Health Impact Assessment of Housing Improvements
A Guide

Public Health Institute of Scotland and MRC Social and Public Health Sciences Unit

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Scottish Household Survey household types
The household types in the Scottish Household Survey are defined as follows:

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single adult</td>
<td>1 adult of non-pensionable age and no children.</td>
</tr>
<tr>
<td>Small adult</td>
<td>2 adults of non-pensionable age and no children.</td>
</tr>
<tr>
<td>Single parent</td>
<td>1 adult of any age and 1 or more children.</td>
</tr>
<tr>
<td>Small family</td>
<td>2 adults and 1 or 2 children.</td>
</tr>
<tr>
<td>Large family</td>
<td>2 adults and 3 or more children or 3 or more adults and 1 or more children.</td>
</tr>
<tr>
<td>Large adult</td>
<td>3 or more adults and no children.</td>
</tr>
<tr>
<td>Older smaller</td>
<td>1 adult of non-pensionable age and 1 of pensionable age and no children</td>
</tr>
<tr>
<td></td>
<td>or 2 adults of pensionable age and no children.</td>
</tr>
<tr>
<td>Single pensioner</td>
<td>1 adult of pensionable age and no children.</td>
</tr>
</tbody>
</table>

Table of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIH</td>
<td>Chartered Institute of Housing</td>
</tr>
<tr>
<td>HIA</td>
<td>Health impact assessment</td>
</tr>
<tr>
<td>LA</td>
<td>Local authority</td>
</tr>
<tr>
<td>RSL</td>
<td>Registered social landlords</td>
</tr>
<tr>
<td>SHCS</td>
<td>Scottish House Condition Survey</td>
</tr>
<tr>
<td>SST</td>
<td>Scottish Secure Tenancy</td>
</tr>
</tbody>
</table>
This guide has been written to help people doing a health impact assessment (HIA) of a housing proposal. It is written primarily for those with little or no knowledge of housing but some knowledge of public health.

**The guide:**
- Summarises the evidence on housing and health.
- Suggests some questions to help you consider the context of a specific proposal.
- Outlines how to use the evidence to do a health impact assessment.
- Provides some background information on housing in Scotland and the policy context.
- Suggests sources of further data on housing.

This document is not a blueprint for HIA of housing proposals. It brings together some information that should help you to carry out an assessment and help you to find further evidence and data that you might need. The guide is intended to help with HIA of housing interventions like building projects or housing improvements. Although not the primary aim, the evidence may also inform HIA of housing policies or strategies. We hope it is flexible enough to support different approaches to HIA depending on your own situation.

We would be glad to hear comments on this document, including suggestions for improvements to future versions. Please send these to:
Margaret Douglas
Lothian NHS Board
148 The Pleasance
Edinburgh EH8 9RS
E-mail: Margaret.Douglas@lhb.scot.nhs.uk

**Members of the working group**
Margaret Douglas, Consultant in Public Health Medicine, Lothian NHS Board
Hilary Thomson, MRC Social & Public Health Sciences Unit
Marjorie Gaughan, Public Health Specialist, Ayrshire and Arran NHS Board

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1. Hilary Thomson is employed by the MRC and funded by the Chief Scientist Office at the Department of Health, Scottish Executive.
2. As of 1 April 2003, the Public Health Institute of Scotland merged with the Health Education Board for Scotland to become NHS Health Scotland.
This chapter provides a summary of available data on housing in Scotland for non-housing professionals. Together with chapter 5, it aims to help public health professionals understand the constraints and policy context within which housing proposals are developed. Broader policies regarding planning, regeneration and land use are also relevant but are beyond the scope of what can be included in this document. The key relevant policy is the Housing (Scotland) Act 2001, which is summarised in chapter 5.

**Dwellings**

There are an estimated 2.3 million dwellings in Scotland. Over 23,000 new dwellings were completed in 2000, this figure has been rising since 1991. Most were in the private sector, but housing associations built almost 5,000 new dwellings in 2000. Public authorities built less than 100 in 2000.

**Housing conditions**

The Scottish House Condition Survey (SHCS) is a national survey that looks at the physical condition of homes, and interviews the people who live in them. The most recent data available are from the 1996 survey. It found that:

- 38% of occupied dwellings were flats, higher than the proportion in the rest of the UK;
- 64% of dwellings were built after 1945, and one third in the last 30 years;
- 83% of dwellings were in urban and 17% in rural areas;
- Privately rented dwellings had the poorest amenities and housing association stock had the best amenities;
- 1% of occupied dwellings were below tolerable standards, most commonly because of damp;
- 74% of households had full central heating and 14% had partial central heating;
- 25% of dwellings were reported to have damp or condensation;
- 20,000 households included a wheelchair user, but only 5,000 dwellings were of full wheelchair standard.

**Trends in tenure**

The table below shows the changes in tenure since 1990. There has been an increase in the proportion of dwellings that are owner occupied and a reduction in those that are publicly rented. One reason why this is relevant is that publicly rented properties are allocated by need, whereas others are allocated by ability to pay.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total (thousands)</th>
<th>Owner occupied</th>
<th>Privately rented</th>
<th>Rented from housing association</th>
<th>Rented from local authority/ New Town/ Scottish Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>1990</td>
<td>2,124</td>
<td>1,088</td>
<td>51</td>
<td>126</td>
<td>65</td>
</tr>
<tr>
<td>2000</td>
<td>2,325</td>
<td>1,468</td>
<td>63</td>
<td>155</td>
<td>145</td>
</tr>
</tbody>
</table>

Source: Housing Trends in Scotland HSG/2002/1

In the 1996 SHCS, 22% of households had been in their present home for 20 years or more; 18% had moved in the previous 2 years.
Housing in Scotland

Types of household
There are an estimated 2.2 million households in Scotland, and the number is rising. As shown below, the most common types of household are small adult and pensioner households. Single adult and older smaller households (with 2 adults, at least one of whom is of pensionable age) are also common. (The definitions of household types are given in the glossary.)

<table>
<thead>
<tr>
<th>Type of household</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>single adult</td>
<td>14.6</td>
</tr>
<tr>
<td>small adult</td>
<td>16.9</td>
</tr>
<tr>
<td>single parent</td>
<td>5.5</td>
</tr>
<tr>
<td>small family</td>
<td>15</td>
</tr>
<tr>
<td>large family</td>
<td>7.6</td>
</tr>
<tr>
<td>large adult</td>
<td>10.4</td>
</tr>
<tr>
<td>older smaller</td>
<td>14.2</td>
</tr>
<tr>
<td>single pensioner</td>
<td>15.7</td>
</tr>
</tbody>
</table>

Source: Scottish Household Survey 1999/2000

Homelessness
In the financial year 2000/01, there were over 45,000 applications under the homeless persons legislation. This is a rise from 35,061 in 1990/91. In 1999/00 74% of applications were assessed as homeless or potentially homeless and 44% were assessed as in priority need. (Corresponding figures for 2000/01 are not yet available).

Building Standards
In Scotland, and the whole of the UK, all new-build housing, whether construction or renovation must be of a tolerable standard. Similarly new build housing must comply with building standards regulations to ensure certain quality standards. A list of criteria for a tolerable standard has been set out in the Housing Scotland Act 1987. A house meets the tolerable standard only if it:

a. is structurally stable;
b. is substantially free from rising or penetrating damp;
c. has satisfactory provision for natural and artificial lighting, for ventilation and for heating;
d. has an adequate piped supply of wholesome water available within the house;
e. has a sink provided with a satisfactory supply of both hot and cold water within the house;
f. has a water closet available for the exclusive use of the occupants of the house and suitably located within the house;
g. has an effective system of drainage and disposal of foul and surface water;
h. has satisfactory facilities for the cooking of food within the house;
i. has satisfactory access to all external doors and outbuildings.

