared facilities in HMOs. Policy has more recently become concerned with area regeneration to help improve access to shops, employment opportunities, transport, etc. But this is only part of the picture, and currently progress is being made in the areas of community development and social capital, seen as the vital part of addressing inequality from the bottom up.

Those charged with developing strategy addressing poor housing need to be able to address the multi-faceted, interrelated issues surrounding anxiety, stress and depression which are caused or aggravated by poor housing, and which Page (2002) refers to as 'immediate environmental stressors', some of which are outlined in Table 5.1. Alone, each issue may cause some degree of stress, but clearly in combination – particularly experienced by communities powerless to effect change – it is not hard to see how severe stress and depression can result. These issues fall clearly within the wider social inclusion agenda, which recognises that traditional 'vertical' strategies are no longer appropriate and that horizontal strategies need to ensure partnership, and cross-cutting strategic intervention to achieve sustainable change.

Temporary accommodation

In April 2002 the Housing and Homelessness Team at the Greater London Authority (GLA) reported that the number of households in temporary accommodation exceeded 53,000, increasing for the seventh consecutive month, amounting to over 3,000 more of London's households in temporary accommodation than in the previous year. They added that the upward trend in the use of bed and breakfast (B&B) accommodation showed no sign of

Table 5.1
Environmental Stressors: cyclically interrelated factors facing residents in poor housing environments

Factor	Issues involved – features of exclusion	

Individual housing situation	• Cost and 'affordability' (with/without welfare benefits), lack of choice as key determinant of life-chances
	• Tenancy / insecurity / high cost of private sector rents
	• Landlord's behaviour and attitude; lack of tenant control
	• Powerlessness in landlord / tenant relationship
	• Poor housing conditions including:
	  • Disrepair / unfitness / other (e.g. leaking roof, no heating, severe condensation and mould growth)
	  • Overcrowding and over-occupation with sharing of facilities in HMO's
	  • Low likelihood of situation improving in forseeable future; possible homelessness / higher rent / difficulties with landlord if authorities become involved	

Access to community facilities and employment opportunities arising from location	• Private 'low-cost' housing sector (especially B&B type temporary accommodation)	• Peripheral location • Labelling • Stigma • Lack of access to: • Viable, regular work (influence of poverty / welfare trap) in the formal economy • Social support networks • Healthcare • Community groups • Affordable transport • Decent education • Affordable shops for decent food etc • Advice and advocacy • Other organisations / services / or assistance
	• Social housing sector tower blocks etc (poor architecture design and construction)	
Community breakdown	• Isolation, alienation, loss of social network, loss of social capital as 'middle classes' (traditional working class?) withdraw from area • Inadequacy – even failure – of State policy, resource and implementation to sufficiently replace social capital lost in deprived areas (via health and social care personnel?)	
Social behaviour	• Environment aggravates lack of concentration, education etc • Difficulties in supervision, so behaviour learnt from peers, not adults • Crime • Racism (eg asylum seekers) • Cultural and language barriers	
Physical and mental (emotional, psychological) health and safety	• Environmental stressors continue to exacerbate existing poor physical and mental ill-health • Environmental stressors cause poor health or domestic accident e.g. T.B., asthma, stress, depression, fall on stairs, fire etc	

decreasing (GLA, 2002). Added to this is the irony of the term 'temporary accommodation' which is not always particularly temporary – many remain in such accommodation for longer than anticipated through the local authority housing strategy (Ambrosi, 2002a, 2002b; Cumella et al, 1998).

Styron et al (2000) draw together a range of research in suggesting that there are four structural factors that have led to an increase in family homelessness:

- scarcity of decent, affordable low-income housing;
- insufficient income for people receiving welfare benefits or in low-income, unskilled employment;
- inadequate social services and health care; and
- an increase in families headed by women.

In addition, the nature of homeless households is changing and is increasingly associated with mental illness, drug/alcohol abuse, child and adult victimisation, inadequate social support and parenting difficulties. It is unclear whether these are a cause or an effect of homelessness – but certainly the relationship of homelessness and temporary accommodation is not conducive to combating social exclusion.

Households marginalised into such accommodation daily face some of the most basic public health issues they are frequently powerless to tackle. Health and safety issues related to the temporary accommodation living environment – in particular bed and breakfast type accommodation – include the following:

- poor general condition and design; low level of repair and maintenance; cold and damp conditions (Arblaster and Hawtin, 1993; Ballinger, 2002; Conway, 1988; Lowry, 1991);
- overcrowded conditions (inadequate room size for number of occupants), resulting in a lack of privacy, increased likelihood of infectious disease, notably tuberculosis, where levels are 200 higher for homeless people than the rest of the population (Thomas, 2002), difficulties in maintaining relationships and lack of suitable space for child development (Ballinger, 2002; Cumella et al, 1998; Styron et al, 2000; Vostanis et al, 1998);

- sharing insufficient facilities (notably kitchen and bathroom amenities) with strangers (over-occupation), leading to lack of control over personal space in communal areas (Conway, 1988);
- inadequate and inappropriate local health and social care and education services – short-term accommodation may make it difficult to access comprehensive health care, regular education or other support mechanisms (Ballinger, 2002; Bogard *et al*, 1999; Cumella *et al*,1998; Vostanis et al, 1998);
- location away from established, known social networks, leading to alienation and loneliness (Bogard *et al*, 1999);
- increased likelihood of inadequate means of escape in case of fire, thus an increased likelihood of fire injury or death (Home Office, 1989);
- poor external living environment with insufficient facilities such as a good transport system and decent, economically viable food shops;
- feelings of powerlessness about the situation improving – the tenant may be wary of involving the local authority for fear of harassment, or the eviction or rental increase or may not be aware of the potential service (Emmanuel, 1993) accommodation may be part of an 'informal' housing sector where tenants do not want public sector intervention;
- increased physical and emotional/mental health impacts including: home accidents, respiratory disorders, and birth of small babies, as well as increased anxiety, stress and depression arising from uncertainty and poor conditions (Ballinger, 2002; Bogard et al, 1999; Conway, 1988; Cumella et al, 1998; Vostanis et al, 1998).

Temporary acccommodation as an unsatisfactory policy solution

Homeless households in temporary accommodation have the added stress of not knowing how long they might remain there. There has been an increasing amount of research into the mental and behavioural health of homeless families placed into temporary accommodation. Much hinges around how poor health is compounded by the inadequate conditions, insecurity and loss of existing social networks which is faced and how inappropriate some policy solutions to this vulnerable group has been. Homeless families are likely to suffer stress and anxiety before approaching a local authority for rehousing.

Temporary accommodation can be little more than a 'safety net' in the housing welfare system (Styron *et al* 2000). This increasing supply of 'quasi-social housing' – supported largely by state benefits – is frequently unable to provide an increasing number of homeless families with decent, secure housing in a known area where support is available through existing social networks. Such social networks can never be fully replaced by state services (Arblaster and Hawtin, 1993; Bogard *et al*, 1999; Cumella *et al*, 1998; Vostanis *et al*, 1998). Temporary accommodation may be remote from known facilities, and can cause an untraeceble link in the health and social service bureacracy. GPs may be unwilling to register homeless families, who often end up receiving a second-rate health care service by having to resort to accidents and emergency (A&E) departments rather than maintaining a relationship with a GP (Ballinger, 2002; Conway, 1988; Vostanis *et al*, 1998).

Homeless mothers and their children may have already suffered ill-health and trauma and have already been exposed to 'risk factors'. These include poor relationship histories, domestic violence, drug/alcohol abuse, parental mental ill-health, physical and emotional ill-health and depression arising from poor housing and socio-economic conditions. The experience of homelessnesss – especially if it is ongoing – can have a particularly negative impact on a child's well-being, leading to delayed communication, can be disrupting to a child's education and lead to an increase in behavioural and mental health problems. This is largely due to insufficient space for learning and development and is aggravated by a lack of social interaction and increasing susceptibility to poor housing as families spend more time indoors for lack of viable alternative. (Ballinger, 2002; Bogard *et al*, 1999; Brown and Harris 1978; Comella *et al*, 1998; Conway, 1988; Styron *et al* 2000; Vostanis *et al*, 1998).

Homeless households do not easily fit into established health and welfare systems (Vostanis *et al*, 1998) which can make assumptions that the household is homeless as a result of a 'deficiency' of the individual within a problematic socio-economic community, rather than as a result of a wider system that makes it difficult for households to access the housing market (Bogard *et al*, 1996). Homeless households have unique and acute health and social care needs – and the services provided need to be co-ordinated (Cumella *et al*, 1998), sensitive, tailored, individual, flexible and able to

follow the household, which is likely to relocate regularly. There is also a notable general lack of specific psychiatric help for homeless families (Styron *et al*, 2000). For these reasons, Ballinger (2002) argues that (then) HIMPs (now LDPs) should tackle the unique health issues facing homeless families. Clearly, these health needs should be based on a rigorous and thoroughly researched HNA of homeless families living in temporary accommodation.

Breaking the cycle of homelessness and poor housing is a difficult challenge when there is insufficient decent, affordable housing stock available. There can be no substitute for decent housing and integration into an established community in the first place, where existing social networks can be maintained. Social services can never replace what is lost to homeless families in terms of security and a sense of belonging, but where provided, services need to be appropriately tailored. Temporary accommodation and marginal social housing can aggravate existing physical and emotional ill-health in some of the most vulnerable communities.

Alternatives to bed and breakfast accommodation

Social costs aside, what is also staggering is the financial cost of temporary accommodation. O'Kane (2002) calculates that direct temporary accommodation cost to central London local authorities approaches £600 million per year, rising at a rate of more than 10 per cent annually. Notably, little of this is invested long term in housing, and housing investment is around half that of many other European counterparts. This is allied to the detrimental health impacts on some 50,000 homeless households (excluding asylum seekers) in London, double the number from six years previously. A major reason for this is the drop of 16,000 per annum in council lettings and housing association nominations available to new tenants in London, the right to buy policy and declining numbers being rehoused. O'Kane (2002: 23) adds that '(e)vidence of joined-up thinking is as scarce as value for money in temporary housing activities'. Many are denied a chance at inclusion from the very start.

'More than a Roof: A Report into Tackling Homelessness' (ODPM, 2002d) recognised the complicated nature of homelessness and the need for strategic and practical activities to tackle the acute health issues facing children in B&B hotels and people sleeping on the streets, focusing around

why people become homeless and the need for sufficient affordable housing. The Homelessness Act 2002 is central to the approach, requiring local authorities to carry out a homelessness review and develop local strategy to help prevent homelessness and to provide accommodation and/or support to people who are, or may become, homeless. The earlier two-year time limit granted to unintentionally homeless households in priority need is repealed, so housing is secured for as long as it takes the local authority to find settled accommodation.

Additionally, local authorities should only use B&B accommodation for families with children in an 'emergency' by March 2004. This proposal is supported by some £25 million from the Bed and Breakfast Unit (set to end December 2003) to help increase private sector leasing and lettings alongside changes to the housing benefit system, particularly the 'Supporting People' programme from April 2003 (Jackson, 2002; Ambrosi, 2002a, 2000b). Increased quantitative and qualitative evidence-based policy is envisaged in respect of households in temporary accommodation and partnership arrangements should help ensure reasonable standards (ODPM, 2002d). While this is laudable, it is essential that suitable alternative accommodation is available in the form of decent, secure and affordable housing, particularly in areas where prices are particularly high.

Strategic action to tackle poor B&B accommodation – a form of house in multiple occupation – can be found elsewhere in the publication.

Fuel poverty

Fuel poverty exists where low-income households are unable to afford adequate levels of heating, largely due to inadequate heating appliances and poor domestic insulation. People at home all day – who may already be vulnerable by reason of age (young or old), illness or disability – require additional heating over a longer timescale, which of course costs more. The poorest 20 per cent of households spend 12 per cent of their budget on fuel, whereas the wealthiest 20 per cent spend 4 per cent, and this is aggravated by VAT on fuel (Boardman, 1991).

The scale of fuel poverty – as well as local authority activity to address it – is difficult to ascertain, and estimates vary substantially according to

definition. Archer (2002) cites a figure of some 4.3 million households in fuel poverty in England in 1996 and Shenton (2002) cites figures ranging from 2.8 to 7 million households. It is relatively more expensive to heat poor older housing and for private sector housing landlords – where energy inefficient premises are most frequently found (DoE, 1996b) – there is little legal or financial incentive to invest in energy efficiency. Older people in rented accommodation and people in lower occupational groups are less likely to have central heating.

Every winter in Britain, around 30,000 people die prematurely from the cold as a result of poor housing conditions (DEFRA and DTI, 2000). Living in housing that is too cold can lead to:

- physiological changes in the body, leading to an increased likelihood of hypothermia;
- an increase in heart attacks and stroke during the winter months;
- Cardiovascular and respiratory disease (especially in children);
- Asthma and mould sensitivity;
- Stress and depression from the visual effects of mould growth;
- Increased likelihood of accident through changes in behaviour as well as from poor heating appliances; and
- Premature death, mostly attributable to cardiovascular related illness (Arblaster and Hawtin, 1993; Boardman, 1991; DEFRA and DTI, 2000; DETR, 1999a; DoE, 1996b; Ineichen, 1993; Lowry, 1991; Markus, 1993; Ormandy and Burridge, 1988).

Research (Wilkinson *et al*, 2001) confirms the impact of the winter months on excess ill health and premature deaths particularly for older people, a close correlation to poor energy efficient housing – particularly older housing stock, and reported the substantial public health benefit that could arise from addressing thermal efficiency and heating affordability, reducing costs to the NHS (Shenton, 2002). It is likely to cost £15 to £20 billion to bring houses to required standards, and with current government expenditure, it will take until the 22nd century to combat fuel poverty in the UK (cited in Shenton, 2002, and Spear, 2002a).

Poor energy efficiency of housing stock is the most significant factor influencing fuel poverty (Shenton, 2002) and existing legal controls are not

sufficient to combat it. Normally all that can be required is a fixed heater in the main living room and provision for heating (sockets) in other rooms, with minimum loft insulation. Even this requirement is not met in many premises. Older, private sector housing occupied by low-income households tends to be particularly badly insulated – but the private rented sector is even worse, especially where properties are occupied by multiple households (DoE, 1996b).

Clearly, adequate resources are needed to provide additional insulation and improved heating facilities so fuel-poor households expend less of their income on wasted heat. The kind of support needed will vary from simple, low-cost measures – such as covering a hot water tank with a thermal insulation jacket, to a major package of insulation, advice and education provided by skilled personnel. Responses such as cold weather payments are unrealistic, an inefficient use of public expenditure and fail to address the root causes of the poverty which is also key to the fuel poverty debate: what is needed is a proper package addressing poverty, energy efficiency and high fuel costs as the only real way forward (Shenton, 2002; Spear, 2002a), preferably through a known organisation such as a local authority who could hold an overall, consolidated fund for addressing fuel poverty through a unified and coherent strategy.

The Fuel Poverty Strategy 2001 – a partnership approach

Opportunities for assistance available to local authorities dealing with private sector housing have remained sporadic and approaches vary considerably because legislation, funding and requirements to monitor, co-ordinate and report progress have been inadequate, although there have been calls for legal improvements. Local authority environmental health departments (including their home improvement agencies) were previously able to offer limited discretionary grant assistance, but grants are limited as resources are frequently required elsewhere in the private sector housing strategy, such as in tackling unfitness and disrepair, and it is possible that the lack of private sector housing finance ring-fencing will further diminish fund availability for energy efficiency works in this sector (Shenton, 2002). The situation is perhaps clearer-cut for local authorities' own stock, where wider stock regeneration is able to incorporate energy efficiency measures. Indeed, some 80 per cent of (then) HEES grants were paid for local authority and housing association housing rather than private sector housing (Archer, 2002).

Meanwhile, since the government's consultation and the subsequent Fuel Poverty Strategy (see Table 5.2) (DEFRA and DTI, 2001), a number of initiatives – and other players – have entered the scene. These include five warm zone (WZ) pilots based in Northumberland, Stockton, Hull, Sandwell and Newham (see box 5.1). These provide an area-based rather than referral-based mechanism for reaching the fuel poor (Archer, 2002). Funded by national government and the energy utilities, these partnerships involve energy installers, training organisations, PCTs and the business and voluntary sectors – as well as local authorities. If successful, they may be adopted nationwide. In addition, energy efficiency grants have come increasingly from other agencies, notably the EAGA partnership through warm front team (WFT) grants (previously HEES), working with central government, local authorities, charities, and electricity, gas and water suppliers. This latter scheme has been successful for owner-occupiers but has had less impact in the private rented sector. Unfortunately and ironically, many fuel-poor households find themselves ineligible for WFT grants (Shenton, 2002).

While these provide a valuable service, it is difficult for local authorities – who hold strategic responsibility for local housing stock condition – to retain an overview as to energy efficiency status in their areas, particularly for private sector housing, and this is not helpful in delivering and measuring progress locally. The situation could be improved if organisations worked more closely together to develop a package of measures for an individual household – or if local authorities were able to offer a full range of energy improvement works themselves, as part of their private sector housing strategies. With so many agencies and initiatives involved, it is difficult to assess accurately how much will be spent on housing investment (Archer, 2002) and indeed how successful such investment might be, although the Energy Saving Trust (EST) is to evaluate the impact of WFT on vulnerable households over 2001/2.

There can be many obstacles even where a local authority is committed to improving domestic energy efficiency across housing tenures. There have been many high profile cases of civil actions against social landlords where housing stock has been thermally poor and tenants are unable to adequately heat their homes. Litigation costs and staff resource may mean that social landlords are have less resource available to rehabiliate their

Table 5.2
The Fuel Poverty Strategy: key features

Aims to lift 800,000 vulnerable households in England out of the fuel poverty trap by 2004 and to eliminate fuel poverty by 2010. Actions include:

- development of a common, partnership-based approach
- continuing action to tackle poverty, low incomes and social exclusion
- continual review and fine-tuning of energy efficiency programmes and strategies (for example, warm front team and warm zones) to ensure an effective, comprehensive and co-ordinated approach to fuel poor households
- continuing action to decrease fuel bills and encourage fair treatment of lower income households
- ongoing evaluation of alternative fuels, energy technologies and insulation methods – particularly for hard-to-heat homes – with continued improvement of energy efficiency programmes
- Development of a new advisory group on fuel poverty

Based on DEFRA and DTI (2001)

Box 5.1 The Newham Warm Zone

The London Borough of Newham is currently third out of 354 in the indices of deprivation. There are 96,000 properties within the borough, of which 45,000 are owner-occupied and 15,000 are privately rented. A further 12,000 properties are owned or managed by registered social landlords (RSLS) and 24,000 are council-owned properties. Newham has a population of 250,000 people, of which 30,000 are pensioners. Of the 96,000 households in Newham, pensioners occupy 10,000 households. Six per cent of Newham households do not have access to the gas network and 25 per cent do not have central heating. Approximately £55 million of benefits go unclaimed in Newham (NWZ, 2001).

Over half of all domestic dwellings in Newham were built before 1929 and are of solid wall construction and therefore thermally inefficient. Poor building design and construction can have a considerable impact on its ability to retain heat. Even when all energy measures are applied to a 1900s house, such as loft insulation and draught proofing, the property will still be subject to high heat loss. Installing central heating has the greatest effect on a dwelling's SAP rating 1 (NWZ, 2002).

The Warm Zone concept

The Warm Zone concept forms part of the government's fuel poverty strategy (DEFRA and DTI, 2001) which was officially launched on 21 November 2001. Work on the Newham Warm Zone started in January 2001, and was officially launched in June 2001.

The purpose of each Warm Zone is to evaluate a systematic approach to tackling fuel poverty through economies of scale thereby accelerating the process of eliminating fuel poverty. The government has part funded the development of five pathfinder zones across the country and these are known as Warm Zones. The intention of each zone within its three-year life span is to target those households that fall outside of existing energy efficiency schemes, as well as to develop better links with existing schemes.

Aims and objectives

The Newham Warm Zone's ambitious aims and objectives include:

- the identification of all fuel poor households within Newham in order to facilitate the delivery of energy efficiency measures, and to eliminate fuel poverty through improvements to domestic energy efficiency;

- to reduce fuel poverty by at least 60 per cent with priority given to the most vulnerable groups as identified in the government's fuel poverty strategy (DEFRA and DTI, 2001). It further aims to reduce the number of households spending more than 20 per cent of total income on energy costs by at least 74 per cent by 2004;

- to deliver an estimated £15 million pounds of energy efficiency measures to the most vulnerable households within three-years;

- to develop new funding methods for the zone in order to enable the maximum number of households to benefit from funded energy-efficiency measures.

Identifying the fuel poor through desktop analysis

The methodology adopted by Newham Warm Zone was to identify fuel-poor households using desktop analysis of existing data sources. This was considered the most cost-effective way of identifying fuel-poor households, with other zones adopting different approaches. Desktop analysis is fundamental to the success of the warm zone and it was not until late January 2002 that a database capable of producing the quality and quantity of data required became available. The evaluation of the five zones is further complicated, because all of the zones use different operating systems.

A potential disadvantage of this approach is the zone's inability to take individual referrals from other organisations or directly from the public who may be put off applying for help altogether. Unfortunately economies of scale can only be achieved by saturating small manageable areas with publicity in order to maximise the take-up of energy measures. There is no intention of tackling individual cases and once an area has been completed it will not be revisited again. While this method of tackling fuel poverty is considered to be cost-effective, many fuel-poor households could slip through the net.

Figure 5.2 Newham Warm Zone: a unified approach

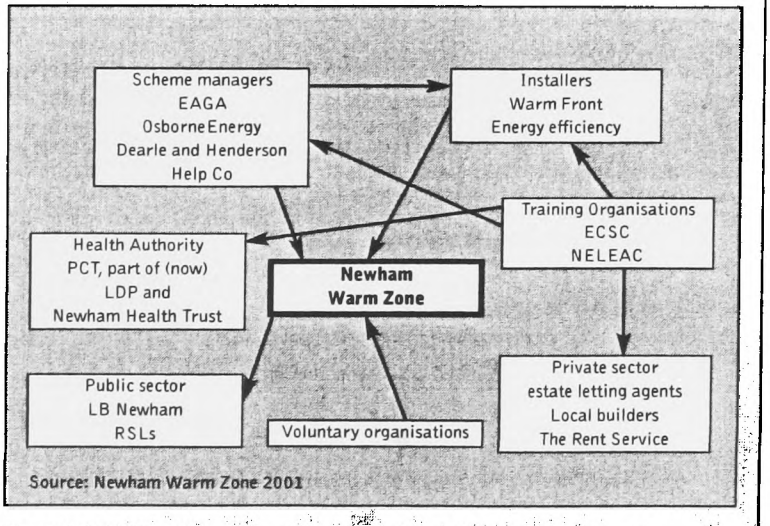


Figure 5.2 The above diagram shows the complex interactions of Newham Warm Zone and how it interlinks with other organisations.

Engaging the fuel poor

Work in the Warm Zone has revealed that there is some level of mistrust and apathy among Newham's residents, with many not believing their homes will be cheaper to heat following the installation of energy efficiency measures (NWZ, 2001). This may be a result of 'survey fatigue' in the area. Such feelings and attitudes need to be sensitively addressed and overcome in order to successfully engage these hard-to-reach households and to meet the targets as part of an overall strategic approach.

The Newham Warm Zone: one year on

A year after researching this chapter (Page, 2002), the author decided to find out whether the Warm Zone was on course to meet its targets and to assess progress being made.

There are a number of barriers that need to be overcome before a house can be removed from fuel poverty. The assessment team initially has to make contact with the fuel poor household which then has to agree to the assessment and referral process. Once agreement has been reached the household has to be eligible for the scheme and accept the installation of insulation within their home. Finally the installed measures have to be sufficient to remove the household from fuel poverty.

In practice the zone has found it difficult to even gain access to some fuel poor households, despite repeated attempts at various times throughout the day, and it is estimated that as many as one in three fuel poor households are being missed. Of the households that have been contacted as many as a third have been found to be ineligible for Warm Front grant assistance, despite it being the mainstay of the UK's Fuel Poverty Strategy. A significant number of ineligible households are believed to be vulnerable elderly low-income households who do not claim a passport benefit.

In order to remove a household from fuel poverty it must first be improved to a level lower than the Fuel Poverty Indicator (FPI), which is less than 10. The majority of homes surveyed have a much higher FPI; therefore unless fuel-poor homes receive additional benefits as a result of the screening process all energy improvements will have to come from physical insulation measures alone. It has been found that increasing insulation levels alone only has a modest increase in the warmth of a dwelling. The greatest impact on the warmth of a dwelling is achieved following the installation of gas central heating and cavity wall insulation. However, this is not possible in some hard to heat or poorly designed dwellings and this combined with a low income will not lift these households out of fuel poverty.

The early indications suggest that the Warm Zone approach will only remove a minority of households completely from fuel poverty. The remainder of households will benefit from some additional warmth flowing from the installation of energy efficiency measures. Lessons learned by Newham Warm Zone are constantly under review and need to be adequately addressed to help ensure the government's target of eradicating fuel poverty by the end of the decade

Note. Standard Assessment Procedure – measures domestic energy rating.

References

Newham Warm Zone (2001 and 2002) *Annual Review*. Newham Warm Zone.
Page, D. (2002) *'Cold Comfort'*. Dissertation submitted as part of the BSc (Hons) Environmental Health at the University of Greenwich, unpublished.

stock. Tenants – particularly HMO tenants in the private rented or permission or obligation sector, where conditions are particularly poor – may have inadequate incentive, or permission or obligation, to carry out works themselves and similarly landlords may fail to do anything for lack of return on investment. Older owner-occupiers – in particular those who have never had central heating or loft insulation – may be suspicious about what the grant is for, or not understand the importance or benefits of improved energy efficiency. Strategy needs to recognise and respond to the often complex concerns of those living in fuel poverty and why this is so, before moving forward.

Local authority officers need to be able to offer individual packages of assistance. They have a strategic overview that enables them to direct resource to where it is most needed and to continue to prioritise those in fuel poverty through analysis of local housing stock and income level. Environmental health, housing and social services are well placed to offer assistance, as they routinely visit low-income households as part of their customary work. They can help encourage maximum grant uptake (from their own or a partner organisation), as well as advise on energy-efficient practices in the home, sometimes resulting in improved energy rating with zero financial investment from the householder.

Many local authorities also have databases of information and existing networks of interested parties such as including tenants' groups, residents associations and landlords' forums who already regularly meet and exchange information, as well as databases of interested parties that offer regular mail shot opportunities. Such outlets can help provide a ready audience and help promote the energy-efficiency message, and where to go for help.

The private rented sector remains particularly difficult to reach. A different enforcement and assistance based approach may be necessary for the private rented sector, particularly for HMOs which are especially complex (see box 5.2). Limited energy-based requirements can be incorporated into statutory fitness protocol under the heating criteria, and statutory nuisance legislation may also be applied. Enforcement activity also needs to be closely allied to assistance in developing a more appropriate and viable package of measures that a landlord is likely to undertake which would ultimately provide low-income tenants with more energy efficient housing, helping save limited income from wasted expenditure on fuel. The forthcoming housing health and safety rating system may be able to offer a more rigorous enforcement-led way forward in this sector.

Box 5.2 Luton: Researching fuel poverty in HMOs

About 1.5 million dwelling units in England are in HMOs. With unfitness levels as high as 20 per cent, generally, but not entirely, the worst and least energy-efficient accommodation is in such homes. The 1996 English House Condition Survey (DETR 1998a) demonstrated that energy efficiency standards are significantly worse in the private rented sector with an average SAP1 of 36 compared to 44 for the whole private sector. Additionally, 39 per cent of households in private rented accommodation are classified as fuel poor compared to 16.7 per cent in the owner occupied sector. Research into the energy efficiency of HMOs is limited which prompted Luton Council in 2001 to undertake an HMO energy survey to establish whether they should be adopting a strategy specifically to target energy efficiency improvements these dwellings. The survey sought to determine how the energy efficiency of HMOs compared with the rest of the housing stock in Luton and to further examine the relative energy efficiency of each category of HMO.

HMOs were unlikely to be energy efficient or to meet reasonable standards of affordable warmth. At the time of the study, Luton Council had 358 Category A HMOs, 593 Category Bs, 4 Category Cs, 73 Category Ds and 183 Category Fs. Using the NHER HECA Home Energy Advisor software package from National Energy Services Ltd it was possible to provide a Home Energy Report for each HMO surveyed, recommending the most cost effective energy-efficient improvements for each property. The report shows the cost, savings and payback period for the recommended measures in priority order.

The average SAP rating for a dwelling in Luton is 54, which is well above the national average. Luton's HMO sector comes out significantly worse with mean SAP ratings of 32 for Category F HMOs, 34 for Category A HMOs, 37 for Category D HMOs and 47 for category B HMOs. The presence of many large new-build student halls of residence obviously has a positive effect on the energy efficiency of Category B HMOs as a whole. If the new halls of residence are excluded from the calculation, then the SAP rating for this category falls to 39 (see table 5.3).

Table 5.3: Average energy performance by HMO Category.

Category	Average energy rating	Average estimated cost (£)	Average annual savings (£ / year)	Average payback time (years)
A	34	1,717	364	4.72
B	47 (39*)	1,503	279	5.39
D	37	2,077	358	5.80
F	32	1,908	422	4.52

* Adjusted figure excluding the new university halls of residence

To a large extent, low SAP ratings are a reflection of poorer heating systems. The LHCS found that room heaters are associated with low sap ratings. 59 per cent of dwellings with a SAP rating of less than 20 rely on room heaters for their main source of heat and the majority of these use solid fuel or on-peak electricity which generate high heating costs. In Category F HMOs, 50 per cent of properties surveyed had room heaters rather than central heating as their main source of heating. Category A HMOs also had slightly higher numbers of room heaters than the average for private rented properties, whereas category B HMOs came out better than the average. The survey data has shown that this is the most significant difference between the HMO sectors with Categories F and A having the worst SAP ratings and a higher proportion of inefficient heating systems.

