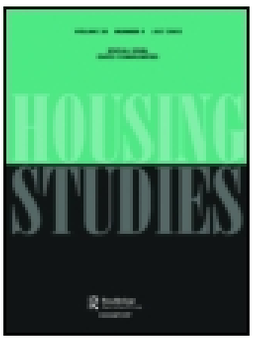

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A politics of care in urban public housing: housing precarity amongst Yolŋu renal patients in Darwin

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ABSTRACT

People with chronic diseases are likely to require some form of domestic care, however their care needs acquire low visibility in housing policy frameworks. Amongst Yolŋu (Indigenous Australians from north-east Arnhem Land), high rates of kidney disease reinforce needs for housing and care. I consider how access to housing shapes relations and practices of care in the families of Yolŋu renal patients in Darwin, Australia; and how Yolŋu relations and practices of care are implicated in housing policy. Through an ethnographic case study approach, I show that in Yolŋu families, practices of extending shelter to kin are care practices fundamental to the performance of domestic labour. I argue that while housing policy frameworks rely on familial relations and practices of care to reduce rough sleeping and achieve other policy objectives, Yolŋu relations and practices of care are also marginalised through the governance of public housing. The politics of care that play out in their places of residence reproduce housing precarity.

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Introduction

Housing represents a locus of practices of sheltering, dwelling, belonging and care essential for human flourishing. While connections between housing and physical health are well established through housing research and in housing policy frameworks (Taylor, 2018), the broader functions of places of residence as sites and resources of care have been comparatively neglected (Power & Mee, 2020). Attending to how housing is instrumentalised in practices and relations of care, and how relations and practices of care are implicated in housing policy frameworks, can furnish our understanding of housing policy frameworks with new insights. Amongst Yolŋu (Indigenous Australians from north-east Arnhem Land), high rates of kidney disease (Australia and New Zealand Dialysis and Transplant Registry, 2017) reinforce needs

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for housing and care. In this paper I consider how access to housing shapes relations and practices of care in the families of Yolŋu renal patients in Darwin, the capital of Australia's Northern Territory; and how Yolŋu relations and practices of care are implicated in housing policy.

The Northern Territory is a vast, sparsely populated jurisdiction, encompassing a tropical north and arid south. Indigenous people comprise approximately 30% of the population of the Northern Territory, a higher proportion than any other Australian jurisdiction, and large socio-economic and health inequalities exist between Indigenous and non-Indigenous Territorians; approximately 72 per cent of Northern Territory social housing properties are occupied by Indigenous households (Australian Bureau of Statistics, 2016).[1] The Northern Territory homelessness rate is almost 12 times the national rate, and Indigenous people comprise 88 per cent of all homeless people in the Northern Territory (Northern Territory Government, 2018b).

In the Northern Territory, 'hub and spoke' service delivery models are a common means of providing healthcare and other social services to people in decentralised Indigenous communities through temporary or permanent relocation to urban centres (Markham & Doran, 2015). A severe shortage of dialysis services[2] in remote communities results in 80 per cent of all Northern Territory dialysis patients, the vast majority of whom are Indigenous, relocating from remote communities to the urban centres of Darwin and Alice Springs in order to access life-sustaining treatment (Gorham *et al.*, 2018). Indigenous Australians with end stage kidney disease who are displaced to urban centres experience the intersection of disadvantage, displacement and illness (Devitt & McMasters, 1998).

Indigenous renal patients who are displaced to Darwin contend with housing precarity. They generally leave social housing, which is often the only form of housing in remote Indigenous communities, to contend with long urban social housing wait lists. Some die before being allocated housing in Darwin. During my fieldwork, the wait list for a one bedroom public housing unit in Darwin climbed to 6–8 years (Northern Territory Department of Housing and Community Development, 2018b). In contrast, average survival rates for renal patients receiving dialysis in the Northern Territory are 6 years (You *et al.*, 2015). While renal patients in Darwin presented strong claims for social housing, meeting eligibility criteria for priority public housing, they still contended with wait times of 3–4 years for priority public housing, on average. Indigenous renal patients are at particularly high risk of homelessness (Habibis *et al.*, 2011). A study of Indigenous renal patients in Alice Springs estimated 15–20 per cent had no secure housing (Cass *et al.*, 2011).

Renal patients are likely to require some form of domestic care in order to manage treatment, compromised immunity, complications of frailty, dietary and lifestyle changes and to prevent disease progression, however their care needs beyond biomedical treatment tend to acquire low visibility in public policy frameworks (Puszka, 2019). In order to conceptualise the problem of housing and care for Yolŋu renal patients in housing policy and in Yolŋu families, in the following sections I review approaches to housing as a site and resource of care, approaches to the housing of Indigenous Australians and the governance of care through social housing in the Northern Territory. I then outline my own approach and discuss my ethnographic methodology. I go on to present ethnographic

case studies and discuss their implications for housing and other public policy frameworks. Terms in Yolŋu matha (Yolŋu languages) are indicated by 'YM'.

Approaching housing as a site and resource of care

In this paper I approach care as both a set of practices and as a relation, constituted through the performance of domestic labour, affective dispositions and entitlements and obligations. As a polysemic concept, care traverses boundaries between domains of public and private, emotional and material, embodied and expert knowledge (Milligan, 2003; Thelen, 2015). Care can be understood as a reciprocal relation within families (Alber & Drotbohm, 2015; Kleinman, 2013) and between citizens and states (Andaya, 2009; Kyeong Seo, 2016). Care is a morally ambiguous practice and relation that may be at once life-sustaining and constitutive of personhood and relatedness; and may also be exploitative, paternalistic or (re)productive of gendered and racial inequalities (Stevenson, 2014).