Although originating from 19th century health related concerns of sanitation, window size and overcrowding, these criteria appear crude and inadequate by today’s standards. There have been calls to add acceptable standards more in line with the 21st Century living standards, for example around equality of access for people who are physically or socio-economically disadvantaged.
Introduction

There is a well established link between poor housing and poor health. Indeed many, possibly hundreds, of cross-sectional studies have reported statistically significant associations between poor housing conditions and poor health. Despite this, eliciting specific housing hazards which could be acted on to improve residents’ health is far from straightforward.

Housing is inextricably linked with socio-economic factors of individuals and area factors which are also important determinants of health. Although it is possible to control for many of these confounding variables there is the possibility of over controlling for factors which are themselves health determinants and also influenced by housing. For example, smoking has been explained as a mediator for the stress of living in poor housing. Disadvantaged individuals are likely to spend more time in the home due to unemployment and lack of leisure opportunities, resulting in higher levels of exposure to a particular hazard. Other important confounders are difficult to control for. For example, number of people and activities such as washing, cooking and type of fuel all influence water vapour levels and temperature in a house. Accurate assessment of these activities and influence on each individual’s exposure to a specific hazard is difficult and costly in terms of time.

Measuring exposure to possible hazards has also been problematic. Levels of mould spores, temperature and dampness may vary widely by room and by day of assessment. In addition, there are issues around the accuracy of methods used to measure these specific aspects of housing conditions.

Furthermore, there is an important distinction between an association and an effect. Once independent associations are established, it may not be clear if the poor health or the poor housing came first. There is also the further complication of a possible time-delay from exposure to effect. Poor health in adulthood may be the result of poor housing conditions in childhood. In addition, it is not always the case that reducing exposure to a health hazard, or variable associated with poor health, will produce the expected and desired effect of improving health.

As a result of some of these issues, interpreting the findings of housing studies can be confusing. In addition, there is a large volume of studies of housing and health. Collating these studies and some of the conflicting findings can be overwhelming. This chapter attempts to provide the reader with an overview of the best available research evidence about the health impacts of housing, housing improvement and related factors.

The research evidence presented in the first section of this chapter focuses on the health impacts of specific hazards. This partly reflects the approaches taken by those investigating aspects of housing as health hazards. Investigating specific hazards and the impact of specific housing improvements may also be of more value in informing specific policy decisions, or in improving the predictive value of a health impact assessment of a specific housing improvement. Broad generalisations about the link between deprivation, housing and ill health are more difficult to apply to a specific investment area such as a specific housing improvement. However, investigating specific aspects of housing as health hazards has been criticised for ignoring the complex nature of housing, deprivation and health. A more holistic approach which identifies individuals who are particularly susceptible to poor housing, and have little control over living circumstances and also recognises the mental health effects of a poor living environment, has been recommended. We have aimed to take a holistic approach to the research included in sections 2 and 3 of this chapter. In addition to research on the health impacts of housing improvement we have incorporated observational evidence of aspects of housing associated with poor health as well as important impacts on social circumstances associated with housing improvement programmes. Impacts and reported relationships between housing and objective and subjective measures of mental and physical health and housing satisfaction have also been included.

The following sections provide a research overview divided into three sections according to the type of research evidence they present:

1. Observed associations between housing and health

A selective review of housing characteristics associated with poor health. Housing improvements which minimise these characteristics may prevent poor health and reduce the association of poor housing and poor health. However, there is insufficient understanding in most of these areas of the relationship and whether or not housing...
improvement has the potential to reduce the exposure or the health effects of these housing characteristics.

2. Studies of housing improvement and health
This section summarises findings from all available studies, published and unpublished, which have monitored health changes following housing improvement. This summary is based on a systematic review of world literature dating from the 1930s to 2000. The review included studies of any design and included studies using objective and subjective measures of health and wellbeing as well as illness and symptoms.

3. Other important effects reported in studies of housing improvement and associated regeneration
This section presents findings from studies of housing improvement which report on the wider social impacts of housing improvement. These findings draw attention to possible explanations for the small health impacts of housing improvement observed in Section 2. Housing investment which minimises the negative impacts reported in this research may have more potential to improve existing residents’ health.

1: OBSERVED ASSOCIATIONS BETWEEN HOUSING AND HEALTH
There are many housing characteristics that have been linked to poor health. This section provides a selective review of observational and qualitative literature which has linked specific aspects of poor housing conditions to health. Where available, up-to-date systematic reviews or comprehensive expert reviews have been used. The research reviewed in this section differs from that in section 2, as it is not possible to forecast the possible health impacts or improvement of housing improvement from reported links. The data in this section provide an overview of the main housing characteristics associated with poor health. Developing housing improvements on this basis may reduce harm but it is not known if such improvements would automatically be accompanied by health improvements of individuals.

A comprehensive, expert review of the risks and health hazards of domestic buildings identified indoor air quality, hygrothermal conditions, radon, falls, house-dust mites, environmental tobacco smoke and fires as the highest health risks. The main housing factors linked to health and which are commonly part of or accompany housing improvements are listed below; these should be considered in an HIA of housing improvements.

Indoor Air Quality
In a recent expert review of the health effects of exposure to airborne particles in the home, the findings of observational, human, epidemiological and toxicological animal studies were reviewed. The most common airborne particles arise from environmental tobacco smoke, cooking, certain heating appliances and human activity. The level of indoor particles is strongly correlated with outdoor levels and raises personal exposure substantially. Short-term elevations in ambient particles are strongly associated with increases in mortality and morbidity; acute cardio-pulmonary impairment being the predominant impact and vulnerable groups such as the elderly and people with asthma being most at risk.

Dampness & Hygrothermal conditions
Dampness and temperature are closely linked and are related to allergen growth and viruses, both harmful to health. The following sub-section presents an overview of the relationship between dampness and hygro-thermal conditions which are of particular relevance in the moderate, wet climate of the West of Scotland. As well as climate, number of bodies, activities such as cooking, laundry, bathing and the use of certain fuels will influence levels of water vapour in indoor air.

The ‘dewpoint’ is the temperature at which water vapour in the air will turn into condensation; the higher the temperature the more water vapour can be held in the air before condensing into droplets. An optimal level of ventilation is required to reduce internal water vapour as well as expelling noxious smells and gases from the home. As warm indoor air is exchanged for cooler outdoor air, heat is lost. If too much heat is lost then the dewpoint will fall and there will be an increased likelihood of condensation.

Condensation is more likely than structural dampness to encourage mould growth. In conditions of penetrative or rising damp the salts which emerge with it tend to inhibit mould growth. Windows are likely to be the first surface where condensation arises, especially single glazing. Although the condensation may cause damage to
the window frames, glass is not a surface which can support mould growth and condensation itself is pure. Thus single glazed windows may help to reduce water vapour by condensation on a non-hazardous surface.13 A warm damp indoor environment encourages the growth of house dust mite and mould spores. Fungal spores released by moulds thrive on the organic material of plaster and wallpaper. Once established, moulds spread easily to furnishings and clothing.

The relationships described above are complex, making it difficult to isolate effects of specific hazards. In addition to the many influences on domestic water vapour levels and hygrothermal conditions, which would need to be controlled for, there are also issues around accurate and reliable measures of respiratory illness, allergens14 and dampness in the domestic setting and individual exposure.