Luton's Private Sector House Condition Survey (2000) indicated that the unfitness rate in the private rented sector, at 12%, is more than double that for owner occupied properties. The 1995 house condition survey identified as many as 37 per cent of HMOs as unfit. Older shared terraced houses, converted flats and bedsits tend to be concentrated in the town centre wards. 40 per cent of category B HMOs are dwellings shared by Luton University students and are concentrated around the University, also in the older town centre wards. There is a strong correlation between the age of a property, the standard of repair of a property and its performance in terms of energy efficiency. The 1996 HECA Report concluded that

Table 5.4: Top 10 recommendation for all HMOs

	% of HMOs	Estimated cost (£)	Annual savings (£/year)	Payback time (years)
Cylinder jacket	25.8	20	20	1
Insulation (200 mm)	79	200	100	2
Fit cylinder thermostat	13	200	62.5	3.2
Cavity wall insulation	12	540	142.1	3.8
Room thermostat	19	200	47.6	4.2
Dry-lining	84	481	100	4.8
Low-energy lights	100	102.6	16.5	6.2
Draught proofing	32	172	18.5	9.3
Condensing boiler	48	1,473	128	11.5
TRVs	16	238	11.3	21

Table 5.4 lists the recommended measures in order of payback periods, ie the estimated cost of the measure divided by the annual savings. Of the measures with the shortest payback periods, only loft insulation upgrades affect a large proportion of the HMO stock (79 per cent) and have an excellent payback period of 2 years. Although cylinder jackets are only recommended for 28% of HMOs, they are the cheapest measure to install and can pay for themselves from energy savings in a year. They could easily be promoted at the Landlords forum. Low energy light-bulbs are the only measure that is recommended for 100 per cent of HMOs and although the payback is an average of 6.2 years, they are the sort of item that can be successfully promoted at a landlords forum. Condensing boilers were recommended for 48 per cent of the HMOs surveyed at an average price of £1,473 and an average payback time of 11.5 years. While it is acknowledged that heating systems have greatest impact on the SAP rating of a property, the long payback and large initial capital outlay suggest that this item would have to be heavily subsidised in the form of grants or discounts to make it attractive to landlords.

Other improvements that are listed include heating and hot water upgrades including thermostatic radiator valves (TRVs), room thermostats and cylinder thermostats. These upgrades tend to be recommended items for properties with better SAP ratings, ie above 40. They are the sort of measure that could be promoted via low/zero interest loan schemes or bulk discount schemes.

Despite promotion of HEES and previous HECA Action grant schemes nationally, take-up in the private rented sector has been low in virtually every case where it has not been targeted specifically. The benefits of energy efficiency to landlords are well publicised – lower repair and redecoration expenditure through reduced condensation, damp decay and mould growth, fewer burst pipes in cold weather; reduced management costs due to complaints, and voids and less enforcement action. However the real cost benefit of improvements is not readily quantifiable, as there is little evidence of benefits of increased rent revenue or increased asset value. Most landlords are looking for revenue and/or operational savings from any investments they make in their properties. Additionally, for dwellings with a SAP rating of under 30, approximately 22 per cent have a payback period of more than 10 years (Battersby, 1997). Consequently, many landlords will not be prepared to undertake improvements with long payback periods if their main motivation is financial savings.

Luton has been awarded Beacon status for its excellent work on Energy Efficiency. Its Affordable Warmth Strategy will shortly be in its fourth year. For the private rented sector, the strategy seeks to assist and encourage private landlords to provide affordable warmth in their properties by making presentations to

the landlords Forum and distributing Warm Front information, investigating the inclusion of energy efficiency as a requirement for HMO Registration, working with the university on standards for student properties, investigating the feasibility of bulk discount schemes and encouraging tenants to make behavioural changes to implement no-cost / low cost energy-efficiency measures. The strategy has achieved significant success in achieving its objectives in many areas. However, it may be argued that the private rented housing sector, and in particular HMOs has been somewhat neglected.

Since the HMO Energy Survey was completed in early 2002, HEES (now Warm Front) has been promoted at the landlords' forum. However, the overall emphasis has been to raise energy awareness and the promotion of no cost/low cost incentives rather than securing commitment for material improvements from landlords. Consultations with local landlords and Luton University regarding accreditation are still being considered and the feasibility of energy rating within the new HMO registration scheme has not yet been fully investigated. This is an option that could be explored in time for the next five year HMO registration scheme or an HMO licensing scheme.

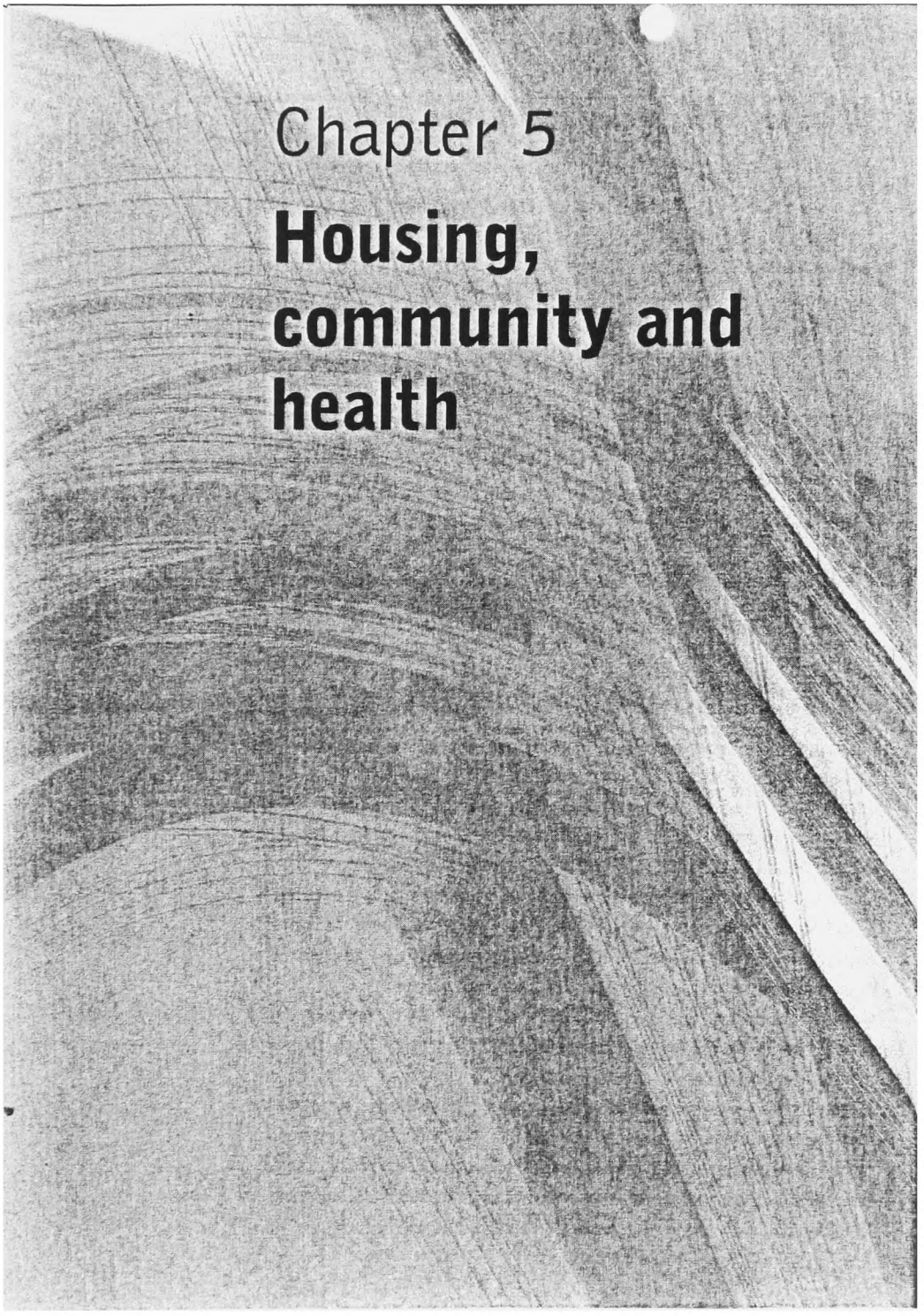
We know that a higher proportion of people living in HMOs are in fuel poverty than those living in any other type of housing. As Warm Front has not been successful in the HMO sector and enforcement through registration conditions is not currently an option, financial incentives should be considered in the form of energy efficiency grants, loans or bulk discount schemes. A survey of landlords in Luton in 1997 (Graves 1997) found that the incentive most likely to encourage landlords to introduce energy efficient measures was grant assistance. The average cost of recommended measures for all HMOs surveyed was £1801.25. Clearly, even if grants were only to cover a proportion of the work, there would need to be a precise rationale for prioritising grant aid and the council would also need to consider additional methods of assisting energy-efficiency improvements such as loans or bulk discount schemes

Energy conservation authorities currently have few powers to deal with inefficiency in the private rented sector, especially HMOs. Until such times as mandatory licensing of HMOs is introduced or the Housing Health and Safety Rating System demands higher standards of energy efficiency in dwellings, local authorities, such as Luton, need to be formulating strategies specifically to target energy improvements in their HMOs. Warm Front together with any schemes run by local utility companies must be fully exploited. Best Value and deregulation of the grants allocation policy will allow for a more holistic approach to be taken towards housing renewal with the flexibility to explore new funding mechanisms and target scarce resources where they are most needed and where they can be shown to have been effective.

It is hoped that the study has provided Luton with a starting point for recognising that action is needed in the HMO sector. The landlords forum will provide a base for consultation. There will also need to considerable commitment from councillors, private sector housing managers and EHOs who will need to be motivated if new policy initiatives are to be effectively implemented and landlords are going to be convinced to invest in energy efficiency improvements.

Table 5.8 Summary of recomendations

- 2004 HMO Registration Scheme (or Licensing Scheme) – impose minimum standards for efficiency
- Landlord Energy Efficiency Grants for properties with SAP ratings below 20
- Promotion of low-cost items, for example cylinder jackets, energy-saving light-bulbs at landlords forum
- Explore bulk discount schemes for loft insulation and dry-lining
- Explore possibilitiy of low-interest loans for landlords not eligible for energy efficiency grants
- Adequate resources must be allocated specifically for marketing, promotion and monitoring of activities
- Continued promotion of WFT (previously HEES) and utility company schemes.



Chapter 5

Housing, community and health

Note

1. The Government's Standard Assessment Procedure (SAP) rates the energy efficiency of dwellings on a scale of 1 to 100, 1 being very inefficient and 100 being very efficient.

References

Battersby, S. (1997) 'Home energy conservation', *Environmental Health*, 105 (8): i – iv

Department of Environment, Transport and the Regions (1998a) *The English House Condition Survey 1996*. London: HMSO. Available online at: www.housing.detr.gov.uk/research/ehcs96/tables/index.htm (30 August 2000).

Graves, S. (1997) *Attitudes and behaviour of landlords and tenants towards energy effiency*, Luton Borough Council.

Lewis E (2002) *Improving the energy effiency of HMOs in Luton*. Dissertation submitted as part of the BSc (Hons) Environmental Health at the University of Greenwich, unpublished.

Summary

Fuel poverty is a complex issue – particularly within the private housing sector – requiring a complex range of measures to bring real change. Partnerships potentially offer a way forward, but action needs to be co-ordinated and outcomes reviewed to ensure that real progress is being made and resources are used to maximum impact where most needed, not just where most easily provided – and to ensure local authorities do not lose a fundamental part of their private sector housing renewal strategies to other organisations. The strategy itself recognises that local authorities know their areas and private sector residents better than anyone else to enable effective fuel poverty strategies – particularly when personal involvement can be crucial – and are uniquely placed to develop partnerships, including with the new warm zones.

Housing and the Communities Plan

The recently published *Communities Plan* (ODPM, 2003a) lies at the heart of government proposals to create thriving, sustainable communities in all regions. It encompasses social and private sector housing, and seeks to ensure that community needs (economic, social and environmental) – not just housing delivery – are tackled through lasting, dynamic solutions. The Plan proposes a continuation of partnership approaches, particularly through LSPs, as part of the wider public health agenda. The Plan has received wide general support not least because it draws together programmes and regimes to help revive poor neighbourhoods and build sustainable communities, with additional housing funding across sectors.

The Communities Plan is wide ranging and encompasses:

- providing more quality affordable housing that recognises and responds to regional differences, housing demand and changing social trends, while recognising the housing need of key workers;
- designing attractive towns, cities and public places, making better use of previously developed land for possible redevelopment and more efficient use of greenfield sites;
- regenerating declining communities and recognising regional differences in housing demand as well as urban/suburban and rural priorities;
- tackling social exclusion and homelessness, tackling empty homes, responding to the demand for decent homes for all by 2010 and recognising neighbourhoods and environmental problems (eg neglect, vandalism and vacancy) as key contributors to the quality of life;
- improving the planning system so that it is faster, fairer and more efficient; and
- empowering local and regional government and improving performance standards.

Reintegrating health and housing: the local authority role across tenures

For environmental health practitioners, just about every aspect of housing law, practice and wider strategy in a public health context is set to change to reintegrate housing and health. Housing should be a key component of the public health agenda, with a renewed emphasis on joined-up solutions through community participation as part of local strategy. Local authorities are being given new powers in the private housing sector to

find new solutions to meet need, and must ensure that they do not lose out on funding to social housing within their areas with 'single pot' housing capital (Merron, 2002). Environmental health practitioners need to continually champion their cause at a time of such rapid change.

Jointly, the Community Plan, the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (see also ODPM, 2002a, 2002b and 2002c) and the Housing Bill 2003 (ODPM, 2003b) change the face of intervention across housing sectors. The Regulatory Reform Order supersedes the power to provide housing grants with a general power to provide assistance, overturning decades of grants as a policy tool in ensuring required housing conditions. The Housing Bill also brings radical change to assessing stock condition and taking enforcement action. Its relevant clauses:

- replace the current fitness for human habitation provisions with the new evidence-based housing health and safety rating system together with a new enforcement protocol;
- introduce a national mandatory licensing scheme for high risk HMOs, with discretionary powers for lower-risk HMOs and a completely new enforcement regime;
- give local authorities powers to license landlords in areas of low housing demand or similar, where a poor quality private housing sector adversely impacts strategy to secure sustainable communities.

(The Housing Act 2004 received royal assent literally as this book was going to press. Readers can therefore refer to the CIEH website for the CIEH Brief on the Housing Act, available at http://www.cieh.org/about/policy/bnotes/2004-11-HousingAct.htm for latest updates.)

Local authorities have responsibilities for housing stock across tenures. Although some still tend to focus on managing their own stock (Goss and Blackaby, 1998), most are recognising the growing political importance of an increasingly self-regulating private housing sector. Strategic action is now about meeting wider strategic socio-economic objectives (such as area regeneration, bringing vacant properties back into use, tackling fuel poverty etc – see box 6.1 for an example) not just in physically maintaining, repairing or improving existing housing. Social and private sector area

regeneration strategies now need to address complex, inter-related issues of social exclusion represented by multiple deprivation indices.

Box 6.1 Gadebank: Horizontal strategies in housing renewal

Addressing poor private sector housing conditions, and finding solutions that suit all interested parties, can be extremely complex. This is particularly so where there is mixed tenure – privately rented and owner occupied – because households frequently have different objectives and interests which need to be recognised. While owner-occupiers might be pleased to have the works done, particularly with the benefit of grant aid[1], increasing their capital asset but not their mortgage, tenants may feel differently if faced with an inevitable increase in rent, especially if on an assured shorthold tenancy where they may already feel insecure. Addressing such issues can comprise as big an issue as the renovation project in itself.

Allied to this is a local authority's responsibilities to meet legal and strategic requirements in its area's housing stock, including ensuring statutory fitness,[2] as well as making inroads to addressing fuel poverty and enabling more effective use of available private sector housing stock in meeting homelessness and other local housing need, such as bringing vacant properties back into use, as well as making sustained efforts to engage a new relationship with communities.

Nature of the renovation project

Gadebank comprised 16 private sector dwellings that were statutorily unfit by reason of substantial disrepair. In addition, the poor thermal quality of the construction gave rise to condensation and massive heat loss, aggravating fuel poverty for many of the low-income households living there. Three of the properties were long-term vacant and difficult to let which was having an impact on the feeling of the area and adding to a general downward spiral that had not been tackled (see Figures 6.1 and 6.2).

These dwellings were not a common construction type and were not designated under the Housing Defects Act. Step one, therefore, was to employ a structural engineer to identify the particular type of construction and whether it was even feasible to renovate them, and extensive concrete tests had to be carried out. It was found that the properties were structurally sound and could therefore be overclad to provide a serviceable life of at least thirty years. This information enabled initial discussion negotiations with the private sector landlord who owned 14 of the 16 dwellings (including the vacant ones), the remaining two being in owner occupation.

It was also important that all residents were involved in discussions about the present situation and future options for the site. Visits were arranged to each household individually allowing the opportunity for

Figure 6.1

Figure 6.2

Notes:

1 House renovation and other grants have recently been superseded by the power to provide assistance for private sector housing renewal.

2 The statutory standard of fitness is to be imminently replaced by the Housing Health and Safety Rating System

initial discussion. Officers attended with samples of the overcladding material, information on comparable renovated sites in the area and an information sheet containing details of useful contacts such as housing advice. It was clear that most residents were sceptical about whether the project would take off. However, all were keen for the works to go ahead, despite the fact that it might mean an increase in rent. It was a useful opportunity to discuss many related issues and what residents would like to see in the future.

We discussed with the landlord their possible eligibility for renovation grant aid toward the cost of works and raised issues discussed with the residents regarding works falling outside the scope of the fitness standard. The tenants had some good ideas which were incorporated into the scheme, such as partitioning the master bedroom, locating the bathroom there and thereby maintaining three bedrooms with more living space downstairs. The landlord was also willing to decant tenants to the newly refurbished vacant properties if this was necessary. The landlord proved to be extremely co-operative and agreed in addition to fund some additional works falling outside of the fitness regime, particularly in the vacant properties which presented greater potential for internal redesign. This included relocating the bathroom/WC upstairs, creating a large and modern kitchen/diner downstairs and installing full central heating. Efforts were made to keep the residents informed and feel they were involved throughout, although it was difficult for a relatively short-tem project where there would not be a long-term relationship with the local authority on completion.

Notices were served and the landlord made a grant application for each of their properties which was closely tied to the owner-occupier's grant applications. For uniformity, the scheme was to be dealt with as one project, despite the mixed tenure. Following discussions, the landlord's site manager was keen to oblige in overseeing all works once the financial contributions were established.

Internal works and external works had to be kept separate due to the specialist nature of the overcladding. Internal works were carried out first, with more extensive works to the vacant properties. Some residents chose to enhance the upgrade, for example by paying the difference themselves for a higher specification front door. Once the internal contractors were offsite, the specialist contractors were instructed to commence overcladding under a separate site manager.

Outcomes of the renovation scheme

One of the main objectives of the scheme was to enhance the poor thermal standard of the construction. External walls were prepared to receive the insulating board and rendering was carried out in two coats, using a traditional coloured top-coat pebbledash finish of a colour that residents had jointly agreed. Issues like resiting drainage pipes and residents' satellite dishes also needed to be taken into account (see Figures 6.3 and 6.4).

Figure 6.3

Figure 6.4

Taking the building as a whole, it was calculated that the typical U value for a dwelling was 0.40W/M²K. The overcladding works increased this value to 0.77W/M²K, taking the thermal insulation above current building regulation requirements. Double glazing with trickle vents combined with insulation to all loft spaces (with necessary additional ventilation provided to the roof) made an important contribution to addressing fuel poverty.

This scheme provided a valuable and timely scheme of works to improve the housing conditions, thermal efficiency and local environment for 16 dwellings. The scheme met many of the council's private sector housing strategy objectives, particularly in respect of the authority's obligations under housing legislation, as well as bringing vacant properties back into use and implementing anti-poverty and energy efficiency initiatives at a relatively economic cost to the local authority with a specific targeting of limited resources.

Sorce: Stewart and Nunn (1999)

The majority of housing is in the private sector, and the proportionately worst housing is in the private rented sector, particularly in HMOs. This sector is generally older stock than local authority dwellings, so it is of no surprise that conditions can be worse, such as the lack of internal WC in pre-1919 dwellings, etc. As improvements have taken place along with new build over successive years, numbers requiring standard amenities have declined and the main reason for unfitness is now substantial disrepair (ODPM, 2003c) – see Tables 6.1 and 6.2. Some three fifths of low-income households in England live in poor conditions in this sector (cited in Wilcox, 2001), with increasing numbers of vulnerable households finding accommodation at the bottom end of the privately rented sector through lack of alternative (Cowan, 1998). There remain fundamental problems in housing supply, quality and delivery that is both inadequate and increasingly insufficient to meet need.

For social housing, identifying a boundary for strategic intervention is relatively clear-cut and resource regimes well established. However, it is not quite so straight-forward in the private sector where ownership and responsibility for renewal works is more complex. Private sector housing regeneration strategies have long been criticised for their inability to be able to incorporate some of the issues that social housing sector regeneration strategies take for granted, although there has been an increasing move toward sustainable private sector regeneration. Private sector housing renewal law – and associated funding opportunities – lies at the heart of the problem as it is frequently limited and reactive, and not able to address many of the wider issues in physical housing conditions – let alone environmental improvements – comprehensively, or the reasons for people living in poor quality accommodation in the first place. Current changes in legislation and local strategy seek to address such issues, with a new emphasis on evidence-based and area activity to bring wider socio-economic regeneration.

Area action

Renewal areas provide a focus for intense housing and area renewal over a ten-year period and once established enable local authority environmental health practitioners to consolidate regeneration activity with an emphasis on increasing personal responsibility for housing conditions (DoE, 1996a; ODPM, 2002a, 2002b). Part of setting up a renewal area involves carrying

- 21.1 million dwellings overall, with 20.5 million households, an increase since 1996 survey
- 39% (8.1 million) housing stock built before 1945; 21% (4.4.million) before 1919
- 70% stock owner occupied, 10% rented from private landlords, 7% owned by registered social landlords; profile of stock differs substantially between tenures
- HMOs comprise 1.1 million dwellings, providing homes for 1.3 million households; over half of these are self-contained flats, 82,000 have been converted into bedsits providing accommodation for 27% households (363,000) living in HMOs
- 43% (700,000) dwellings are vacant, a decrease since 1996 survey, about half of these being 'problematic' vacants
- 7 million dwellings are non-decent (33% of all dwellings), a fall of almost a quarter since 1996 survey; main reasons for non-decency are:
  - 5.6 million dwellings (26% total stock) fail to meet thermal comfort criterion
  - 1.9 million dwellings (9% total stock) fail to meet disrepair criterion; least progress has been made here since last survey
  - 0.9 million (4% total stock) fail to meet fitness standard
  - 0.5 million (2% total stock) fail to meet modernisation criterion
- The average cost to make homes decent is nearly £7,200, representing a total cost of £50 billion.
- 6.7 million households live in non-decent homes (33% of all households), compared to 8.9 million (45% households) in 1996; of these:
  - the majority of households are owner occupiers (63%), with RSL 22%, private landlords 15%, but private sector tenants are most likely to occupy non-decent housing
  - 49% households comprise people living alone, sharing with others or lone parents
  - ethnic minority households comprise 9% of all living in non-decent homes; 40% ethnic minority households live in non-decent homes
  - poorest fifth of all households (42%) around twice as likely (42%) to live in non-decent homes compared to highest fifth (24%)

Note: Detailed results for the 2001 English House Condition Survey are now available online at: *http://www.housing.odpm.gov.uk/research/ehcs/continuous/index.htm*

Source: ODPM (2003c)

Table 6.1
Findings of the English House Condition Survey 2001

Continuous ODPM survey reporting on:

- Trends in tenure
- Composition of households, mobility and accommodation across all tenures
- Attitudes of tenants toward their landlord
- Mortgage payments and arrears
- Housing benefit receipt, rent payment and arrears
- Factors affecting rent levels
- Results are analysed using the Index of Multiple Deprivation

Note: For Survey of English Housing see
http://www.housing.odpm.gov.uk/statistics/publicat/summaries/009/index.htm

Table 6.2
Survey of English Housing

out a neighbourhood renewal assessment (NRA) to decide the best way forward, taking issues such as socio-economic status, environmental infrastructure, community opportunities and housing condition into account in consultation with residents.

Local authorities are increasingly encouraged to adopt area-based renewal strategies as a wider strategic framework for regeneration, responding to the local need to demonstrate commitment to the area. This is seen to stimulate further partnership investment and build confidence. The Regulatory Reform Order relaxed earlier renewal area designation criteria which is allied to the new power to give assistance in renewal areas. The ODPM has issued substantial guidance to support the new Order (see for, example, ODPM, 2002a, 2002b).

Some concern has been expressed that there is no explicit requirement to assess 'health' within the community before initiating area-based activity. As a result, the Rhymney Health Study (Jones, 2002) was established to help inform a partnership approach to community regeneration as an additional component to the NRA in December 1999, an integral part of a wider process of health and social needs assessment across the county borough area. The exercise was found to add a health improvement focus to the declaration of the area, with private sector housing renewal providing the impetus to a real opportunity to engage with communities thus enabling partnership working and improving local health. The key recommendation arising was to make health needs assessment pivotal and integral to the process of renewal area declaration.

Strategically, local authorities need to be able to optimise their legal duties and powers to ensure that activity is properly and effectively targeted to areas where it is most needed. This is allied to a wider vision of economic development, social inclusion and cohesion, enabling better use of the privately rented housing sector to meet local need. Environmental health practitioners must not lose sight of what they are trying to achieve overall: an improvement in healthy housing and communities, not just the continual delivery of segregated services that fail to tackle the root causes of social integration through a betterment of housing and environment.

Publication 14 Stewart, J., Clayton, J., and Ruston, A. (2006a) Personal responsibility for private sector housing renewal: issues in health improvement, *Health Education Journal*, 65 (01), pp.73- 83.

Personal responsibility for private sector housing renewal: Issues in health improvement

Jill Stewart[1], Julie Clayton[2] and Annmarie Ruston[3]

Abstract

Objective To investigate current policy in respect of resourcing private sector housing renewal to promote healthy housing and communities.

Design A qualitative study using focus group research investigating what low-income home owners would find helpful in carrying out maintenance and repair to their homes.

Setting The focus groups were held in the area office of a South London (private sector housing) Renewal Area.

Method Exploratory focus groups were held in 2003 to 2004, to represent low-income ethnically diverse home-owners within the Renewal Area.

Results Respondents were open to looking at new ways of maintaining and repairing their homes, although tended to focus around their own needs rather than the works a local authority may strategically wish to see carried out in private housing sector to meet legal housing standards and promote healthy housing.

Conclusion Local authorities need to be able to find new, evidence-based ways of supporting home-owners to carry out maintenance and repairs to their homes as part of a wider public health agenda.

Key words: private sector housing renewal, health promotion, housing and public health, health and housing, health improvement

Introduction

The links between housing and health are well documented[1,2,3,4,5] and there is renewed

[1]Senior Lecturer, School of Health and Social Care, University of Greenwich. [2]Research Fellow, School of Health and Social Care, University of Greenwich. [3]Director of Research, School of Health and Social Care, and Director of the Centre for Health Research and Evaluation (CHRE).

Correspondence to: Jill Stewart, Senior Lecturer, School of Health and Social Care, University of Greenwich, Avery Hill Campus, Bexley Road, Eltham, London UK SE9 2PQ. j.l.stewart@greenwich.ac.uk

interest in housing as a social health determinant[5,6,7,8]. Owner-occupiers now account for 70 per cent of English housing stock, with important implications for lower-income groups who are disproportionately represented in poor housing[9]. There remains a lack of information about what works to help lower-income owner-occupiers to improve their housing, and therefore their health status.

Private sector housing renewal policy is currently subject to major overhaul to reintegrate health[10]. This includes a range of measures, such as the introduction of the new evidence based Housing Health and Safety Rating System[11], the Decent Homes Standard[12], and the Community Plan[13], which seeks to promote sustainable communities. These run parallel to the wider public health agenda with its focus on addressing health inequalities through partnership working. The current Labour agenda pivots around interventions that are evidence based and work[3,4].

Concurrently there has been a return to 'personal responsibility' for resourcing poor housing conditions in the owner-occupied sector as part of wider governmental policy and a withdrawal of earlier government expenditure[14,15,16,17,18], raising the question of how private sector housing renewal is to be funded into the future. The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002[16] subsumed earlier private sector grant legislation and provided local authorities with a new power for 'assistance', with new responsibilities in private sector housing. Simultaneously health gains need to be demonstrated[3]. Local authorities are now required to develop new participative, community led and bottom up approaches to private sector housing renewal, introducing new roles in home maintenance.

Health improvement through improved housing

There is much evidence about the relationship of housing to both physical and mental health, but impacts on health are complex and adaptive[19,20,21]. Evidence of the effects of interventions is lacking, arising from difficulties in researching housing and health issues and a more holistic approach is necessary to respond to the complex issues in housing, health and deprivation[5]. Current policy changes in private sector housing renewal and public health however offer potential to meet some of these challenges, with new roles and relationships for both local authorities and communities[3,22], within the challenges of a private sector housing market (*Figure 1*).