Housing constitutes an essential materiality of care (Smith, 2005). Anthropologists have often approached housing and practices of dwelling as a mode of social organisation through which residents' responsibilities to one another are established (Alexander *et al.*, 2018; Silverstein, 2004). Housing patterns the social and economic organisation of care work and is deployed in its governance (Mee, 2009; Power & Mee, 2020). Care practices may be governed through housing to produce particular kinds of citizens, communities and nations (Alexander *et al.*, 2018). In this paper I conceptualise care as a set of practices and as a relation enacted both in families and between public housing tenants and states. Housing is understood as both a site and a resource of care.

Australian indigenous practices of dwelling and care

A body of literature on Australian Indigenous practices of housing alterity describes mobility between houses and on a regional basis, and co-residence of extended family groups (Memmott, 2003; Morphy, 2010; Musharbash, 2008; Read, 2000). Indigenous scholar Godwin Thompson (2014) describes such practices as enactments of Indigenous conceptualisations of health that require the ongoing maintenance of relationships with kin and country. In Yolŋu society, practices of extending shelter to visiting kin operate through an ethics of care, apprehended through the obligations and expectations of kinship. Interlocutors in my research valorised qualities of 'generosity' and *guŋga'yunhamirr* (helpfulness – YM), said to be evident in responding to the material and immaterial needs of kin. Caring for elderly or unwell relatives was said by interlocutors to be an expression of 'respect', while those seen to receive inadequate care from their families were said to experience 'shame'.[3] Yolŋu with end stage kidney disease were at times cared for by several relatives, through collective, rotating practices of care, and tended to have large numbers of visiting relatives, who often stayed for several weeks or months. Interdependencies existed between Yolŋu with end stage kidney disease who extended shelter to visiting kin, and their visitors who cared for them. Amongst Yolŋu, housing was mobilised as a resource for care,

mobility and the maintenance of social bonds, as well as a mode of emplacement. Co-residence of multiple generations and collective provisioning could be an expression of interdependent networks of care. Two interlocutors commented to me separately that 'we never really leave home', despite sometimes travelling away from places of residence. They drew a contrast between Yolŋu practices of co-residence and relations of interdependency with rites of passage in Western societies of moving out of one's parents' home and establishing financial independence.

Studies investigating access to housing amongst Indigenous Australians are complicated by the intersectionality of Indigenous disadvantage and cultural difference in practices of dwelling. Research investigating housing for Indigenous Australians has predominantly adopted one of two approaches, namely, ways of occupying domestic space; or housing policy and governance arrangements.[4] Few studies exemplify both traditions, although Christie et al (2013) and Fisher (2015) are exceptions. Scholars pursuing the former approach have argued that Indigenous housing alterity is essential to ongoing enactments of kinship bonds, but poorly recognised in publicly-funded housing programs (e.g. Birdsall-Jones & Christensen, 2007; Daly & Smith, 1999; Day, 2000; Fantin, 2003; Godwin Thompson, 2014; Musharbash, 2008). Others investigating the policy and institutional context of Indigenous Australians' housing find housing programs are poorly designed and resourced to meet high levels of disadvantage amongst Indigenous Australians (e.g. Habibis *et al.*, 2013; Holmes & McRae-Williams, 2008; Neutze, 2000; Prout Quicke & Green, 2017; Sanders, 2005; Taylor, 2007). A growing body of scholars who have placed the living arrangements of Indigenous Australians in biomedical regimes of value, by examining connections between housing and biomedical health, have tended to broadly support the conclusions of other research adopting a housing disadvantage orientation (e.g. Bailie & Wayte, 2006; Dockery *et al.*, 2013; Pholeros *et al.*, 1993; Thomas & Stevens, 2014).

In this paper, I attempt to bypass the academic division of labour in Indigenous housing research. In this paper I respond to the research questions: How does access to urban public housing shape relations and practices of care in the families of Yolŋu renal patients? How are Yolŋu relations and practices of care are implicated in Northern Territory housing policy?

The governance of care through social housing in the Northern Territory

Across developed Western states, the restructuring of social housing programs embodies a neoliberal philosophy of care. In social housing programs, both care and housing have been repositioned as an individual responsibility (Fennell, 2015; Power & Bergan, 2019). Disinvestment in social housing has been accompanied by the problematisation of social housing dependency as a psychological and economic failing of residents (Alexander *et al.*, 2018). Through increasing conditionality of tenancies, attempts to reshape tenant conduct according to certain norms associated with self-care have emerged (Habibis *et al.*, 2013; Power & Bergan, 2019). Through a 'politics of behaviour', the governance of housing increasingly encroaches on differentiated modes of dwelling (Flint, 2003, 2004).