Mould & house dust mite allergens: links to health
Moulds release spores which are also allergens, although mould allergy is less common than allergy to other domestic allergens such as house dust mite.14 Exposure to mould spores may lead to toxic effects, infection or allergy and vulnerable groups are at particular risk. Associations between mould growth and health status have been frequently reported, however there is debate about the strength of the relationship owing to the many confounders mentioned above, the range of moulds and different hazardous exposure levels, and measurement difficulties.14 In a review of studies of the associations between damp and mould and respiratory health the authors concluded that if the home was damp or mouldy there was a small increased risk of respiratory symptoms, and recommended that new build housing is designed to prevent the proliferation of indoor allergens.15

The main allergen in house dust comes from the faecal pellets of the house dust mite. A systematic review16 of the effectiveness of house dust mite control measures in the management of asthma has been carried out. Measures used included vacuuming and acaricidal chemical measures. The authors concluded that current chemical and physical measures to reduce exposure to house dust mite allergens seem to be ineffective in the management of asthma. This is partly because asthma sufferers are often sensitive to other allergens as well as house dust mite. An additional controlled study recently carried out in Lanarkshire, Scotland found that reducing allergens and dampness does improve respiratory symptoms among people with asthma. However, this study was small (n=54) and is insufficient to change the conclusions of the systematic review.

Temperature & Warmth
Damp cold air has a greater cooling effect than dry cold air thus affecting temperature and thermal comfort. Penetrative damp in the fabric of a house will also contribute to a cooling effect. Thermal comfort is determined by a number of environmental, physiological and psychological factors as well as personal taste. Although minimum and maximum indoor temperatures have been recommended it is not possible to predict accurately what temperature limits are hazardous to health.17 Provision of central heating in housing may not automatically result in warmer homes. Heating systems which can provide affordable heat is an important consideration when installing new heating systems into homes, especially social housing. It has been suggested that health problems associated with cold housing are more strongly linked to the ability to fund fuel bills rather than the characteristics of the house itself.18

The 30% increase in UK death rates between the summer and winter months in the UK is strongly related to winter reductions in outdoor temperatures.19 Those at the extremes of life are particularly vulnerable, i.e. the elderly and very young. Although influenza epidemics contribute to the seasonal variation in deaths, deaths from other respiratory illnesses, heart disease and cerebrovascular disease also increase. Deaths from hypothermia only account for a small part of the increase. Recent analyses suggest that the seasonal variations are related to indoor rather than outdoor temperature, and that this annual increase in winter deaths could be reduced by helping residents protect themselves from cold weather conditions.20-22

Housing tenure
Home ownership has been independently linked to improved health of residents. It is thought that home ownership may generate a degree of security and control, though the direction of the relationship needs further investigation.21 However, home ownership is not always health promoting. Nettleton and Burrows’ study of the health impacts of mortgage arrears suggested that those living on the margins of home ownership suffer increased
insecurity and detrimental mental health impacts. In addition, cultural variations in rates and meaning of home ownership may give rise to international variation.

**Housing Design**
Flat dwelling, in particular high-rise flats, has been linked to factors associated with stressful living conditions such as increased social isolation, crime, reduced privacy and opportunities for safe-play for children. However, there are many factors related to flat dwelling which may confound findings of surveys and there are no conclusive data that height of home from ground level is associated with reduced health or satisfaction with housing.

A recent review of epidemiological surveys showed a consistent pattern of decreased levels of mental health associated with housing height and multi-unit dwelling. It is unclear how these studies were selected for review and the authors point out that they are unable to draw conclusions of a causal link due to the poor quality of research in this area.

**Housing satisfaction**
Overall satisfaction with neighbourhood has also been linked to health. Although not an explicit health or illness indicator, neighbourhood satisfaction has been used as a proxy for life satisfaction and general affect influencing mental health. Neighbourhood satisfaction is most strongly influenced by satisfaction with housing and private space, although it is unclear how neighbourhood satisfaction influences housing satisfaction. There are also unanswered questions as to how specific area characteristics, especially amenities, influence overall neighbourhood satisfaction. Poor quality housing, flatted housing and overcrowded housing have been associated with low levels of mental health and emotional wellbeing particularly amongst women and children.

Evidence from the review of health gains following housing improvements adds further weight to this as a mechanism by which poor housing and housing improvements may impact on mental health.

2: STUDIES OF HOUSING IMPROVEMENT AND HEALTH

Despite extensive searching for studies in all languages only 18 studies were identified which had assessed the health impacts following housing improvement. The literature reviewed here relates to housing conditions and home accident prevention measures. Literature on radon, lead and carbon monoxide were also excluded as there are already measures in place to protect residents from those hazards. The previous section reviewed studies of the strong and persistent links between housing and health. This section reviews studies that may support forecasts of the health impact of health improvement programmes on existing residents.

### General wellbeing, physical health and illness episodes

Fourteen studies have assessed changes in general health following housing improvement. Ten studies found some health improvements, and five studies found no difference in some measures. Some studies found mixed effects. Measures used included self-reported wellbeing, activity, symptoms or illness episodes and health service use. Two studies used a validated general health measurement.

Three studies of rehousing and community regeneration reported adverse effects on general health. One study found increases in reported illness episodes (+56%), though this was in part attributed to a flu epidemic. In a further study, age standardised mortality rates increased for all ages, except infants, five years after rehousing from a slum area.

### Mental health

Half the studies identified used a measure of mental wellbeing (including the Hospital Anxiety and Depression Scale (HADS), self-reported mental health and hypnotic prescribing levels). These studies assessed the health impacts of medical priority rehousing, energy efficiency improvements, refurbishment, rehousing and
area regeneration. All of these studies, except one study of central heating installation, found improvements one month to five years after the housing improvements were completed. In one large, prospective controlled study the degree of improvement in mental health was directly related to the extent of housing improvement, demonstrating a dose response relationship. This consistent pattern of improvements in mental health would suggest that improving housing would generate mental health gains.

## Mental Health

**Overall assessment:** Improvements in housing are likely to result in improvements in residents’ mental health.

## Respiratory Health

Four studies investigated changes in respiratory symptoms. Measures used included self-reported symptoms and respiratory prescribing. Three of these studies were of rehousing and area regeneration; two of the studies reported increases in respiratory symptoms. One study found an increase in chronic respiratory conditions (+12%) among adults five years after the move while the other study found reductions (-11%) in bronchial and asthmatic symptoms 1-4 years after the move. The study of routine respiratory prescribing data found no significant changes, though the use of routine data which is not linked to individuals is not easy to interpret as it was not clear if the original residents had been displaced from the regenerated area.

In the fourth study, children’s respiratory symptoms improved and fewer days were lost from school due to asthma three months following installation of central heating.

## Respiratory Health

**Overall assessment:** Improvements in respiratory health following housing improvement can not be assumed. Improved energy efficiency may improve respiratory symptoms.

## Unintentional injury, falls and fires

A systematic review of prevention of unintentional injuries in children and adolescents included a section on the home environment. Interventions aimed at prevention of burns and scalds, poisoning as well as general home injuries were included. The authors conclude that the use of safety devices in the home, particularly smoke alarms and child resistant packaging on poisonous products, can reduce the risk of unintentional injury. Targeted programmes of free distribution of devices along with education and home visits are recommended to achieve highest level impact. In the case of smoke alarms, recent findings from a large randomised controlled trial (n=20,050) suggest that problems of installation and maintenance may prevent proper functioning and use of smoke alarms; thus the potential for injury prevention is negated. Type of smoke alarm and power source may also be an important determinant of functioning in the long term. Smoke alarms using an ionisation sensor and powered by a ten year lithium battery are most likely to be still functioning one year after installation.