In public health, there have been calls for more evidence-based activities. The Wanless Report[23] has focused attention on how deprived communities might become more 'fully engaged' in their own health; how front line organisations can priorities interventions and target priority groups; and what evidence would be required to do this better. The Health Development Agency (HDA) started to collate research around what works to deliver healthier housing and communities, acknowledging that housing refurbishment generally improves physical and mental health[24]. The *Learning from Effective Practice System and Standard* (LEPSS) (currently under development) seeks to capture and share effective research based practice of successful interventions to

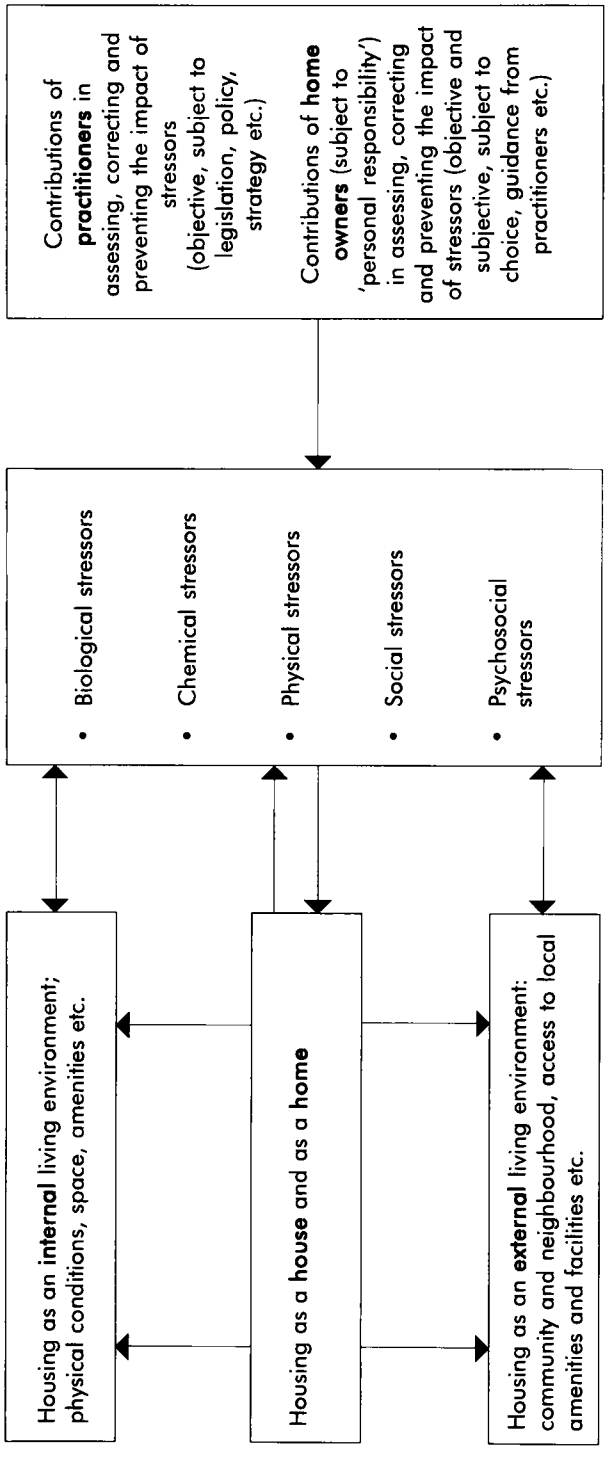


FIGURE 1 Health impacts on housing as a living environment

(Adapted from Burke *et al*, 2002[22].)

improve front line service delivery[25]. This approach squares with the view that housing research tends to lack a broader conceptual framework and rarely addresses practical guidelines or policy issues required for innovative interventions[21]. Indeed, greater health impact is achieved by organisations working with communities, particularly where the needs of specific groups are flexibly and responsively targeted[3,24].

Methods

The overall aim of this study was to explore and support the development of new policies for helping home-owners to take more responsibility in achieving effective home maintenance within the public health agenda.

Interviewees were selected from the Renewal Area in conjunction with the local authority to participate in exploratory focus groups. Three focus groups of approximately 10 respondents aged over 60 were undertaken to represent the local ethnic mix. Each groups lasted for around 1.5–2 hours. The discussions were centred around a topic guide and facilitated by an experienced researcher and were tape-recorded. The tapes were transcribed verbatim. The data were analysed using content analysis, which is a technique for making replicable and valid inferences from data to their context. The analysis was conducted separately by two researchers to ensure all relevant themes were identified and verified.

The focus groups enabled group data to be collected to cover a range of views, capture a diversity of perceptions and help offer new insights. Focus groups are quicker than individual interviews; enable researcher interaction with the respondents to probe and clarify responses; and provide an opportunity to obtain large and rich amounts of data in the respondents own words.

Results

Differences between local authority and respondents' needs and priorities in housing

The focus groups revealed a difference, or even 'tension' between the local authority and respondents' objectives. Local authority strategies revolve around meeting legal standards, area regeneration and health promotion activities. Respondents tended to focus around their personal needs or cosmetic home improvements, such as having a new shower, a loft conversion or a new front door.

Respondents reported that there were sometimes barriers to getting works done, so they often responded to, rather than anticipated maintenance and repairs. Some reported that age, ill health or losing a partner prevented them from being proactive and shifted their priorities. The following quote illustrates what the groups were thinking:

> *DIY is one of the things that gets more difficult as you get older. I look around my house and see the things that I did when we moved in 25 years ago and I think*

how on earth did I manage to do that?

In addition, respondents saw the level of emotional support available as extremely important and relevant to carrying out maintenance and repairs, particularly for older people:

> *I think actually losing your husband or wife is actually an extremely important element because... generally one or other of you could arrange to get the works done... if there is only one of you it's quite another matter.*

Respondents showed some knowledge of the relationship between health and housing. For example some made comments about dampness as being 'very bad for your health'. Mainly, health related concerns focused around emotional/mental health, such as how their housing made them feel, or general neighbourliness.

The fall and rise of community spirit in promoting healthy housing and communities

Respondents made several comments about how their community had changed over the years ('You used to help neighbours in the old days'), and the effect this had on neighbourliness and doing favours for one another. Respondents acknowledged that the Renewal Area itself had seemed to play a role in encouraging community spirit, as illustrated by the following quotes:

> *... We have got to know each other much better through [the Renewal Area].*
>
> *... I know most people on the street because of it. It's been very good that way hasn't it?*

Respondents also viewed some local amenities and business as helping them in carrying out maintenance and repairs to their homes. For example, a local shop had provided impetus to many:

> *The shop on the corner here is very helpful with things like that now. And they have got all the workmen there in case you live nearby. And because they have got a shop there they look after you.*

In terms of neighbours helping (or even knowing) one another, the experience of living in London was felt by respondents as different from what might be found in living in a more rural setting as illustrated by the following quote:

> *Could I just mention my experience of being an owner-occupier because the first house that I owned was in an Oxfordshire village and the thing there was that if you needed jobs done whether it was electrical or plastering or whatever, there was somebody there who everybody knew who would do that. They wouldn't always do it terribly well but at least you knew who they were...*

Another respondent added that this was important so that it would be possible to contact that same builder again.

Generally, respondents said that they would be happy to help one another out on an ad hoc basis, but would not expect anything in return for such a favour.

Services that respondents would find helpful from local authorities in maintaining and repairing their homes

The respondents' views frequently centred around accessing finance and other resources to enable them to carry out works to their homes themselves. Respondents seemed relatively well informed about the resource required to maintain their homes, and this was possibly because they were from an existing Renewal Area. Lack of money proved a barrier to respondents in carrying out maintenance and repairs, and the following quote illustrates what the groups were thinking:

> *And you haven't got the money to pay for it as well. So it's very hard to keep up any one of those houses there anyway.*

Respondents showed personal initiative in finding ways of making maintenance and repair works more affordable. Methods included Do It Yourself (DIY), reading books, learning from others and accessing the internet for guidance ('I know I haven't got the money so I have a go myself') and cheaper materials. Many respondents wanted to learn how to carry out maintenance works as illustrated by the following quote:

> *There used to be a very good class... that you could go to where you learnt how to do... like if you are a woman and you didn't know because your husband had always done it, you could go and learn how to change a plug and put up a shelf and...*

However, respondents reported that they were not always able to carry out maintenance and repairs themselves and would sometimes need someone qualified and reliable to be able to do works for them, such as with electrical installations: 'No, I wouldn't have anything to do with electrics, because it could start a fire'. Several respondents also reiterated the issues of reliability of builders, which at times provided a barrier to them arranging to get works done. The following quote illustrates what the groups were thinking:

> *And the builders come in, you have a job there which they are qualified to do it and most of the time when they come and then finish and then go it's worse than when they came...*
>
> *...The problem is when they come to do a job they start it and then they go and leave you. You never get anybody doing a complete day's work.*

In respect of being able to fund and afford works, respondents favoured schemes that they could contribute to on a regular basis, such as insurance type schemes. In addition they also tended to favour a home maintenance strategy where they might be able to share some costs with neighbours. They generally favoured builders lists, but only where those listed could be guaranteed to be reliable.

Discussion

The starting point for this research was the withdrawal of grants in favour of personal responsibility for private sector housing conditions. This has come at a time when evidence based health and housing initiatives have become more important in respect

of 'what works' in policy. Very few studies focus on the intervention level, particularly in private sector housing renewal. Assumptions appear to have been in the Regulatory Reform Order made that lower income home-owners will take personal responsibility to invest in their own homes in a way that meets government objectives for healthier housing and communities, although this research did not fully support this. The respondents tended to look at the practicalities of carrying out works, such as affordability or accessing local trustworthy builders, rather than health gain in itself.

This research helps plug a gap in the current evidence base, whilst also supporting the local authority's role in developing new strategies that the community feel they own. It is, however, recognised that this was an exploratory study, and that focus groups are limited in their generalisability to a wider population, but can help provide a baseline of evidence for future research in developing good practice at implementation level.

The dilemma: private sector housing as an asset or social determinant of health?

The fundamental issues seem to stem from whether housing renewal should primarily be seen as a personal asset, or as a social determinant of health. Whilst low-income home-owners would have liked to invest more resources into their homes, there were often barriers in the way. Loss of interventionist grants also herald loss of some sense of control by local authorities in what they can require in housing. Whilst local authorities may wish to objectively assess, correct and prevent the impact of housing stressors in the context of legislation, policy and strategy and based on research of the health relationships[22], home owners may take a more subjective view, based on personal choice, with or without appropriate guidance from the local authority (*Figure 1*).

One benefit of the modern public health agenda and the emphasis on local strategies is that it enables some of these dilemmas to be overcome and allows multiple-strategies to be applied[3,8]. This is important in areas like housing renewal where wider indicators of health gain include social inclusion, neighbourliness and comparative rates of deprivation[5]. As poor housing often exists along with other deprivation, strategies need to be able to ensure that communities' needs can be appropriately and sensitively met in ways that work. It is important to assess the likely success of interventions[5,24] which can help reduce negative health impacts and address health inequalities. The Health Education Authority (predecessor to the HDA) report that it is necessary to apply the best research evidence, current debate and discuss the health promotion implications where appropriate[20].

How can low income home-owners get the help they need?

This research suggested that some of the government favoured options (equity release, more closely targeted grants, home loans)[26,27] were not necessarily what the respondents in this study favoured. Many wanted to do works, yet their low income presented the main barrier. In overcoming this, they looked for ways to make works less expensive

and more accessible, such as proactively saving (subject to appropriate supports in place); having regular, ongoing contact with local and trustworthy builders, particularly for more specialist works including electrical installations; and having a strategy that could respond to their changing needs arising from age, loss of a partner and so on. In respect of health, respondents appeared to refer more to emotional/mental health rather than physical health issues, and valued a close community network to meet their needs. Generally, respondents seemed to favour more individual approaches where they retained more personal control.

One issue with this – with a more individually centred approach – is that it may not lead to local authorities being able to require that legislative standards are fully met, and loss of interventionist grants also heralds some loss of local authority control over physical housing condition. However, in respect of health gain, it is possible to argue that emotional health (which appeared to be priority for respondents here) would be enhanced by enabling more feeling of individual control over their environment, even if this were to result in for example a new blocked front garden (which would not meet housing legislative requirements) as opposed to a new roof (which would).

In balancing these positions, the local authority has been developing a local Home Maintenance Strategy[18] that seeks to cover many to the evolving issues identified. This is likely to be successful as the community has been involved from the outset.

The Renewal Area: impetus to community spirit

The ongoing work in the Renewal Area is not just about physically improved housing, but also creating a supportive environment for personal and community empowerment, a distinct move away from the 'grant dependency culture' as an interventionist option[26,27,28,29]. Such health promoting activities recognise the need for improved housing, but also synthesise personal choice and social responsibility in getting there[30,31,32], which are now important factors in local housing (and health) strategies. The manner in which the community are being included in such early stages is likely to yield beneficial results as the relationship between the local authority and community continues to evolve[24].

Ongoing activities in the Renewal Area are key to help support individuals and communities to develop their own solutions to home maintenance. The actual process of the Renewal Area as well as this research appeared to have had some influence on developing – even 'reintroducing' community spirit into the area, but the situation is fluid and complex in a private sector housing market. The constant challenge facing those working in private sector (as opposed to social housing) renewal is that of gentrification and a rise in house prices, so the traditional low-income community is being replaced.

Conclusions: Implications of this research

Private sector housing grants have existed for decades, but the Regulatory Reform Order

introduces new powers for assistance, calling for more personal responsibility in housing conditions and presenting new challenges to local authorities and communities in delivering healthier housing. The main challenges seem to be balancing the tension between local authorities expert roles and the community's individual needs and aspirations in investing their own resource. Flexible, innovative interventions are required as occupiers age, change health status, their housing conditions alters and they have differing needs during the course of their lifetime[21]. The local authority in this study has been recognised for its pioneering approaches to private sector housing renewal, such as the development of its Home Maintenance Strategy. It is now involving its relevant communities in other new strategic developments, which will help ensure that needs are met. Whilst this can contribute to health improvement, it remains too early to evaluate the impact on health arising from a range of new initiatives to enable low-income home-owners to take more responsibility for their housing conditions in ways that work, but good foundations are certainly in place.

Acknowledgement

This research was commissioned and funded by the Bellenden Renewal Area, London Borough of Southwark. The views expressed in this paper are those of the authors and do not necessarily represent those of the London Borough of Southwark.

References

1 Stewart J. *Environmental Health and Housing.* London: E and F N Spon, 2001.

2 Ormandy D. 'Housing Conditions and Health'. In: W H Bassett (Ed), *Clay's Handbook of Environmental Health* (19th edition), Part Five: Housing, Chapter 16, 349–363. London: Spon Press, 2004.

3 Stewart J, Bushell F, Habgood V. *Environmental Health as Public Health.* London: Chadwick House Group, 2005.

4 Stewart J. A review of UK housing policy: Ideology and public health. *Public Health,* 2005: **119**: 525–534.

5 Thomson H, Petticrew M, Morrison D. Health effects of housing improvement: Systematic review of intervention studies. *British Medical Journal,* 2001: **323**: 187–190.

6 Department of the Environment, Transport and the Regions (DETR). *The Housing Green Paper: Quality and Choice: A Decent Home for All.* London: HMSO, 2000.

7 Department of Health (DoH). *Saving Lives: Our Healthier Nation.* London: HMSO, 1999. Online. Available HTTP:// http://www.ohn.gov.uk/ohn/ohn.htm (accessed 30 August 2000).

8 Krieger J, Higgins D. Public health matters: Housing and health: Time again for public health action. *American Journal of Public Health,* 2002: **92**(5): 758–768.

9 Office of the Deputy Prime Minister (ODPM). *English House Condition Survey 2001.* London: HMSO, 2003.

10 Office of the Deputy Prime Minister (ODPM). *Housing Bill – Consultation on Draft Legislation.* London: HMSO, 2003. Online. Available HTTP: http://www.odpmgov.uk/Information/consult/housingbill/01.htm (1 April 2003).
11 Office of the Deputy Prime Minister (ODPM). *Housing Health and Safety Rating System Guidance (Version 2).* London: ODPM, 2004. Online. Available HPPT: http://www.odpm.gov.uk/stellent/groups/odpm_housing/documents/page/odpm_house_032782.pdf (18 March 2005).
12 Office of the Deputy Prime Minister (ODPM). *A Decent Home: the Definition and Guidance.* London: ODPM, 2004.
13 Office of the Deputy Prime Minister (ODPM). *Sustainable Communities: Building for the Future.* London: HMSO, 2003. Online. Available HTTP: http://www.communities.odpm.gov.uk/plan/main/overview.htm (6 March 2003).
14 Department of the Environment, Transport and the Regions (DETR). *Housing Research Summary Encouraging Home Owners to Repair and Maintain their Homes: A Review of Initiatives (no. 92, 1998).* London: HMSO, 1998. Online. Available HTTP: http://www.housing.dtlr.gov.uk/hrs/hrs092.htm (12 April 2000).
15 Department of the Environment (DoE). *DoE Circular 17/96: Private Sector Renewal: A Strategic Approach.* London: HMSO, 1996.
16 Department of Transport, Local Government and the Regions (DTLR). *Statutory Instrument 2002 No. 1860: The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002.* London: HMSO, 2002. Online. Available HTTP: http://www.hmso.gov.uk/si/si2002/20021860.htm (1 October 2002).
17 Stewart J. Lend them a hand. *Environmental Health Journal*, 2003: **110**(4): 212–214. Online. Available HTTP: http://www.ehj-online.com/archive/2000/july2003/july5.html
18 Stewart J. Home maintenance: Initiatives in the Bellenden Renewal Area, Peckham. *Journal of Environmental Health Research*, 2003: **2**(1): 10–21. Online. Available HTTP: http://www.jehr-online.org.volume1/issue2/5/index.asp
19 Cave B, Molyneux P, Coutts A. *Healthy Sustainable Communities: What Works?* Milton Keynes and South Midlands Health and Social Care Group, 2004.
20 Health Education Authority. *Health Update, Environment and Health: Housing.* London: Health Education Authority, 2000.
21 Lawrence RJ. Editorial introduction: Housing, health and well-being: Moving forward. *Reviews on Environmental Health (Freund Publishing House Ltd)*, 2001: **19**(3-4): 161–176.
22 Burke S, Gray I, Paterson K, Meyrick J. *Environmental Health 2012: A Key Partner in Delivering the Public Health Agenda.* London: Health Development Agency, 2002.
23 Wanless D. *Securing Good Health for the Whole Population.* London: HM Treasury and the Stationery Office, 2004.
24 Health Development Agency (HDA). *The Evidence of Effectiveness of Public Health Interventions – and the Implications: HDA Briefing No. 1, June 2004.* London: Health

Development Agency, 2004.

25 Health Development Agency (HDA). *Learning from Effective Practice Standards System (LEPSS): Outline Programme 2004–2007.* London: Health Development Agency, 2004.

26 Mackintosh S, Leather P (Eds). *Home Improvement under the New Regime. Occasional Paper 38.* Bristol: School of Advanced Urban Studies, 1992.

27 Department of the Environment, Transport and the Regions (DETR). *Private Sector Housing Renewal: Reform of the Housing Grants, Construction and Regeneration Act 1997, Local Government and Housing Act 1989 and Housing Act 1985: A Consultation Paper.* London: DETR, 2001. Online. Available HTTP: http://www.housing.dtlr.gov.uk/information/consult/pshr/pdf/consult.pdf (12 February 2002).

28 Department of the Environment, Transport and the Regions (DETR). *Housing Research Summary Encouraging Home Owners to Repair and Maintain their Homes: A Review of Initiatives (no. 92, 1998).* London: HMSO, 1998. Online. Available HTTP: http://www.housing.dtlr.gov.uk/hrs/hrs092.htm (12 April 2000).

29 Department of the Environment, Transport and the Regions (DETR). *Private Sector Housing Renewal: Reform of the Housing Grants, Construction and Regeneration Act 1997, Local Government and Housing Act 1989 and Housing Act 1985: A Consultation Paper.* London: HMSO, 2001. Online. Available HTTP: http://www.housing.dtlr.gov.uk/information/consult/pshr/pdf/consult.pdf (12 February 2002).

30 World Health Organisation (WHO). *Health Promotion: A Discussion Document on the Concept and Principles.* Copenhagen: WHO Regional Office for Europe, 1984.

31 World Health Organisation (WHO). *Ottowa Charter for Health Promotion.* Ontario: WHO, 1986.

32 Beattie A (1982). Cited in Beattie A (1991), Knowledge and control in health promotion: A test case for social policy and social theory. In: J Gabe, M Calnan, M Bury (Eds), *The Sociology of the Health Service.* London: Routledge, 1994.

Publication 15 Stewart, J. and Rhoden, M. (2006) Children, housing and health, *International Journal of Sociology and Social Policy*, 26 (7/8), pp. 326-341.

Children, housing and health

J. Stewart
School of Health and Social Care, University of Greenwich, London, UK, and
M. Rhoden
School of Architecture and Construction, University of Greenwich, London, UK

Abstract

Purpose – To consolidate and review current literature that relates children's health to their housing and living environments.

Design/methodology/approach – A range of published sources which review the relationship between children, housing and health. The sources consolidate research that applies specifically to children and their domestic situation. The paper also reviews literature around municipal tower block estates and the unique health/architecture relationship before turning to children living in temporary bed and breakfast accommodation. An overview of current public health policy that seeks to reintegrate housing and well-being is undertaken.

Findings – Decent housing lies at the heart of health for all. Generally, the picture is more positive, but action remains slow. Children's needs must be given a higher priority in housing in future to promote physical and emotional well-being.

Research limitations/implications – It is not an exhaustive list and the sources are mainly UK publications.

Practical implications – The UK approach to children, housing and health may be of interest to a number of overseas countries in Eastern Europe, Africa and Asia.

Originality/value – This paper fulfils an identified information/resources need and offers readers such as students, academics and practitioners an overview of the UK approach.

Keywords Children (age groups), Personal health, Housing, Public health, Homelessness

Paper type Literature review

Introduction

Many factors affect health inequality, and it has been estimated more than 70 per cent of all medical and health care is for preventable conditions, frequently where determinants are known (Harrison, 2001). It is improvements in health determinants – not medical health care – that ultimately make the most difference in addressing health inequality (Cornell, 1996; Harrison, 2001; McKeown, 1976; Naidoo and Wills, 2000). Health is not evenly distributed and there are inequalities linked to social class, gender, race and geography (Townsend *et al.*, 1988).

Housing is a key health determinant both as an internal and external living environment. Internal housing health and safety factors are well documented and there is increasing recognition that the wider housing environment location represents access to employment, training, facilities, decent food, social cohesion and so on. A lower income leads to less – if any – choice in housing and this is aggravated by stress, lack of social support and sometimes health-damaging behaviours (Blackburn, 1991), which can damage physical and mental health (Naidoo and Wills, 2000).

The health and housing relationship is compounded for children, who are still too frequently housed in unsatisfactory living conditions that can give rise to physical and emotional ill health that – once suffered – can be magnified into adulthood. The complex relationship of children, housing and health is documented, but not commonly drawn together into the impact of poor living environments in general on health, which

International Journal of Sociology and Social Policy
Vol. 26 No. 7/8, 2006
pp. 326-341

0144-333X
DOI 10.1108/01443330610680416

was recognised by Acheson's "inquiry into inequalities in health" (Acheson, 1998) as representing a key aspect of inequality.

This paper consolidates and reviews current literature that relates children's health to their housing and living environments, and the housing and health relationship is summarised in Table I. It considers children on polarised social housing estates and homeless children in temporary bed and breakfast (B&B) accommodation, before turning to strategies that can help address poor housing and living environments to promote health for children.

Health/safety issue	Comments
Poor domestic conditions/housing standards/inadequate amenities	Disrepair, insufficient amenities and sanitation can have negative physical health impact and increased likelihood of accident and ill health, notably in B&B where amenities may be shared with strangers
Home accidents/fire	More accidents (including fatalities) than other environments; closely correlates to housing standards and vulnerability of occupant; young children have high levels of domestic accident as are inquisitive
Security of tenure/temporary accommodation	Can lead to insecurity, stress, etc; lack of stability for children in school, access to healthcare etc; impact on physical and emotional health
Cultural needs	Anomie, alienation, language barriers
Special needs housing	Suitability of housing for actual/future needs e.g. age, disability, ill health
Cold and damp/fuel poverty	Low income, poor housing, poor heating leading to respiratory disease, accident, discomfort, hypothermia etc – young children tend to be in the home environment longer, once have asthma, more likely to be aggravated in the future; lack of heated space may affect issues such as ability to do homework in own room etc
Indoor air quality/pollutants	Poor quality can cause ill-health or death e.g. carbon monoxide poisoning, radon etc
Community	Social cohesion and social capital; support networks; access to health and welfare services; empowerment
High rise municipal flats	Poor design and architecture; socio-economic exclusion; polarised communities
Emotional health/depression	Poor housing environments (e.g. B&B) can exacerbate poor emotional health; learn behaviour from possibly already traumatised/stressed families
Overcrowding	Mainly found in multiply occupied premises (e.g. B&B); increases risk of infectious disease e.g. tuberculosis; education may suffer for lack of space to do homework etc
Noise pollution	Can cause tension, stress
Pest invasion	May result from lack of refuse disposal provision/ architecture etc, rat and cockroach infestations increasingly common
Local crime, nuisance and anti-social behaviour	Children may cause – or be affected by – levels of crime, drug abuse etc within local community

Note: Adapted from Stewart (2005)

Table I.
Health and housing: the relationship

Children and housing as a health determinant

The Public Health Green Paper (Department of Health, 1998) formally acknowledged that housing was a key health determinant and aspect of inequality. Some commentators have argued that housing policy through the 1980s aggravated inequality more than any other policy issue (Balchin, 1995; Malpass, 2005) and that Britain's housing situation today has created an increasingly polarised society (Shelter, 2004). There remains a serious housing shortage in some parts of the country such as the South East leading to an increase in homeless in these areas. The private rented sector remains in particularly poor condition with 50 per cent of the sector categorized as non-decent homes in the 2001 English House Condition Survey (Office of The Deputy Prime Minister, 2003a). Furthermore, many polarised housing estates have skewed concentrations of the poorest tenants and high concentrations of ethnic minorities. Such strict classifications between tenures have caused tension and divisiveness in society (National Federation of Housing Associations, 1985). In addition, the 2001 English Housing Condition Survey (Office of the Deputy Prime Minister, 2003a) reported that black and minority ethnic communities and women headed households (with their children) are over-represented in poor housing and frequently trapped by lack of choice because of their income.

The extent of the homelessness problem in the UK is that the number of homeless households arranged by local authorities under homelessness legislation at the end of December 2004 was 101,030. Of these 84 per cent were in self-contained accommodation such as temporarily leased housing and 16 per cent were in accommodation with shared facilities such as B&B hotels (Office of the Deputy Prime Minister, 2005).

Poor housing and subsequent poor health for children is most acutely manifested through two distinct types of housing: tower block type municipal estates, and temporary B&B accommodation. Whilst it is relatively easy to map multiple deprivation – as well as to longitudinally measure progress – in social housing estates which have a clear geographical boundary, it is less so to track equally deprived, but more dispersed communities in B&B accommodation, who may miss out on necessary support regimes. This paper reviews issues around children's health in polarised social housing estates, before turning to B&B accommodation.

Children and polarised social housing estates

The legacy of tower block type municipal housing from the 1960s and 1970s (see Plate 1) has engendered previously unforeseen problems such as children causing disruption and noise which often resulted in the blocks becoming hard to let "as respectable and ambitious families tried to avoid exposing their children to conditions they could not control" (Power, 1999, p. 285) . Thus, social and economic exclusion is frequently closely related to their unique architectural features and polarised low-income (welfare dependant) communities such as female headed households. Communities – housing large numbers of families with children – have had a high need for services such as good transport links and medical centres, which often went unmet in the past (Power, 1993; 1999).

Coleman, A. (1990) argued that much criminally related behaviour on such estates was a response to the architecture, or due to "design disadvantagement rating". (Power, 1993; 1999) pointed to wider socio-economic issues in communities as key to estate decline and polarisation. Both agree that the characteristics of such estates encourage

Plate 1.
Stonebridge Park, London: before redevelopment

cyclical repetition of social problems for parent(s) and child, such as vandalism and crime reinforcing insecurity, low self-esteem and underachievement.

Coleman's research developed earlier work in respect of the need for (psychic and actual) "surveillance" and "supervision" to help maintain social stability. Where this was lacking, children would learn from peers rather than adults, so gain little sense of respect or acceptable behavioural norms due to the potential for anonymity, escape from detection and lack of routine adult eyes placing boundaries on behaviour. Coleman, A. (1990) argued that such estates could fuel social instability and encourage an increased likelihood of graffiti, littering, family breakdown and criminal behaviour.

What are the solutions?

Many such estates seem so polarised that it is difficult to see a strategic way ahead in regenerating both physical housing conditions and community cohesion. However, Power (1999) has found many estates to have enormous potential by having in place relaxed and friendly interracial community contact and a good level of care taking and cleaning services, seemingly against many odds regeneration of such estates relies on a distinct response closely allied to architectural typology combined with new forms of housing management that necessitate resident involvement at their core,(now deemed "neighbourhood management"), which represents a holistic approach to management. Key to this are new partnerships that are able to address social exclusion, between housing and allied health, welfare, education, police and so on, and which help promote sustainable development through better housing and improved community cohesion through increased social capital.

Within the context of social housing, Coleman, J.S. (1990) defined social capital as being within the structure of relations "between persons and among persons". He stated that it is transitory and often declines with growing affluence. Coleman, J.S. (1990) acknowledged that networks and relationships are easily created and strengthened by adverse circumstances but as key problems are resolved public participation declines. The World Bank defined social capital as the ability of individuals to secure benefits as a result of membership in social networks or other social structures. It is a term that is often used in discussions about deprived neighbourhoods and social exclusion as the growth of social capital is seen as important for improving deprived communities. Social capital is seen as the foundation on which social stability and a community's ability to help itself is built.

Encouraging and developing social capital is an aspect of regeneration strategies and seen as increasingly important in the public health agenda to address inequalities. A development of social capital can help bring positive benefit to communities, notably identity, trust, belonging etc. (Putnam, 1993; 2000). Although, as stated above, deprived areas tend to lack social capital its development offers significant potential for optimising health improvement, particularly in deprived communities when accompanied by regeneration policies (Campbell and McLean, 2002; Cattrell and Herring, 2002; Swann and Morgan, 2002). Children are often seen in a negative light, but present enormous potential to heterogeneous social networks in longer term inclusion, cohesion and integration, helping to lead to community cohesion (Morrow, 2002; Cattrell and Herring, 2002). Indeed, some estates have focused attention on meeting children's needs a priority.

The acute levels of health need in many such estates are represented by higher than anticipated levels of socio-economic and environmental problems, both when compared locally and nationally. Indicators include skewed resident profiles (by age and

ethnicity); low incomes, high unemployment and benefit dependency; high levels of crime; high numbers of lone parent families and children; nuisance from children, such as anti-social behaviour; numbers of households requesting transfers etc.

Regeneration policies have been funded through a range of partnership based initiatives that consolidate housing and wider regeneration budgets focused on deprived areas, such as the Market Renewal Pathfinders, the Decent Home Standard, Single Regeneration Budget, New Deal for Communities as well as allied welfare budgets such as Sure Start and the Supporting People programme (discussed later in this paper). These align to wider health based partnerships, such as (then) Health Action Zones and continuing Healthy Living Centres, new management arrangements involved varied teams of staff and fiscal options to regenerate the estate and provide new opportunities where resident involvement is key to help engender a new sense of community.

