Housing status and health implications for Pacific peoples in New Zealand

KIRI MILNE*
ROBIN KEARNS**

Introduction

The goal in this paper is to review research that has surveyed and analysed housing/ health relations with particular reference to the welfare of Pacific peoples in New Zealand. Pacific peoples currently comprise approximately 6% of the New Zealand population[1] and 32% of all households experiencing 'serious housing need'.[2] Given the high growth rate of this population (the number of Pacific peoples increased eight times faster than the national population between 1986 and 1991),[3] it is reasonable to expect that the proportion of Pacific Island households experiencing housing need has increased significantly since the estimates were released. Furthermore, because the distribution of Pacific peoples in New Zealand corresponds with established North Island population patterns, most of those living in poor housing situations are located in Auckland and, to a lesser extent, Wellington. Given this concentrated experience of housing need among Pacific peoples in North Island metropolitan centres, it is especially unfortunate that few initiatives have been put in place to alleviate this need. Rather, the housing reforms earlier this decade effectively privatised the state housing stock[4] and, for many families, decreased the proportion of household income available for non-housing expenses such as food, clothing and health care. Significantly, each of these expenditure categories has a profound bearing on the promotion and maintenance of human health.

Given this concentrated experience of housing need among Pacific peoples in North Island metropolitan centres, it is especially unfortunate that few initiatives have been put in place to alleviate this need.

*Department of Geography, The University of Auckland, Private Bag 92019, Auckland. k.milne@auckland.ac.nz or r.kearns@auckland.ac.nz

Terminology

Changes in the nomenclature of people from Pacific Islands over the course of the last four censuses in New Zealand indicate the confusion surrounding the categorisation of this population. In 1981 the Pacific population was categorised as either '*Pacific Island Polynesian*' or '*Pacific Island Polynesian Descent*' (Department of Statistics, 1981); in 1986 they were divided into '*Solely Pacific Island Polynesian*' or '*Pacific Island Polynesian Origin or Descent*' (Department of Statistics , 1988); in the 1991 Census, the term '*Pacific Island Ethnic Group*' was employed (Department of Statistics, 1993); and in 1996 people from the Pacific were referred to as '*Pacific Islands people*' (Statistics New Zealand, 1998).

Of the 170,000 people who placed themselves in this category in 1996, approximately 50% were Samoan, 23% were Cook Islander, 16% were Tongan, 9% were Niuean, and the remainder were Fijian, Tokelauan, Tuvaluan, Solomon Islander, or from various other small Pacific Islands[1]. To further complicate the composition of this 'single population', many of these so-called 'Pacific Islanders' had 'multiple ethnicity' (for example, Samoan/Palagi, Samoan/New Zealand Maori, mixed Pacific Island ancestry), and many were actually born in New Zealand. This latter point is significant, given that the differences between Pacific people born in the Islands and Pacific people born in New Zealand are becoming increasingly obvious. For example, those born in the Islands are less likely to hold post-school qualifications and more likely to have unskilled jobs and lower incomes than those born in New Zealand[5]. Thus, to speak of a 'single' ethnic group serves only to disguise the heterogeneity of the Pacific population in New Zealand[6]. This 'homogenising' is not only offensive to Pacific people, who value the uniqueness of their different cultures and languages as much as other ethnic groups,[7] but it also limits the effectiveness of many analyses by diminishing the importance of cultural variables.

Our ability to recognise the heterogeneity of New Zealand's Pacific population in this review is constrained by the limitations of official health statistics and analyses, which,

up until now, have tended to treat the Pacific peoples of New Zealand as a single population[5]. Increasingly, however, it is recognised that if the health status of, and services for, Pacific people are to be improved, information on individuals and families particular to their cultural groupings must be collected[3]. In this review the term 'Pacific peoples' will be used to refer to all people who identify with one or more Pacific Island ethnic groups, recognising that within this population there are significant differences between the communities associated with different Pacific Islands and between those born in New Zealand and those born in the Islands.

A theoretical context

We organise our review of housing status and health effects around the 'agency/structure' dynamic that informs much theorising in the social sciences. By invoking this dynamic, we are concerned with "... the intersections between knowledgeable and capable human agents and the wider social systems in which they are implicated"[8]. With reference to Pacific peoples we are interested in separating out, where possible, the issues of choice and constraint in housing, and considering the degrees of freedom available to individuals and families seeking to resolve housing-related health problems.