The governance of care through social housing in the Northern Territory reflects, in part, a local articulation of neoliberal housing restructuring. In contemporary times, the housing exclusion of Indigenous Territorians in urban areas has largely

been a product of a lack of affordable private rental properties and significant shortages of social housing (Anglicare Australia, 2018; Taylor, 2007). In 2018, a rental affordability report found that at the time of research, there were no private rental properties that were both affordable and appropriate in all of the Northern Territory for recipients of almost all categories of social security (Anglicare Australia, 2018).[5] Most social housing in the Northern Territory is public housing (Northern Territory Department of Housing and Community Development, 2018a). Declining public housing stock in Darwin has been a product of dilapidated properties not being replaced; the shifting of public housing stock to the community sector and to an affordable housing program providing subsidised accommodation to low to medium income workers in key industries; and sales to private developers (Northern Territory Department of Housing and Community Development, 2018a; NT Shelter, 2016). The Northern Territory Government's Homelessness Strategy aims to reduce rough sleeping and other forms of homelessness in urban areas, including through a long-term plan beyond the life of the strategy to increase access to and supply of private rental, affordable and social housing, but contains no new investment in public housing (Northern Territory Government, 2018b).

Historic continuities exist, however, in Northern Territory housing policy, through measures that attempt to produce particular kinds of citizens; and in the application of such measures to Indigenous Territorians. Historically, housing policies in the Northern Territory have been instruments of colonisation, implicated in processes of dispossession, segregation and assimilation (Markus, 1990; Read, 2000; Wells, 1995). From the period of early European settlement until the mid 20th Century, Indigenous Territorians were prohibited from residing in urban areas, while authorities attempted to gradually institute sedentary ideals through various forms of institutionalisation (Read, 2000). Mid-20th century 'transitional housing' programs designed to house Indigenous people, affording structures of corrugated iron and canvas without running water or ablutions, embodied a paternalist philosophy of inculturating sedentarisation and other Western norms of dwelling through a staged approach (Ross, 2000).

A politics of behaviour continues to play out in the homes of Indigenous residents of public housing in urban areas of the Northern Territory.[6] The contemporary governance of urban public housing embodies a philosophy of care that is at once neocolonial and neoliberal, premised on sedentarisation and care for oneself and a nuclear family. Sedentary ideals are advanced through limits posed on absences from houses and prescriptive lists of acceptable reasons for long absences. Urban public housing is cast in policy frameworks as a resource for hygiene, sanitation and self-care through restrictions imposed on numbers of residents and visitors, and two week time limits on visitors (Northern Territory Department of Housing and Community Development, 2015, 2016). In the Northern Territory, I suggest, a politics of behaviour plays out as a politics of care.

Conceptualising care as an interdependent practice and relation: theoretical framework

In order to understand this politics of care, I draw from care theory developed by scholars of disability and social gerontology. These scholars have contested the

problematisation of physical, social and economic dependency in (neo)liberal theory, arguing that ideals of autonomy and self sufficiency are modelled on the lives of white, middle class, middle aged, able-bodied men. They approach care as an interdependent relation and situate care as a social responsibility (Barnes *et al.*, 2015; Feder Kittay & Feder, 2002; Weicht, 2010). In this paper I situate social housing in interdependent relations and practices of care within Yolŋu families and between citizens and states.

People with chronic diseases have particular housing and care needs. I argue that in the families of Yolŋu renal patients, housing and care needs invoke interdependent relations among kin, as well as interdependent relations between families living in public housing and the state. In the families of Yolŋu renal patients living in public housing, practices of extending shelter to kin are care practices fundamental to the enactment of interdependent familial relations and performances of domestic labour. While the governance of public housing in the Northern Territory relies on such relations and practices of care in Yolŋu families to reduce rough sleeping and achieve other policy objectives, in unacknowledged ways, Yolŋu relations and practices of care are also marginalised through the governance of housing. The politics of care that play out in their places of residence work to (re)produce bodily, social and economic precarity and other undesirable outcomes for public policy.

Methodology

I take up Bengtsson's invitation (2015) to housing scholars to develop new understandings of the politics of macro-level phenomena, such as housing precarity, through studies of the agency exercised by actors in housing institutions and programs. Ethnographic case study methods, such as those adopted within the research reported here, can forge connections between micro and macro phenomena (Burawoy, 2009), offering unique insights into the practices of actors within social housing programs.

In exploring experiences of urban public housing amongst Yolŋu renal patients, I undertook 16 months of fieldwork in Darwin, as well as making three visits to north-east Arnhem Land, in collaboration with two Yolŋu co-researchers, Yinin Dhurrkay and the late Mr Muŋul̲purr. I was closely engaged with 15 Yolŋu receiving dialysis treatment in Darwin, and their families and carers, who were referred to the study by Ms Dhurrkay and Mr Muŋul̲ purr from their personal networks, and who were selected through a purposive sampling approach. I conducted semi-structured and unstructured individual and group interviews with interlocutors, in Australian English, Aboriginal English and Yolŋu matha, at their places of residence and in public places such as parks and reserves. I accompanied interlocutors, when invited to do so, to dialysis appointments, public events and hunting trips, and I became embroiled in peoples' life projects in responding to requests for lifts around Darwin. Some interlocutors called on me to assist them to access housing and other community services, however personal information that I was exposed to in the course of assisting interlocutors has been excluded from the dataset. Yolŋu renal patients involved in this research chose the ways in which they have been identified in this paper. I also

completed audio-recorded qualitative interviews with 35 health professionals, health policymakers and staff of the Northern Territory Department of Housing and Community Development (known colloquially as Territory Housing), in addition to a review of health and housing policy documents. Interlocutors who were interviewed on the basis of their professional roles have been de-identified.

Throughout fieldwork I took notes during qualitative interviews about interview content and other observations, in addition to extensive notes about observations during day-to-day events that I participated in and notes about policy documents that I analysed. I also maintained a separate diary of reflections and theorisations. Thematic analysis of data (interview transcripts and notes) proceeded through a process of data immersion and reflection with regards to research questions; and through discussions with Ms Dhurrkay, Mr Muŋuḻpurr and occasionally, interlocutors themselves, about interpretation; and categorisation of transcripts and notes according to emergent key themes.