Wider options are being made available to address inclusion and tackle poverty, whilst also giving children aspiration for the future and break the cyclical poverty trap from parent to child, with a renewed focus on meeting actual need (i.e. gaps in service provision), not just delivering re-defined and segregated services. Such activities, which are now seen as housing related issues, include supporting individuals in accessing training and employment opportunities through a range of initiatives which include capacity building. Resident involvement activities have also been able to support people in locally devised activities such as community organisations, funding for health workers and drug advice centres and local initiatives to cut crime.

However, what is really key is provision of decent and affordable housing stock in the first place as recommended by Kate Barker for the South East (Barker, 2004) and the government through the establishment of nine Market Renewal Pathfinders which are located in areas of low demand in northern cities and former industrial and mining areas and so lends itself to sustainable community cohesion. An example of redevelopment of the estate shown in Plate 1 to a more traditional construction typology is illustrated in Plate 2.

Children and homelessness: temporary B&B accommodation

The extent of housing inequality is frequently manifested in children as poor health as some 100,000 children are currently homeless. In March 2002 there were approximately 4,000 homeless families housed in B&B hotels for more than six weeks. The government set a target in 2002 that by March 2004 no homeless family with children would be housed in B&B hotels except in an emergency, which should last no longer that six weeks (Office of the Deputy Prime Minister, 2004b).

However, many homeless households are placed in temporary B&B accommodation because of a lack of alternative housing options due to insufficient housing supply, lack of other suitable accommodation, low incomes, inadequate allied services and an increase in women headed households (Styron *et al.*, 2000). In March 2004, the number of homeless families with dependent children in temporary accommodation was 64,340 (Department for Work and Pensions, 2004). For children the situation is particularly acute as increasing numbers of homeless households suffer mental illness, drug/alcohol abuse, child and adult victimisation, inadequate social support and parenting difficulties.

Many children are suffering serious and prolonged illness exacerbated by poor housing conditions. It is widely acknowledged that B&B accommodation is inappropriate for childrens" health and well-being as this aggravates gastroenteritis,

Plate 2.
Stonebridge Park, London: after redevelopment

skin disorders, chest infections and so on, due to inadequate amenities, poor and unsafe conditions (Ballinger, 2002; Office of the Deputy Prime Minister, 2002). In B&B accommodation, the situation is aggravated by unsatisfactory physical living conditions (Arblaster and Hawtin, 1993; Ballinger, 2002; Conway, 1988; Lowry, 1991); overcrowding (which can diminish proper child development and aggravate relationship problems) (Ballinger, 2002; Cumella *et al.*, 1998; Styron *et al.*, 2000; Vostanis *et al.*, 1998); and problems in accessing allied social, support, educational and health care services and loss of earlier services and networks (Ballinger, 2002; Bogard *et al.*, 1999; Cumella *et al.*, 1998; Vostanis *et al.*, 1998).

Homeless families are likely to suffer stress and anxiety, even trauma, before approaching a local authority for re-housing. Their situation is frequently compounded by lack of access to wider services – which cannot replace more sustainable social networks – but can help plug some gaps. As a result, for children health and social care needs may not be sufficiently met, compounding their difficulties. Most homeless households in London include dependant children, pregnant women, domestic violence and relationship breakdown which accounted for some three quarters of homeless applications (Greater London Authority, 2002).

For children, homelessness has a negative impact on well-being. Physical ill health arising from poor housing is well documented, and there is a growing body of evidence concerned with emotional/mental ill health attributable to poor housing (see Table I). Research suggests that the experience can lead to delayed communication, disruption to education and contribute to behavioural and mental health problems (Ballinger, 2002; Bogard *et al.*, 1999; Brown and Harris, 1978; Cumella *et al.*, 1998; Conway, 1988; Shelter, 2004; Styron *et al.*, 2000; Vostanis *et al.*, 1998).

It is clear that homeless children (and their mothers, with whom they most commonly live) suffer unique health issues arising from poor conditions and temporary status, and it is of little surprise that there is a need for coordinated services – including

additional psychiatric help (Styron *et al.*, 2000) – which is not currently met. There have been calls for services to homeless households to be tailored toward actual need (see for example Ballinger, 2002) in partnerships that align housing and health more closely based on statutory – not voluntary – government guidance (Shelter, 2004).

What are the solutions?

Better integration in a network of social relations is known to benefit health. There is a need for increased social cohesion and inclusion through economic integration, reduced unemployment, material security and narrower income differences. community infrastructure and developing social capital are seen as key to impact environmental, behavioural and lifestyle determinants (Wilkinson, 1997; Harrison, 2001).

As mentioned above, additional funding was set aside to reduce the numbers of families with children being housed in B&B, with a deadline of March 2004 (except in an emergency, supported by additional funding) more private sector housing provision (Barker, 2004) and changes to the benefit system. The government is keen to see a revival of the private rented sector through Landlord Accreditation Schemes to support further housing provision and availability, although in general this is the most expensive housing sector to rent compared to council housing or registered social landlords tenancies, the situation is particularly acute in London.

It is generally Environmental Health Practitioners who address poor conditions in private sector accommodation, including B&Bs, but they are unable to meet all the challenges alone. At local level, partnerships have therefore emerged to help deal with the unique issues of families in B&B accommodation. For example, the bed and Breakfast Information Exchange (BABIE), a non-statutory scheme, has since 1988 collated information on B&B hotels and hostels used for homeless households in London (BABIE, 1995), with the objective of promoting standard's in some of the capital's worst accommodation which houses some of the most vulnerable households.

BABIE inspections continue to reveal situations such as high relative numbers of children related to adults in B&B (representing a skewed community suffering overcrowding and over-occupation) where there are inadequate amenities for the number of residents. BABIE is also able to go beyond strict legal requirements and make reference to tenant's "lifestyle" needs, such as access to a washing machine, or facilities for doctors or social worker to visit. Since its inception, BABIE has been able to ensure that some B&B establishments have showed improvements, and some taken out of use. However, with continued demand for accommodation, there is the ever present risk of homeless households being housed in unsatisfactory conditions or conditions in once "suitable" B&B accommodation which have declined due to a lack of regular inspection.

Reintegrating children's housing and health: a role for government

Access into decent housing

The only real solution is decent, secure and affordable housing to help ensure inclusion and the development of health and well-being from the start of a child's life. Housing must be safe, secure, affordable and of appropriate standard. The Housing Green Paper (Department for Environment, and Transport and the Regions, 2000) proposed a renewed focus on a range of housing and health issues. It established a wider strategic approach to address inequality and momentum for improved housing standards, on issues such as inequality, decent homes for all, and protection of vulnerable households.

The subsequent "More than a Roof: A Report into Tackling Homelessness" (Office of the Deputy Prime Minister, 2002) outlined the need for strategic and practical activities to tackle the acute health issues focusing around why people become homeless and the need for sufficient affordable housing. It referred specifically to the complex nature of homelessness in B&B hotels and called for appropriate strategy at local level. The Homelessness Act 2002 now requires every local authority to develop a homelessness strategy to help prevent homelessness, but also to ensure accommodation and support for the homeless and those at risk of becoming homeless. This is the first time that legislation has had such a proactive emphasis. The Act essentially required a needs assessed approach to homelessness to provide accommodation for the homelessness, with an emphasis on security to help alleviate some of the worst excesses of temporary accommodation.

It has, however, been difficult to evaluate the impact of this Homelessness Act for children. Rashleigh (2005) reported from a "Roof" survey of 60 homelessness officers or managers of homelessness units found that 63 per cent felt pressurised to reduce numbers accepted as homeless. Some of the concerns were that while the Act encourages authorities to adopt homelessness prevention strategies, it should not be used as a means of gatekeeping and preventing people from applying as homeless in order to meet government targets. Ongoing problems include a shortage of affordable housing and the restrictions on the use of B&B hotels.

The action plan, "Sustainable Communities: building for the future" (the "Community Plan") (Office of the Deputy Prime Minister, 2003b) consolidated and extended many regimes across housing tenures to help ensure that housing as well as social, economic and environmental community needs are sustainably addressed for the future as part of the public health agenda. The Community Plan advocates partnership approaches to help regenerating declining communities, tackle social exclusion and homelessness and to bring decent homes and communities for all to the core of policy. "Decent housing" includes a home being wind and weather tight, warm and having modern facilities, in reasonable repair with reasonably modern facilities and services, adequate insulation against external noise, adequate size and layout of common areas in flats and reasonable degree of heating and insulation.

Area regeneration strategies such as Market Renewal Pathfinders, have been particularly favoured for social and private sector housing to encourage and consolidate partnership working to deal with the range of issues presented. Partnership approaches have been nurtured to engage communities and stimulate private sector investment. Such activities help demonstrate commitment to an area, and the process is intended to bring long term, sustainable change. This clearly has implications for children as they are able to benefit from the development of sustainable communities, increasing levels of employment and responds to some of the concerns of poor housing outlined above. Such activity has also been supported by "Best Value" since April 2000, requiring review with year on year improvement leading to high level performance agendas nationally in horizontal service integration, particularly in areas of health, community safety, poverty and sustainability. Best Value applies to all local authority housing functions, including regeneration.

In addition, statutory organisations have been encouraged to adopt strategies that more closely related resource input to health outcome. A good example of this is fuel poverty, where low income households spend proportionally more of their income on heating than wealthier households, and households with children need more heating as they are more likely to be at home more often during the day (Department for

Environment, Food and Rural Affairs and Department of Trade and Industry, 2001). Increasingly home improvement agencies (HIA) are offering differing client centred support services with renewed emphasis on private sector resource such as funding and advice on loans, insurance and equity release. There are proposals to reform HIA's part of the "Supporting People" policy, strategic private sector regeneration, debt and poverty reduction, whilst simultaneously addressing related issues of health and housing.

Both "Supporting People" and "Sure Start" can help provide welfare assistance for housing and health related issues. Supporting People offers support to various vulnerable client groups, including homeless families with support need for housing related support, through reviewed and evaluated partnership working. However, Delargy (2004) expressed some concern regarding the lack of coordination and the impact on the homeless, arguing that homeless people move across borough boundaries and local authorities should be working more closely together to decide where best to place local services and hostels. There currently appears to be little information about how Supporting People relates to young homeless children in particular.

Sure Start is key to the Government's drive to tackle child poverty and social exclusion. It particularly seeks to improve health and well-being of families and children under 4, partly through assisting service development in disadvantaged areas, delivered through community based local programmes (Ball, 2002; Barnes *et al.*, 2004). A national evaluation is currently underway to assess its early impact, implementation and cost effectiveness and how it is adding to and enhancing existing services at local and national level. There is an emphasis on improved partnership working focusing on experiences of health, education and community services available (Sure Start, 2002). This is a major challenge as the national evaluation is to run until 2008. Some early concerns have been expressed as to the extent to which communities are included or excluded, the nature and quality of consultation and relationships with the partnership (Ball, 2002). More recent research shows that Sure Start local programme areas continue to experience amongst the worst deprivation in England. The Sure Start areas have more social housing and less owner occupation (although private renting is not specified) than other areas in England, and – in relation to housing – more overcrowding is recorded and crime rates have increased. There remain higher hospitalisation rates than other parts of England for illnesses including gastroenteritis, respiratory infection and severe injury (Barnes *et al.*, 2004), although these have not been related to housing conditions *per se*.

A wider public health agenda

The Acheson Report (Acheson, 1998) argued that higher priority should be given to families with children, including a reduction in income inequalities and improvement of living standards of poor households and an emphasis on the social environment and networks. Recommendations included health inequalities impact assessment, better housing, and a distribution of resources according to need and partnership working.

The Government continues to establish and promote the national policy framework to improve public health, which includes combating social exclusion, supporting families, tackling housing, education and welfare. This has included a range of organisational changes as well as local partnership working and new needs based welfare benefits such as Supporting People and Sure Start to respond to multiple disadvantage and deprivation. Local Strategic Partnerships help provide a wide partnership based focus to the complex and interrelated issues of social exclusion manifested as health inequalities and deprivation indices. The Government argues that

sustainable, socially inclusive communities are central to enhancing local quality of life and local needs based partnership strategies are paramount. This is a pivotal concept in the public health agenda.

A Minister of Public Health was appointed in 1997 to coordinate health policies. The "Saving Lives" White Paper (Department of Health, 1999) encouraged partnership working in delivering solutions to priority issues including poor housing. Partnership working has become more formalised as primary care trusts (PCTs), local authorities and related health organisations are now required to develop joint strategies including local delivery planning (LDP) (led by the PCTs), community strategies (led by the local authorities) and joint strategies such as local strategic partnerships (LSP) and public service agreements (PSA). These seek to provide a new impetus to focus on health determinants and inequalities which more closely focus on addressing health in new ways. See Table II. Most recently, partnership arrangements with other health agencies (including HIAs) have helped achieve more of a holistic focus.

However, whilst this public health agenda is strategically and organisationally well established, concerns have been raised about how cohesive and shared the new strategies, in development, implementation and evaluation (such as through joint health impact assessments) really are (Evans, 2004; Hunter and Sengupta, 2004; Wills and Woodhead, 2004). There is still a major emphasis on targets and target setting (Cordell, 2004) which are not always about partnership based strategic health gain. Shelter (2004) has continued to raise concerns as to inconsistent application of strategies, confusion in partnership roles, poor working relationships and lack of emphasis on housing issues. Key public health documents such as the Wanless's report (2004) continue to point toward issues such as the lack of evidence based practice and the holistic cost effectiveness of practitioner activities. There has been an emphasis on evidence-based policies and finding new ways of tackling determinants of health, with the health development agency (HDA) being established in 2000 to assess policy effectiveness. The HDA is working toward applying the *Learning from Effective Practice Standard System* (LEPSS) system across all government departments to put some of the research into practice (Health Development Agency, 2004). This is still in developmental phase and it remains too early to assess its policy impact through health gain.

The public health agenda and more specific housing policies have enabled more of a focus on childrens' health in recent years, with more of an emphasis on addressing inequality, meeting need and evaluating health gain from policy intervention. Whilst housing is clearly a key health issue for children, the "Choosing Health" Public Health White Paper (Department of Health, 2004) tended to shift away from wider health determinants and toward lifestyle issues. It emphasised the government vision of not being overly intrusive in individual choices and creating mixed massages about what the public health agenda should comprise, such as the extent to which children's health and housing is relevant.

However, "health choices" are not so clear-cut for homeless families and Shelter (2004) has called for more rigorous evidence based partnership services working for this already marginalised community and to ensure that needs are appropriately met.

The government has proposed more of an emphasis on children's health (see Children Bill, 2004). This has generally been welcomed as a means of streamlining children's services and a focus on specific groups such as homeless families. Shelter (2004) argues that the links between housing and health (and wider access to services)

Strategy	Led by	Strategic purpose
Local delivery plan	PCT	Emphasis on health inequality to tackle poverty, poor housing, pollution, low educational standards, joblessness and low pay
Healthy living centre	Joint	Focus on deprived and rural areas, raising awareness on diet, smoking, drink, drugs and activity
Health action zone (now disbanded)	Joint	Priority areas of need; local integrated agreed strategy to sustainably improve health
Local strategic partnership	Joint	Public, private, business, voluntary and community initiatives and services to support and work together; non statutory, non executive organisation; operates closely with individual neighbourhoods – community based decisions, aligned with LA boundaries, clear vision, objectives and commitment to partnerships - seen as pivotal to joined-up approach to tackle key local priority areas e.g. crime, jobs, health and housing
Community strategy	LA	To sustainably promote socio-economic and environmental well-being, partnerships to meet community need; enhance quality of life; long-term vision focusing on outcomes, addressing national and global concerns through local action, needs assessed priorities according to resources
Public service agreement	LA	LAs commit to delivering key national and local priorities in return for operational flexibilities and grants, enabling access to a Performance Reward Fund; focus on exclusion and targets include education, housing and employment and reducing crime and health inequalities, partnerships etc, linked to BV
Best value	LA	Service reviews examine extent of existing services meeting community priorities cutting across traditional service boundaries; LA can fund activities, take on functions currently undertaken by other providers, wide range of service delivery

Notes: PCT – primary care trust; LA – local authority

Table II.
Current strategies to address health (and housing) inequality

are still insufficiently recognised; that the scale or implications of child homelessness are not fully appreciated and there is a need for new models of partnership working to meet need and overcome some of the negative health consequences of poor housing and homelessness.

Shelter's Million Children Campaign, reported in "Generation Squalor" (Minton, 2005) sought to secure government commitment to end bad housing for children. Its research was based on evidence from a partnership of housing and health practitioners, teachers etc., finding that some 1 million children in Britain live in bad housing. Shelter argue that the number of homeless households in temporary

accommodation has more than doubled since 1997 and now affects 116,581 children, which differs from government data. The report said that homeless children risk missing education, suffer poor mental health, live in poor and overcrowded conditions. It called on the government to treble spending on social housing, through a new dedicated Department for Housing and Communities.

Conclusions

Benefits to health should focus around the availability of housing, quality and environmental safety to promote public health and reduce inequalities. In addition to physical housing provision and availability, it is important to reducing homelessness, promote community development, enhance social networks, ensure mixed housing environments, energy efficiency, home safety and removal of hazards.

Of course children and their housing and family income do not sit in isolation, and efforts are being made at national and local level to address need where it is most acute. A variety of policies and organisations are seeking to address this income levels, such as organisations are trying to address in partnerships, which are seen to offer integrated solutions to joined up problems of poverty, poor housing and poor health.

Some of the most deprived municipal tower block estates are now being regenerated and offering children the chance of a more inclusive, sustainable healthy living environment that removes some of the architectural and polarised community issues identified. Far too many homeless children still live in B&B accommodation, which is wholly unsatisfactory. Efforts are being made to reduce numbers being temporarily housed there, by local authorities are frustrated in their efforts by lack of alternatives, although steps have been made in this direction. Partnership working has become paramount, to address housing conditions and area regeneration, but also to maximise income to low-income families and meet other social needs.

Generally, the picture is more positive, but action remains slow Childrens' needs must be given a far higher priority in housing in the future to promote physical and emotional well-being.

References

Acheson, D. (1998), *Independent Inquiry into Inequalities in Health*, Department of Health, London.

Arblaster, L. and Hawtin, M. (1993), *Health, Housing and Social Policy*, Socialist Health Association, London.

BABIE (1995), *London Boroughs Bed and Breakfast Information: The BABIE Hotel Grading System*, The London Research Centre, London.

Balchin, P. (1995), *Housing Policy: An Introduction*, 3rd ed., Routledge, London.

Ball, M. (2002), "Sure start national evaluation: getting sure start started", Department for Education and Science Publications, Nottingham, available at: www.surestart.gov.uk/ensuringquality/research/localprogrammeevaluation/nationalevaluation/

Ballinger, S. (2002), *Home Sick: Shelter and Bradford and Bingley's Campaign for Healthy Homes*, Shelter, London.

Barker, K. (2004), *Review of Housing Supply Delivering Stability: Securing Our Future Housing Needs*, HMSO, Norwich.

Barnes, J., Broomfield, K., Frost, M., Harper, G., Dave, S., Finn, J., Knowled, J., Desousa, C. and the NESS team. (2004), National Evaluation Summary: Characteristics of Sure Start local

programme areas – 2001-2. Department for Education and Science Publications, Nottingham, available at: www.surestart.gov.uk/ensuringquality/research/localprogramme evaluation/nationalevaluation/

Blackburn, C. (1991), *Poverty and Health: Working with Families*, Open University, Buckingham.

Bogard, C.J., McConnell, J.J., Gerstel, N. and Schwartz, M. (1999), "Homeless mothers and depression: misdirected policy", *Journal of Health and Social Behaviour*, Vol. 40, pp. 46-62.

Brown, G.W. and Harris, T. (1978), *Social Origins of Depression: A Study of Psychiatric Disorder in Women*, Tavistock, London.

Campbell, C. and McLean, C. (2002), "Social capital, social exclusion and health: factors shaping African-Caribbean participation in local community networks", in Swann, C. and Morgan, M. (Eds), *Social Capital: Insights from Qualitative Research*, Health Development Agency, London.

Cattrell, V. and Herring, R. (2002), "Social capital, generations and health in east London", in Swann, C. and Morgan, M. (Eds), *Social Capital: Insights from Qualitative Research*, Health Development Agency, London.

Coleman, A. (1990), *Utopia on Trial. Vision and Reality in Planned Housing*, revised edition, Hilary Shipman Ltd, London.

Coleman, J.S. (1990), *Foundations of Social Theory*, Belknap Press, Cambridge.

Conway, J. (Ed). (1988), *Prescription for Poor Health. The Crisis for Homeless Families*, London Food Commission, Maternity Alliance, SHAC and Shelter, London.

Cordell, A. (2004), "Public health and children", *Children and Society*, Vol. 18, pp. 243-6.

Cornell, S.J. (1996), "Do environmental health officers practice public health?", *Public Health*, Vol. 110, pp. 73-5.

Cumella, S., Grattan, E. and Vostanis, P. (1998), "The mental health of children in homeless families and their contact with health, education and social services", *Health and Social Care in the Community*, Vol. 6, pp. 331-42.

Delargy, M. (2004), "Out of Step", *Roof*, Vol. 29 No. 3, May/June, pp. 24-5.

Department of Environment, Food and Rural Affairs and Department of Transport and Industry (2001), *UK Fuel Poverty Strategy*, Her Majesty's Stationery Office, London.

Department of Environment and Transport and the Regions (2000), *The Housing Green Paper. Quality and Choice: A Decent Home for All*, joint publication from the Department of the Environment, Transport and the Regions and the Department of Social Security, London.

Department of Health (1998), *Our Healthier Nation: A Contract for Health*, Her Majesty's Stationery Office, London.

Department of Health (1999), *Saving Lives: Our Healthier Nation*, Her Majesty's Stationery Office, London.

Department of Health (2004), *Choosing Health? Making Healthier Choices Easier*, Department of Health Publications, London.

Department for Work and Pensions (2004), "Opportunity for all: indicators for children and young people", available at: www.dwp.gov.uk/ofa/indicators/indictor-17.asp

Evans, D. (2004), "Shifting the balance of power? UK public health policy and capacity building", *Critical Public Health*, Vol. 14 No. 1, pp. 63-75.

Greater London Authority (2002), "Homelessness in London 38 electronic sources", Greater London Authority, available at: www.london.gov.uk/approot/mayor/housing/homelessness_bull/docs/2002/bull_38_2002.rtf

Harrison, D. (2001), "Integrating health section action on the social and economic determinants of health: The UK response under new labour", Review of Health Promotion and Education, available at: www.rhpeo.org.ijhp-articles/e-proceedings/verona/1/index.htm

Health Development Agency (2004), *Learning from Effective Practice Standards System (LEPSS): Outline Programme 2004-2007*, Health Development Agency, London.

Hunter, D.J. and Sengupta, S. (2004), "Editorial: 'building multidisciplinary public health'", *Critical Public Health*, Vol. 14 No. 1, pp. 1-5.

Lowry, S. (1991), *Housing and Health*, British Medical Journal, London.

McKeown, T. (1976), *The Role of Medicine: Dream, Mirage or Nemesis*, Nuffield Provincial Hospitals Trust, London.

Malpass, P. (2005), *Housing and the Welfare State: The Development of Housing Policy in Britain*, Palgrave Macmillan, New York, NY.

Minton, A. (2005), *Generation Squalor: Shelter's National Investigation into the Housing Crisis*, Shelter, London.

Morrow, V. (2002), "Experience in 'community': implications of social capital discourses", in Swann, C. and Morgan, M. (Eds), *Social Capital: Insights from Qualitative Research*, Health Development Agency, London.

Naidoo, J. and Wills, J. (2000), *Health Promotion: Foundations for Practice*, 2nd ed., Balliere Tindall in association with the Royal College of Nursing, London.

National Federation of Housing Associations (1985), *Inquiry into British Housing Report*, NFHA, London.

National Housing Federation (2002), cited in *London's Housing Facts and Figures 2002*, London Branch of the Chartered Institute of Housing, London.

Office of the Deputy Prime Minister (2002), *More Than a Roof: A Report into Tackling Homelessness*, Her Majesty's Stationery Office, London.

Office of the Deputy Prime Minister (2003a), *The English House Condition Survey 2001: Key Facts*, Her Majesty's Stationery Office, London.

Office of the Deputy Prime Minister (2003b), *Sustainable Communities: Building for the Future*, Her Majesty's Stationery Office, London.

Office of the Deputy Prime Minister (2004), "Number of Families with Children in B&B accommodation on 31 March 2004", available at: www.odpm.gov.uk/stellent/groups/odpm_homelessness/douments/page/odpm_home_028572.hcsp

Office of the Deputy Prime Minister (2005), "Statutory Homelessness: England Fourth Quarter 2004", available at: www.odpm.gov.uk/pns/displaypn.cg?pn_id=2005_0055

Power, A. (1993), *Hovels to High Rise. State Housing in Europe since 1850*, Routledge, London.

Power, A. (1999), *Estates on the Edge. The Social Consequences of Mass Housing in Europe*, Routledge, London.

Putnam, R. (1993), *Making Democracy Work: Civic Traditions in Modern Italy*, Princeton University Press, Princeton, NJ.

Putnam, R. (2000), *Bowling Alone: The Collapse and Revival of American Community*, Simon and Schuster, New York, NY.

Rashleigh, B. (2005), "Keeping the numbers down", *Roof*, Vol. 30 No. 1, January/February, pp. 18-21.

Shelter, (2004), *Toying with their Future: The Hidden Cost of the Housing Crisis*, Shelter, London.

Stewart, J. (2005), "A review of UK housing policy: ideology and public health", *Public Health*, Vol. 119, pp. 525-34.

Styron, T.H., Janoff-Bulman, R. and Davidson, L. (2000), "'Please ask me how I am': experiences of family homelessness in the context of single mothers' lives", *Journal of Social Distress and the Homeless*, Vol. 9, pp. 143-65.

Sure Start (2002), "National evaluation of Sure Start", available at: www.surestart.gov.uk/publications/?Document=103

Swann, C. and Morgan, M. (Eds). (2002), *Social Capital: Insights from Qualitative Research*, Health Development Agency, London.

Townsend, P., Davidson, N. and Whitehead, N. (1988), *Inequalities in Health: the Black Report and the Health Divide*, Penguin, Harmondsworth.

Wanless, D. (2004), *Securing Good Health for the Whole Population*, HM Treasury, London.

Vostanis, P., Grattan, E. and Cumella, S. (1998) "Mental health problems of homeless children and families: longitudinal study", *British Medical Journal*, Vol. 316, pp. 898-902.

Wilkinson, R.G. (1997), "Health inequalities: relative or absolute material standards", *British Medical Journal*, Vol. 314, p. 591.

Wills, J. and Woodhead, D. (2004), "'The glue that binds...': articulating values in multidisciplinary public health", *Critical Public Health*, Vol. 14 No. 1, pp. 7-15.

Further reading

Lewis, H. (2004), *Consultation Response: Shelter's Response to the Government Green Paper "Every Child Matters"*, Shelter, London.

Lewis, H. (2004), *Consultation Response: Shelter's Response to Choosing Health? A Consultation on Action to Improve People's Health*, Shelter, London.

Office of the Deputy Prime Minister (2004a), *What is Supporting People?* ODPM, London.

Corresponding author
M. Rhoden can be contacted at: rm08@gre.ac.uk

Publication 16 Stewart, J., Ruston, A. and Clayton, J. (2006) Housing as a health determinant: Is there consensus that public health partnerships are a way forward? *Journal of Environmental Health Research*, 5 (02), 87-94.

Housing as a health determinant: is there consensus that public health partnerships are a way forward?

Jill Stewart[1] MSc BSc MCIEH FRSH PGCE ACIH, Professor Annmarie Ruston[2] MSc PGCE, Julie Clayton[3] MSc BA

[1] Senior Lecturer, School of Health and Social Care, University of Greenwich
[2] Professor of Health and Social Care Studies, Faculty of Health and Social Care, Canterbury Christ Church University
[3] Research Fellow, Centre for Health Research and Evaluation, School of Health and Social Care. University of Greenwich

Correspondence: Professor Annmarie Ruston, North Holmes Campus Canterbury, Kent. CT1 1QU.
Telephone: 01227 782676. Fax: 01227 784408. Email: a.ruston@blueyonder.co.uk

Abstract

Policy makers have been increasingly interested in measuring the health effects of housing and in gathering evidence to shape policy and recent policy changes in private sector housing have once again brought housing and health issues to the fore. Partnership working is seen by the Government as a way forward to reducing inequalities in health and developing sustainable communities. Seventeen people who are responsible for private sector housing in one area of the South East of England were interviewed to ascertain their role in partnership working and the extent to which evidence-based housing was being promoted within these partnerships. Four main themes were explored: two at the level of the individual practitioner – housing as a health determinant and applying evidence to practice and two at the partnership level – current partnerships and measuring health gain.

The findings suggest that it will be quite some time before those responsible for private sector housing will be in a position to influence the cross agency, cross sector public health agenda within local partnerships. In particular, they need to develop their analytical capacity and refocus their partnership arrangements to move beyond the purchaser/provider relationships.

Public health partnerships were reported as variable in effectiveness. Respondents, although positive about the future contribution of such partnerships to positioning housing as a central health determinant, suggested that there was a need to more clearly define the roles, responsibilities and objectives before they could become really effective.

Key words: Environmental health; health determinants; housing; partnership working; public health.

Introduction

Housing and health

The association between housing conditions and physical and mental ill health has been empirically established through epidemiological studies (Thomson *et al.*, 2001). The relationship is, however, complex comprising of the interaction of poverty, inequality, access to housing and housing as an internal and external living environment. Aspects of housing that affect health outcomes are often described in relation to the internal and external environment. Factors influencing the quality of the internal environment include indoor pollutants, cold and damp, hazardous internal structures and fixtures and noise. Those affecting the external environment include neighbourhood quality, infrastructure deprivation, neighbourhood safety and social cohesion (Taske *et al.*, 2005). The causal links between these different dimensions of housing, neighbourhood, environment and health can operate at a number of interrelated levels. Additionally, as poor housing is also linked to other forms of deprivation, such as poor education, unemployment, social isolation etc, it is difficult to isolate, modify or assess the overall health impact of housing conditions (Taske *et al.*, 2005).