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One important element of the structural context in which housing and health relations operate is the positioning of Pacific people in New Zealand's labour and housing markets. Due to a lack of formal educational qualifications, and the fact that many from the Pacific Islands migrated to New Zealand at a time when manual labour was needed for post-war industrial expansion, many Pacific people in New Zealand have depended upon unskilled and semi-skilled employment in the manufacturing sector. Their resulting marginalised status in the labour market, combined with the fact that people from the Pacific Islands are easily identified as ethnically 'Other', has meant that many Pacific groups have been prone to racism, poverty and marginalisation in the housing market. This marginalisation has intensified over the last 15 years as restructuring of the New Zealand economy has resulted in a declining demand for unskilled workers, and subsequent job losses for many Pacific peoples[5,9].

A second important aspect of the structural context surrounding housing and health are the culturally proscribed priorities that represent structural determinants of health and well-being. Such priorities may include the provision of remittances and participation in family events, and, for some, choices made in favour of communal living. To understand the ways in which these priorities interact with health and well-being, one needs to have some insight into how concepts of health and well-being are constructed by Pacific communities[10].

For many Samoans and Cook Islanders, for instance, illness is often seen as an inevitable, unpredictable and a powerful discontinuity in the flow of life. This discontinuity is considered to be directly related to the disruption of a kin-based social order, and consequently, both the cause and the cure are sought within the family realm. For some, living in New Zealand is seen as a particular source of ill health relating to family, as the lifestyle is associated with a declining commitment to traditional lifestyle and customs. Consequently, Samoa and the Cook Islands seek to ameliorate the ill health linked with living in New Zealand by attempting to maintain good family relationships over long distances. They do this by sending money, food and clothing 'back home', by attending family occasions in the Islands, and by hosting family members in New Zealand[11].

Tukuitonga and Finau[3] argue that these traditional commitments to family and society have perpetuated a 'hand to mouth' existence for many Pacific families in New Zealand. For many in the general population, such commitment would be seen as choice, but seen from within the Pacific cultural framework, it is clearly a constraint. To neither give nor participate would surely be to marginalise oneself.

Such culturally generated expectations can place constraints on housing market participation. As Loomis has pointed out with respect to Cook Island people in New Zealand, many do not place a high priority on home ownership, with a large proportion of first and second generation migrants preferring to channel their resources toward participation in community activities and mutual assistance[12]. However, earlier surveys have indicated that Pacific peoples living in New Zealand desire home ownership as much as the rest of the population[3] and Tukuitonga argues that 'communal living' is more likely to be due to economic hardship than cultural preference[14].

In his discussion of the nature of community life among Cook Islanders in New Zealand, Loomis suggests that a dialectical relationship exists between structural change,

such as unemployment, and socio-cultural responses. He cautions against either investing minority 'traditional' cultures with some sort of timeless resilience in the face of structural change, or viewing the behaviour of individuals and groups as being determined' by the political and economic structures of wider society[12]. With this warning in mind, it is appropriate to turn to the agency side of the structure/agency dynamic. On this side of the equation, individuals and households within the Pacific population have varying degrees of freedom to make choices about housing, and to overcome some of the constraints already discussed. For instance, Pacific children born in New Zealand may not necessarily affiliate with any single cultural group, and nor might they totally accept the traditional social and cultural values that act as structural constraints on their parents' decisions. Similarly, inter-marriage and cultural assimilation have produced sub-cultures of importance within the Pacific community[3]. In the Wellington area, participants in a research project investigating Samoan perspectives on mental health said that the familial arrangements, which once defined the way in which Samoan people associated with each other, are being supplanted by the economic and social values which prevail in contemporary New Zealand. They saw this, and the resultant deterioration of extended family support, as contributing to mental stress, especially for elders[15].

Health effects of housing

With some understanding of the structural context in which housing and health interactions occur, we can proceed to evaluate the direct and indirect effects of housing on health. Our discussion is divided into two sections. The first section discusses the underlying factors that contribute to the housing status of Pacific people in New Zealand. The second section is concerned with the links between physical condition of a dwelling, the number of occupants, and health problems.

At the outset it is worth remembering that housing involves both a site and a situation[16]. With respect to the former, a dwelling occupies a specific and absolute location in (usually urban) space and, at this site, health may be threatened by aspects of the structure itself (e.g. poor insulation), the property on which it is built (e.g, dampness), or the lack of 'fit' between people and dwelling (e.g. overcrowding). The health effects of housing are not limited to the specific characteristics of the dwelling itself, however. Any house also has a situation; that is a relative location vis a vis other housing, services (e.g. schools, public transport and recreational opportunities) as well as 'negative externalities' such as pollution from nearby industries[17]. In considering housing and health, it is wise to bear in mind that there is usually more scope to alter the physical aspects of the dwelling itself than the issue of where the dwelling is situated.