Although I make no claims to the positionality of a 'native anthropologist', I was personally and professionally embedded within 'the field' prior to the commencement of this project. I have worked in the Indigenous health sector in Darwin for 10 years and have collaborated with Yolŋu through various research and life projects over that period. Ethical approval for this research was granted by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (#17-2921), the Charles Darwin University Human Research Ethics Committee (#H17133) and the Australian National University Human Research Ethics Committee (#2017-760).

Case studies

Helen

One morning Helen invited Yinin and I to visit her at her one bedroom public housing unit, located in a major suburban public housing complex. I was grateful when she motioned for me to sit beside her on the lino-covered floor – I was uncertain where to sit, or how to make my way inside the front door. Helen had almost no furniture, but I counted ten people inside her tiny unit besides Yinin and I. Some were sitting on the living room floor, sharing a breakfast of rice and minced meat, eaten out of cooking pots, and milky tea sipped communally out of large plastic containers. Others were lying on mattresses, still sleeping. Still others spilled out into the kitchen, sitting on the benches. I visited Helen many times during my fieldwork, and while she and her daughter Bilinydjan, who was caring for her, and Bilinydjan's two teenage children were the usual residents, there were always several visitors.

Helen had been living in Darwin in order to access dialysis treatment for 13 years before I met her. In that period she had had a varied housing history, moving between two hostels and a relative's public housing abode, as well as spending a brief period sleeping rough (known locally as *living in the longgrass*[7]) before securing public housing herself. After Bilinydjan started caring for Helen, they had applied for a transfer to a larger property, but never seemed to be allocated one. Helen and Bilinydjan had first applied for a transfer several years prior, and continued to wait

throughout my fieldwork. Their circumstances meant that Bilinydjan's husband couldn't live with her due to Yolŋu protocols of appropriate relations between mothers-in-law and sons-in-law known as 'avoidance relations' – the one bedroom unit was too small for them to avoid being in the same room or seeing each other enter the bathroom.[8]

Helen was at once a care-giver and care-receiver and expressed a desire for housing that reflected Yolŋu practices of care. She described a need for a spare bedroom for visiting carers and other relatives, including children she would look after, but who were not recognised in bureaucratic systems as being in her care, and for public housing rules which were more permissive of visitors:

> I … need 2 or 3 bedrooms because the kids have to stay for holidays, Christmas, but still they can't. I need to stay with family, they visit for a few weeks. People still come to see me. I'm still in a one bedroom house. I want to see my grandkids sitting and talking with me, arguing, making fun of me. I need them. I need to be yelling and screaming to my grandkids, like screaming's love. That's why I'm a bit worried. They (Territory Housing) say you have to stay here (in the present house) because Bilinydjan's two kids are not in your care.

Collective practices of care in which grandparents provided extensive care to young grandchildren, particularly when parents were teenagers or young adults, were common amongst interlocutors but poorly recognised in housing policy as well as eligibility criteria for social security. As elders, grandparents described their responsibilities as central points of authority in the lives of grandchildren, and as teachers of Yolŋu knowledge.

The reasons that Helen's visitors gave for their presence in Darwin were diverse, but often embodied objectives of care and frequently reflected the centralisation of government services in the town. One woman was visiting a grandson in jail. Another was a fellow renal patient who had been living in the longgrass. Some young women had come to take children to the Darwin show (an annual carnival) during the school holidays.

Helen was not always amenable to the presence of visitors in the unit. She often complained about the cramped conditions, and of some visitors failing to meet expectations of reciprocity in contributing to groceries and cleaning chores, while she was also concerned about negative reports from housing inspectors. Feeding a large household was an expensive undertaking and Helen often ran out of money ahead of her fortnightly Disability Support Pension payments and she and the other residents frequently went hungry. She asked me to loan her money for groceries from time to time, and she and Bilinydjan sometimes took out small loans with payday lenders. When she invited me to visit her at dialysis one day, her recorded weight was only 41 kg, and a nurse was administering a nutritional supplement to her blood.[9] Helen, however, felt that asking visitors outside of close relatives to contribute to the household was impinging on their autonomy, explaining, 'I can't ask them, let them think for themselves'. In another conversation, she added, 'how I'm gonna kick them out – look after me still?', evoking interdependencies between kin of shelter and care.

It was not always clear why some of Helen's visitors didn't contribute financially to the household. One visitor, however, was paying much of her income in debts to a

payday lender. Those receiving unemployment benefits or Youth Allowance received around $546 AUD a fortnight or less (Puszka, 2019), and some may have been contributing rent to properties elsewhere: the sedentary objectives and assumptions of Northern Territory housing policy made it difficult to register frequent changes of address, and doing so through official means could also impact the tenancies and rents of other residents.

Helen evidently felt an obligation to provide care and shelter to her visitors beyond expectations of reciprocity. However, Helen's felt obligations, the actions of her visitors and the expectations contained within her tenancy agreement could leave her feeling conflicted. Helen's visitors sometimes brought her gifts of wild honey from north-east Arnhem Land and she sometimes described herself as a queen bee, ensconced in her nest while other relatives whirred around her, as in the following conversation with Yinin:

> Helen: I worry when the next lot of family is coming. I don't know. They come and visit Darwin, I always say stay here unless you're drinking, but it's ok for your family to stay … (I feel) like a honey bee, (they go) in and out. I look after them and they look after me.
>
> Yinin: There are too many people, she complains, but as soon as they leave she worries straight away. Lots of people come in, ask for food.
>
> Helen: Make me feel loved, cared for.
>
> Yinin: that's the connection, kinship … if you see lotta people living in one house that's the way it is, not gonna stop.