Thus, it can be seen that housing should have a prime place on the health inequalities agenda. It also has wider importance because small health effects can have a large impact at the population level (Thomson *et al.*, 2001). Policy makers have been increasingly interested in measuring the health effects of housing and in gathering evidence to shape policy and recent policy changes in private sector housing have once again bought housing and health issues to the fore for those involved in delivering housing improvements. For example, there has been an increased emphasis on sustainable housing and communities across tenures. Also a growing interest in meeting housing related need at a strategic level e.g. tackling tuberculosis, home safety or fuel poverty, as well as, at a more individual level by, for example, meeting the needs of an older home owner through services delivered by a Home Improvement Agency. More recently, health impact assessments, which have become more important in accounting for health gain arising from policy success, are starting to find their way into the housing arena. It is now recognised that those responsible for improving housing conditions will need to recognise and respond to environmental stressors (see figure 1.0) in order to be able to promote healthier housing and environments (Burke *et al.*, 2002).

Housing policy has increasingly recognised the need for decent housing for all in sustainable communities, with priority given to the most marginal social housing estates (DETR, 2000a; ODPM, 2003a; ODPM, 2004a). There has been an accelerated emphasis on local strategic solutions to housing issues, notably in ways of delivering private sector housing renewal (DETR, 2000b; Stewart *et al.*, 2005). In addition, the Housing Act 2004 introduces a completely new way of assessing housing conditions across tenures through the evidence based Housing Health and Safety Rating System (HHSRS) (ODPM, 2003b; ODPM, 2004b).

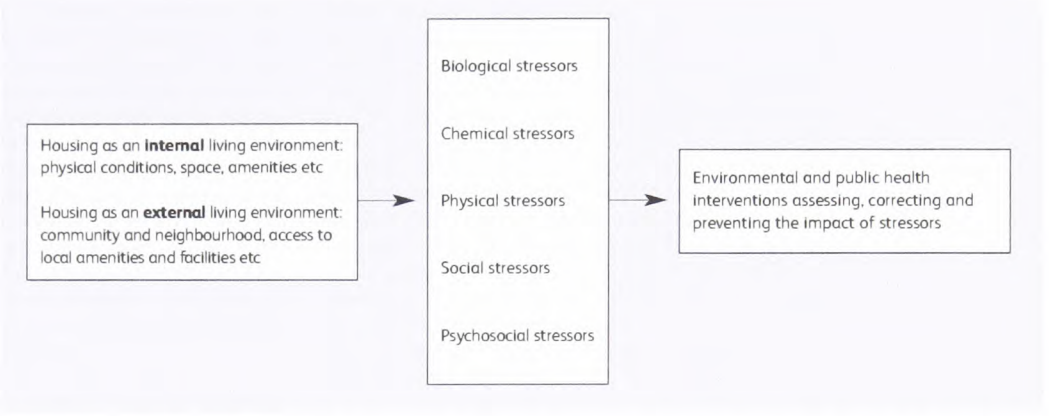


Figure 1.0
Health impacts on housing as a living environment (adapted from Burke *et al.*, 2002)

The Government has set a Public Service Agreement (PSA) target of bringing all social housing into a decent condition – with most improvement taking place in deprived areas and for vulnerable households in the private sector – and increasing the proportion of people who live in homes that are in decent condition by 2010 (ODPM 2003a, 2005a, 2005b). This represents a considerable task given that in 2001 there were 6.7 million households living in non-decent homes, of which 5.2 million households lived in the private sector and 1.5 million were social tenants. Much of this work will be of concern to those environmental health and/or housing officers who have responsibility for private sector housing.

These policy changes present challenges for local authorities that are seeking to ensure that housing stock in their area is contributing to the overall health of their population. However, local authorities should no longer be alone in meeting these challenges. The public health agenda – with its emphasis on partnership working to address health inequalities – now offers the potential for joint working to help meet the complex interrelationships of health and housing. Indeed, public health is an integral concern within urban planning processes relating to the physical and social environment (Taske *et al.*, 2005). Partnership arrangements including Local Strategic Partnerships, Community Strategies and Local Delivery Plans should help those charged with delivering healthier housing to access a wider range of resources to meet their targets. However, although the new partnerships are well established in theory, concerns have been expressed about whether the partners are really working together and sharing values, focus, vision, direction and objectives (Evans, 2004; Hunter and Sengupta, 2004; Wills and Woodhead, 2004). Barriers include unresolved issues in partnership working, capacity problems, organisational changes and differing performance management regimes. Indeed, it has also proven difficult, so far, to assess health gain arising from some local partnership strategies, such as fuel poverty even where the strategy itself has received national recognition in its development and implementation (Stewart and Habgood, work in progress).

It is within this context that the research reported here sought to explore, in particular, private sector housing managers/officers perceptions of housing as a health determinant, the extent to which they felt able to promote housing on the public health agenda within public health partnerships and whether partnerships result in cohesive, evidence-based, joint strategies for private sector housing renewal.

Methods

The overall objectives of the study reported here were to:

- Ascertain private sector housing managers/officers perceptions of housing as a health determinant;
- Examine the extent to which private sector housing mangers/officers feel they influence joint planning through public health partnerships;
- Ascertain the extent to which joint plans influence private sector housing renewal;
- Investigate the extent to which the HDA/NICE Evidence Base informs practice and strategy development.

One county in the South East of England provided the geographical parameter for the study. Each local authority in the County, the County Council, the Unitary

Authority and a sample of housing associations was contacted to identify who within the organisation was responsible for private sector housing renewal. This task proved to be difficult because in some organisations the responsibility was with the environmental health department, in others it was the housing department and in some it was not clear who had responsibility for the private sector. Additionally, the people identified as having responsibility for private sector housing were not necessarily the same as those that engaged in partnership working. Tracking down suitable respondents took a considerable degree of persistence and time. In total 20 organisations were contacted and interviews eventually secured in 17 of these.

Two sources of data were accessed. First, each organisation that was contacted was asked to provide its policy documents relating to public health and housing. Once assembled, these were read and analysed in order to examine the extent to which housing was identified or raised as a health determinant, which aspects of housing were covered within policies and strategies for dealing with problems identified.

Second, semi structured telephone interviews were held with key representatives within the organisations selected. An interview guide was used and questions covered the nature of the public health partnerships that respondents were part of, how health determinants were categorised and prioritised in the partnerships, their views on housing as a health determinant, housing-related strategies delivered by the partnerships, how housing was promoted within the partnerships, whether they were evidence-based and any barriers to joint working.

The interviews were tape recorded and transcribed verbatim. Analysis was conducted using a cut and paste technique for content analysis (Kippendorf 1980). The content analysis utilised four separate passes through the transcripts to cover all evolving categories. Patterns and meanings emerging were then identified.

The data from the semi-structured interviews and analysis of publications have been synthesised to address the study objectives.

Results

The major focus of public health is on improving health and reducing inequalities and the public health agenda has been concerned with organisational change to the NHS to deliver public health through PCTs' partnership arrangements with other organisations, notably local authorities (Stewart, 2005). In order to examine the potential of those with responsibility for private sector renewal to be able to effectively influence the public health agenda within these partnerships, it is useful to explore a number of factors which might affect the way in which they engaged with the public health agenda. Factors include first, those specific to the individual; that is the way in which housing is perceived as a health determinant and their use of evidence to inform practice. Second, those relating to partnership working; that is the way in which housing is prioritised on partnership agendas, the extent to which partnerships have cohesive, shared objectives and the measurement of health gain from housing interventions.

Individual level – housing as a health determinant

Health and housing were described as being very much interrelated by most respondents with the majority referring to the internal housing environment as a main source of problems that could potentially affect the health of residents:

> *"My personal opinion is that housing has a very detrimental effect – if we have poor housing conditions yes; that has a very direct correlation with health. In particular damp housing, houses that are not easy to heat, fuel poverty, all have a direct effect – there is no doubt in my mind that this is the case and that is one of the reasons why we try and deal with all of those issues in the various bits of grant money that we do have." Int 5*

A smaller proportion also identified external environmental factors that were considered to potentially influence health:

> *"Yes, basically things like rubbish accumulation, nuisance from noise, problems with burglary – home safety really." Int 10*

In line with research evidence about the relationship between housing and health, respondents described physical and mental health consequences for residents of living in poor housing:

> *"I think there is a clear link...obviously it's around the physical connection in that poor standard accommodation links directly to illnesses and problems that are easily and readily identified – whether it's dampness and chest infections and those sorts of things that arise from that, or whether*

it's around the other areas which aren't often readily identifiable, about the effects that poor quality housing has on people's own aspirations and their mental health." Int 17

They also generally reported that the new Housing Health and Safety Rating System (HHSRS) would shift the emphasis away from housing defects towards dealing with people's health and safety needs – moving away from bricks and mortar to the occupiers. Thus respondents' descriptions revealed a public health perspective of the relationship between housing and health and a clear understanding of the evidence of housing factors that could affect health. However, housing was only specifically mentioned in relation to health in two of the policy documents analysed.

Individual level – applying evidence to practice

The written policy documents revealed that some organisations had carried out local surveys of the state of their housing stock and the existence of evidence of the effects of poor housing on health. A number of respondents also mentioned the existence of research evidence relating the effects of poor housing on people's health but they were considerably less confident about the use of evidence to underpin practice. In order to tease out the extent to which evidence was informing their individual practice respondents were asked if they used the public health evidence provided by the Health Development Agency (now part of the National Institute for Health and Clinical Excellence). Although respondents reported that they had not themselves accessed this type of information they felt that it may be possible that others within their organisation would have done so:

"It's not something that I have referred to, but it could be something that my officers who are responsible for the strategy may well have referred to. We certainly refer to health data in terms of prevalence around learning disability and mental health in order to develop needs analysis which reflects national or regional prevalence, so that we can try and direct our resources appropriately to the service user groups that need it most." Int 15.

Clearly, when needing to produce policy documents respondents would expect to include health statistics but not necessarily be aware of any evidence of what constitutes effective housing interventions or routinely apply it to practice.

Partnership level – current partnerships

Respondents were asked about the public health partnerships that they and their private sector housing colleagues were involved in. Three respondents reported being unsure about whether there were any partnerships and a further three reported that they thought there were partnerships but that they themselves were not involved:

"I don't know that there are any formal ones whatsoever. Our role is very much a reactive role. The section that I look after is very small – myself and two other officers, field officers and half an admin person – so private sector housing is three and a half people basically all together. So we are almost always reacting to complaints and investigating complaints and there is really very little, if any, proactive work going on." Int 8

The remaining respondents (11) were able to identify at least one public health partnership that they were involved with. However, respondent's descriptions of the nature of these partnerships varied from partnerships that were perceived as a form of monitoring of services,

"At the moment the only formal agreement we have is with 'Supporting People' which is obviously a government initiative – it comes out of the Deputy Prime Minister's Office. Those are our regulators if you like. They monitor our service delivery and make sure that what we are providing is adequate and is also value for money and needed in the local area." Int 4

to partnerships where respondents (3) described their umbrella organisation taking a lead role:

"I mean the chief executive – he actually chairs the Health Policy Board which comprises of all the local authorities, the PCTs and they are sort of fully engaged with the health agenda and are members of the Teenage Pregnancy Group. We have a multi-agency joint assessment and referral procedure for social housing etc., which is under the Supported Housing Needs Scheme." Int 6

Partnership working was reported as a political necessity but it was clear from respondents that they perceived the effectiveness of public health partnerships in relation to achieving a shared vision and objectives to be variable. Respondents views varied from one extreme where partnerships were seen as successful in meeting the public health agenda and containing housing targets,

"We have input in the local strategic partnership and we have actually got some indicators in there of how well we are doing and we have taken that a step further with the County Council because they are an 'Excellent Authority'. They are able to exhibit some freedoms if you like from control from central government, and they have come up with agreement where they have agreed with all local authorities that they will be delivering on certain issues, and there are a couple of housing targets we have put in there." Int 5

through a middle ground perspective where respondents were positive that in future partnership working would become more effective from a housing perspective,

"I think the other element that will work when it's a bit more defined, but it's certainly a start, is the Community Plan, where we have fed in elements of our housing strategy, the PCT have fed in elements of theirs etc., but at the moment it's quite a cumbersome document and as a result I think the danger is it will gather dust unless it can, in that sense, be made a bit more relevant. But I think there is real potential there for working that up, so that there will be some better defined common outcomes and aims and objectives basically." Int 13

to the other extreme where housing was seen as incidental to the main business of the partnership:

"Well, we tend to have meetings about different subjects but in terms of housing, I have to say that the meetings are limited to my knowledge and as I say it's because of the fact that it's not... high on the agenda. If it's an opportunity to develop housing, fine, or opportunity to purchase land or something of this nature, so that we can move forward with other strategic objectives." Int 9

Partnership level – measuring health gain

One of the ways of showing the effectiveness of joint strategies would be to ascertain whether health gains arising from the joint plans, and housing interventions in particular, are considered and measured. Generally speaking, respondents considered the area of achieving and measuring health gain to be problematic and alien to their sphere of work. For example, the following respondent felt that the collection and analysis of that type of data was beyond their skills. Respondents reported being more likely to make assumptions about the effectiveness of any intervention rather than obtaining definitive evidence:

"We have got a renewal area here and the idea is to try and improve the area, to improve the conditions for the people, in part, who are living there now. So yes, it's always going to have an effect on them and we are aware of that, but for us it's a slightly different thing. Because we are not looking at the collection of, say, health statistics the way people like the PCT are, we are not aware of what we might be doing having a direct effect on an individual's health or even the health statistics in the area. Somebody else would probably look at that because we wouldn't necessarily comprehend the statistics... we are not really competent to say whether or not the statistics were collected properly or not, so we wouldn't know if it was actually having a long term effect – we would just believe it would. We wouldn't be able to prove it, to be fair, because it would take too long for somebody to collect the statistics to prove it." Int 3

Respondents reported being in favour of being able to provide evidence of effectiveness, particularly in light of the requirements of the new Housing Act, but again felt that it was very difficult to achieve:

"This has proved difficult because it would be ideal, particularly with the falls prevention to see if housing intervention has decreased the hospital admissions ...unfortunately we haven't been able to do that as yet, but it is something that would be really great, particularly with the new legislation coming on board sort of thing. It is part of the Falls Strategy Action Plan to gain the evidence because obviously a lot of funding rests on evidence base etc and particularly with health it is quite difficult sometimes to actually gain that evidence base that ...as a result of housing action has actually contributed to that health effect sort of thing. It is quite difficult. So yes, it is quite difficult to back up – even though you know it's commonsense really that you are sure it's true." Int6

Ensuring effectiveness of joint plans and housing interventions was, however, considered to be dependent on the setting of clear strategies and defined outcome measures and partnerships were considered to be some way off achieving the required common strategies. Nevertheless, the future potential was reported:

"There is a lot of scope for better joint working, common strategies and input into one another's strategies and defining outcomes. The end result of that, of course, is that the impact of programmes on health gain isn't best defined or evaluated because

that's the end product and I think the sooner we move to having better defined outcomes at the start and commonality of data collection in terms of targets and objectives to say the least then I think the faster we will move to a clear assessment of 'OK, what have these programmes achieved in terms of health and health improvement?'" Int 13

Partnership level – how is housing promoted within partnerships?

To further explore the extent to which housing was seen as a health determinant within partnerships, respondents were asked how housing was promoted and prioritised. A dichotomous response emerged: either respondents were not aware of any means by which housing was promoted as an issue:

"It's not really. Again, I think it's probably incidental rather than actively promoted." Int 8

Or they reported that it would be achieved by a process of representation:

"I guess it's promoted really directly at the meetings that the various officers have. I am obviously involved in all of them, but I think really we are always – when we come across primary care personnel – we are always beating the drum about housing because it's something that they come struggling to. As I say they are not really necessarily seeing that they need to do anything." Int 9

"That's a hard one, really. Other than through representation... I think the process is more trying to be involved with other agencies, where it seems appropriate to be involved and through that, in a sense, to champion the housing issues when it is right to do so. So our Housing Strategy Development as an example started off with involving all agencies in what the issues are. So part of that process is to get everybody else involved in the housing issues, so that the actual development of the strategy itself is done across agency and with a large number of people." Int 11

It was evident from respondents' discourses that partnership working was valued but that as yet it was not fully developed in relation to tackling housing as a public health issue. The majority of respondents described partnerships in terms of groups or organisations working together out of necessity. Successful partnership working was, therefore, localised and was more akin to joint working to meet individual organisations' objectives or to meet individual needs:

"Well, a lot of the time it is essential; we wouldn't have got anywhere with our grants if we hadn't had Care and Repair. I mean, we have worked with them for a long time...and we were able to get them to do an awful lot – or they can do an awful lot for us. If they hadn't been there; we wouldn't have spent the money, we wouldn't have got the work done to be honest." Int 3

"The Supporting People – local plan – that's been very effective. Basically, that is for people with housing needs that have some Supported People input, whether it be as a result of mental health conditions etc. or they are vulnerable etc; then all the parties come together and actually sit down and discuss their housing needs and where it would be perhaps suitable." Int 6

The data suggests that partnerships could potentially provide the means by which housing is promoted as an important health determinant and by which evidence of the effectiveness of housing interventions to reduce inequalities could be collected and disseminated. However, partnerships need to develop further before this becomes a reality and before housing is proactively tackled as a major cause of health inequalities. Respondents reported reacting to policy requirements as the focus of their work rather than being in a position to drive the public health agenda forward – partnership working has not fully facilitated this move.

Discussion

The Government has set out its vision for creating genuinely sustainable communities through Community Strategies and Local Strategic Partnerships (ODPM, 2005). Local Strategic Partnerships are expected to develop a common vision for a more sustainable future which is based on an in-depth analysis of the specific needs of the area and which results in priorities that can be translated into meaningful outcomes. The Sustainable Community Strategy is envisaged as performing an over-arching role to ensure effective and transparent allocation of resources in the locality. They will set out a vision of an area and co-ordinate and drive the delivery of local services leading to improved outcomes for citizens that go beyond the remit of any one partner. Key to this will be the ability to influence the polices and structures of partner agencies. This is expected to address some of the problems created by individual agencies or thematic partnerships that have developed local plans entirely separately (ODPM, 2005).

In particular, it is expected that housing strategies should be developed with reference to the Sustainable Community Strategy.

Given the central position of housing in the health inequalities agenda it will be important for those who are responsible for housing to be able to ensure that local housing evidence is translated into potential health outcomes and that these are articulated within the key public health partnerships by influencing the policy and practices of partner organisations.

However, the data from the study reported here suggest that there is some way to go before this can be fully realised. A number of themes emerged which are of importance. First, respondents tended to view partnerships as an essential means of delivering individual housing-related* policies rather than integrated public health policies across partnerships. Thus, partnerships were successful where good relationships had been established between the housing staff and those who were delivering services on their behalf. Thus, narrowly focused views about the role of partnerships tended to limit the potential for respondents to articulate a clear housing/health vision.

Second, respondents were unclear about how they could contribute to both the assembly and implementation of evidence-based housing strategies to improve the health of the population. In a situation where they were unclear how to action this in relation to their own work, it was unlikely that they would be able to articulate and strongly influence the agenda of other organisations, particularly the health services. Indeed respondents indicated that not only did they not have the requisite skills or analytical capacity but they did not see it as part of their remit. In these circumstances, the partnership agenda may well be medically dominated in relation to health and health inequalities.

Third, it was evident both from the data and from the range of individuals and organisations that it was necessary to access to determine who was responsible for private sector housing that this is not a homogenous group of professionals. Therefore, it would be difficult for them to collectively influence the public health agenda. The majority of respondents indicated that the only way in which they contributed to the strategic development of public health was through representation on various partnerships but they were not necessarily achieving their aim of influencing health care or primary care trusts about the importance of housing and health.

Thus, although the majority of espondents considered that housing represented a key health determinant, they were not necessarily being successful in raising its profile on the public health agenda within partnerships. Nevertheless, partnerships were viewed positively and expected to be of value in the future providing there were clear and measurable objectives set. There would need to be joint plans which were monitored within each organisation in relation to the overall public health strategy set by the partnership and each partner would need to have a mutual understanding of how each organisation worked. This again presents a problem in relation to private sector housing as the role is not clearly defined, nor is the organisational structure within which it sits.

Thus, although partnerships were viewed as the way forward in the future, it was clear that there is a need to develop the public health role of private sector housing officers before they will be in a position to effectively promote housing as a health determinant within partnerships. In particular housing officers' analytical capacity, use of evidence-based housing solutions and strategic approach to problem solving needs to be further developed.

Conclusions

Housing conditions have been associated with both physical and mental health problems, housing variables make deprivation indicators a good proxy for morbidity and it is clear that tackling inequalities in housing also addresses health inequalities (Smith *et al.*, 1997). Partnership working is seen as the way forward in devising cross-agency and cross-sector solutions to health inequalities though the sharing of resources and plans. However, if housing is to take centre stage in this process, the impact of private sector housing needs to be acknowledged and those responsible for this area of work need to be able to influence the public health agenda more effectively within partnerships.

Acknowledgements

This research was part funded by a research grant from the Chartered Institute of Environmental Health.

References

Burke S, Gray I, Paterson K and Meyrick J (2002). Environmental Health 2012: A key partner in delivering the public health agenda. London, Health Development Agency.

Department of Environment, Transport and the Regions (DETR). (2000a). A Decent Home: the revised definition and guidance for implementation. Sections 1&2. London, DETR.

Department of Environment, Transport and the Regions (DETR). (2000b). The Housing Green Paper. Quality and Choice: A decent home for all. London, Joint publication from the Department of the Environment, Transport and the Regions and the Department of Social Security. Available online at *www.communities.gov.uk* [Accessed 20/07/06].

Evans D (2004). 'Shifting the balance of power?: UK public health policy and capacity building' in *Critical Public Health*, 14, issue 1: 63-75.

Hunter D J and Sengupta S (2004). Editorial: 'Building multidisciplinary public health' in *Critical Public Health*, 14, issue 1: 1-5.

Kippendorf K (1980). Content analysis: an introduction to its methodology. Beverly Hills Sage.

Office of the Deputy Prime Minister (ODPM). (2005). Local Strategic Partnerships: Shaping their future – A consultation paper. London

Office of the Deputy Prime Minister (ODPM). (2005a). Sustainable Communities: Homes for all. London, ODPM

Office of the Deputy Prime Minister (ODPM). (2005b). Sustainable Communities: People, Places and Prosperity. London, ODPM

Office of the Deputy Prime Minister (ODPM). (2004a). A Decent Home: the definition and guidance. London, ODPM.

Office of the Deputy Prime Minister (ODPM). (2004b). Housing Health and Safety Rating System Guidance (Version 2). London, ODPM. Available online at *www.communities.gov.uk* [Accessed 20/07/06].

Office of the Deputy Prime Minister (ODPM). (2003a). Sustainable Communities: Building for the future. London, ODPM. Available online at *www.communities.gov.uk/* [Accessed 20/07/06].

Office of the Deputy Prime Minister (ODPM). (2003b). Housing Bill – Consultation on draft legislation, London: HMSO. Online. Available *www.communities.gov.uk* [Accessed 20/0706].

Smith S, Alexander A and Easterlow D (1997). Rehousing as a health intervention: miracle or mirage? *Health and Place*, 3 No. 4, 203-216.

Stewart J, Bushell F and Habgood, V (2005). *Environmental Health as Public Health*. London, Chadwick House Group Ltd.

Stewart J and Habgood V (work in progress) The benefits of a Health Impact Assessment in relation to fuel poverty: assessing Luton's affordable warmth strategy and the need for a national mandatory strategy.

Stewart J and Gray I (2005). Health and Housing, *Environmental Health Journal*, 113 (06) pp. 24-25. Available online at *www.ehj-online.com/archive/2000/june2005/june6.html* [Accessed 20/07/06].

Stewart J (2005). A review of UK housing policy: ideology and public health. *Public Health*, 119, 525-534

Taske N, Taylor L, Mulvihill C and Doyle N (2005). Housing and public health: a review of reviews of interventions for improving health. *Evidence Briefing NICE.*

Thomson H, Pettigrew M and Morrison D (2001). Health effects of housing improvement: systematic review of intervention studies. *British Medical Journal*, 323, 187-190.

Wills J and Woodhead D (2004). 'The glue that binds …: articulating values in multidisciplinary public health'. *Critical Public Health*, 14, issue 1: 7-15.

Publication 17 Stewart, J., Clayton, J., and Ruston, A. (2006) Encouraging and enabling owner-occupiers to maintain their homes: an exploratory study, *Property Management*, 24 (05), pp. 449- 463.

Encouraging and enabling low-income owner-occupiers to maintain their homes

An exploratory study

Jill Stewart and Julie Clayton
School of Health and Social Care, University of Greenwich, Eltham, UK, and
Annmarie Ruston
School of Health and Social Care and Centre for Health Research and Evaluation (CHRE), Eltham, UK

Received May 2005
Revised November 2005

Abstract

Purpose – The purpose of this paper is to show that owner occupation has become the prevailing tenure in the UK with owners increasingly being seen as holding primary responsibility for the condition of their properties. The UK has had a long tradition of public sector enforcement and grant-led intervention to help preserve the nation's private sector housing stock. Recent housing policy changes have subsumed earlier grant legislation and provided a general provision for "assistance" to help owner-occupiers maintain and repair their own homes. Simultaneously, the role of local authorities continues to shift from provider to enabler of service, with greater discretion and an increased role for other agencies at local level.

Design/methodology/approach – This paper shows the focus group discussions that were held in South London to explore what low-income owner-occupiers in an ethnically-diverse area would find helpful from the local authority in carrying out maintenance and repair works to their homes.

Findings – This paper reveals that some of the wider policy options put forward by the government were not always what respondents favoured, but that many would like to carry out further maintenance and repairs, given the right resource and support opportunities.

Research limitations/implications – The paper contains an exploratory study, limited to homeowners aged over 60.

Practical implications – The paper suggests that a range of resource and support mechanisms are required for home-owners to carry out works to their homes as private sector housing grants continue to decline.

Originality/value – The paper seeks to put national private sector housing renewal policy into strategic practice at local authority level in helping ensure that home-owners receive the most appropriate means of assistance and support in carrying out works to their homes.

Keywords Housing, Grants, United Kingdom

Paper type Research paper

This research was commissioned and funded by the Bellenden Renewal Area, London Borough of Southwark. The views represented are those of the authors and not those of the officers at the Renewal Area.

Property Management
Vol. 24 No. 5, 2006
pp. 449-463

0263-7472
DOI 10.1108/02637470610710510

Introduction

An ideological trend favouring owner occupation and "personal responsibility" began in the Conservative administration after 1979 and has been continued by the current Labour administration. Nettleton (1997) states that, "contemporary forms of welfare are increasingly requiring that individuals take personal responsibility for their own future and purchase goods and services which are designed to meet their personal requirements. A range of risks are presented by the 'experts' and it is up to individuals to calculate the likely consequences of certain actions for themselves."

Such an emphasis on "personal responsibility" is now inherent in private sector housing policy as the government role has shifted from service provider to enabler. The government's policy intentions were clearly established in 1996 when the then Department of the Environment (DoE, 1996: paragraph 2.2.1) stated that:

> Private housing is a private asset. Owners are responsible for its repair and maintenance. Many owners can afford to repair and maintain their properties to an acceptable standard. An effective strategy should aim to encourage owners to keep properties in good order by making them aware of the importance and longer term cost benefits of doing so.

Despite a change of government, Ministerial Foreword to the Housing Bill 2003 (ODPM, 2003a), stressed that:

> Four-fifths of households in England and Wales live in the private sector, whether renting or owning their own home. Responsibility for these homes must rest first and foremost with the homeowner or the landlord, but Government recognises that it has to ensure that those in the private sector, as much as those in social housing, have the opportunity of a decent home.

The private sector now accounts for some 70 per cent of housing stock (ODPM, 2003b, c), and the figure is rising, including amongst lower income groups who were previously unable to access mortgages. This has substantial implications for housing tenure and responsibility for issues allied to owner occupation, notably ensuring that private sector housing stock is maintained, repaired and improved.

The UK has had a long tradition of an interventionist grant policy to help repair and improve the nation's private sector housing stock. This is to help prolong its life as well as to help to ensure a healthy living environment (for further discussion see Stewart, 2001, 2003a, b). However, such interventionist policy has been increasingly questioned since the Local Government and Housing Act 1989 (when mandatory grants were means tested and related to statutory fitness) and the Housing Grants, Construction and Regeneration Act 1996 (when grants became discretionary), see Table I. Alongside a wider sea change to encourage personal responsibility, capital budgets for private sector housing renewal have been in general decline (Wilcox, 2001). This represents a shift from public to private sector spending on private sector housing renewal, as well as raising questions as to the objectives and direction of grant policy (see, for example, Leather, 2000; Mackintosh and Leather, 1993; Revell and Leather, 2000).

Essentially, research points to the fact that there is currently insufficient self-initiated and funded maintenance, repair and renewal, possibly brought about to some extent by a culture of dependency on grants (DETR, 2000a, 2001, 2002; Mackintosh and Leather, 1992). Whilst this might be true, there remain too many low income households who are not in a position to afford necessary maintenance and repairs to their homes, and it is normally low income households (particularly ethnic

Act	Key grants/assistance purpose
Local Government and Housing Act 1989	Introduction of mandatory means tested house renovation grants based on revised fitness standard Introduced home repair assistance (small scale grant) Introduced renewal areas and group repair schemes
Housing Grants, Construction and Regeneration Act 1996	Shift from mandatory to discretionary grants further proposals for renewal areas and group repair schemes home repair assistance extended
DoE Circular 17/96	Guidance on private sector renewal activity, emphasis on local housing strategies and home-owner responsibility
The Regulatory Reform (housing assistance) (England and Wales) Order 2002	Subsumed existing grant legislation into new local authority power to provide "assistance"

Source: Adapted from Stewart (2003b)

Table I.
Recent legislation in private sector housing regeneration

minority and lone parents) who occupy the poorest housing stock (ODPM, 2003b). They are normally those with the greatest housing-related health risks with least (financial) ability to do much about it (see, also, Easterlow *et al.*, 2000). The government drive is for homeowners to take more responsibility for their housing conditions, but is this possible? The situation is complex, since it is at the interface to the government/community/individual relationship. In addition, a local authority's strategic housing objectives will not necessarily go hand in hand with what owners may choose to spend any of their income on.