Specific housing recommendations arising from a review of falls prevention in the elderly include regular monitoring by community services and appropriate environmental modification. Apart from physical safety modifications, interventions which reduced the risk of falling included exercise, balance training and tailored interventions for those on sedative/hypnotic drugs or suffering from postural hypotension. Three subsequently published relevant studies were also identified. Two controlled studies found that an exercise and balancing programme reduced the number of falls. The third study monitored the number of self-reported falls, scalds and burns in 141 elderly people six months before and six months after a variety of environmental modifications were introduced, i.e. removing clutter and electrical cords, securing rugs, installing hand rails. Reported falls were reduced by 60%.
Housing improvement and health: Research findings

Unintentional injury, falls and fires

Overall assessment:
The use of safety devices in the home, particularly smoke alarms and child resistant packaging on poisonous products, may reduce the risk of unintentional injury. Mechanisms to ensure proper installation and maintenance of smoke alarms are required to promote long term functioning. Smoke alarms using an ionisation sensor with a ten year lithium battery are most likely to be still in operation one year after installation. Tailored exercise programmes for the elderly may also reduce risk of falling in the home.

3: OTHER IMPORTANT EFFECTS REPORTED IN STUDIES OF HOUSING IMPROVEMENTS AND ASSOCIATED AREA REGENERATION

Increased rents
Two studies of rehousing and area regeneration provide good examples of the potential for unintended adverse effects due to increased rents. One study reported increases in standardised mortality rates in the rehoused residents. This was attributed to a doubling in rents, which in turn affected the households’ ability to buy an adequate diet. However, it is unlikely, with welfare provision, that such dramatic rises in rent would be passed on to tenants these days. More recent work in Stepney also reported that rents in the new houses increased by an average of 14.8%, and some residents reported this as a barrier to employment opportunities. Some residents reported economising on food to accommodate the increase in rent.

Research done in the USA supports the potential for rents to impact on residents’ lives. In the USA housing or rent subsidies have been used as a way of offering public housing tenants more control and choice in where they live and of promoting more integrated public housing tenancy. This is done by means of housing vouchers which can be used in privately rented accommodation and allow low income families to consume more housing and free up funds to be spent on other work related expenses as well as increasing employment opportunities and earnings. In one survey of child growth and nutrition, children whose family were on the waiting list for housing subsidy were over eight times more likely to have low growth indicators than similar children whose families already received a housing subsidy (OR 8.2, 95% CI 2.2-30.4). However, voucher programmes are affected by, and themselves affect, other important and inter-related factors such as housing supply and demand levels and quality of new-build subsidised housing.

Social context & area effects
Four studies of housing improvement measured changes in a range of social outcomes and each found improvements. Residents reported a reduced sense of isolation, reduced fear of crime, increased sense of belonging and feelings of safety, increased involvement in community affairs, greater recognition of neighbours and improved view of the area as a place to live. These are important changes and may affect residents’ satisfaction with their house, however, it is not known if improvements in such measures translate into health improvements.

Neighbourhood effects: relocation to a new area
The socio-economic characteristics of a neighbourhood may have an effect on an individual's health status. Work ongoing in five major cities in the USA is looking at the health effects of relocation from areas of deprivation to improved housing in middle income areas. After 13 years employment opportunities, education and social integration were improved. The suburban movers attributed increased employment to increased job vacancies, increased neighbourhood security and less local gang activity. The most recent report from a similar project demonstrated that households in the intervention groups experienced improved health among household heads, and children in the experimental group were less likely than the control group children to experience an asthma attack.

Relocation and the process of moving
Although moving to an improved house may be a positive experience in the long term, the stress of the moving process should not be underestimated. Moving house is considered to be a stressful, health damaging life-event. In the field of social housing this has been attributed to lack of opportunity to negotiate with the housing authority.
Housing improvement and health: Research findings

regarding control around the move. Housing relocation has also been associated with loss of community, uprooting of social networks and unsatisfied social aspiration that may counteract satisfaction with improved housing. The meaning and context of housing varies between individuals and it may not be possible to detect tangible or consistent health effects of moving and relocation.

In addition to issues of control over individual housing, the negative impacts of delay, protracted disruption and uncertainty over wider area changes were raised in a review of regeneration and health. In one study 58% of residents complained about the regeneration process linking uncertainty to negative health impacts. Consultation with residents included in proposed housing changes and broader regeneration is important.

Displacement
Some area and housing regeneration projects can lead to displacement of original residents. This may result in misleading shifts in routine social and health statistics that will not be identified unless a more detailed analysis of individual data is performed. It is therefore necessary to identify reasons and potential for displacement in advance. If health impacts of housing improvement are to be predicted it must be clear who the recipients of the improved housing will be and where existing residents will be relocated.

Social exclusion and community division
In addition to the above issues identified, a review of regeneration and health highlighted the possibility of increasing exclusion and area division through regeneration. In one study levels of stress and depression experienced by residents living on the margins of the regeneration area were reported to be exacerbated by their experience of being left out. Some studies of regeneration have reported that areas may become divided by regeneration, however, it is not known what the health effects of this are.

Gentrification
Neighbourhoods undergoing regeneration may also be considered to experience ‘gentrification’ where traditionally working-class areas are transformed into middle-class areas. A systematic review of the benefits and harms associated with this process has reported many of the impacts already reported above. The review was interested in wider socio-economic impacts in addition to impacts on existing residents and highlights some of the trade-offs and the complexities of an overall assessment. A range of complex and conflicting findings were reported in this review impacting on housing demand and prices, social diversity, social mix, crime, occupancy rate, private and local investment, population loss from other areas. Few studies have followed the impacts on original residents and fewer still have followed the health impacts. Furthermore, local contexts will vary widely and may have important influence over the direction of these impacts.
Social impacts of housing improvement and area regeneration

Overall assessment:
Housing improvements may have wider social impacts which may be positive or negative. Many of these wider impacts are related to area improvements and regeneration often associated with large-scale housing improvement. It is difficult to attribute impacts to specific changes in housing or to wider area changes. However, it is important to investigate these secondary impacts in order to identify ways in which the health impacts of the housing improvement may be maximised.

Issues of relocation and displacement should be clear before a health impact assessment is conducted so as to determine which residents will benefit from improved housing or area improvements. If residents are to be relocated to a new area an assessment of the change in their economic and educational opportunities should be made.

Positive impacts of housing and area improvement reported include improved reports of safety, community involvement, area satisfaction. Negative impacts reported include increased housing costs, displacement of original residents, social exclusion and community division for those in neighbouring areas not benefiting from the improvements, disruption, uncertainty and lack of control around the move. Only some of these impacts have been linked to subsequent health impacts, the most negative being the result in increased housing costs following housing improvement.

The use of safety devices in the home, particularly smoke alarms and child resistant packaging on poisonous products, can reduce the risk of unintentional injury. Tailored exercise programmes for the elderly may also reduce risk of falling in the home.

CONCLUSION
The lack of a strong evidence base on which to base health improvement claims around new or improved housing may be a disappointment. The relative lack of evidence may seem to question the value of housing as a public health investment. However, absence of evidence should not be confused with evidence of absence. It is also important that the harmful effects of housing improvement can be identified and minimised prospectively. It is possible that these harms have, in the past, counteracted the health benefits conveyed by improved housing.

The importance of social context and satisfaction with housing and the local area is highlighted in the findings presented above. Building new healthy housing in an area with reduced access to services and amenities may not generate health gains. Providing a high quality central heating system which residents cannot afford to use will not increase room temperatures. The potential for health gain may also vary. Those already unwell and at the extremes of life have been identified as particularly vulnerable to the harmful effects of poor housing; housing improvements among these groups may have the potential for greater health gain. However, poor housing may be one aspect of multiple deprivations experienced and may not be sufficient to improve the health and wellbeing of the extremely disadvantaged. These issues highlight the need to consider aspects of the local context when assessing likely health impacts of regeneration and housing interventions. The next chapter considers how to do that.