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Three general influences upon the housing status of Pacific people in New Zealand are low socio-economic status, marginalisation in the housing market, and geographical concentration. These factors contribute to overall housing status, interact with each other, and have a significant impact on health status through a variety of mechanisms. We will discuss each in turn.

Socio-economic status

The Pacific communities of New Zealand have a high level of unemployment (23% compared with 9.5% for the total New Zealand labour-force) which is concentrated among people aged 15 - 34 years[5]. Many Pacific peoples believe that lack of employment is a major factor contributing to the poor health status of their communities. Unemployment means a restricted ability to obtain quality housing, to meet health costs and to access health care. These constraints may also encourage increased smoking and drinking, and be linked to cases of depression and other mental problems[5,18]. In 1991, nearly 80% of Pacific Island income earners had incomes below $20,000 per annum (compared with 64% of income earners in the total population), and 68% of 20 - 39 year olds were receiving a benefit.[5] The critical issue of housing cost is borne out in the key finding from a 1993 survey in Manukau City: 68% of Pacific heads of households reported problems in meeting their housing costs compared with 50% of Palagi heads[19].

Such high levels of unemployment and low levels of income, combined with the fall in real disposable incomes experienced by many Pacific families in recent years (as a result of rising unemployment, the Employment Contracts Act, dependence on part-time work, and benefit cuts,[18] have produced heightened levels of economic hardship for many Pacific communities. Bathgate et al. suggest that this hardship is manifested in reduced expenditure on health care and food, and dependence on inadequate, damp and overcrowded, housing[5]. This claim is borne out by Salvation Army statistics which show that, in 1992, Pacific families comprised 60% of South Auckland emergency housing

clients, and received a third of the food parcels distributed[19]. Legat also suggests that, for those in poverty, the combination of poor nutrition, inadequate housing, lack of health education and awareness, and lack of access to affordable primary health care, can mean that run-of-the-mill illnesses easily develop into virulent medical conditions[20].

Marginalisation in the housing market

Health is directly influenced by low socio-economic status, via reduced expenditure on food and reduced usage of, and delays in seeking, medical care. Low socio-economic status also indirectly influences health through its contribution to marginalisation in the housing market. As mentioned earlier, one of the many responses to economic hardship is to spend less on accommodation. This may result in an increased dependence on overcrowded and sub-standard dwellings. It is important to note, however, that because housing costs are invariably less flexible than other categories of expenditure, it is frequently food (followed by heating and clothing) that is adjusted to meet the demands of poverty.

... people experiencing economic hardship will attempt to reduce their expenditure by cutting back on food, health care, and housing costs. Reductions in housing costs are often achieved through families sharing homes (producing overcrowding and its attendant stresses), moving to cheaper (and often sub-standard) dwellings, returning to the Islands, or in some extreme cases, living on the streets.

Due to the low average income levels of most Pacific families in New Zealand, and the preference among some Pacific groups for channelling resources into the community,[12] many families have insufficient disposable income to purchase a home or even to make the initial deposit[5]. Consequently, the level of home ownership amongst Pacific people is low, and there is significant dependence on Housing New Zealand rental units. In 1991, 51% of the dwellings occupied by Pacific families were rented, compared with only 23% for the total population[5]. Furthermore, studies have shown that Pacific people, particularly women, experience a significant degree of discrimination in the New Zealand rental accommodation market[21,22].

For a population in which security of tenure is often low, and for whom housing difficulties are frequently heightened by racial discrimination, it takes only a small reduction in income (perhaps through a wage or benefit cut, or loss of a job for a family member) for a Pacific family to be pushed further down the housing status continuum towards 'serious housing need'[23]. In 1988 the National Housing Commission described 'serious housing need' as situations in which households are living in overcrowded, sub-standard, unaffordable housing, or where re-housing is desirable because of poor physical and mental health or abuse. They claimed that approximately half of those households in central and south Auckland categorised as having a 'serious housing need' were headed by a person from the Pacific Islands.[1] More recently, Waldegrave and Sawrey estimated that Pacific households made up 21% of New Zealand households in 'serious housing need'[4]. Futhermore, homelessness - an extreme expression of 'serious housing need' - is concentrated among the Pacific and Maori populations[25].