Although the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 brings with it substantial change to local authority housing renewal strategies, there has been very little research into the practicalities of how this might be implemented, and with what possible success. Essentially the change is about levering in additional private sector finance, and the preferred options emerge as targeting grants more effectively, home improvement loans and increasing emphasis on equity release schemes (Mackintosh and Leather, 1992; DoE, 1996; and DETR, 1998). However, working with the private sector is essentially individual and market-driven and not necessarily related to property condition. Some private sector schemes can be expensive and have in the past given cause for concern (such as risk of possible debt or repossession arising from some equity release schemes. Note: here equity release refers to freeing up existing capital from the property to finance current works as a form of loan to be paid back on the sale of the property, plus interest). The market has not really provided much by way of replacement to grants, but the government is focusing in this area. For other options, see Table II.

Many homeowners are not financially, technically, organisationally or otherwise able to maintain their own homes, although this sector is favoured and the government is seeking new ways of levering in private finance. This research was conducted to investigate what lower income owner-occupiers may find useful in helping themselves to maintain their properties, set against the policy background discussed above. This paper presents research exploring what homeowners in an established Renewal Area within South London would find helpful as support from the local authority in enabling and assisting them to carry out maintenance and repairs to their homes.

Initiative	Organisation responsible
Private sector housing grant	LA and/or HIA
LA home improvement loan	LA
Equity release scheme	Private sector or new not-for-profit organisation
Handy person services	Scheme facilitated by LA, HIA, voluntary sector, etc.
Subscription based emergency repair services	Private companies, funded by charging client
Subscription based maintenance service	Local building companies may be managed by LA
Money advice	LA, citizens advice, voluntary sector, etc.
Advice and information	LA, HA, HIA, etc.
Home maintenance surveys	LA, HA, HIA, etc, either free of charge, or fee to cover costs
Tool loans	LA or community based organisations
Home maintenance training	LA as well as possible funding from other organisations
Volunteering schemes	LA and/or existing community groups
Builders list	LA or community group
Maintenance strategy	LA led
Do-it-yourself (DIY)	Private sector, instigated by home owner

Table II.
Options for home maintenance and repair: organisations and resource opportunities

Notes: LA = Local Authority; HIA = Home Improvement Agency; HA = Housing Association
Source: Adapted from Stewart (2003b) and based on Leather (1998); Mackintosh and Leather (1992); DoE (1996); Davidson *et al.* (1997); DETR, (2000b) and Davidson and Leather (2000)

Methods

In order to meet the overall aim of supporting the development of new policies to enable homeowners to take more responsibility for effective home maintenance, a series of focus groups were conducted. Focus groups are effective for addressing the type of research questions being posed in this study for a number of reasons. First, they enabled data to be collected from a group of people more quickly than individual interviews, second, the researcher was able to interact directly with the respondents to probe and clarify responses, and finally, the open response format of the focus groups provided an opportunity to obtain large and rich amounts of data in the respondents own words with the advantage of participant interaction. The main disadvantage of focus groups, however, is that they are limited in their generalisability to a larger population.

Interviewees were selected from the Renewal Area in conjunction with the local authority to reflect both the segment of the local population considered most likely to find difficulty in maintaining their homes and the local ethnic mix. Three focus groups were undertaken, each comprising approximately ten respondents aged over 60 years, some of who had in the past, received assistance from the local authority. This group were typically lower-income owners in the area, and available to participate in the groups. Each groups lasted for around 1.5-2 hours each. The topic protocol used to guide the discussions covered the following areas: respondents' understanding and skills in relation to home maintenance; their perceptions of the value of undertaking home-maintenance; factors that acted as barriers and those that facilitated home-maintenance; and their perceptions of what constituted disrepair and their perceptions of what would be of value in supporting them to prevent their property getting into a state of disrepair and/or putting it back in order. A series of prompts were available to the researcher.

The focus group discussions were led by an experienced researcher/moderator. They were tape-recorded and transcribed verbatim. The data were analysed using content analysis, which is a technique for making replicable and valid inferences from data to their context. The analysis, was conducted separately, by two researchers, to ensure all relevant themes are identified, and verified.

It is important to note that the Renewal Area is sited within a progressive authority which has offered a participative approach to residents in the context of housing and area regeneration for a period of years. As such, it is acknowledged that responses may to some extent be atypical, but results are presented as arising from this study.

Results

The findings of this study are presented under two main headings as:

(1) Barriers identified.

(2) Facilitating factors in assisting and enabling homeowners to maintain and repair their homes.

1) Barriers identified preventing homeowners from maintaining and repairing their homes

i) Available finance

The primary barrier to maintenance and repair was that of available finance, concerned with both level of income and the (likely and actual) cost of maintenance and repairs: "Having enough money yes, number 1". However, the extent to which financial issues either enabled or prevented respondents from carrying out the maintenance and repair was difficult to identify. Although many respondents were restricted by a lack of funds, this was not universally the case.

The way in which respondents could find, identify or access funds differed widely and was very individual in nature (e.g. one suggested just getting an overdraft), and only one person of all the respondents set aside a particular "home maintenance budget" for routine maintenance and repairs. Funding, tended to be ad hoc, and very individual in nature, relating to personal situations arising, and other priorities in respondents' lives. There was however, some agreement that it would be wise to put some money aside each month to pay for maintenance and repairs and plan more effectively for the future.

ii) Builders

A number of issues were raised in connection with builders, mainly with regard to cost of maintenance and repairs, additional cost from unforeseen works, cost of decoration that would become necessary as a result of the works and also additional miscellaneous costs, e.g. electricity.

Respondents generally reported that they minimised costs as far as possible through DIY to help make maintenance and repairs more affordable, as well as alleviating some concerns about unknown builders. Some respondents commented that they would rather do maintenance and repairs themselves, as they would at least have some level of control over quality, other than, "having some ropey workman in doing it badly", particularly when "paying someone to do it and they are not doing it properly". However, there was an overall agreement that things should be done at an early stage

before they got worse, affected other things, and costing more. Respondents reported that it was easy to, "shut their eyes" to things that needed doing to their homes, and therefore cost more in the longer run.

This issue of lack of trust in builders was raised time and again, emerging as a key barrier, sometimes preventing people carrying out maintenance and repairs even if they did have funds available. Being able to get reliable builders – both to start and finish the works – was a strong theme emerging from the research. Older people, particularly women, felt intimidated when given a quotation and did not know how to handle the situation from then on, lacking both technical skills and contracting skills to ensure they were getting a good, value for money, service. The following quote illustrate what respondents were thinking around this issue:

> And the other problem is, if you can't do it yourself it's difficult to find somebody that is able ... that you can rely on to do it for you at a reasonable price because most of us here are on very, very limited budgets and if you haven't got the money and trying to get estimates ...

Some older people had the money to do the maintenance and repairs, yet found it difficult to get reliable builders and found this daunting enough to deter them from getting the maintenance and repairs done.

This was exacerbated by respondents' bad experiences in the past of being "conned", for example, "you feel a bit suspicious if it's a roofer working on the roof next door, because you think oh is he only looking for a job?". Respondents also said other things put them off instigating works. These included having to wait for maintenance and repairs to start and also to be completed in a reasonable timescale, etc. being required to pay up front for maintenance and repairs and concern over contracting a reliable builder. Finding a reliable and available builder was seen as a major problem, particularly for small scale, relatively low cost maintenance and repairs.

iii) Motivation and ability to carry out works

The practicalities of actually getting around to carrying out maintenance and repairs alongside other priorities and commitments in homeowners' lives rated highly. A number of factors were reported as leading to a lack of motivation to proactively instigate maintenance and repairs. For example, those living alone lacked a partner with whom to discuss what work needed to be done. This negatively impacted on them both on a practical level, and on motivation to do the maintenance and repair works. Respondents reported that this was compounded by difficulty in securing a contractor/builder to do minor works such as putting up shelves or changing fuses, which was found to have a knock on effect in instigating more major maintenance and repairs, such as painting or re-roofing. Respondents also reported that as they got older, the house got older around them, and they may not notice that maintenance and repairs might need doing, or would be too stressful to have done.

Respondents reported that a combination of ill health and age meant that tasks that may have been simple in the past became more problematic, and older people reported that they were more frightened of home accidents, which in itself prevented them from trying maintenance and repairs themselves. Getting older came across as a strong theme and the following quote illustrates what people were thinking:

> DIY is one of the things that gets more difficult as you get older. I look around my house and see the things that I did when we moved in 25 years ago and I think how on earth did I manage to do that?

As owners grew older, so did their homes:

> Because you don't realise that you are getting older, and your house is getting older as well. It's one of the problems with living in an old house.

Health care took priority over home maintenance, and some reported that with not being well, they had effectively neglected home maintenance and repairs they knew needed doing. Some felt that there was little point having major repairs done if they were older, and one who needed major repairs doing but could not cope with the stress, quoted the builder as saying:

> you can either have it completely taken away and rebuilt or bodged. So I thought, "I am 71" and I said "I will go for bodged".

Allied to this was the loss of a spouse, leaving the remaining partner feeling vulnerable and sometimes unable to cope with the upheaval of major repairs due to lack of close support. This seemed particularly true for older women, whose husbands had traditionally dealt with maintenance and repair issues.

iv) Competing priorities for resource

In addition, respondents reported that home maintenance and repair is not always of great interest to people and lifestyle issues frequently take priority, such as holidays or new carpets. However, some respondents' reported that home maintenance was important:

> I think the house comes first ... Because you have got to live somewhere and keep up the house the right and proper way ... you should concentrate on the house and make sure that the house has everything, which it needs anyway.

And that this could be done by having a regular home maintenance check by a trusted source (such as a good builder) to identify what needed doing, check on this regularly and,

> what ever needs to be done, don't leave it until a year, or two or three years because it's getting worse.

v) The local community

Respondents suggested that the dispersed nature of communities and families in London proved problematic, although the Renewal Area process had helped build cohesion. The level of community trust also extended to trust in builders. Local builders were favoured as they were seen as an integral part of the same community who could be contactable again, not just attending as a one off. Respondents generally said that even if they were not considered to be the best builders in the world, being trustworthy and reliable were highly valued.

The discussion led to how more formal "social networks" might assist in home maintenance and repair, but respondents reported that such schemes depended very

much on the local community, and the following quotes illustrate the general thinking of the respondents:

> Excellent if you live in certain neighbourhoods. But I mean, there are some people ... I'd be frightened of asking some people into my house.
>
> ... This is the problem.
>
> ... There are issues around security and ...
>
> It sounds a wonderful idea, I mean very often I have thought of putting my name down, I have but I think "oh god you don't know who is coming".

However, turning existing informal social networks into something more formalised locally, was not favoured. The general feeling of the respondents was that people were happy to help each other out and not to expect a financial reward, but possibly a return favour in the future.

In addition, behaviour and tenure of others in the community was felt to have an impact. Difficulties of living in mixed tenure areas, or simply where neighbours had been carrying out maintenance and repairs, were found to have a major impact on owners doing maintenance and repairs to their own homes, particularly in terraced housing. This also extended to the standard of work carried out, and timing of those works, and comment was also made about supervision and quality of work.

vi) Local authority duty v personal responsibility and choice

Another issue arising was the difference – possibly even defined as a tension – between the local authority's strategic role in housing renewal and what respondents, saw as important. This is also allied to the changing role of local authorities from provider to enabler of service. Whilst the local authority, for example, may wish to get the envelope of the houses weather tight under earlier Group Repair Schemes provisions, or to ensure houses met the statutory standard of fitness (due to be imminently superceded by the Housing Health and Safety Rating System), respondents tended to focus on their needs, not physical characteristics of the property. Respondents believed in having personal choices. Several comments illustrate this point as follows:

> If you own your own house it's nothing to do with the council.
>
> I think the advantage of owning my place is that I can let it fall down if I want to!
>
> If you are a homeowner you don't expect anybody else to pay for that..

This led to some differences in the local authority's and the respondents' definitions of maintenance, repair, improvement and DIY and what each would like to see from a strategy. Whilst the local authority's objective would focus around legal and policy-driven standards, the respondents tended to focus around their individual needs and aspirations. Respondents also favoured maintenance and repairs to the inside of homes because, "Well, you are living in there, inside". Other views however squared with the local authority's objectives more closely in that enveloping schemes were important, "because it's keeping up the house, isn't it, to protect you as well."

2) Facilitating factors assisting homeowners to maintain and repair their homes

i) Affordability

As the cost of maintenance and repairs was a key barrier, so finding ways to make works more affordable became a key solution, or at least part of a solution. Therefore, making home maintenance affordable emerged as a key theme and was seen as something the local authority could potentially help with as a partnership between individual and local authority, with both mutually benefiting. Some respondents reported that they were happy to do the maintenance and repairs themselves, but would still struggle with the cost of the materials, and raised the possibility of the local authority helping with this.

The respondents had found their own ways to make things more affordable, such as though DIY and helping each other, getting reliable trades people in the first place (where possible) and entering pre-payment insurance based schemes.

In addition, some of the respondents favoured some type of regular payment scheme to help pre-plan and cover the cost of future maintenance and repairs. Some respondents already made provision for insurance-based schemes, mainly relating to gas and electricity (perhaps because these are widely advertised and relatively easy to join). The culture for such schemes therefore already exists, suggesting that home maintenance schemes and surveys may be an attractive option with payments spread over the year, although some suggested that this would still prove too expensive:

> No, the only thing, as I say, is the gas board, we pay an insurance on the boiler and they give you a yearly check.

> Yes. It's what you were saying about having the sort of maintenance contract which is fine if you ... yeah ...

> Well, I think you are a little bit better than I am because you can afford to pay the payments for your boiler.

But there was also a counter argument to this:

> I want to pay for that to happen and I haven't got the money to.

ii) Having the right skills

To carry out DIY of course, people needed the right skills. Respondents said they had developed their own skills through a variety of means, including technical training schemes previously offered by the local authority, which had been well-received. Several respondents were prepared to turn their hand to most things for DIY purposes, but tended to steer clear of more "specialist" works. They reported that they used common sense, learned their skills from school, and self-driven learning such as by reading books, asking or watching other people (such as when buying materials), having the right tools available. The following quote is typical of the discussion in that it would be:

> ... so useful to have had a kind of home maintenance course just to sort of prepare you for how to do things like simple electrics ...

The internet was also cited as a major source of information, both in terms of learning skills (e.g. to aid early detection and costings) but also in accessing cheaper materials:

> Things like the prices of things, whether they were in stock. Whether there were alternatives. How to do things, how to fit something, there is quite a lot of instruction out there you know, so you can use all of that.

Respondents also suggested therefore that help with the internet would prove useful.

Some female respondents in the focus groups particularly favoured having more information, both to carry out maintenance and repairs themselves and to help prevent builders assuming that they did not have sufficient technical knowledge. For example:

> [Builders] think that you don't know anything and if you actually talk to them ... and I know quite a bit about how things [...] and if you start talking on that sort of technical level then they do alter their attitude.

iii) Trusting builders

Being able to trust builders was seen as paramount, and word of mouth recommendation – rather than recommendation from the local authority – was the most favoured method. Other respondents found builders through sources such as Yellow Pages, basing their choice on "Credentials or certificates". However, respondents did not feel that simply being given a "Builders List" was necessarily the answers as not everyone felt that had had a satisfactory service from the local authority in the past. The general feeling of respondents was that it was preferable to contact a builder recommended by family or friends or via a local and trusted DIY shop, as illustrated by the following quote:

> The shop on the corner here is very helpful with things like that now. And they have got all the workmen there in case you live nearby. And because they have got a shop there they look after you.

iv) Pride in the area

The extent to which the local authority's initiatives in the Renewal Area had motivated households to invest their own resources in additional maintenance and repairs to their home was unclear, as was whether there would be a longer term, sustainable impact. However, there was certainly an indication that respondents were proud of the maintenance and repairs done, with an apparent renewed sense of local identity. Respondents commented that the roads looked better than they had in the past, and picked out several where group repair schemes had been implemented to illustrate this. Respondents felt that there was a knock on effect beyond the actual maintenance and repairs done, with neighbours getting to know each other more, which may lead to more mutual help and motivation in the future in a variety of innovative ways.

Most respondents reported that they would be happy to help their neighbours, but were wary of over reliance on asking for favours and would also like the option of asking their family if they lived locally enough, or paying a local builder. Many expressed regret that helping neighbours was not so common now as in the past, although the Renewal Area was reported to have played a role in re-nurturing this

social role as people had got to know each other better. For example one respondent said:

> I know most people on the street because of it. [The Renewal Area's] been very good that way hasn't it?"
>
> ... I've had the man from across the road said "do you realise that you have got a slate missing". You can't see it but they can see it from their house.

Discussion

The research was extremely timely with the shift away from housing grants to other forms of assistance. It enabled issues relating to both maintenance and repair of private housing sector as well as issues around affordability – in the absence of a local authority grant – to be explored.

There are various ways in which local authorities are able to support, assist and enable homeowners to carry out maintenance and repairs to their homes. Respondents demonstrated commitment and interest in carrying out maintenance and repairs themselves, with appropriately tailored help from the local authority. However, the research was about individual home-owners and did not explore wider issues in addressing renewal at street/area level, such as an enveloping scheme, or strategy to improve all houses in a given street, and how this might be possible without the leverage of grants.

The results raise some interesting questions. Local authorities have to deliver government policy locally. Providing more choice and options for residents invariably complicates the local authority's strategic objectives. This study poses challenges to the delivery of a range of options to help maintain and repair private sector housing stock in a variety of innovative ways (as outlined in Table II), which have not traditionally been part of local authority housing functions. This also ties into how those working for the local authority see their role (as top down bureaucratic, as bottom up enabler' etc.), how residents engage with the local authority (or its agency) when they have a choice whether to or not, and the nature of "empowerment" in communities. Indeed, it has historically been more straightforward for local authorities to offer nationally prescribed grants with established objectives, than a range of largely untested options locally.

A key issue emerging was that of choice, in what an owner would choose to spend "housing" funds on, in comparison to what the local authority might strategically wish such expenditure to fund, such as renovating the envelope of a building. Loss of grants to some extent represents a loss of local authority control over local private sector housing conditions, and this is an important issue. This research gives some insight, but it remains too early to examine the extent to which this will impact the nation's housing conditions overall in the longer term.

The Government has suggested three key options for replacing nationally prescribed grants with more closely targeted grants; more choice between grants and loans; and equity release. The government have also indicated that other options are given consideration. The focus groups in this study did not necessarily favour the government's suggested options, but gave some insight into what older, low income homeowners may find more helpful. This gives some indication that policy and local

strategies should ensure that new services are tailored to need and that they are helpful in maintaining and repairing homes locally. If the government wants to address conditions in the private sector housing stock, it needs also to address key beliefs to achieve the outcomes. The focus groups helped determine what the community wants and needs from the local authority and suggested that there is some scope for the local authority to meet the needs of its local community more closely. Older people may have different horizons for their housing needs than younger homeowners, and services need to be adapted accordingly.

Some issues and potential solutions emerged from the research that the local authorities may be able to deliver on, notably supporting home-owners to take more personal responsibility for their homes; developing a new enabling relationship with the local community; encouraging homeowners to prioritise home-maintenance works above other competing priorities; further exploring the role of other agencies in delivering local strategy; and encouraging more reliable and cost effective solutions to home maintenance.

As stated previously, there was little expectation that the local authority should provide grants, but respondents seemed to adopt the "personal responsibility" role favourably, seeing a possible role for the local authority to support what they wanted to do. Effectively, this squares with a more individual approach, whereby conditions are likely to be individually – rather than property – led in the future (see, for example, Stewart, 2003b). In addition, ideas for funding private sector housing renewal by the government – other then a re-targeting of grants – did not seem to be favoured by the focus groups, notably equity release. Once again, such schemes are still in their early stages and bad publicity about private schemes in the past may negatively impact on such an approach.

Local authorities officers need to develop new skills that are no longer "top down" to engage with communities. This involves engendering new relationships whereby local authorities identify and meet the needs of the residents, and not the other way around. Respondents in this study particularly favoured issues such as training in maintenance, subscription-based services as well as more reliable and available builders. Respondents also raised issues that concerned them, including untrustworthy builders, potential cost of works, and so on. These are all issues that local authorities are very well placed to address and deliver on by taking new roles in educating home-owners in areas such as early detection of housing defects, and in finding ways of closer working with reliable, cost-effective and trustworthy builders. Part of the new local authority role may be to develop effective survey packages and home maintenance schemes, which help empower homeowners.

This goes hand in hand with a new range of services that local authorities – in conjunction with other housing renewal agencies – may be able to offer in the future. Local authorities could enhance their roles in coordinating assistance packages to suit need. New services such as offering home maintenance plans, helping ensure good builders and education for homeowners on both DIY skills and issues around contracting builders and understanding estimates seem key. Whilst there may be some difficulties in local authorities "recommending" builders, there seems to be a place for assisting homeowners to find decent builders through a local list, thus helping avoid poor builders. Local authorities already have staff whom are well placed to adapt their

existing skills in survey, specification, negotiation, costing and project management accordingly as grants continue to decline and other options are explored.

The fundamental question to ask is whether homeowners are more likely to invest further in their own homes as a result of changes to national housing policy. It is perhaps too early to answer that question. Indeed, there has been little research in the past to explore the extent to which owners invest their own funds into their homes following local authority fund injections (e.g. following group repair to the exterior of properties) or whether such schemes in themselves encourage sustainable maintenance by owners in the future following the scheme's exit (Revell and Leather, 2000). Further research is needed here and such assumptions need to be investigated more fully. This study suggests that homeowners have different priorities as to what they choose to spend their money on which may not tie in to local authority objectives. Nevertheless, local authorities may be able to offer new ways of encouraging and enabling low-income homeowners to repair and maintain their homes in the future that have not to date had a major place in housing renewal initiatives.

Conclusions

It is of mutual benefit to local authorities, communities and individuals to keep costs of maintenance and repair in private sector housing to a minimum. Public funding through the housing grants systems has been in decline for many years, as the role of government shifts from provider to enabler and assistance is delivered through an increasing number of agencies. The new policy put forward in the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 supercedes earlier grant legislation with a power for local authorities to provide new forms of assistance. Local authorities need to coordinate assistance and develop strategies that respond to more homeowners' needs, and to repair and maintain existing stock now and in the future in ways that are appropriate, tailored and enabling.

Owners in this study seemed to favour options giving them maximum scope to keep a sense of control over their own houses, and favoured looking for the most cost-effective solutions such as DIY, although DIY may not necessarily offer a longer lasting solution to home maintenance. This ties in with a more individualistic approach to home-ownership, with personal responsibility for condition, yet it is low income households who are particularly vulnerable to poor housing conditions, with perhaps less ability to be able to access some of the resource options now on offer. This is particularly true for older households, or those in ill health who are least able to minimise costs through DIY. "Personal responsibility" is invariably limited in respect of age, education, health and available funds for home maintenance and repair.

The UK's private sector stock is ageing and its owner-occupiers growing in number. New ways need to be found to meet the changing need of homeowners who – both nationally and internationally – will be increasingly expected to provide their own housing renewal solutions. There is a shift from government to private expenditure in housing renewal, which represents a shift from grant dependency to one of self-reliance, but what is not yet known is whether this will make a real difference to physical housing, social communities, both, or neither. Language and rhetoric of empowerment is one thing, what really matters is how – or if – it can translate into action.

References

Davidson, M. and Leather, P. (2000), "Choice or necessity? A review of the role of DIY in tackling housing repair and maintenance", *Construction Management and Economics*, Vol. 18, pp. 747-56.

Davidson, M., Redshaw, J. and Mooney, M. (1997), *The Role of DIY in Maintaining Owner Occupied Stock*, The Policy Press Housing Repair and Maintenance Series, Bristol.

Department of the Environment (DoE) (1996), *DoE Circular 17/96: Private Sector Renewal: A Strategic Approach*, HMSO, London.

Department of the Environment, Transport and the Regions (DETR) (1998), *Housing Research Summary Encouraging Homeowners to Repair and Maintain Their Homes: A Review of Initiatives (No. 92)*, HMSO, London, available at: www.housing.dtlr.gov.uk/hrs/hrs092.htm (accessed 12 April 2000).

Department of the Environment, Transport and the Regions (DETR) (2000a), *The Housing Green Paper: Quality and Choice: A Decent Home for All*, HMSO, London.

Department of the Environment, Transport and the Regions (DETR) (2000b), *Best Value in Housing Framework*, HMSO, London, available at: www.housing.dtlr.gov.uk/information/bvhf/4.htm (accessed 3 April 2002).

Department of the Environment, Transport and the Regions (DETR) (2001), *Private Sector Housing Renewal: Reform of the Housing Grants, Construction and Regeneration Act 1996, Local Government and Housing Act 1989 and Housing Act 1985: A Consultation Paper*, HMSO, London.

Department of Transport, Local Government and the Regions (DTLR) (2002), *Statutory Instrument 2002 No. 1860: The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002*, HMSO, London, available at: www.hmso.gov.uk/si/si2002/20021860.htm (accessed 1 October 2002).

Easterlow, D., Smith, S. and Mallinson, S. (2000), "Housing for health: the role of owner occupation", *Housing Studies*, Vol. 15 No. 3, pp. 367-86.

Leather, P. (1998), *Repair and Maintenance in the Owner Occupied Sector*, CURS, Birmingham.

Leather, P. (2000), "Grants to homeowners: a policy in search of objectives", *Housing Studies*, Vol. 15 No. 2, pp. 149-68.

Mackintosh, S. and Leather, P. (1992), *Home Improvement under the New Regime*, Occasional Paper 38, SAUS, Bristol.

Mackintosh, S. and Leather, P. (1993), *Renovation File: A Profile of Housing Conditions and Housing Renewal Policies in the United Kingdom*, Anchor Housing Trust, Oxford.

Nettleton, S. (1997), "Governing the risky self: how to become healthy, wealthy, and wise", in Petersen, A. and Bunton, R. (Eds), *Foucault Health and Medicine*, Routledge, London.

Office of the Deputy Prime Minister (ODPM) (2003a), *Housing Bill – Consultation on Draft Legislation*, HMSO, London, available at: www.odpmgov.uk/Information/consult/housingbill/01.htm (accessed 1 April).

Office of the Deputy Prime Minister (ODPM) (2003b), *English House Condition Survey 2001*, HMSO, London.

Office of the Deputy Prime Minister (ODPM) (2003c), *Sustainable Communities: Building for the Future*, HMSO, London, available at: www.communities.odpm.gov.uk/plan/main/overview.htm (accessed 6 March).

Revell, K. and Leather, P. (2000), *The State of UK Housing: A Fact File of Housing Conditions and Housing Renewal Policies in the UK*, 2nd ed., The Policy Press, Bristol.

Stewart, J. (2001), *Environmental Health and Housing*, E and FN Spon, London.

Stewart, J. (2003a), "Lend them a hand", *Environmental Health Journal*, Vol. 110 No. 4, pp. 212-4, available at: www.ehj-online.com/archive/2000/july2003/july5.html

Stewart, J. (2003b), "Home maintenance: initiatives in the Bellenden Renewal Area", *Peckham, Journal of Environmental Health Research*, Vol. 2 No. 1, pp. 10-21, available at: www.jehr-online.org.volume1/issue2/5/index.asp

Wilcox, S. (2001), *Housing Finance Review 2001/2002*, Joseph Rowntree Foundation, York.

Corresponding author
Jill Stewart can be contacted at: j.l.stewart@ greenwich.ac.uk

Publication 18 Stewart, J. and Habgood, V. (in press) The Benefits of a Health Impact Assessment in relation to Fuel Poverty: assessing Luton's Affordable Warmth Strategy and the need for a national mandatory strategy, *Journal of the Royal Society for the Promotion of Health*

The Royal Society for the Promotion of Health

38A ST. GEORGE'S DRIVE, LONDON SW1V 4BH
TEL: (+44) (0)20 7630 0121 FAX: (+44) (0)20 7976 6847 EMAIL: rsph@rsph.org WEBSITE: www.rsph.org
Established 1876 **PATRON:** HER MAJESTY THE QUEEN

8 August 2006

Ms Jill Stewart
School of Health and Social Care
University of Greenwich
Avery Hill Campus
Bexley Road
Eltham
London SE9 2PQ

Dear Ms Stewart,

Re: JP1329 **The Benefits of a Health Impact Assessment in relation to Fuel Poverty: asessing Luton's Affordable Warmth Strategy and the need for a national mandatory strategy**

I am pleased to confirm that the above paper has been accepted for publication in *JRSH* and will be published in a forthcoming issue.

I enclose our Transfer of Copyright Conditions and the Publishing Agreement form which we need you to sign and return to us prior to publication.

Two copies of the form are enclosed; please sign both and return one to us in the enclosed envelope.

If you have any queries please do not hesitate to contact me.

Yours sincerely,

Mandy Murphy
Editorial Assistant

The Benefits of a Health Impact Assessment in relation to Fuel Poverty: assessing Luton's Affordable Warmth Strategy and the need for a national mandatory strategy.

Authors
Jill Stewart MSc BSc (Hons) MCIEH FRSH PGCE ACIH

Senior Lecturer
School of Health and Social Care
University of Greenwich
Avery Hill Campus
Bexley Road
Eltham
London SE9 2PQ

Telephone: + 44 (0) 20 8331 8218
Fax: + 44 (0) 20 8331 9926
Contact j.l.stewart@greenwich.ac.uk

Veronica Habgood MSc BSc (Hons) MCIEH
Director of Learning and Quality, School of Health and Social Care,
University of Greenwich

The Benefits of a Health Impact Assessment in relatio.
Poverty: assessing Luton's Affordable Warmth Strategy
need for a national mandatory strategy.

Abstract
The links between fuel poverty and poor health are well documented, yet there is no statutory requirement on local authorities to develop fuel poverty strategies, which tend to be patchy nationally and differ substantially in quality. Fuel poverty starts from the perspective of income, even though interventions can improve health. The current public health agenda calls for more partnership based, cost-effective strategies based on sound evidence. Fuel poverty represents a key area where there is currently little local evidence quantifying and qualifying health gain arising from strategic interventions. As a result, this initial study sought to apply the principles of a Health Impact Assessment to Luton's Affordable Warmth Strategy, exploring the potential to identify health impact arising – as a baseline for future research – in the context of the public health agenda. A national strategy would help ensure the promotion of targeted fuel poverty strategies.

Key words
Affordable warmth; fuel poverty; housing and health; health impact assessment; Luton Borough Council.

The Benefits of a Health Impact Assessment in relation to Fuel Poverty: assessing Luton's Affordable Warmth Strategy and the need for a national mandatory strategy.