Other interlocutors often described frail, elderly relatives in public housing as lacking the strength to manage visitors, and elders such as Helen may have been even more tightly wrapped in needs and expectations of care.

Helen enlisted my help on a few occasions to find second hand furniture to purchase – beds, couches, a TV stand and a set of drawers. While other relatives were concerned that there would be no space for furniture in the unit between all of the bodies inhabiting it, Helen's intention was to reduce the amount of space in which visitors could be accommodated. On my subsequent visits to Helen's unit, invariably, the furniture would end up pushed against the walls or on the nature strip outside.

Helen's narrative illustrates how public housing is instrumentalised in Yolŋu families in care practices of physical mobility, domestic labour and sharing shelter and food. The negotiation of care in Helen's household invoked interdependencies amongst kin. Helen was cared for by visitors while looking after their children and providing shelter and sustenance to all. The failure of some of Helen's guests to fulfil her domestic expectations was not described by Helen as grounds for relinquishing her own responsibilities of care, or asking them to leave: extending shelter and hospitality to kin did not invoke immediate, mutual obligation. Helen did impose some behavioural constraints on visitors, refusing to accommodate those who were drinkers. However, drinkers may have been turned away on the basis of their likely disruption of other responsibilities and interdependencies of care of care within Helen's household, particularly those concerning young grandchildren, as well as on the basis of drinkers' contravention of Helen's tenancy agreement.

Helen's narrative also illustrates how contention between Yolŋu public housing tenants and Territory Housing over the presence of visitors, and the conduct of some, represented divergent ontologies of care in practices of dwelling. Such contention, which I term the 'visitor problem', expressed conflicting expectations of housing, as a resource of biomedical health and care for oneself and a nuclear family; and as part of the materiality of kinship, responsibilities to others and interdependencies of care. While public housing was imagined to be a site of sedentarisation by Territory Housing, and became a form of fixity for those receiving dialysis due to the demands of their treatment, for carers and other visitors, housing was often a resource for mobility. The 'visitor problem' could manifest in conflicts between residents and, in Bilinydjan's case, the separation of families; as well as in internal conflicts and conflicts between tenants and housing officers. Conflicts over care were underscored by a housing officer involved in conducting housing inspections, who was frustrated by the task of checking where people were residing. 'I wish they'd just stay put, it makes it really hard for us', he complained. The mobility of residents could mean that 'all our data is gone'.

The 'visitor problem' could threaten tenancies and in some cases result in eviction. Those evicted from public housing could be excluded from applying for or residing in public housing for two years, or until any debts owed to Territory Housing were settled. Interlocutors evicted from public housing were likely to seek accommodation in other relatives' public housing, leading to a cascading effect of threatened tenancies. As being on the public housing wait list was also a criterion for accessing several forms of supported accommodation and other support services, the 'visitor problem' could have broad ramifications for housing security. Through a punitive approach to tenant conduct, the governance of housing could marginalise Yolŋu relations and practices of care, and could reinforce housing precarity.

Virtually all interlocutors living in public housing had experienced the 'visitor problem'. Wapiriny complained that:

> Once you get a house you've got lots of family. Family will know once you get a house, they're the ones who are gonna kick you out. Unless you get a place in Humpty Doo (a rural town on the edge of Greater Darwin), a long way out, that's good, no one's gonna come … back home there are no problems, family's your enemy here.

Wapiriny subsequently conceded that in north-east Arnhem Land communities, a different set of problems existed in accessing properly maintained houses. Another interlocutor, Gutjan, agreed that the 'visitor problem' was not a fixture of north-east Arnhem Land communities, although people did visit one another, and was produced by Darwin's 'housing rom (laws, rules or norms – YM), if family wants to stay, only two weeks'. Interlocutors agreed that two weeks was not sufficient time to enact the relational practices that motivated their visits. Wapiriny and Gutjan's comments also suggest that Territory Housing's approach to visitors could lead to strains in familial relations.

The 'visitor problem' is extensively documented in studies of Indigenous housing from across Australia (Birdsall-Jones & Christensen, 2007; Daly & Smith, 1999; Habibis *et al.*, 2013; Long *et al.*, 2007; Milligan *et al.*, 2011). Territory Housing operated an Intensive Support Unit to assist tenants at risk of eviction, which included

assistance with 'visitor management'. Staff described the work of 'visitor management' as reminding tenants of their responsibilities as stipulated in tenancy agreements, and sometimes asking visitors to leave on behalf of tenants.

While the extension of shelter and care to kin could express familial obligation that worked through an affective register in some cases, interlocutors did not always welcome visitors gladly, or describe hosting visiting kin as motivated by altruism: discharging responsibilities to kin made one who one was. Another interlocutor retold the story of a relative who had told housing inspectors concerned about the presence of several visitors, 'all I know is that I don't count people. Because the kinship counts'. Housing authorities who saw themselves as helping residents to manage unwanted visitors missed the point that practices of providing shelter were enactments of relatedness and personhood. As anthropologists of Yolŋu and other Australian Indigenous societies have argued, kinship relations may be constitutive of one's personhood, and require ongoing affirmation, including through enactments of care (Peterson & Taylor, 2003; Sansom, 1988). Denying kinship evidently presented an existential threat which, for some, was a more serious proposition than the threat of food insecurity and the threat of eviction and the longgrass.