Although the effects of housing reforms in the early 1990s have yet to be fully researched, it is widely recognised that the increase in state rental prices to market rates has increased the level of 'serious housing need' amongst Pacific families[5,26]. In 1992, a survey of 45 Housing Corporation (HCNZ) clients in the Porirua district showed that 39 of them would be below a living income when the full rent increase took effect in July 1993. Respondents suggested that they would go without food and essential services, consider migrating back to the Islands, or contemplate moving in with another family, in order to avoid defaulting on their rent payments[27].

Morrison tells the story of Tiare, a 28 year old New Zealand-born Cook Islander with three children under eight years old, who was forced to move in with her parents and younger sister when rent increases first occurred. Tiare remained financially stretched, even after moving in with her parents, particularly since her four year old child was asthmatic and required weekly medical attention. She was considering sending her oldest son to the Islands to live with his grandparents because she could not afford the cost of his schooling in New Zealand[26].

Such comments support the argument made earlier, that people experiencing economic hardship will attempt to reduce their expenditure by cutting back on food, health care, and housing costs. Reductions in housing costs are often achieved through families sharing homes (producing overcrowding and its attendant stresses), moving to cheaper (and often sub-standard) dwellings, returning to the Islands, or in some extreme cases, living on the streets. The pervasiveness of these responses is borne out in research by Kearns and Smith, which found that rates of residential mobility are higher amongst people experiencing 'serious housing need' than in the general New Zealand population[28]. For this group, moving may be a means of alleviating the stress of inadequate housing.

Geographical concentration

The final aspect of housing status we wish to address is that of geographical concentration. Since the early 1950s the largest proportion of New Zealand's Pacific population has been concentrated in the Auckland urban region, followed by Wellington[5]. This has two major implications.

- These urban areas have the highest housing costs in the country, with the result that low-income Pacific families end up paying more for poor quality housing than people in other parts of the country[25], and
- Secondly, people of similar socio-economic status (e.g., low incomes, high unemployment, low educational achievements), living in similar circumstances (e.g. sharing sub-standard accommodation with other members of extended family), and often with equally poor access to services (e.g., primary health care providers, schools), are geographically congregated, creating the potential for a 'neighbourhood effect'. This is the idea of housing constituting a situation as well as a site: an individual's access to services and opportunities for advancement may be negatively affected by the fact that he or she lives in proximity to low-status housing. For example, private service providers may choose to locate in more prosperous areas: it is well known that the availability of primary health care is lower in areas with high Pacific and Maori population densities[29].

The health effects of housing itself

There is an extensive body of international scholarship that has investigated the influence of specific aspects of housing itself on the health of household members[30,31]. In the limited amount of New Zealand research on this theme, results are generally supportive of overseas findings: it is the poorest populations, most prone to forms of discrimination, who have least control over their housing circumstances and thus are most afflicted by housing-related health problems[32].

The suggestion that the poor housing of Pacific people in Auckland might influence their health status was raised as early as 1975 by Barnett, who claimed that in order to maintain close family ties and to obtain cheap rental accommodation, large families and groups of families were occupying substandard, overcrowded homes. He identified a direct link between the inadequate, overcrowded housing of Pacific people and the high incidence of tuberculosis, impetigo, scabies, respiratory problems and gastro-intestinal illnesses[33]. This link was investigated by the National Housing Commission in 1988, which identified overcrowding as contributing to an array of mental and physical health problems[2]. Additionally, hospital social workers and public health nurses claimed that there was a strong link between the readmission of children to Auckland's Princess Mary Hospital and housing conditions. Many respondents knew of newborn babies being taken home to caravans, garages, or damp conditions. These respondents also noted that high stress, depression, apathy, resignation and low self-esteem were problems compounded by extended stays in unsatisfactory housing. Although these comments did not specifically apply to Pacific people, the generally recognised poor health and housing status of Auckland's Pacific communities suggests that they would have comprised a large proportion of these cases[2]. Building on these findings, Kearns et al. reported that many Pacific households in Auckland and Christchurch identified colds, running noses, influenza, asthma and stress as problems related to, or exacerbated by, their dwelling[23]. Finally, representatives of a number of Pacific communities participating in meetings organised by the Public Health Commission agreed that overcrowding contributed to high blood pressure and asthma amongst their people[5].