Introduction

Fuel poverty may cost the National Health Service (NHS) some £1 billion annually (1). Substantial public health benefits could arise from appropriate housing regeneration (2), addressing thermal efficiency and heating affordability and thereby reducing health care costs (3). Despite the general paucity of evidence on the financial and social costs of fuel poverty, the Department of Environment, Food and Rural Affairs (DEFRA) (4) argues that a reduction in cold, damp housing would reduce costs to the NHS . Although full data is not available, there is general agreement that excess winter mortality and morbidity could be reduced by local partnership based interventions delivered by local authorities, Primary Care Trusts (PCT) and the voluntary sector.

The health effects of cold homes are well documented (4,5) (see table 1), although this ill health may also be partly related to income and lifestyle. The Department of Health (DoH) recently reported that 2.5m homes are cold enough to cause ill health during any winter in England (6). DEFRA reported an estimated 25,000 to 45,000 excess winter deaths annually in England and Wales, many of which are likely to be related to the cold (4). Healthy and active people are able to generate more of their own heat than sedentary or ill people and generally a living room temperature of 18-21°C is considered comfortable. Health risks arise in prolonged colder temperatures. Below 16°C there is a decrease in ability to stave off respiratory illness; below 12°C, increased blood pressure and heart rate, associated respiratory disorders; and below 6°C, risk of hypothermia (7).

(INSERT TABLE 1 NEAR HERE)

The government's Fuel Poverty Strategy defines a fuel poor household is defined as, *"one that needs to spend in excess of 10 per cent of household income on fuel in order to maintain a satisfactory heating regime"*, (5:3). It is difficult to accurately ascertain the extent of fuel poverty because the definition hinges on income level (fuel *poverty*), not quality of housing stock, so numbers can change with different income occupiers of the same housing. Estimates of numbers in fuel poverty can therefore vary substantially and establishing a baseline for strategy can be difficult. It has proven easier to address fuel poverty in the social housing sector, where strategies more readily revolve around planned stock maintenance programmes. The private housing sector is more fragmented and proves harder to reach, although energy inefficiency in this sector is known to be more acute (5). The already vulnerable are particularly at risk: low-income households tend to spend more time in their home because of unemployment, age (old or young) or illness, and needing warmth over an extended timescale.

The government's strategy sees an important role for public health in developing localised and focused interventions to address fuel poverty and has encouraged appropriate strategies through Local Strategic Partnerships (LSP) (4). LSPs comprising PCTs, local authorities and other agencies are now seen as key to addressing health inequalities, protecting and promoting health by addressing the determinants of health around issues such as fuel poverty (6,8). However, there is still no statutory duty to deliver fuel poverty strategies. As a result, less that 50 per cent (4) of local authorities have a fuel poverty strategy and the framework is currently patchy and non sustainable.

Allied to this is the issue of assessing health impact arising from fuel poverty strategies. The 1999 Public Health White Paper (9) identified the importance of applying Health Impact Assessment (HIA) to promote health concerns in policy. However, there is no statutory duty

to apply HIA methodologies. There is very little information about how to measure health impact arising from fuel poverty strategies locally. This would be useful in assessing the cost effectiveness of such strategies, helping to attract additional resource at the point of health determination.

In the context of the public health agenda, fuel poverty could have health ramifications but links need to be proved, as health outcomes are implicit rather than explicit. Luton Borough Council has achieved Beacon status (10) for its Affordable Warmth Strategy, and therefore provides an interesting strategy to study. It already has a good quantity of data to assess, which could be subject to a HIA. Applying HIA to other local authority's fuel poverty strategies would be worthwhile, requiring an alignment of strategies and data across the UK.

Luton Borough Council's Affordable Warmth Strategy
Luton's Affordable Warmth Strategy (AWS) uses the definition that, "*no household should have to spend more than 10 per cent of disposable income on fuel to keep comfortably warm*" It sees fuel poverty as a number of interrelated difficulties, which locate around areas of low incomes, poor domestic energy efficiency and high or unequal fuel prices (11), which are seen to contribute to poor physical and mental health, reduced quality of life and unsatisfactory housing conditions.

Luton's AWS is an intrinsic part of tackling deprivation, poor housing, social exclusion and improving health. The partnership approach is key to its success, since it enables multiple health determinants to be addressed including access to service and assistance, personal, social, cultural, economic and environmental influences (12,13,14). (See table 2). The approach is initially concerned with technical implementation and variety of approaches necessary to respond to the diverse and sometimes 'hard to reach' communities affected. Luton's Unified Referral Scheme (see figure 1), relies on trained agencies for its three types of assistance:

- Warmth – i.e. Warm Front or Cosy Homes grants;
- Benefits – i.e. checks to ensure full uptake on eligibility; and
- Social – i.e. aids and adaptations, home care assessments etc (see table 3)

(INSERT FIGURE 1 NEAR HERE)

(INSERT TABLE 2 NEAR HERE)

(INSERT TABLE 3 NEAR HERE) – includes ref 15

The partnership approach also enables issues such as health to be considered in well-established forums and networks. It continues to investigate new options across organisations to meet the need of vulnerable groups. The (then) Health Action Zones brought a health focus, with reference to wider determinants of health (see table 2) and the need to integrate closer with the PCT was seen as important with wider health practitioners (11). Much work is now going on around a health ethos brought by the new partnerships. The LSP for example now has themed groups including a Health and Social Care Group, which considers cold houses, excess winter deaths and the costs of heating. The Housing and Sustainability Group considers issues around the decent homes standard and private sector housing. Such issues may otherwise be marginalised. Partnership working has been found to help pool budgets such as a Reach Out Project, which helps focus on need, to raise profiles all round for issues such as the Winter Flu campaign and carry out some work on assessing domestic temperatures.

Fuel poverty and health: applying the principles of a Health Impact Assessment
Luton's ASW has already received recognition for its success. However, to date, and like

other local fuel poverty strategies, it is primarily about *income* (poverty) rather than *health*. This squares with DEFRA's approach to fuel poverty as primarily about addressing poverty and social exclusion, rather than addressing health improvement *per se* (4,5). However, fuel poverty strategies are also implicitly about health and interventions should have positive impact on already disadvantaged low income communities. Although health gains arising are implicit, they are not explicit in such strategies. In order to take the health ramifications of fuel poverty further, it could be subject of a HIA.

The government stated its commitment to applying HIAs to relevant policies in the 1999 White Paper *'Saving Lives: Our Healthier Nation'* (9) for policies at local and regional level. This is relevant to bring health considerations to the fore in all policies where health is an issue, but not necessarily the primary reason for intervention. Health is not however specifically defined, but includes addressing wider health determinants including well-being and quality of life, through adopting multi-method approaches. HIA help focus policy on health determinants and interventions addressing the needs of disadvantaged and marginal communities to promote equity whilst addressing health inequalities and reducing costs to the health care sector (16-21).

Whilst there is a growing literature on HIAs, the extent to which the methodologies are applied remains unclear. This paper reports on an initial exploratory study carried out by the authors. This approach was undertaken as an initial exercise, with scope for a more in depth HIA in the future. The purpose of this HIA was to help provide a starting point in the process of information gathering (both in terms of current evidence available, as well as what is not currently available) for what is needed in order to more closely target future interventions in health improvement arising from fuel poverty strategies and exploring some of the barriers. The principles of a *Rapid Retrospective HIA* were applied, reviewing existing literature and local evidence, supported by semi-structured discussion with key players at Luton Borough Council focusing around the following issues:

- Definition and agreements on health and health determinants from fuel poverty partnerships;
- Joint approach to addressing health inequalities (notably poverty);
- Symptoms of health from fuel poverty (as indicated in table 1);
- Existing data as evidence; proposals for further research
- Nature of partnership and reasons for members; extent of collaborative working;
- Outcomes of fuel poverty strategy: links back to demography; inequalities; other research; hospital admissions etc;
- Interaction with other strategies: social inclusion; sustainability; environmental health and private sector housing regeneration;
- How is strategy being evaluated and moving forward?

Luton's Annual Public Health Report 2003 (14) was also scrutinised in its relationship to issues around fuel poverty. Informal discussion with relevant representatives from the PCT helped gain initial insight and to explore additional public data they may hold relating to cold homes and health care needs arising from fuel poverty.

Fuel poverty and health data at Luton

At the time of this work, Luton's strategy had been largely about delivery, rather than evaluation. However, Luton now has a growing evidence base of quantitative and qualitative data that help provide some weight to the health aspects of the strategy. To date, much of Luton's data is quantitative and concerned with issues around referrals and who is receiving assistance. Data available includes the nature and extent of new benefits awarded; energy grants allocated by type of award; number and percentage of referrals by ethnic group by type; number and percentage of referrals by age; organisations making referrals and key individuals in organisations making those referrals.

Many households in Luton experience the combination of low-income, poor housing and heating that contribute to fuel poverty. Some 15,455 households in Luton Borough Council (25.8 per cent) of all households in Luton spend more than 15 per cent of net income on fuel. Of these, an estimated 6,733 households spend more than 15 per cent, and are classified as being in serious fuel poverty. Main causes of death locally include circulatory and respiratory disease (14), which *may* be related to fuel poverty. However, excessive cold is seen as being amongst the most frequently occurring domestic hazards in Luton (11). In 2002, 5 per cent of Luton's private sector housing stock was unfit for human habitation and some 28 per cent did not have adequate loft insulation, let alone other energy efficiency measures (14), although this figure has since reduced. Data on Luton's wards most affected by fuel poverty are summarised in table 4 (11,14).

The AWS is indeed helping ensure that welfare benefit uptake is increased. For example, from January to June 2004, some £231,000 was generated in benefits for Luton residents. Every household receiving a (maximum) Warm Front Grant saves an average £134 per year on their heating bills, although this does not in itself ensure that fuel poverty is resolved for that household. The Referral Scheme has also been successful in accessing 'hard to reach' groups, including exceeding targets for black and minority ethnic groups. Overall, 70 per cent of all people referred to the AWS are in the target range of 60 year old and over. The Luton NHS PCT (14) also refers to the success of work around encouraging benefit take up to maximise income. Whilst this would help alleviate fuel *poverty* by tackling income level, it would not necessarily improve health.

Luton has trained more than 400 health practitioners in energy awareness, including GPs, District Nurses, Advanced Nurse Practitioners, Health Visitors, Social Workers and Mental Health Practitioners, who are now making referrals. Additionally, local people have received some £400,000 extra welfare benefits; 700 people have been referred for advice and assistance since April 2001, with 76 per cent recipients in the private housing sector, and 81 per cent over 60, closely targeting black and minority ethnic communities (11,14).

Despite this, there are gaps in some assistance regimes even where fuel poverty is established. Ironically, not all fuel poor households have been eligible for assistance such as Warm Front Team grant. As many as 25 per cent may be ineligible, and 60 per cent of these are single elderly households and other older couples, who may 'under-occupy' their homes (4). Ethnic minorities may also have problems in accessing Warm Front Team grant. This squares with Luton's research and practice experience, which shows that – since Warm Front Team are essentially a one off payment that may not be fully utilised initially – the client would lose access to remaining funds for which they would have been eligible. This makes Luton's approach successful, as the client-centred, supported application is very important, to maximise access to grants. Warm Front Team 2 (WFT2) (from June 2005) eligibility criteria should help with ensuring more extensive assistance for households identified as eligible, as well as including children more directly, a potentially vulnerable group.

At implementation level, Luton's AWS has achieved recognition of its good practice through achieving Beacon status. Despite this, it remains very difficult to realistically and usefully establish and evaluate health and health care datas relating to fuel poverty locally, even though the Unitary Authority shares coterminous boundaries with the PCT. This is characteristic of the national situation. Like many other organisations, data for fuel poverty is not comparable due to a lack of national reporting requirements for fuel poverty across organisational boundaries and different performance management regimes. Health gains are inferred but cannot currently be substantiated on individual organisation or partnership level, a repeated difficulty of the public health agenda in seeking to adopt a more cost effective approach.

Learning from Luton: aligning national strategies and data

The public health agenda has helped ensure a re-focus on health at the heart of policy. HIA offers a valuable means for reassessing policy and strategy in the light of health determinants and health inequalities and asking questions about what might work best in a health promoting strategy. This points to the need for a national, mandatory strategy with recommendations for nationally recognised set of health indicators for fuel poverty that can work across organisational boundaries.

The Wanless report (23) criticised the lack of evidence in health improvement, and called for the need for a greater evidence base. Wanless also pointed to the paucity of mechanisms for PCTs and local authorities to gather reliable (and comparable) evidence on their local populations, partly due to a lack of skills in undertaking HIA and disseminating resulting information to enable dynamic health comparison, with lessons adopted from successful, innovative, evidence based strategies such as Luton's.

One reason for the paucity of evidence has been the lack of funding to enable collaborative academic/practitioner research work. It is difficult to see a way forward when HIA are not a mandatory requirement, particularly in such a key public health strategy. There is therefore a need for fuel poverty and health links to be formally identified to fill in gaps in the public health evidence base. Compiling and assessing public health research remains and ongoing function of the National Institute for Health and Clinical Excellence (NICE) (previously under the auspices of the Health Development Agency), the organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

Establishing a fuel poverty and health evidence base would be useful for those involved in strategies development and evaluation. There is already a range of general data available, but more needs to be done at to help explore health impact arising from strategic interventions. Data needs to be both qualitative and quantitative. The range of evidence should be readily easy to capture across partner organisations involved and be able to be dynamically compared and evaluated both locally and nationally. Luton (and some other local authorities) already collates a range of health datas to enhance the health aspect of its strategy, providing a very useful starting point and focus for other local authority strategies whose strategies are less developed.

Some of the datas collated by Luton have already been identified above, but they have also been involved in other research. For example, Luton has commissioned and have been analysing qualitative research from the Centre for Sustainable Energy to evaluate the adequacy of the referral scheme in tackling fuel poverty and accessing hard to reach households. It has particular reference to the client's perspective, to recommend improvements where appropriate, and to help promote best practice more widely. This research seeks specifically to obtain information on the impact of referral routes on the clients' actual fuel poverty levels.

At the time of this work, and on a more medical basis, Luton were considering initiating analysis through using World Health Organisation coded classification of reasons for hospital entry to help focus on morbidity level that is likely (i.e. indicative only) to have arisen from fuel poor households. Whilst this may be a useful indicator of health impact over time, it would take some time to establish longitudinally and may require additional performance indicators to ensure fuel poverty and health data is not oversimplified. Over time, this could help estimate the real cost of cold homes to the NHS at local level.

To further explore and imply health impact arising, it could be useful to look at local housing stock (regardless of occupier's financial status) before and after interventions (physical condition, heating installation, insulation etc) to demonstrate additional warmth arising and its effect on health. Analysing likely temperature gains in domestic properties after interventions could help estimate health gains based on existing knowledge of temperature over time, and

such a model could be adapted for different housing. Notably, there is still little evidence generally evaluating the effects of housing interventions on health improvement (see for example 23).

As part of a wider public health agenda, fuel poverty strategies should continue to target vulnerable groups, both by geography (e.g. through post code analysis) but also by social group (e.g. black and minority ethnic communities, low income households with children or older people) and to continue to seek new means of identifying and working with vulnerable communities, that may be 'hard to reach'. Particularly, activity should be targeted in the private housing sector. Barriers (organisational, reporting etc) need to be broken down at national and local level to enable health gain inferred in fuel poverty strategies to be assessed and reported to enable dynamic evaluation.

Conclusions

Although health issues arising from cold, damp housing are well documented, there remains a gap between this knowledge and accounting for their health impact. A fundamental problem is that fuel poverty strategies are not mandatory and there are no national reporting mechanisms relating to health impact. Nationally the situation is patchy and not a priority for many local authorities. Current monitoring of performance across different organisations can make dynamic comparisons of health gain inferred from fuel poverty strategies difficult to establish. It would be helpful if this data could be more closely aligned to establish a viable basis for fuel poverty strategies as a cost effective approach. There must be more rigorous uptake of such strategies in helping avoid cold related illness in the first place. Policy and strategy are increasingly directed at strengthening the public health role of PCTs and local authorities and facilitating partnership working, but capacity, organisational changes and differing performance regimes still present barriers.

Collaborative Health Impact Assessments would help further reintegrate health and policy, and help raise the profile of fuel poverty strategies. HIAs help focus on a socio-economic concept of health, recognising that inequalities are concentrated in already disadvantaged communities, and points to the need for a partnership approach, using a range of health and heath care datas. An increasing base of evidence quantifying and qualifying the dynamic health impacts arising, would surely present the case for prioritising and attracting resource to help promote cost-effective fuel poverty strategies locally. Adopting such an approach nationally would help to protect the health of some of the most vulnerable individuals and communities, particularly in the private housing sector who are frequently marginalised from assistance regimes and continue to live in fuel poverty. There remains a need to work toward a partnership based, national performance-monitoring regime to optimise the potential of fuel poverty strategies.

Acknowledgement

The authors are extremely grateful to Sarah Allen at Luton Borough Council for her time, information and advice in compiling this paper. The views however reflect those of the authors and not those of Luton Borough Council.

References

1) Henwood, M. Fuel Poverty, Energy Efficiency and Health. Keswick: Energy Action Grants Agency (EAGA) Charitable Trust. 1997
2) Ambrose, P. Barlow, J. Bonsey, A. and Pullin, M. The Real Costs of Poor Homes. London: Royal Institution of Chartered Surveyors. 1996
3) Wilkinson P, Landon M, Armstrong B, Stevenson S, Pattenden S, McKee M and Fletcher T. Cold Comfort: The social and environmental determinants of excess winter death in England 1986-1996. Bristol: the Policy Press. 2001
4) Department of Environment, Food and Rural Affairs. Fuel Poverty in England: The Government's Plan for Action. London: HMSO. 2004
5) Department of Environment, Food and Rural Affairs and Department of Transport and Industry. UK Fuel Poverty Strategy. London: HMSO. 2001 Available Online. HTTP: http://www.dti.gov.uk/energy/fuelpoverty/fuelpeng.html
6) Department of Health. Choosing Health? A consultation on action to improve people's health. London: HMSO. 2004
7) National Energy Action (NEA) HECA 1995: Advice to Energy Conservation Authorities in Dealing with Households with Special Circumstances. Newcastle upon Tyne: NEA. 1996
8) Department of Health. Tackling Health Inequalities: A Programme for Action London: HMSO. 2003
9) Department of Health. Saving Lives: our healthier nation. CM 4386. London: HMSO. 1999
10) Energy Action Grants Agency (EAGA) Partnership Charitable Trust, Innovation and Development Agency (I&DeA) and National Energy Agency. Tackling Fuel Poverty: A Beacon Council Toolkit for Local Authorities. 2003. Online. Available HTTP: http://www.nea.org.uk/localauthorities/aff_warmth.htm (1 November 2004)
11) Luton Borough Council. Warmer Luton: Our strategy to tackle fuel poverty. Bedfordshire, Luton Borough Council. 2002
12) Department of Health. Our Healthier Nation: a contract for health. CM 3852 Green Paper. London: HMSO. 1998
13) Dahlgren, G. and Whitehead, M. Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for Futures Studies. 1991
14) Luton NHS PCT. Annual Public Health Report 2003: Health Inequalities in Luton – Getting to the Point. Luton NHS Primary Care Trust. 2003
15) Luton Borough Council. Warmer Luton Affordable warmth referral Scheme 2004 Guidance Notes, Luton Borough Council in partnership with Luton Citizens Advice Bureau, Powergen Warm Front, Cosy Homes. Unpublished: Luton Borough Council. 2004
16) Scott-Samuel A, Birley M and Ardern K. The Merseyside Guidelines for Health Impact Assessment. Second Edition. International Health Impact Assessment Consortium. 2001
17) World Health Organisation. Health Impact Assessment. Main Concepts and suggested approach. Gothenburg Consensus Paper. European Centre for Health Policy: WHO. 1999
18) World Health Organisation. Technical Briefing: Health Impact Assessment. EUR/RC52/BD/3 (Regional Office for Europe: WHO). 2002
19) London Health Commission. Health Impact Assessment – Draft Air Quality Strategy. London Health Commission and the Environment Committee of the Assembly. 2001
20) Taylor L. and Blair-Stevens C. (Eds) Introducing Health Impact Assessment (HIA): informing the decision-making process. London: Health Development Agency. 2002
21) Appleby J. Health Impact Assessment: Desireable, but difficult? In Health Impact Assessment : Report of a Methodological Seminar. London: Department of Health. 1999
22) Wanless, D. Securing Good Health for the Whole Population. London: HMSO. 2004

23) Taske N, Taylor L. Mulvihill C and Doyle N. Housing and public health: a review of reviews of interventions for improving health - Evidence briefing, London: National Institute for Health and Clinical Excellence. 2005

Table 1
Health effects of cold homes

• Physiological changes in the body, including hypothermia
• Heart attacks and stroke
• Cardiovascular and respiratory disease (especially in children)
• Asthma and mould sensitivity (once sensitised, increased future response likely)
• Stress and depression (related to mould growth)
• Accident (cold affected behaviour, also due to unsafe heating appliances)
• Premature death (mostly attributable cardiovascular related illness)

Table 2
Fuel Poverty and Health Determinants

Categories of influences on health	Examples of health determinants
a) Biological factors	Age
b) Personal/family circumstances and lifestyle	Family structure and functioning; education, (un)employment; income (poverty)
c) Social environment	Social and community networks; culture
d) Physical environment	Housing and living conditions; communications (road, rail, bus networks); energy
e) Public services	Access to (location, disabled access), and quality of local health and health care services (NHS/PCT), including social services; housing; social security services; public transport; other health-relevant public services; non-statutory agencies and services
f) Public policy (social policy)	Economic, social (including social exclusion/inclusion), environmental and health priorities, policies, programmes and projects at national and local level

Source: adapted mainly from 12.13

Table 3

Affordable Warmth Referral Scheme (for private sector households)

Agents taking referrals	Comments
Energy Efficiency and Keeping Warm Warm Front	Grants for insulation and improved heating in private sector housing, aimed at householders on certain benefits with greatest health risks
Cosy Homes Scheme	Currently covers private sector households not eligible for Warm Front, with income below £12,000; provides free insulation measures combined with energy advice
Luton Borough Council Energy Officer and Bedfordshire Energy Advice Centre	Available for those ineligible for above; alternative sources of assistance and/or energy advice and information
Benefits/Money Advice Luton CAB	Free and confidential service for people who require benefits eligibility and/or money advice and support
Social/Community Care Community Link Worker - Affordable Warmth	Free and confidential service for people who may need some assistance with regard to home care, personal care or social links such as local clubs or societies; befriending; other community activities based around assessment of client's needs to provide appropriate support and maximise income, warmth and tackle social exclusion

Source: adapted from 15

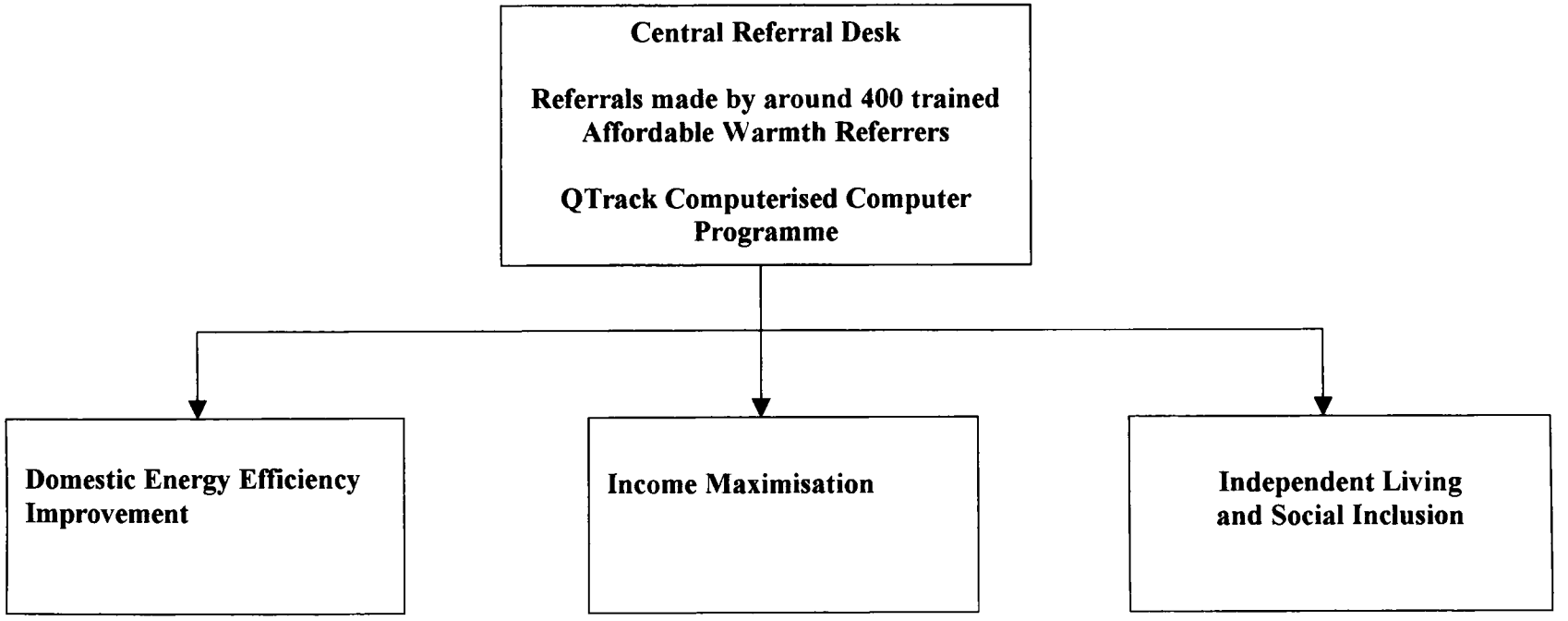
Table 3
Luton wards most affected by fuel poverty (geographical needs assessment)

Ward	In fuel poverty	In serious fuel poverty	Unfit houses *	Index of Multiple Deprivation 2000	Unemployment	Health indicators
Biscot	763 households (24%)	796 households (25%)	11-14%	Amongst top 10 deprived wards in England; high child poverty scores	LBC remains an area of high long term unemployment, 3.9 % above regional and national averages (3.1%). Out of 16 wards, these 4 wards account for 25.7 % of all unemployed people	**Not specifically related to ward, but in Luton generally:** • Birth weights less than the rest of Bedfordshire • Perinatal mortality 40% higher than national average • Comparatively high accidents, notably falls among older people • SMR of 107 (96 for East of England as a whole) • Minority ethnic health risks are 4x national average for heart disease, strokes, infant mortality and accidents.
Dallow	354 households (11.7%)	877 households (29%)	21%	Amongst top 10 deprived wards in England; high child poverty scores		
High Town	512 households (11.6%)	450 households (10.2%)	11-14%	n/a		
Saints	329 households (15.4%)	329 households (15.4%)	11-14% (for all tenures)	n/a		

- Statutory unfitness has recently been replaced with the Housing Health and Safety Rating System
- Adapted from 11,14
- LBC = Luton Borough Council

Figure 1

Luton's Referral Scheme for households in fuel poverty



PART F

APPENDICES

Appendix 1

National Public Health Evidence Base

NB – from April 2005 the HDA's evidence base work continued under the auspices of the National Institute for Health and Clinical Excellence (NICE). This is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. NICE produces guidance in three areas of health, including public health to support the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector

(Source: http://www.nice.org.uk/ and http://www.nice.org.uk/page.aspx?o=aboutnice)

HDA Evidence Base

H

About the HDA Evidence Base

- What is the evidence base for public health
- The content
- Populating the HDA Evidence Base

What is the evidence base for public health?

What 'counts' as good quality evidence for health promotion and health improvement is not a
are a number of **different arguments** as to what constitutes appropriate or reliable forms of
Evidence Base will not attempt to derive consensus as to what constitutes evidence, but will ai
of information that could be used to inform public health practice. Information about 'what wo
range of sources including **systematic reviews**, research reports and journal articles, interne
Government guidance and unpublished research databases. Topics covered in these sources s
medical interventions through to the impact of social factors on public health. HDA Evidence B
full range of factors, interventions, policies and practices that impact on public health and redu

We have developed some basic **criteria** to determine the quality of the research content or 'ev
resource, which you can view by **following this link**.

We are also working with other key organisations to develop a more comprehensive statement
quality standards for public health evidence, and information about this work will be posted on

The Content

HDA Evidence Base aims to provide access to the best available information on what works to
health inequalities via the Internet. This resource is aimed at a wide range of practitioners and
public health work.

Building and disseminating the evidence base on health improvement, development and healt
considerable undertaking. This is the first version of the HDA Evidence Base, and the resource
development. The site and resources it contains will develop over time, delivering a wide rang
health professionals, evidence based decision making and practice. In the longer term it will b
other web site initiatives that aim to support the national implementation of **Saving Lives: O**
the **NHS Plan**. These initiatives include the **National Electronic Library for Health**, **The Pu**
Library, **Our Healthier Nation in Practice**, and **HAZnet**.

The information and evidence contained within this resource falls into four main categories:

- Information about the **history** and further **development** of the site, and the HDA's wor the evidence base for public health.

- Evidence Base, a **searchable database** of electronically available **systematic reviews** literature reviews, meta-analyses, expert group reports and other review-level informati improve health and reduce health inequalities. This **database** contains summaries of re commissioned or carried out by the HDA, as well as links to reviews and reports elsewhe Web. Every effort is made to include only items where it has been possible to obtain or l internet, either a PDF file of the document or a summary HTML file. If, however, the full are unavailable, or the authors and/or publishers do not agree to its inclusion in the dat only will be included in the HDA Evidence Base.

  NOTE: The HDA Evidence Base has recently merged with HealthProm*is*, the national pul database for England and is contained as a topic database within HealthProm*is*. This nev powered by iLink, will allow you to search the HDA Evidence Base either as an individual databases. Search results will produce the bibliographic references, with links to the full where available.

- The Evidence Base **Gateway**, providing you with easy access to reviews, databases, orc concerned with gathering and publishing evidence about what works to improve health a inequalities.