While Yolŋu practices of extending shelter to kin could result in overcrowded dwellings, Helen's narrative suggests that such practices addressed chronic social housing shortages. Helen's accommodation of kin addressed housing needs created by the centralisation of government services, and provided shelter to some who may have otherwise resided in the longgrass. Official data provide some evidence of this phenomenon at a population level. Homelessness amongst Indigenous people in the Northern Territory differs in severity and character to homelessness amongst other populations. As noted in the Introduction, Indigenous people comprise 88 per cent of all homeless people in the Northern Territory (Northern Territory Government, 2018b). The Australian Bureau of Statistics defines a person as homeless if their living arrangement is in a dwelling that is inadequate (for example, overcrowded); they have no tenure, or their initial tenure is short and not extendable; or their living arrangement does not allow them to have control of, and access to space for social relations. In the Northern Territory, 81 per cent of homeless people live in severely overcrowded dwellings, compared to a range of 16–45 per cent of homeless people in other states and territories (Australian Bureau of Statistics, 2018). Extremely high rates of homelessness amongst Indigenous Territorians, the vast majority of which manifests in severely overcrowded housing, suggest that the longgrass population would be substantially higher in the absence of Indigenous practices of sheltering kin. Interdependencies of care existed within the families of Yolŋu renal patients; and also between Yolŋu public housing tenants and the state. While some housing officials saw Indigenous visitors to Darwin as exploiting relatives' access to housing, public housing programs and Indigenous practices of care and redistributing shelter were mutually parasitic.

Annie

Annie was playing basketball with her sisters and cousins in her home town of Milingimbi when she started to feel weak and tired. After the game she went to the

local health centre, where following some tests she was told she had end stage kidney disease and would need to move to Darwin for dialysis treatment, immediately and permanently. She was 38 years old.

Annie was awaiting the arrival of her sister in Darwin when I met her, who she explained would care for her. Annie's sister would liaise with her doctors to get a better grasp of Annie's condition and treatment, and together they would decide whether Annie would seek a kidney transplant, or whether she would pursue dialysis services in north-east Arnhem Land, Annie explained. However, Annie's sister's competing obligations of caring for Annie and her new baby made caring for Annie difficult, and Annie continued to await her sister's arrival after my fieldwork concluded. Annie's sister's inability to care for her may have been impacted by Annie's lack of housing. The conditions of care in the longgrass were likely to subject longrass residents with children to the attention of child protection services. Of her lack of carers and visitors, Annie said, 'it makes me getting weak'. The lack of care made her feel 'gora' (shame – YM).

I first met Annie when I was visiting Helen, Annie's classificatory sister. Annie had relocated to Darwin and commenced dialysis around one year prior. Annie had come to visit Helen and to have a shower and a meal. One of her relatives who was also present at Helen's unit asked her for some money but Annie said she had none. She was receiving unemployment benefits and was subjected to job search requirements while she awaited the assessment of her application for a Disability Support Pension, which was paid at a much higher rate. Her lack of a fixed address and mobile phone, her lack of personal ID and her inability to pay for a copy of her birth certificate had delayed the process. She had been waiting for over 8 months. In that period, the 6 weeks of subsidised accommodation provided by the Northern Territory Department of Health had run out and she could not afford to continue to stay at the Aboriginal Hostels Limited facility she had been living in. A number of interlocutors resided at such hostels designated for Indigenous visitors to Darwin. Established in 1973, these facilities were intended to provide temporary accommodation for Indigenous Australians (Ross, 2000), but Darwin-based hostels had accumulated many long term residents who were often renal patients.[10] Hostel residents were charged a flat rate of $31 AUD per night, which was well below market rates but still unaffordable for people receiving some categories of social security including unemployment benefits (Puszka, 2019).

Annie sometimes stayed with her mother's ex-husband, an elderly man also undertaking dialysis in Darwin, in his public housing abode, along with his family. Patients like Annie who were unable to afford hostel tariffs and who had not secured their own public housing leases tended to live in relatives' public housing, contributing to crowded conditions. Other residents in the two bedroom unit at times complained that Annie didn't contribute enough towards rent or groceries. Living in the unit entailed living with men with whom she had avoidance relations, which brought her discomfort and stress. She was sometimes subject to violence from another relative living in the house. The circumstances of crowded public housing in Darwin could mean that for some, the living spaces of relatives were not experienced as places of care.

Social workers at the hospital tried to help Annie, applying for a social security crisis payment to enable her to stay elsewhere for a spell, but the promise of temporary

relief proved elusive. Because the violence Annie was subjected to did not take place inside the house, she was ineligible. On at least two occasions, social workers secured temporary accommodation for Annie at a women's shelter, but the two week time limit for crisis accommodation saw her return to the troubled unit after each stay. Annie sometimes slept rough in the longgrass when relations in the unit became intolerable. She often appeared exhausted and complained, 'Looking for a place, sleeping in the longgrass, staying with family, I can't sleep, I can't rest'. When residing in the longgrass, she was sometimes subject to police surveillance. In the longgrass, Annie sometimes missed her dialysis treatment when the patient bus couldn't find her. On one occasion, when she became sick from the build up of fluids and toxins in her body, she was rushed to the emergency department.