It should also be noted that health improvement is not the only weighty justification for housing improvement; there are issues of social justice, global energy conservation and general comfort. In addition, it is important that there are options for people to move to more appropriate housing, should their needs, such as reduced mobility, change over time.
Housing improvement and health: Research findings

SUMMARY OF FINDINGS FROM PREVIOUS RESEARCH

Main housing factors which have been associated with health variation and targeted as part of common housing improvements.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indoor air quality</td>
<td>Influenced by many factors and can impact on health. Elderly and people with asthma especially at risk.</td>
</tr>
<tr>
<td>Dampness &amp; hygrothermal growth</td>
<td>Small increased risk of respiratory symptoms.</td>
</tr>
<tr>
<td>House dust mite &amp; allergens</td>
<td>Current measures to reduce exposure do not improve health or reduce asthma symptoms.</td>
</tr>
<tr>
<td>Temperature &amp; warmth</td>
<td>Elderly at increased risk from cold weather. Measures to improve protection from the cold in this group may have positive health impact in this group.</td>
</tr>
<tr>
<td>Home ownership</td>
<td>Associated with improved health, however, negative health impacts are associated with mortgage arrears and insecure home ownership.</td>
</tr>
<tr>
<td>House type and design e.g. flat or house</td>
<td>Flats associated with poor mental health but also associated with other adverse conditions which may impact on health.</td>
</tr>
</tbody>
</table>

Other issues associated with housing improvement.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relocation to a new area</td>
<td>New area may provide different social environment, educational and employment opportunities. Positive changes to the economic and social environment may have health benefits.</td>
</tr>
<tr>
<td>Housing costs</td>
<td>Increased rents affect ability to buy adequate diet, create benefit trap limiting employment opportunities.</td>
</tr>
<tr>
<td>Moving &amp; relocation</td>
<td>• Can lead to loss of social networks.</td>
</tr>
<tr>
<td></td>
<td>• Stress of moving.</td>
</tr>
<tr>
<td></td>
<td>• Uncertainty and lack of control over changes and living circumstances.</td>
</tr>
<tr>
<td>Displacement</td>
<td>Original residents may be displaced and not benefit from the housing improvement.</td>
</tr>
<tr>
<td>Exclusion and area division from non-regenerated areas</td>
<td>• Residents in neighbouring areas not part of regeneration may feel excluded.</td>
</tr>
<tr>
<td></td>
<td>• May result in community divisions between improved and non-improved area.</td>
</tr>
</tbody>
</table>
Housing improvement and health: Research findings

<table>
<thead>
<tr>
<th>Health impacts of housing improvement *</th>
<th>Health impact</th>
<th>Strength of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health and wellbeing, illness episodes, health service use</td>
<td>• Regeneration has unclear overall impact on health or illness. • Energy efficiency measures and medical priority rehousing improve self-reported health.</td>
<td>↔</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Numbers of smokers reduced.</td>
<td>↑</td>
</tr>
<tr>
<td>Mortality</td>
<td>Higher mortality linked to rent increases.</td>
<td>↓</td>
</tr>
<tr>
<td>Respiratory symptoms</td>
<td>• Conflicting findings from studies of regeneration and housing refurbishment. • Improved energy efficiency may reduce respiratory symptoms.</td>
<td>↔</td>
</tr>
<tr>
<td></td>
<td></td>
<td>↑</td>
</tr>
<tr>
<td>Mental health</td>
<td>• Regeneration and medical priority rehousing improve mental health. • No improvements reported following improved energy efficiency.</td>
<td>↑</td>
</tr>
<tr>
<td></td>
<td></td>
<td>↔</td>
</tr>
<tr>
<td>Injuries</td>
<td>• Safety devices in the home, such as smoke alarms and child resistant packaging on poisonous products, can reduce unintentional injury. • Environmental modifications and tailored exercise programmes help prevent falls in the elderly.</td>
<td>↑</td>
</tr>
<tr>
<td></td>
<td></td>
<td>↑</td>
</tr>
<tr>
<td>Social impacts</td>
<td>• Increased community involvement, social support, sense of belonging and feeling of safety. • Reduced fear of crime and sense of isolation. • Increased rents led to reduced income to buy adequate diet. • Improved energy efficiency led to less school time lost due to asthma symptoms, but not other symptoms.</td>
<td>Not known</td>
</tr>
<tr>
<td></td>
<td>Not known</td>
<td>↓</td>
</tr>
<tr>
<td></td>
<td>↑</td>
<td>+</td>
</tr>
</tbody>
</table>

Note: Improved energy efficiency measures include central heating, improved warmth and insulation measures such as double glazing.
* This is a synthesis of findings from studies of housing improvement. Overall assessment of health impacts may include findings from one or more studies.
** Conclusions of a systematic review

Direction of health impact
↑ Improvements to health or reductions in illness
↔ No clear overall effect on health or illness indicators
↓ Reductions in health or increases in illness

Not known: although social impacts are reported in some studies the research evidence for such a link is missing at present

Strength of evidence measured by study quality
+++ Strong association: evidence from prospective controlled studies with good levels of follow up
++ Moderate association: evidence from at least one prospective controlled studies
+ Weak association: evidence from uncontrolled studies
Applying the evidence to the local context

To assess the impact of a housing proposal, you need to apply the evidence to the specific proposal and specific local context. This means considering:

• populations who will be affected;
• features of the area and surrounding areas;
• details of the proposal and how it will be implemented.

It is important to think laterally to identify possible indirect effects of the proposal and also to consider different phases of the proposal (e.g. consultation phase, building phase), how long each phase will take, and different impacts at different stages.

Informed by the findings from the research review presented in the previous chapter, we have devised questions to help identify the most likely health impacts of housing improvement. Based on the limited evidence of health gain from housing improvement programmes, many of the questions aim to identify possible harmful effects. Identifying and minimising potential harms should help to maximise the health benefits of new or improved housing.

Questions to ask in a HIA of housing improvement, derived from research findings

Details of changes
• What are the specific housing changes/improvements that are proposed?
• Are there other housing changes not detailed in the proposals that may occur? (This may include individual housing changes or wider area changes to facilities such as shops and transport)
• Are there going to be any changes in housing costs?
• Is there any other change that may affect living costs – transport, food, access to amenities?
• What levels of displacement can be predicted over the period of improvement?
• What explanations might there be for displacement?

Implementation of housing improvement
• Was there sufficient consultation about the housing improvements?
• What is residents’ baseline satisfaction level with their housing?

Linking changes to health impacts
• What is the evidence that these changes will affect health and any specific symptoms?
• Are there vulnerable groups (i.e. elderly, asthmatic people) who may benefit particularly from the proposed changes?
• When can health gains be realistically expected?
• Will the improvement be too marginal to detect?

Source: We would like to acknowledge the Journal of Epidemiology and Community Health in allowing us to reproduce this table.

Questions to ask of wider regeneration initiatives part of housing improvements

• When will planned regeneration be confirmed to the residents?
• Will delays in regeneration impact on routine maintenance in the area?
• Is the regeneration area surrounded by similarly disadvantaged neighbourhoods currently not benefiting from regeneration investment?
• Are other regeneration initiatives planned aiming to improve economic and educational opportunities for existing residents?
Using the evidence for health impact assessment

This is an outline of the stages to go through in using the evidence of the health effects of housing to inform a health impact assessment of a proposed housing intervention in a local area. It is adapted from Health Impact Assessment: a guide for local authorities (CoSLAVPHIS 2001). Although described as linear stages, in real life it is more iterative. Sometimes findings of later stages mean you have to re-visit earlier ones.