- A **Current Awareness** service which informs about the latest news and information rel evidence base. This includes recent press releases; on-line bulletins and publications; in research or reports; as well as a comprehensive listing of **conferences, workshops an**

Populating the HDA Evidence Base

This initiative is still very much in a developmental stage. However, over the next 2 years, the Information Directoriate's programme of work will be orientated towards populating the Evide of reviews, syntheses of evidence and briefing documents. This task will be achieved by worki and organisations in the field including the Cochrane and Campbell Collaborations, the NHS CF

During the course of building the Evidence Base, it has become apparent that there are a num health where good systematic reviews are required. Please follow this link for a comprehensiv identified, to date.

By Spring 2003, the Evidence Base will also include a series of briefing papers across a range provide accounts of the state of the evidence in these areas, identify gaps in the research bas recommendations for future research.

- Information about the **history** and further **development** of the site, and the HDA's wor the evidence base for public health.

- Evidence Base, a **searchable database** of electronically available **systematic reviews** literature reviews, meta-analyses, expert group reports and other review-level informati improve health and reduce health inequalities. This **database** contains summaries of re commissioned or carried out by the HDA, as well as links to reviews and reports elsewhe Web. Every effort is made to include only items where it has been possible to obtain or l internet, either a PDF file of the document or a summary HTML file. If, however, the full are unavailable, or the authors and/or publishers do not agree to its inclusion in the dat only will be included in the HDA Evidence Base.

  NOTE: The HDA Evidence Base has recently merged with HealthProm*is*, the national pul database for England and is contained as a topic database within HealthProm*is*. This nev powered by iLink, will allow you to search the HDA Evidence Base either as an individual databases. Search results will produce the bibliographic references, with links to the full where available.

- The Evidence Base **Gateway**, providing you with easy access to reviews, databases, org concerned with gathering and publishing evidence about what works to improve health a inequalities.

- A **Current Awareness** service which informs about the latest news and information rel evidence base. This includes recent press releases; on-line bulletins and publications; in research or reports; as well as a comprehensive listing of **conferences, workshops an**

Populating the HDA Evidence Base

This initiative is still very much in a developmental stage. However, over the next 2 years, the Information Directoriate's programme of work will be orientated towards populating the Evide of reviews, syntheses of evidence and briefing documents. This task will be achieved by worki and organisations in the field including the Cochrane and Campbell Collaborations, the NHS CF

During the course of building the Evidence Base, it has become apparent that there are a num health where good systematic reviews are required. Please follow this link for a comprehensiv identified, to date.

By Spring 2003, the Evidence Base will also include a series of briefing papers across a range provide accounts of the state of the evidence in these areas, identify gaps in the research bas recommendations for future research.

HDA Evidence Base

H

HOME CRITERIA DEVELOPING EB ARCHIVE HELP DISCLAIMER

search for evidence | key papers | gateway | current awarenes

About the HDA Evidence Base

- What is the evidence base for public health
- The content
- Populating the HDA Evidence Base

What is the evidence base for public health?

What 'counts' as good quality evidence for health promotion and health improvement is not a
are a number of **different arguments** as to what constitutes appropriate or reliable forms of
Evidence Base will not attempt to derive consensus as to what constitutes evidence, but will ai
of information that could be used to inform public health practice. Information about 'what wo
range of sources including **systematic reviews**, research reports and journal articles, interne
Government guidance and unpublished research databases. Topics covered in these sources s
medical interventions through to the impact of social factors on public health. HDA Evidence B
full range of factors, interventions, policies and practices that impact on public health and redu

We have developed some basic **criteria** to determine the quality of the research content or 'e
resource, which you can view by **following this link**.

We are also working with other key organisations to develop a more comprehensive statement
quality standards for public health evidence, and information about this work will be posted on

The Content

HDA Evidence Base aims to provide access to the best available information on what works to
health inequalities via the Internet. This resource is aimed at a wide range of practitioners and
public health work.

Building and disseminating the evidence base on health improvement, development and healt
considerable undertaking. This is the first version of the HDA Evidence Base, and the resource
development. The site and resources it contains will develop over time, delivering a wide rang
health professionals, evidence based decision making and practice. In the longer term it will b
other web site initiatives that aim to support the national implementation of **Saving Lives: O**
the **NHS Plan**. These initiatives include the **National Electronic Library for Health**, **The Pu**
Library, **Our Healthier Nation in Practice**, and **HAZnet**.

The information and evidence contained within this resource falls into four main categories:

HealthPromis
The Bibliographic Database of the HDA

Search Catalogue Evidence Base CA Bulletins Topic Databases Links Portal
Electronic Archive Thesaurus Personal Login

<< Go back | Previous | Next | Kept | Help | Contact us | Disclaimer
About HP | Teenage Pregnancy | Exit HP

Search Results

"Stewart, J" search found 5 titles.

#1 **ARTICLE** **2003**

Details **A review of social housing regeneration in the London Borough of Brent**
Stewart, J.

Keep

#2 **ARTICLE** **2002**

Details **A question of need**
Stewart, J.

Keep

#3 **ARTICLE** **1999**

Details **Observations on the effect of abolishing analgesic abuse and reducing smoking on cancers of the kidney and bladder in New South Wales, Australia, 1972-1995**
McCredie, M.

Keep

#4 **ARTICLE** **1998**

Details **Building up Eire's run down estates**
Stewart, J.

Keep

#5 **ARTICLE** **1996**

Details **Substance use and abuse in adolescence: an overview**
Segal, B.M.

Keep

SIRSI

TOP

HealthPromis
The Bibliographic Database of the HDA

Search Catalogue | Evidence Base | CA Bulletins | Topic Databases | Links Portal
Electronic Archive | Thesaurus | Personal Login

<< Go back | Limit Search | Previous | Next | X - Refs | Kept | Help
Contact us | Disclaimer | About HP | Teenage Pregnancy | Exit HP

Search Results

author "stewart, j" AND subject "housing" search found *2* titles.

#1 **ARTICLE** **2003**

Details **A review of social housing regeneration in the London Borough of Brent**
Stewart, J.

Keep

#2 **ARTICLE** **1998**

Details **Building up Eire's run down estates**
Stewart, J.

Keep

Search Again

words or phrase | And
author | stewart, j | And
title | And
subject

Search | Reset

format: ANY
Publication year:
sort by: new to old

SIRSI

TOP

HealthPromis
The Bibliographic Database of the HDA

Search Catalogue | Evidence Base | CA Bulletins | Topic Databases | Links Portal
Electronic Archive | Thesaurus | Personal Login

<< Go back | Limit Search | Previous | Next | X - Refs | Kept | Help
Contact us | Disclaimer | About HP | Teenage Pregnancy | Exit HP

Search Results

author "stewart, j" AND subject "health" search found *11* titles.

#1 **ARTICLE** **2002**

Details **A question of need**
Stewart, J.

Keep

#2 **ARTICLE** **1999**

Details **Self-efficacy, outcome expectancy, dental health value, and dental plaque**
Stewart, J. E.

Keep URL

#3 **ARTICLE** **1998**

Details **Education of women about the prevention of preterm birth**
Davies, B L.

Keep

#4 **ARTICLE** **1997**

Details **Development of a dental value questionnaire**
Strack, S.

Keep

#5 **ARTICLE** **1996**

Details **Changes in dental knowledge and self-efficacy scores following interventions to change oral hygiene behavior**
Stewart, J.E.

Keep

#6 **ARTICLE** **1996**

Details **The road to healthier streets**
Stewart, J.

Keep

#7 **NOT HELD** **1996**

Details **Innovations in public participation**
Stewart, J.

Keep

#8 **ARTICLE** **1996**

Details **Disadvantaged women and smoking**
Stewart, M.J.

Appendix 2

CIEH calls for EH Evidence Base

cial magazine of the Chartered Institute of Environmental Health | March 2006 | volume 114/03

VIRONMENTAL HEALTH PRACTITIONER

EHP

SPECIA
CAMPAIG
EDITION

MAKE THE CASE FOR HE PROFESSION

S ISSUE

RCH
neshaft risk amblers

EMERGENCY PLANNING
The role of the profession

HEALTH AND SAFETY
Protecting child workers

PROFILE
Audrey Lewis

FOOD SAFETY
Tracking food outbreaks

ditor
tuart Spear
20 7827 5828
spear@chgl.com
eputy editor
ick Warburton
20 7827 5854
warburton@chgl.com
ditorial email: ehp@chgl.com

ub editor
ue Balding

ontributors
lark Ball
arah Daniels
ani Fiumicelli
ill Hatchett
avid Holmes
athryn Humphries
teve Miller
eron Smith
oanne Walley
ndrew Walsh

esigners
on Hill
onny Dhamu
20 7 5906
dhamu@chgl.com

oup advertising manager
aul Prior
20 7827 5830
prior@chgl.com
les executive
nie Lorenzini
20 7827 5853
lorenzini@chgl.com
dvertising fax: 020 7827 9930
oduction manager
mes Phillips
20 7827 6304
phillips@chgl.com

ecutive editor
raham Jukes
ead of publishing
nthea Bain
terim managing director
berts

ubscription rate
82 a year. Subscription covers
onthly *EHP* and weekly *EHN*
end cheque, made payable to
hadwick House Group Ltd, to Jewels
odden, Chadwick Court,
6 Hatfields, London SE1 8DJ
ublished by CHGL on behalf of the
IEH. Telephone 020 7928 6006

inted on paper from a sustainable source
y the Manson Group Ltd, St Albans, Herts.

ABC
Circulation 10,596.
Audit for the period
1 July 2004 and
30 June 2005

Editorial

Stuart Spear
Editor

We make the case for the profession

This special themed issue of *EHP* heralds the launch of the CIEH Make Your Case campaign. The aim is to encourage the profession to develop an environmental health evidence base.

There comes a point in the growth of any profession when it is required to provide evidence that its interventions are effective. The medical profession can point to peer-reviewed research. Equally chemists, botanists, physicists, vets and biologists can all point to reams of empirical evidence. If environmental health wants to gain more influence, whether over government policy, elected local government members or corporate bosses, i is going to have to follow suit.

In this issue we hear from senior CIEH managers about why the campaign is needed. We hear that academics need environmental health to become a discrete research subject. The profession will only be able to attract grants if can point to a body of research proving it is worthy of discrete funding. We also hear from the policy team that the revolving door policy that has been adopted within the civil service is now leading to a loss of historic knowledge about government policy. The CIEH needs to prove which interventions work and which do not to stop the endless reinventing of the wheel that now dogs government.

Then there are the reforms of local government and the better regulation agenda. Both could herald a sea-change in the fortunes of environmental health unless the profession can prove the need for its interventions.

But empirical research is not all that is needed. The breadth of issues that the profession is involved in never ceases to amaze. Our story on page 12 is a case in point. Stop your average council tax-payer and ask what they think their environmental health department is responsible for and it's almost guaranteed they will not think of preventing risk from disused mineshafts. And yet, as our story shows, research into the scale of the problem has attracted government funding as the Countryside and Right of Way Act allows ramblers access to areas pockmarked with mines, a legacy from our industrial past.

"A much wider audience needs to become aware of the role of the profession"

One way of demonstrating the breadth of subjects tackled by environment health teams is to point to the growing number of case studies being written up by members and posted on to the CIEH website. There are already 50 waiting to be posted up, ranging from the use of antisocial behaviour orders to stamp out prostitution and crack smoking to regenerating districts that have been paramilitary strongholds, a story we will be covering next month.

A much wider audience needs to become aware of the role of the profession, with the case for environmental health being supported by concrete evidence.

This month's issue of *EHP* marks the launch of Make Your Case, a CIEH initiative that aims to raise the profession's profile in all its areas of influence.

At the heart of the initiative is a simple idea. Environmental health has matured to the point where it needs to develop an evidence base.

It is time for all EHPs, whether working with national or regional government or working in academia, commerce or local government, to demonstrate the efficacy of their work. Through Make Your Case, the CIEH is calling on its members to document their public health interventions, look for research opportunities, target specialist magazines and publicise the projects they are working on.

To help achieve this, the CIEH is launching a series of national training programmes and providing a toolkit to aid EHPs in the publication of research and case studies and to help them deal with the media.

The CIEH will help fund research, creating an internet-based good practice resource and encouraging peer-reviewed research.

Later this year specialist groups and the regional centres will be targeted to provide forums to spread good practice and build evidence bases in support of regional public health interventions.

Over the next pages *EHP* hears from the CIEH's senior management to discover why environmental health has decided to raise its game.

We find out why the dangers posed from mineshafts have attracted CIEH and Defra funding and we interview a Westminster councillor who demonstrates what can be achieved when elected members support the profession.

In this themed issue we also look at what you can expect from the training toolkit, at good practice in Cheltenham tackling child safety in the workplace and repeat a call for more membership participation in a report on the work of the expert advisory panel over 2005.

MAKE YOUR CASE

HOUSING

he environmental health rofession needs to advance its vidence base to demonstrate its alue as a public health champion. **ick Warburton** reports on the IEH's training workshops and good ractice toolkit offering advice to nembers on how to establish an vidence base

lick through the pages of *Environmental Health News* and *Environmental Health Practitioner* and immediately the reader is struck by just how important a role environmental health plays in making lic health gains. Across the UK, EHPs are lying their skills and expertise to a myriad of vities, be it campaigning for a ban on king in public places, raising awareness of dangers of using sunbeds or working through mmunity projects to improve diet and ition.

nvironmental health has a long and proud k record when it comes to improving health. with so many issues to influence, it is not rising that many EHPs are too busy to find to write up their work activities as case lies or prepare research papers to promote the heir work.

Inlike the medical profession, which has a ure of writing up its work as case studies to l into an evidence base, environmental health yet to fully grasp the opportunities that can leaned from doing this.

or instance, imagine that you are a local hority that has a particular problem in your . How useful would it be if you could find out r colleagues around the country have tackled same problem and imagine if you could ss case studies from other authorities, which vided just the information that you needed have it at your fingertips? Well, that is tly what the CIEH is in the process of doing ncouraging members to help advance the ronmental health evidence base.

s enhancement

ing in May (*see dates, opposite page*), the CIEH host a series of training workshops aimed at iding EHPs in both the public and private rs with the skills they need to add their to the evidence base and hence make it able to others. Run over two days, with a six-week gap between the two days, these interactive workshops offer an opportunity for members to enhance their existing skills and enable colleagues around the country to access information on good practice.

To complement the training, the CIEH's communications and education teams have developed a toolkit, which will only be available to those who attend a course. The toolkit contains practical guidance on how to turn good practice into case studies, write articles and papers for publication in technical journals and produce publishable research.

Written in an easy-to-use format and divided into six sections, the toolkit kicks off by looking first at the value of good practice in environmental health before going on to explain how EHPs can apply for funding for research projects. The following sections offer advice on how to write for a peer-reviewed journal as well as non-peer reviewed publications such as *EHN* and *EHP*. The final sections then look at how to prepare a good practice case study and how to prepare a presentation for a conference or seminar.

Good practice case studies

A vital ingredient in advancing the evidence base is the inclusion of good practice case studies that emphasise the value of environmental health. The toolkit contains two examples from beacon councils – Coventry City Council and Westminster Council, both of which have been proactive in putting in place projects that have produced measured successes.

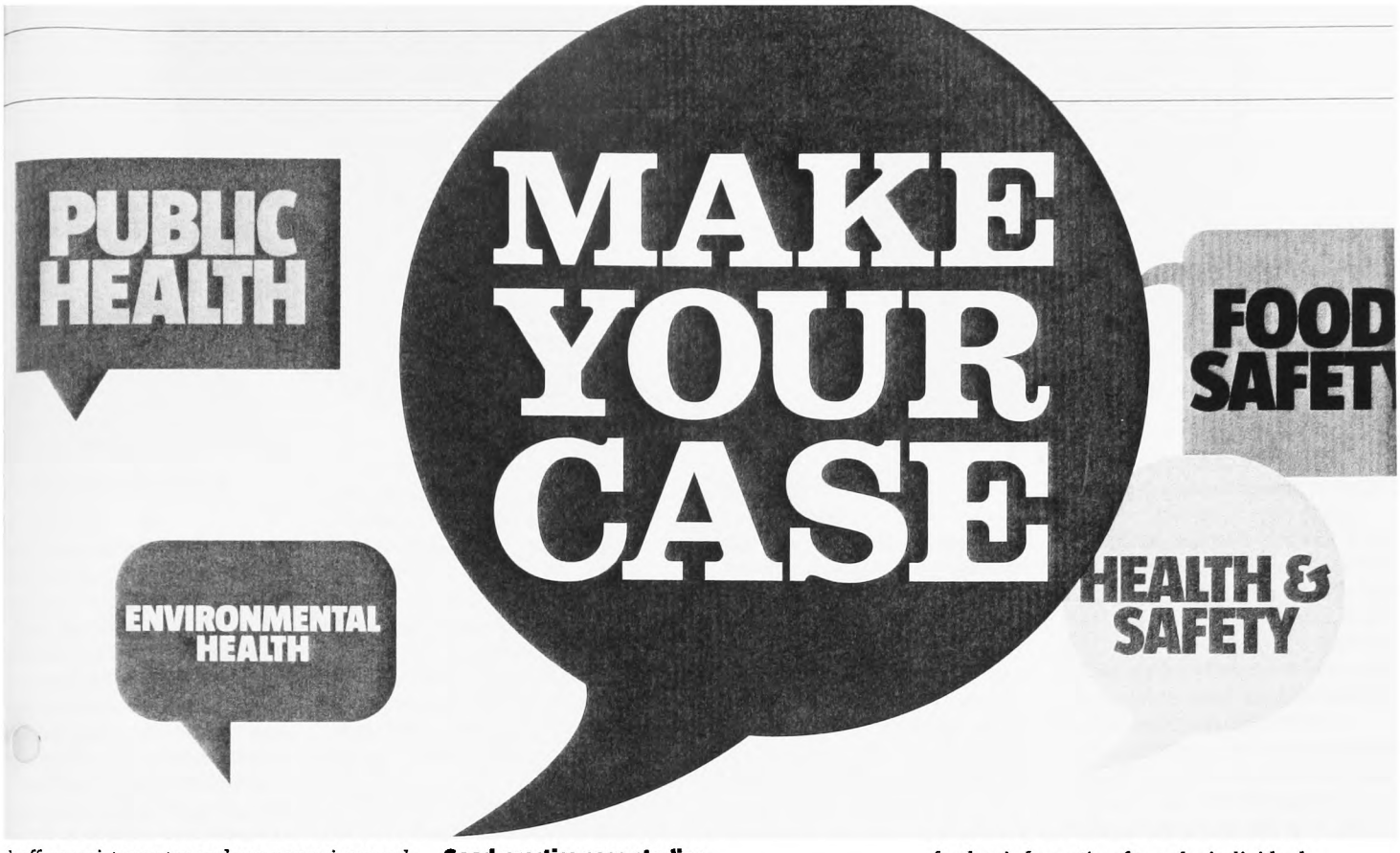
Westminster is notable for achieving good performance in all areas of environmental health (*EHP, November 2005, page 24*) and has also demonstrated excellence and innovation. The toolkit uses the council's prominent licensed premises list as an example of good practice to underline how environmental health interventions can have a measured impact. The case study concerns a target list which is produced every month by the council's intelligence unit for the purpose of identifying licensed premises within the borough that may be experiencing crime and disorder issues. Data collected is used to score each premises and put them on a list. Using a multi-agency approach, a range of actions is employed, which ultimately will remove the premises from the list over future weeks or months.

In Coventry's case, the environmental health team has been recognised for developing and supporting sustainable development in the community and improving its health (*EHP, September 2005, page 34*). The team's food safety advisory service, which targets owners and managers of small and less developed food businesses in the city with the aim of improving food safety standards, is included as another case study to underline the measured impact of environmental health interventions. The project works by bringing in an adviser from the catering industry who provides peer support by offering practical information and advice to caterers, particularly in relation to hazard analysis. The approach has proven to be highly successful and shows how compliance with the law can be secured without resorting to formal enforcement action.

Research is vital

As the toolkit explains, "undertaking a piece of research is not the minefield that many think". Support is available and undertaking research is an excellent opportunity both for personal development and as a way to contribute to the evidence base.

The purpose of this section therefore is to encourage members to consider areas for research. To assist in this, the toolkit contains information on the CIEH's research grant scheme and other sources of funding. Because the CIEH recognises that carrying out research can be expensive both in time and money, it has set up a research fund,



ch offers assistance towards expenses incurred ndertaking environmental health-based rch (up to £3,000 per application). However, does not include assistance towards the ent of fees or staff costs.

e funding section also contains a case study uccessful applicant for the CIEH research – David Holmes, who has investigated the tory nuisance of mineshafts (*see page 12*). Mr es also provides his sample application form.

ng writing skills to use

her important way to contribute to the onmental health evidence base is for bers to send articles to the peer-reviewed *al of Environmental Health Research*. Not only contributing benefit the individual but it h... the profession to establish the subject own right.

e *JEHR* is looking to encourage a range of tial authors, including those who wish to ert an academic dissertation into a journal r (original research paper) as well as subject ts who wish to undertake a detailed review e literature (review articles). It is also ng for environmental health and other ssionals who have evaluated a professional ice issue and wish to write it up ssional evaluation).

e toolkit gives practical guidance on how to it ideas and articles, detailed information w to write and get articles published, and xamples of good practice.

t it is not just peer-reviewed research that build the evidence base. The CIEH's non-eviewed publications, *EHN* and *EHP*, are mportant forums for discussion and debate n the profession as well as disseminating nation on good practice. In this section, ers can find out what types of articles are hed, how and what they should contribute editors, as well as tips like how best to send s and photographs, and meeting deadlines.

Good practice case studies

Unlike other professions such as the medical community, environmental health does not have a culture of writing up examples of good practice (a case study). Huge benefits can be reaped from writing these up – foremost being that they enable the wider environmental health community to learn from individual successes and failures. Equally important, case studies can be used by the CIEH press office, members' employers or the local media to publicise important work.

A good case study incorporates many elements, for example, it must have clear objectives, a statement of the issue, and the aspects of environmental health work that it is concerned with. In the section on "how to prepare a good practice case study", EHPs can find out what elements to incorporate as well as refer to a case study proforma, which provides guidance when writing up work they have done themselves or by colleagues. The section also contains the "eat clever" toolkit as a practical example. Its summary puts the case study in to context – in this case tackling rising obesity and poor nutrition – what the response was, including the environmental health action, and the measured outcomes. Readers can also find out further information from the individuals involved.

What the good practice toolkit covers

- an introduction explaining why the profession needs an evidence base
- the value of good practice in environmental health
- how to apply for funding for research projects
- how to prepare an article for a peer-reviewed journal
- how to prepare for a non-peer-reviewed journal or magazine
- how to prepare a good practice case study
- how to prepare a presentation for a conference or seminar

Presenting your case

The toolkit's final section looks at how EHPs can promote good practice case studies or research projects through conference or seminar presentations. Through their work in the local community, EHPs develop good interpersonal skills, and speaking at events is a natural progression and a useful skill to develop. Many people, however, find speaking at public events intimidating and the purpose of this section is to provide advice on how to get the best out of these events.

The guidance comes with a good practice PowerPoint presentation from Alan Page, senior lecturer in environmental health at Middlesex University, on sustaining the environmental health community, which outlines how to write a good presentation.

Make your case

EHPs are dedicated and passionate advocates of public health and many are working at the forefront of this challenging agenda. A first and important step in raising the profile and status of environmental health is to do what other professions have done and advance the evidence base to underline how environmental health interventions can bring measured improvements. With a good solid evidence base, EHPs can draw inspiration from the work of others, spread good practice and provide the profession with the tools it needs to make its case. ■

Successful applicants will be invited to attend the training workshops, which will be run over two days, with a six-week gap in between. They will be run in:

- **Leeds on 2 May and 15 June**
- **London on 4 May and 12 June**
- **Bristol on 16 May and 27 June**
- **Derby on 18 May and 26 June**

hy the sudden need for an evidence base? Senior CIEH staff explain the rationale behind the Make Your Case campaign

RAISING

raham Jukes

EF EXECUTIVE

ou suffer an infectious disease tbreak on your patch, it is often ar-cut what has to be done. Swabs e taken, the infection root is tablished, the source is isolated and ntacts are traced. There is a entific link between the spread of r and the control mechanisms ve put in place. Unfortunately s is not the case with all aspects of ironmental health. Proof that our erventions achieve what they set to achieve can sometimes be chy. This often hinders our empts to influence government icy, gain academic credibility or ess resources.

The time has come for us to quivocally demonstrate what we achieve by writing up tried and ed methods in a way that rides an evidence base for eagues so we are not perpetually venting the wheel or having to ve our case again and again.

The need for an evidence base has ome more important with the ernment proposing changes to the al government landscape. The gulation agenda is creating a mework against which the delivery nvironmental health is likely to be ged.

As this culture grows we are easingly going to be required to monstrate the positive effects of vironmental health.

For those colleagues working in primary care trusts and the Health Protection Agency, they are joining a culture where evidence underlines strategy. They are going to need support as they argue their case with our clinical colleagues.

An evidence base will also support our colleagues in the commercial sector. We have EHPs working in organisations as diverse as British Airways, Manchester United football club and the supermarket chains. They equally need to be able to make the case to their employers that by taking a precautionary approach you are helping stimulate the economy not dampening it, as has been suggested in the Hampton review.

> "We need the evidence that if you get rid of regulation it will impact on wellbeing, as long as that is the case"

Regulation is a tool not an end in itself. If it does not work we need to know. Equally if it is effective we need to be able to make the case. We must no longer be on the back foot. We need the evidence that if you get rid of regulation it will impact on wellbeing, as long as that is the case.

If the CIEH is to raise the profile of environmental health we really need participation, the evidence lies in the work you do and we need you to share your experiences with us.

Ian Foulkes

POLICY DIRECTOR

When we are trying to influence government policy we need evidence to prove our case. Otherwise all we are expressing is our opinion, which is challengeable, and may not result in us achieving the outcomes we seek.

This is something we have learnt from experience. For example, when we campaigned on pest control and public health around the 2012 vision document we were able to point to hard evidence that backed up our case. This made our position very powerful compared to that of other organisations.

In the policy team we hear about important, innovative and challenging work carried out by EHPs across the country. This often informs our opinion but unless that work is properly evaluated, and the lessons learned from it effectively captured, it often leaves us with nothing concrete to support our view. For us to garner the influence that the membership expects of us we need that evidence.

We need to take the view that all EHPs are science graduates and so understand how to design an experiment, which includes the proper evaluation of results. It is time we introduced that discipline back into the day-to-day work routine to the benefit of everyone in the EH community.

This has become particularly important over the past few years as a result of a cultural shift in the running of the civil service. In the past a civil servant would work in the same department for 30 years. They knew everything that had happened historically in their area. Now the civil service is much more dynamic. Civil servants are in and out of a ministry in two years and every time you get a change-over, policy goes backwards as the wheel gets reinvented.

The CIEH has a role in stopping this happening, a task made much easier if we can point to evidence of a strategy working or failing. A CIEH view, supported by evidence, will ultimately make the policy process more productive. Instead of endlessly going over old ground we will be driving policy forward.

The CIEH recognises a need to change local government's attitude towards staff training and research. We are working with the Employers' Association, Lacors and the LGA to generate change, to bring local government more in line with the NHS. But it will take time, which should not prevent environmental health acting as the vanguard and building up its evidence base, with a comprehensive suite of case studies.

> "Civil servants are in and out of a ministry in two years and every time you get change policy goes backwards"

lichael Dunmore

MMUNICATIONS DIRECTOR

o years ago we asked you what
u wanted from the CIEH. Following
ensive research with members,
members, employers and
ernment we produced the policy
ument, *Leading Environmental
into the Future*.

identified four key aims. You
nted greater recognition of your
tribution to improving
ironmental health and your

> ou felt you were not
> tting the recognition you
> served and risked losing
> ur professional status"

fessional status to be raised.
wanted us to promote
rovements in environmental health
cy and you wanted us to ensure
n professional standards.
n short, you felt that you were not
ting the recognition that you
erved and that as a result you
ed losing your professional status.
ke Your Case initiative,
ched this month, aims to address
ir concerns.
The CIEH has raised the profession's
file in the media. We now need
d evidence to prove that anyone
esting in environmental health will
only get soft benefits but hard,
nonstrable returns.

By pointing to case studies and research we will be able to demonstrate that environmental health will not only provide measurable returns to employer's organisations but also to whole communities.

An evidence base will provide us with the ammunition to communicate the efficacy of environmental health, whether that is to chief executives of companies, the elected members of local authorities, stakeholders, government or the general public.

Case studies will demonstrate the breadth and depth of the work done by EHPs and that, as a profession, you are involved in initiatives far beyond what most think of as the traditional remit of environmental health.

The aim of the national training courses, along with our toolkit, is to equip CIEH members with the skills to access research funding, to place articles in the specialist press, to write up research and to put together case studies.

We will be helping you to get your message over to the local press, providing a website to post your case studies and the research journal to publish peer reviewed research.

We will also be developing the work done in Wales and Northern Ireland across the new regions, encouraging stakeholders and elected councillors to learn the true value of environmental health.

You are our members and we need your participation because the evidence lies in your work and experiences.

Paul Robinson

EDUCATION DIRECTOR

Academics in the field of environmental health research are caught in a chicken and egg situation.

On the one hand they struggle to receive appropriate recognition and public funding for their research because within the research assessment framework, environmental health is not recognised as a discrete research area like medicine, geography or physics. On the other hand, environmental health is not considered a subject area in its own right because it lacks a large enough evidence base.

Some funded research is taking place in environmental health subjects. But for the purpose of the government's research assessment exercise it has to be linked to other recognised research areas, such as "subjects allied to medicine" or "the built environment".

We need to be able to argue the case that environmental health should be recognised as a research subject in its own right. However, we are not going to achieve this without being able to present a significant body of evidence proving the need. What better place to start than to have a database of research including case studies, peer-reviewed research and examples of initiatives that have already attracted research funding?

We need to establish a firm academic footing if the profession is to move forward. Something that the Make Your Case initiative aims to provide. The CIEH will be equipping members with the tools to create that evidence base by helping you produce mixture of case studies identifying bes practice, research-based articles and papers along with presentations to conferences and seminars.

Those EHPs who have participated i the programme will be equipped to

> "We need to argue that environmental health shoul be recognised as a research subject in its own right"

take their research skills to the next level, enabling them to work with academic colleagues in their local universities to produce publishable research and to potentially register for M Phil and PhDs and, or, post-graduat doctorates.

MAKE YOUR CASE

THE PROFILE