Annie often spoke of her hunger. At Helen's unit Annie sometimes sought food and a shower, but she admitted that 'sometimes there's no food (at relatives' houses)', and she attempted to get by just by consuming small amounts. Yinin, who was also present during many of our discussions, and knew of Annie's trials, elaborated, 'sometimes she tries to think of people she could go to for help but she always ends up at Helen's place, she has no one else'. Annie had attempted to seek help from other relatives previously, but, Yinin continued, 'sometimes the people are not home, it's hard to get into a place to change *girri* (clothes – YM), shower, get ŋ*atha* (food – YM)… She walks away feeling not wanted, alone. Some people tell her to leave. She thinks, how did I get into this?'

Annie's predicament illustrates how the governance of urban housing in the Northern Territory could strain relations of care among kin. Annie was subjected to multiple public policy failures, compounded by strains on the interdependencies of kinship and domestic care. Discord existed between the ways in which medical services were provided, creating urban displacement, and the governance of housing, through which extreme urban public housing shortages persisted. Annie's inadequate access to housing and accommodation, and to the Disability Support Pension, meanwhile, were mutually implicated. Without a Disability Support Pension, she could not afford to continue staying at an Aboriginal Hostels Limited facility and had limited ability to make financial contributions to her mother's ex-husband's household. Without a stable fixed address, correspondence regarding her Pension application was not received and dialysis treatment was difficult to sustain. It was the way that urban housing was governed, however, creating conflicting responsibilities among public housing tenants to their kin and to Territory Housing that strained familial relations and ultimately led to Annie's homelessness. The 'visitor problem' made seeking assistance from relatives in Darwin difficult for Annie. Inadequate housing also prevented Annie's sister from caring for her. It was the conflictual relations and lack of care in her mother's ex-husband's crowded unit that finally relegated her to the longgrass.

Annie described her lack of care as an experience of 'shame', and her experiences evidently made her wary of seeking further help. Yinin suggested that the 'shame' experienced by Yolŋu renal patients who lacked carers and who were unable to seek assistance from kin could lead to them taking up drinking and missing or ceasing treatment. Helen had also lived in the longgrass for a period and was a self-described non-drinker, refusing to allow drinkers in her house, but felt that it was impossible to resist alcohol in the longgrass, telling me 'I couldn't help it'. In the longgrass, the bonds of solidarity

with other drinkers were the only form of care that Helen had. When I asked Wapiriny about what happened to patients without care, he replied that those patients had 'already gone' – ending their treatment and leaving Darwin to return to their homelands, and gone from this world to another domain. If being encompassed in interdependent relations of kinship and care formed part of who one was, if followed that those without care could suffer a loss of their personal substance.

A lack of housing and care led to Annie missing treatment and being admitted to hospital. Renal patients in the Northern Territory generally have high rates of hospitalisation and low rates of survival (Australian Institute of Health and Welfare, 2017; You *et al.*, 2015). Annie described her lack of domestic care as manifesting in physical weakness. Congruent with my own observations, interlocutors themselves often commented that renal patients who had stable carers tended to be admitted to hospital on far fewer occasions than those who did not.

A lack of housing and care for renal patients could also impact on hospital admissions in other ways. In recognition of health services' duty of care to patients, Royal Darwin Hospital has a patient discharge policy of 'no exit to homelessness'. Senior Department of Health officials confirmed that in cases when no accommodation is available to refer patients to, staff at times operationalise the policy by keeping patients at risk of homelessness as hospital inpatients. This practice can place pressure on hospital beds, resulting in periods of 'delayed discharge' or 'bed block' in which all elective surgery is cancelled (Byrne, 2018). I was relayed second-hand information about similar practices at Alice Springs Hospital, where a blind Indigenous renal patient had been living for two years, after relocating to Alice Springs for treatment without accompanying relatives, and after being assessed as ineligible for supported accommodation. The woman's lack of domestic care made other forms of accommodation inappropriate. At Royal Darwin Hospital, there were at least three prolonged periods of 'delayed discharge' in 2018 (Northern Territory Government, 2018a). For some renal patients, the presence of carers could eliminate patients' need for specialist, high care accommodation.

Discussion

Attending to housing as a site and resource of care provides a different vantage point on housing policy. It requires attending to the interplay between structural conditions and local relationships and practices in places of residence. Attending to housing as a site and resource of care has enabled me to explore the interaction between chronic disease and housing, beyond matters of hygiene and sanitation. The case studies presented illustrate how access to housing shapes relations and practices of care for two Yolŋu renal patients facing different sets of circumstances; and how such relations and practices of care are implicated in Northern Territory housing policy.

The case studies presented demonstrate how access to housing invokes social roles, processes of personhood and interdependent relations of care among kin in the families of Yolŋu renal patients. Housing is integral to Yolŋu relations and practices of domestic care, as a locus of care practices of domestic labour, sheltering and sharing; and as a resource encompassed within and interdependent relations among kin.

Interdependent relations among kin may further extend to processes of recognising personhood through relatedness, through the recognition of one's basic needs by others and in responding to those of kin.

Helen and Annie's narratives also illustrate how relations and practices of care in the families of Yolŋu renal patients living in urban public housing are implicated in Northern Territory housing policy through interdependent relations between Yolŋu families and the state. Helen's case study shows that despite the contending values and expectations of care in Northern Territory housing policy and among Yolŋu families, housing policy relies on relations and practices of care in Yolŋu households. Policy objectives of reducing rough sleeping, in the absence of sufficient investment in social housing to meet the housing needs of eligible applicants, require Northern Territorians at risk of homelessness to reside with relatives in crowded housing. Helen's narrative reveals how the governance of public housing mobilises yet marginalises Yolŋu redistributive practices of extending shelter to kin, producing the 'visitor problem'. As a public housing tenant, Helen was cast as housing dependent in Northern Territory housing policy; yet she was also a provider of shelter to kin.