STAGE 1: ‘SCREENING’ DECIDE WHETHER YOU NEED TO DO A HIA

This means deciding whether you should do a HIA on the proposal. Those developing the proposal are responsible for this, but they may consult with public health specialists, community representatives, and others.

First, consider whether the proposal impacts on one or more determinants of health. You can do this using information in the previous chapters on the health effects of housing, and also use a checklist to help you to think broadly about all the possible ways that the proposal might affect people. The checklist of potential health impacts/health determinants given in stage 4 can be used to help you do this (see page 18/19).

If the proposal does have health impacts, you will need to use judgement to decide if some further assessment would be useful by informing change to the proposal or other actions. Use the questions below to help inform this decision.

Questions to use in screening

- What population subgroups will be affected by the proposal?
- Who might be disadvantaged by the proposal?
- What is the geographical and population scale of the proposal?
- Will any of the results of the proposal be irreversible?
- Is there conflict or disagreement about the proposal? If so, would a HIA help to resolve it?
- Are there time, money and expertise to do a HIA?
- Is it possible to change the proposal if necessary?


The possible outcomes of this screening stage are:

- There are no likely significant health impacts. ➔ No further action required.
- There are likely health impacts but recommendations to gain maximum benefit from the proposal are already obvious and no further assessment is required. ➔ Decide who should make and implement the recommendations.
- There are possible significant health impacts and uncertainty about which impacts are most significant and how, or if, the proposal should be adjusted. ➔ Go to stage 2.

STAGE 2: SET UP A TEAM TO DO A HIA

Usually a team of people is needed to do a HIA, as it requires different kinds of knowledge and expertise.

The team’s role will include:

- Scoping the work (see below)
- Brainstorming to identify likely impacts
- Reviewing evidence and its local relevance
- Consulting stakeholders
- Doing any further assessment required, eg to calculate how many people will be affected by different impacts
- Debating and agreeing the recommendations
The team should report to a group with authority to agree terms of reference for an assessment and to implement the recommendations.

The group should include people with knowledge of:
- the proposal
- housing policy and practice
- the local area and population
- health

**STAGE 3: SCOPING**

This means deciding the boundaries of the assessment: the geographical scope, the population groups to consider and the timescale over which to try to predict impacts.

Proposals often affect people who are not the intended target, so it is important to consider other groups of people and how they may be affected. This means explicitly considering different relevant groups and including them in the terms of reference for the assessment. Similarly, the terms of reference should define the geographical scope and the timescale over which to try to predict impacts.

There is no magic formula or tool to make these decisions. Usually the HIA team debates and agrees appropriate boundaries.

Sometimes later in an assessment it becomes clear that impacts will be spread more widely than originally thought, and the scope has to be reconsidered.

**STAGE 4: IDENTIFY POSSIBLE HEALTH IMPACTS**

In this stage, you aim to identify all the possible health impacts, to define them and decide which might require further assessment. The findings of stage 1 should already give some insight into likely impacts, but in this stage a wider trawl should be done. As HIA means looking for unintended impacts, you should be systematic and transparent about how they are identified.

Impacts may be identified by:
- Reviewing the evidence on health effects of housing.
- The HIA team brainstorming other possible effects of the proposal. The questions suggested in chapter 3 should help you to think about possible local effects.
- Using a checklist of health determinants and considering whether each could be affected by the proposal. A checklist you could use is given below.
- Consulting with local people to identify their ideas about how the proposal could affect their health. Focus groups, questionnaires, open meetings etc can all be used to consult but it is important to include the different population groups identified in stage 3.

The most important thing at this stage is to think broadly! Impacts often arise in an indirect way, and are at different stages of a causal pathway.
Using the evidence for health impact assessment

One way to present the findings is to prepare a matrix showing impacts and population groups. This should help make it explicit who will bear what impacts, and indicate the overall balance of positive and negative impacts on each population group.

Sometimes simply identifying impacts is enough to guide recommendations.

Often you may have a long list of impacts and want to focus on those that are most significant. The matrix should help with this. ‘Significant’ impacts may be:

- potentially severe or irreversible negative impacts
- impacts affecting a large number of people
- impacts affecting people who already suffer poor health or are socially excluded
- positive impacts with potential for greater health gain

Sometimes more information is needed, for example to help decide which impacts are ‘significant’ as defined above, to weigh up benefits and harms, or to suggest ways to mitigate adverse impacts.

Before carrying out further assessment of the identified impacts, decide the aims of that assessment: what questions do you need to answer in order to inform recommendations?

**STAGE 5: ASSESS THE IMPACTS**

At this stage, further scientific assessment of the identified impacts is done. This is not just for scientific interest, but should help you to decide what changes, if any, should be made to the proposal. For example, you may want to know:

- how many people will be affected by each impact
- the pathways by which impacts occur, so you can recommend actions that enhance or mitigate these effects
- what value people place on each impact
- what priority to give to each impact, compared with other impacts or other factors

HIA does not require new methods or new skills and there is no ‘blueprint’ for this stage. The methods and evidence used will depend on exactly what information you need to inform decision making, the kind of impacts identified, and the scope of the proposal. Both quantitative and qualitative methods may be appropriate.
If not already part of the HIA team, it is helpful to involve someone with expertise in public health or health promotion. Sometimes you may need to commission the work externally. Remember to involve affected communities, especially when trying to value or prioritise impacts.

**STAGE 6: MAKE RECOMMENDATIONS**

By this stage, you should have enough information to guide recommendations to mitigate any harm arising from the proposal, and maximise the benefits. Recommendations may be broader than the proposal being assessed, for example following your assessment of a housing proposal, you may recommend changes to transport infrastructure.

The HIA team should debate and agree appropriate recommendations based on the available information. This should be reported to a group with the appropriate authority to implement them.

**STAGE 7: MONITOR IMPACTS**

Finally, it is often useful to monitor health impacts of a proposal after it has been implemented. The aims of this monitoring may be:

- To monitor implementation of the recommendations of the HIA team
- To identify impacts that were not foreseen in the HIA
- To inform the evidence base for future assessments, particularly where there has been uncertainty over the likely impacts

Monitoring should be meaningful. This means defining the population(s) to monitor and deciding in advance the aims of monitoring and questions to answer. The sources of data in chapter 6 may be helpful in monitoring changes in housing conditions.
Housing (Scotland) Act 2001

This summary is limited to a brief description of some of the main provisions of the Act. It has been produced with the help of the Chartered Institute of Housing (CIH, professional body of housing professionals). The Housing (Scotland) Act 2001 received royal assent in July 2001. The Act is the largest and most technically complex legislation to be considered by the Scottish Parliament. The Act takes forward a number of key strategic policies like the single tenancy, the single framework of regulation, reforms to the right to buy and the enhanced strategic role of local authorities. These policies are strongly advocated by the CIH.

Summary of the Housing (Scotland) Act 2001

The Act provides the legislative framework for the following changes in Scottish housing:

1. Rights for homeless people and changes to the way housing is allocated;
2. The introduction of a single tenancy, the Scottish Secure Tenancy (SST) to replace the existing secure and assured tenancies;
3. Reforms to the right to buy for new tenants;
4. New responsibilities on landlords for tenant participation;
5. A single framework of regulation for all registered social landlords and council landlords;
6. The transfer of Scottish Homes functions to a new executive agency, Communities Scotland;
7. Powers and duties to enhance local authorities’ strategic role and the statement of fuel poverty;
8. Reforms to the repair and improvement grants system;
9. An emphasis on promoting equal opportunities in implementing the provisions of the Act.