There is clearly an abundance of reports and research that support the claim that overcrowded, sub-standard housing is strongly linked with health problems amongst New Zealand's Pacific communities. Although descriptive statistics are powerful indicators of the burden of illness, they fail to present the human face of suffering. Few studies have been undertaken on housing and health in New Zealand since the 'qualitative turn' in health research that has occurred in the late 1990s. We are therefore left to rely on media reports and the anecdotes of housing workers to convey the stories of those most affected by substandard housing. Jesson for instance, describes the situation of a young Samoan woman living in a concrete-block garage at the back of a relative's property in Otahuhu with her one month old baby, her partner, her partner's two children, and a friend. The garage was draughty, lacked heating, and had a concrete floor. The walls were wet with condensation and the mattress shared by the couple and the young baby was noticeably damp. The author also profiles a number of other 'problem living situations', such as the family of eight living in a one-bedroom flat, to demonstrate that the Otahuhu case is not unusual[34].

Although Jesson's article is now eight years old, the level of overcrowding and sub-standard housing amongst New Zealand's Pacific population remains a serious problem. Statistics from the 1996 Census show that more than 40% of Pacific families in New Zealand are sharing their homes and living in overcrowded conditions (compared with 17% of families in the general population). The most common household size for Samoans is seven or more, and nearly a quarter of Tokelauan homes accommodate at least eight people. Furthermore, in 1994 Pacific peoples were the largest group to rate their overall health as 'poor/not so good',[1] their children have poorer health status than other New Zealand children[5] and the hospital admission rates for preventable conditions such as asthma and diabetes is 2-3 times the national rate[3].

Discussion

In their 1994 survey, Bathgate et al (1994) identify the main housing problems faced by Pacific people in New Zealand as being the three interrelated issues of affordability, overcrowding and housing design (e.g., insufficient space for meetings or to accommodate visiting friends/family)[5].

In concluding this survey, we wish to emphasise that the problems relating to Pacific peoples' housing status are in one sense no different to those experienced by other marginalised groups in the New Zealand population such as some Maori and women headed households[5]. However, the distinctive characteristics of Pacific peoples, such as larger family size, do make this group especially vulnerable to receipt of poorer housing and associated health problems.

What are the prospects for improvements in housing quality and affordability for Pacific peoples? At one level, the outlook remains poor. Pacific peoples lack the political clout of Maori, the other major ethnic group marginalised in the housing market... Further, with the separation of social policy from housing policy... the prospects for linking health promotion initiatives to housing interventions would seem bleak.

What are the prospects for improvements in housing quality and affordability for Pacific peoples? At one level, the outlook remains poor. Pacific peoples lack the political clout of Maori, the other major ethnic group marginalised in the housing market. There are no analogous housing schemes to those available to (especially rural) Maori[36]. Further, with the separation of social policy from housing policy under the current government, the prospects for linking health promotion initiatives to housing interventions would seem bleak. However, in modest ways, a research-driven awareness of the potency of the housing/health relationship seems to be growing. An intersectoral working party on housing and health met in Wellington throughout 1998 and a dismissive government reaction to the National Health Committee's (1998) report Social, Cultural and Economic Determinants of Health resulted in a South Auckland initiative developing local solutions to locally-perceived housing problems.

In terms of methodology, most findings reported in the review employed the use of census or survey data. A minority sought stories from 'insiders': Pacific people actually experiencing serious housing need. In order to understand the links between choice and constraint in the urban housing market, we advocate a heeding of Franklin's call for ethnography in housing studies[37]. Our advocacy of such research through participant observation is made with the contention that it should be Pacific researchers undertaking such studies. Research of this nature may be ethically vexing, as it will require investigators to befriend, and become involved in, the lives and culture of those at risk of ill-health. However, we believe that such research may yield rich insights into the trade-offs made in adjusting family dynamics to constrained housing choice, and the health-related outcomes of such adjustments.

We opened our discussion by noting the heterogeneity that lies within the commonly used 'Pacific Islander' label. While there are pressing concerns about the housing status and health of Pacific peoples in general, we believe that a research task is to disaggregate the label not only into groups of national identity, but also by demographic subgroup so as to ascertain the issues facing potentially vulnerable groups such as elderly persons and women householders with children.

We lastly recommend that researchers work towards combating subtly racist public perceptions that would attribute overcrowding in Pacific households as largely a matter of choice. Although a decade has passed since the weighty, five-volume April Report of the Royal Commission on Social Policy was released, the words of housing commentator Campbell Roberts merit reiterating. To him, satisfactory housing is more than 'just another commodity'. Rather, it is a major contributor to security, nurturing, access to community resources, and the effective base for family life[25]. If health is to be taken seriously as more than the absence of disease, then the dis-ease of inadequate housing should be indelibly written onto the public health agenda.

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