Annie's case study, meanwhile, shows the consequences of the 'visitor problem'. Through the 'visitor problem', Yolŋu public housing tenants face contending responsibilities to their families and to housing authorities. The 'visitor problem' could in some circumstances compromise relations and practices of care among kin. The 'visitor problem' could subject renal patients such as Annie, who were unable to secure their own housing and unable to live with kin to substantial bodily, social and economic precarity. The 'visitor problem' could also lead to other undesirable consequences for public policy, through the use of hospital beds to accommodate those sleeping rough in some cases and, I have suggested, by contributing to high rates of hospitalisation among renal patients.

The ethnographic case-study approach adopted in this study, although involving only a small number of interlocutors selected through purposive sampling strategies, enables a rich understanding of Yolŋu relations and practices of care in public housing. Case studies have been supplemented with other interlocutors' perspectives and other research and data where possible. While practices and social meanings of dwelling and care may be culturally specific, the documentation of similar care practices of extending shelter to visiting kin among Indigenous people from across Australia (e.g. Birdsall-Jones & Christensen, 2007; Daly & Smith, 1999; Habibis *et al.*, 2013; Long *et al.*, 2007; Milligan *et al.*, 2011) suggest a similar politics of care may play out in other locations. Moreover, a substantial proportion of Indigenous households are likely to be providing care to members with chronic disease.[11] International ethnographic research describes interdependent practices of sharing, pooling and care amongst poor and marginalised households (Graeber, 2001; Han, 2012; Williams, 2005), suggesting a wider resonance for approaches to housing research and housing policy that foreground housing as a site and resource of care.

Conclusions

In Northern Territory housing policy, urban public housing is disembedded from the social relations and care practices through which it operates, and on which it

depends. Neocolonial and neoliberal policy frameworks cast public housing tenants as dependent on the state, requiring transformation into sedentary, self-caring subjects. Yet, through inadequate urban public housing stock, housing policy relies on inter-dependent relations between Yolŋu urban public housing tenants and the state to care for renal patients and accommodate many of those facing the prospect of rough sleeping. Through the 'visitor problem', contention over values of care and practices of dwelling could obscure distributional questions about the adequacy of public housing stock. Through the unacknowledged ways in which housing policy mobilises yet marginalises relations and practices of care in Yolŋu families, a politics of care works to reproduce housing and other forms of precarity.

Notes

1. The Australian Bureau of Statistics defines an 'Indigenous household' as a household in which one or more members identifies as Indigenous.
2. People with end stage kidney disease require renal replacement therapy (either kidney transplant or ongoing dialysis treatment) in order to sustain life. Few Indigenous Australians with end stage kidney disease receive kidney transplants for reasons which are likely to include structural racism (Cunningham *et al.*, 2005; Khanal *et al.*, 2018).
3. Concepts of 'shame' as used in Aboriginal English may express transgression of social norms, failure to show expected proprietary or respect, individuals being cast into the spotlight in front of or apart from a group and uncertainty about appropriate behaviour in a social situation (Harkins, 1996). I interpret the 'shame' described here as a perception of being separated from others. Renal patients without stable carers were also frequently described as 'lonely'.
4. Sanders (2008) describes this literature as mapping onto one side or another of a tension in Indigenous affairs between equality and difference, with equality-oriented literature focussed on access to housing and difference-oriented studies exemplifying a culturally appropriate housing agenda. In a literature review, Long and colleagues offer classifications of Indigenous housing research as 'micro level' (living environments) and 'macro level' (policy agendas) (Long *et al.*, 2007).
5. The report's methodology took into consideration the eligibility of low income private rental tenants for Rent Assistance.
6. The governance of social housing in remote areas of the Northern Territory, where in many cases there is no private rental sector, takes on different forms. Social housing in remote areas is governed through different sets of eligibility criteria, different allocation processes, differential rents and fewer restrictions on visitors receiving (Northern Territory Department of Housing and Community Development, 2017); and, according to interlocutors, less strict enforcement of tenancy agreements.
7. This is a regional term that refers to speargrass which grows to over two metres tall during the wet season months and reflects attempts amongst homeless people to camp away from the surveillance of authorities (Day, 2000). The term is commonly used amongst Indigenous communities in Darwin, as well as amongst service providers and local authorities.
8. Yolŋu in particular kinds of relationships (e.g.: a man and his mother in law; siblings of different gender) practice social norms of maintaining a respectful distance, such as avoiding eye contact, refraining from directly facing one another or sitting next to one another without another person between, and in some cases, avoiding direct communication or being in each other's presence.
9. Malnutrition among renal patients may represent complications of end stage kidney disease, as well as the social and economic environments of patients (Hoy *et al.*, 2001, Kovesdy, 2016).

10. Aboriginal Hostels Limited operate one hostel designated specifically for renal patients in Darwin, however other hostels also attract many renal patients. In practice, residents tended to congregate at hostels together with their kinfolk, within the confines of hostel policies, and some Darwin hostels have become associated with Indigenous groups from various parts of the Northern Territory.
11. The prevalence of diabetes alone may be as high as 33% in some Indigenous communities (Burrow & Ride, 2016).

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