Homelessness and the Allocation of Housing

1. Rights for homeless people and changes to the way housing is allocated.

A number of new duties for local authorities and registered social landlords on homelessness and the allocation of housing are outlined. There is a requirement for local authorities to carry out an assessment of homelessness and to prepare and submit strategies for preventing and alleviating homelessness in their area. Homelessness strategies must encourage equal opportunities. There is a duty on local authorities to make sure that advice on homelessness and the prevention of homelessness is available free of charge to all. Temporary accommodation, advice and assistance should be made available to anyone who they believe to be homeless, regardless of whether they have a priority need or are intentionally homeless. A duty to accommodate a homeless person in priority need and not intentionally homeless continues until they are found permanent accommodation. In most cases this is either a Scottish Secure Tenancy or an assured tenancy. Homeless people have a right to have decisions reviewed by a senior officer and must be informed of this right.

Registered social landlords (RSL) have duties laid out in the Act. They have a duty to comply, within a reasonable time period and with a reasonable request from a local authority, for accommodation for a homeless person, unless they have a good reason for not doing so (Ministers may issue guidance for a common application on these terms). The Act makes provision for a process of arbitration in the event of disputes between registered social landlords and local authorities arising over the allocation of a house to a homeless household. New regulations will set out the occupancy rights of people living in hostel accommodation. This will include a minimum period of notice but will not prevent the earlier termination of accommodation where there is a serious danger to staff or residents.

Each local authority will develop a Common Housing Register. Any person aged over 16 years is entitled to admission to the housing list. Registered social landlords must comply with any requests for information from local authorities regarding the development of a common housing register. They become subject to the rules regarding allocation laid out in the Housing (Scotland) Act 1987. These rules already apply to local authorities and have been substantially modified by the new Act.

Scottish Secure Tenancy

2. The introduction of a single tenancy, the Scottish Secure Tenancy (SST), to replace the existing secure and assured tenancies.
All tenants of local authority and registered social landlords, including housing co-operatives, will be subject to the Scottish Secure Tenancy. Where a property is the sole or principal home of all the occupiers they will have the right to a joint tenancy. Recovery of possession, where a court grants an order to bring a tenancy to an end, is largely unchanged in the new Act though harassment is now included as grounds for eviction. In the event qualifying occupiers can now defend possession proceedings in court alongside the tenant occupier. The Act has a definition of reasonability to be used by the court in possession proceedings. Registered social landlords and local authorities now have to follow the same abandonment procedure when a tenant leaves a tenancy without giving due notice. Similar abandonment procedures come into effect to deal with any joint tenant who leaves the tenancy in similar circumstances.

The Act describes the range of people who qualify to succeed to a tenancy on the death of a tenant. Carers are included in this group where it has been their principal home. Tenants have a right to a written tenancy agreement and information on request to a range of their landlord's policies and rules on allocations, repairs and maintenance. Landlords have a duty to inform tenants of their complaints procedure. They must also inform tenants of the obligations that they are likely to incur if they exercise their right to buy. Tenants and landlords rights and obligations to repair and improvements to their homes are also set out. Tenants rights to assignation and subletting and to exchange their house remain largely unchanged.

Councils and registered social landlords can offer a short form of tenancy to people in particular situations, the details of which are outlined in the Act. Short Scottish Secure Tenancy will be for a period of not less than six months. Where this is granted on the grounds of anti-social behaviour the landlord must ensure that the tenant is provided with support.

Right to Buy
3. Reforms to the right to buy for new tenants.

The right to buy will be included in the Scottish Secure Tenancy subject to a number of changes for new tenants and exemptions and suspensions of property in certain circumstances. Tenants who currently have the right to buy will retain their right to buy for the property they currently live in under the terms and conditions set out in the existing right to buy scheme. For new tenants with the Scottish Secure Tenancy the exemptions include Charitable Housing Associations, Co-operative Housing Associations and Special Needs Housing. There will be a 10-year exemption period for housing association properties. Right to buy can be suspended for up to five years in areas designated as pressured areas. The new right to buy scheme will also be subject to new discount levels.

Tenant Participation
4. New responsibilities on landlords for tenant participation.

Local authority and registered social landlords have new responsibilities to implement tenant participation. They should keep a register of tenants’ organisations based on set criteria, prepare a strategy for tenant participation which includes an assessment and statement of resources required for the implementation of the strategy and outlines the consultation and involvement strategy between tenant and landlord. Landlords should notify tenants and registered tenants’ organisations of proposals relating to housing management, standards of service and the tenant’s participation strategy itself, they have a duty to take cognisance of representations made to them by individual or groups of tenants. The Act replaces the existing arrangements for a tenant management co-operative to enter an agreement with their landlord.

Regulation of Local Authority Landlords and Registered Social Landlords
5. A single framework of regulation for all registered social landlords and council landlords.

The new framework of regulation will encompass all registered social landlords, the housing management and homelessness functions of local authorities and the factoring services provided by these bodies to private owners. Because of the abolition of Scottish Homes and the transfer of its powers and functions to Communities Scotland the regulatory powers are now vested in Ministers rather than Scottish Homes itself.
Ministers have a duty to maintain a register of social landlords. Detailed provision for registration and removal from the register are set out in the Act, including the right of appeal. Ministers will have powers to carry out an inspection and a duty to publish inspection reports. They will also have the power to appoint a special manager to ensure a registered social landlord is brought up to an appropriate standard or to deal with specific aspects of the landlord's performance.

The Act makes arrangements for local authorities and registered social landlords. Some of these arrangements are separate and some are common to both. The common arrangements include the Minister and or people authorised by them having the power to obtain information from the organisations and individuals in respect of their provision of accommodation and related housing. The Minister may issue guidance to a local authority and registered social landlord on the range of housing accommodation and related services provided. This is likely to take the form of performance standards against which landlords will be measured. Guidance on best ways to implement policy and practice on wide ranging functions will be issued. These will include meeting housing needs, prevention of homelessness, managing traveller's sites, allocation, maintenance and repair and the prevention of anti-social behaviour.

The Act (schedule 7) makes detailed provision about the regulation of registered social landlords. It includes provisions that cover the control of payments by the landlord to member officers and employees of the landlord; and the amalgamation, dissolution, rearrangement or reconstitution of the registered social landlord. Detailed arrangements are also set out dealing with the procedures which landlords, lenders and Ministers must follow in the event of the insolvency or threatened insolvency of a registered social landlord.

Ministers will have the power to carry out an inspection of the housing management and related functions of local authorities and the duty to publish inspection reports. Where an area of their service is deemed unsatisfactory in a report the minister can require a remedial report from a local authority. Where a remedial plan is not being implemented satisfactorily Ministers have the power to appoint a special manager to a local authority.

Scottish Homes
6. The transfer of Scottish Homes functions to a new executive agency, Communities Scotland.

All powers of the new executive agency reside in Scottish Ministers. Detailed arrangements for the abolition of Scottish Homes and its replacement by the new executive agency through which Ministers will work are provided. The new agency, Communities Scotland, was established in November 2001.

Strategic Housing Function of Local Authority
7. Powers and duties to enhance local authorities' strategic role and the statement of fuel poverty.

The Act outlines a range of new powers and responsibilities for local authorities to adopt a wider strategic and enabling role for housing in their area. A responsibility on Ministers now exists to publish a statement on addressing the issue of fuel poverty. A statement will be published explaining measures which Ministers and local authorities have taken and will take to prevent people living in fuel poverty. Targets will be set on the elimination of fuel poverty over a 15-year time span. Updates on progress will be provided on a four yearly basis.

Local authorities will have a duty to carry out an assessment of housing needs and provision in their area, which will inform the local housing strategy. Ministers will provide a specification for local housing strategy and the process to be followed in its preparation. Implementation updates of the strategy should show how equal opportunities have been incorporated into the strategy.

Ministers will have the power to make grants to local authorities for housing purposes. They will set terms and conditions for the provision of these grants. This facilitates local authorities to take on the development funding function previously administered by Scottish Homes. Local authorities will have the powers to provide assistance to registered social landlords and individuals for housing purposes. They have the powers necessary to provide assistance, financial or otherwise, to registered social landlords and other persons for housing purposes and for

Housing (Scotland) Act 2001
preventing or alleviating homelessness. This will include provision of grants or loans. Ministers may set out, in
regulations and in guidance, provisions governing assistance from local authorities to registered social landlords
and other persons. They provide a power for local authorities to set terms and conditions on the grants that
they themselves make.

**Private Sector Improvement and Repair Grants**

8. Reforms to the repair and improvement grants system.

The reforms in the provision for private sector repair and improvement grants include the eligibility for
improvement grants. Work eligible for improvement grant include installation of a heating system and
insulation, replacement of unsafe electrical wiring and installation of smoke detectors. Further work also
includes the installation of security entry systems for buildings in common ownership. Tolerable standards of
accommodation will now include a suitably located bath or shower. Applicants for grants will be required to
give details on their income and financial circumstances in order that local authorities will be able to assess the
appropriate level of contribution applicants would make toward the cost of work being carried out. Applicants
will have the right of appeal. There will be a maximum and minimum percentage grant, which will not exceed
£20,000.

The new Act amends the Housing (Scotland) Act 1987 in relation to several issues, which include:

- The maximum amount of repair grants payable.
- The provision of means of escape from fire in houses of multiple occupation, where the local authority has
  served a notice which requires such provision.
- The encouragement of work to improve energy efficiency and safety.

**Equal Opportunities**

9. An emphasis on promoting equal opportunities in implementing the provisions of the Act.

The functions in the Act conferred on Ministers, local authorities and registered social landlords must be
undertaken in a manner which encourages equal opportunities and observes equal opportunity requirements
laid out in other legislation and regulations.

**Implementation Phase**

Within the Act there is an overarching statutory responsibility on local authorities and a strong emphasis
on meeting equal opportunities obligations on all functions conferred by the Act. Guidance and secondary
legislation will follow to assist housing professionals.
Sources of information and data on housing

Some useful sources of information and data are given below.

**Chartered Institute of Housing (CIH)**
The Chartered Institute of Housing is the professional body for people working in housing. It aims to maximise the contribution that housing professionals make to the wellbeing of communities.
Tel: 0131 225 4544.
Website: www.CIH.org

**Census**
Includes information on household type, property, amenities, tenure, limiting long term illness. Last census 2001.
Website: www.gro-scotland.gov.uk

**The Scottish House Condition Survey (SHCS)**
The survey includes a physical inspection of the property by a building professional and a socio-economic interview with one of the householders.
Data available at Scotland level only. Data by local authority may be available where an authority has boosted its sample. Surveys in 1991, 1996, 2002.
Website: www.shcs.gov.uk/index.html

**Scottish Household Survey**
Topics include household composition, property, amenities, housing types, health of household.
Data available on large councils annually; All councils biennially.
Continuos data collection since February 1999.
Website: www.scotland.gov.uk/shs

**Scottish Executive housing bulletins**
Quarterly bulletins containing data on housing trends including household estimates; new house building; lettings, evictions and sales of public authority dwellings; homeless applications.
Website: www.scotland.gov.uk/stats/bulletins/00034-00.asp

**Homelessness applications**
The Scottish Executive publishes annual figures on homelessness applications to local authorities.
Website: www.scotland.gov.uk

**Property Sales and House Prices**
Land Valuation Information Unit, University of Paisley provides information on property sales.
Website: www.ispolis.co.uk/login.asp

**Scottish Neighbourhood Statistics**
This is a new initiative led by the Scottish Executive to make available at a local level a substantial amount of new information including data on health and housing. It has a working group on housing data that aims to improve housing related neighbourhood statistics by 2004 and produce sets of indicators for geographical areas, to be available on the Scottish Executive website. A briefing is available at: www.scotland.gov.uk/library5/housing/snsbrief.pdf
A review of data sources to be used is given at: www.scotland.gov.uk/library5/housing/snsreview.pdf

**Fuel poverty and health toolkit**
This document aims to encourage health professionals and planners to work with local authorities to develop local strategies to reduce fuel poverty. It contains detailed guidance on the health effects of cold, examples of local schemes to address fuel poverty, available grants, and how to develop a local strategy.
References


Green G, Gilbertson J. Housing, poverty and health: the impact of housing investment on the health and
References

61. Walker R, Bradshaw N. The Oakdale renewal scheme: use of prescribing data to assess the impact on the health of residents: Gwent Health Authority & Welsh School of Pharmacy, 1999.
87. Ekstrom M. Residential Relocation, Urban Renewal and the Well-being of Elderly People. Comprehensive Summaries of Uppsala Dissertations from the Faculty of Social Sciences 1994;42(92).
References

89. The health and quality of life of residents of Liverpool’s tower blocks: First resident survey results. Sheffield: Sheffield Hallam University, 1998.
## Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amenities</strong></td>
<td>Standard features in a house e.g. toilets, bath, water supply etc.</td>
</tr>
<tr>
<td><strong>Assignation and subletting</strong></td>
<td>Assignation is where a tenant signs over their tenancy to another person. That other person then becomes the tenant of the house. Subletting is where a tenant lets the house to another person but still holds tenancy agreement with the landlord.</td>
</tr>
<tr>
<td><strong>Assured tenancies</strong></td>
<td>Granted to RSL tenants pre September 2001. Has now been superseded by the SST. Some tenants of private landlords are Assured Tenants.</td>
</tr>
<tr>
<td><strong>Fuel poverty</strong></td>
<td>Generally accepted definition is a household that is required to spend more than 10% of its income on all household fuel use is in fuel poverty.</td>
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<tr>
<td><strong>Housing association</strong></td>
<td>A not for profit organisation whose main purpose is to provide social housing for rent.</td>
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<tr>
<td><strong>Intentionally homeless</strong></td>
<td>A household is deemed to be intentionally homeless if has deliberately done or it has failed to do something that has resulted in it losing its home, e.g. being evicted for rent arrears or anti-social behaviour failing to pay a mortgage etc.</td>
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<tr>
<td><strong>Priority need</strong></td>
<td>This is one of the tests of homelessness. A homeless household must be in priority need to qualify for permanent housing. See the Scottish Executive Code of Guidance on Homelessness for details of the priority need categories.</td>
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<tr>
<td><strong>Public housing tenancy</strong></td>
<td>The American term for a tenancy agreement with the American equivalent of local authorities and RSLs.</td>
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<tr>
<td><strong>Regeneration</strong></td>
<td>A general term for polices aimed at improving communities in decline. It covers housing, employment, heath, education and environmental issues to stimulate growth and community cohesion.</td>
</tr>
<tr>
<td><strong>Registered social landlords (RSL)</strong></td>
<td>A housing association that is registered with Communities Scotland. It lets housing on a not for profit basis to people in housing need.</td>
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<tr>
<td><strong>Single tenancy</strong></td>
<td>Another name for the Scottish Secure Tenancy (SST).</td>
</tr>
<tr>
<td><strong>Secure tenancy</strong></td>
<td>Granted to local authority tenants pre September 2001. Has now been superseded by the SST.</td>
</tr>
<tr>
<td><strong>Tolerable standard</strong></td>
<td>A test of housing conditions below which a house is deemed unfit to live in.</td>
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</tbody>
</table>