FEANTSA

October 2010

Policy Statement on

Health Care Entitlements for People who are Homeless

FEANTSA, the European Federation of National Organisations Working with the Homeless is an umbrella of not-for-profit organisations which participate in or contribute to the fight against homelessness in Europe. It is the only major European network that focuses on homelessness at the European level. FEANTSA currently has more than 100 member organisations, working in close to 30 European countries, including 25 EU Member States. Most of FEANTSA's members are national or regional umbrella organisations of service providers that support homeless people with a wide range of services, including housing, health, employment and social support. They often work in close co-operation with public authorities, social housing providers and other relevant actors.

Homelessness is understood in the wider sense as part of a continuum of living situations whereby people are roofless, houseless, insecurely housed or inadequately housed, in accordance with the ETHOS typology.

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Introduction

FEANTSA embraces the comprehensive definition of health set out in the preamble of the World Health Organisation's constitution[1], which goes far beyond considerations of access to health care services and implies that a joined up health policy including prevention, promotion, treatment and reintegration aspects. This also requires health to be taken into account across a range of policy areas, such as social welfare, housing, employment, education, environment and so on.

Social exclusion and homelessness are complex and multifaceted realities[2], which affect all areas of people's life and have an unquestionable impact on people's state of health and well being. Health related problems can be among the trigger factors leading to homelessness, while the impact of very difficult and unhealthy living conditions is worsened by problems accessing care and late recourse to medical aid leading to very bad general health.

Although in theory homeless people and other vulnerable groups may be legally entitled to basic health care in many European countries, there are a number of uncertainties and hurdles to overcome, which significantly undermine their effective access to health care services and enjoyment of their fundamental rights. Access to health care often proves to be a daily challenge for many people faced with homelessness, poverty and social exclusion, and this is even more the case in a period of crisis.

The right to benefit from access to health care is recognised in human rights texts at international and European level[3]. Among EU Member States, there is a variety of healthcare and social protection systems, which include provisions for vulnerable groups not able to pay for health care. If there are generally clear entitlements to access health care for free or at minimum cost when the homeless person is a country national or when in a regular administrative situation, this does not always translate into effective access in reality. And the situation may prove much more complicated if the person is of foreign origin and/or not in a regular administrative situation.

Health care entitlements for homeless people vary depending on the country, as well as requirements to access the health care system, although similar features and trends can be evidenced across the European Union (EU). How to ensure that health care systems are organised in a way that is sustainable while making sure that they are accessible to all and meet the needs of hard to reach groups of the population?

Based on the experience of its members in ten EU Member States[4], FEANTSA raises below a number of issues, which need to be addressed in order to allow everyone to access their highest attainable standard of health. It also proposes recommendations aimed at policy makers and other relevant stakeholders as an attempt to contributing to practically improving the existing situation.

[1] "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

[2] FEANTSA has been working in an ongoing way to develop a common understanding of homelessness at European level. This work has lead to the development of a European Typology of Homelessness and Housing Exclusion (ETHOS), which offers a broad understanding of homelessness underpinned by the housing situation that a person is in.

[3] Including: Council Conclusions on the Common Values and Principles in EU Health Systems (2006): "Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay"; Charter of Fundamental Rights of the European Union, Article 35: "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities"; Article 13: of the Council of Europe Revised European Social Charter.

[4] Overview of existing provisions and practice regarding access to health care services for homeless people in Austria, the Czech Republic, Denmark, France, Germany, Greece, Lithuania, the Netherlands, Spain and the United Kingdom. See FEANTSA Briefing paper on Health care entitlements for people who are homeless (2010).

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Entitlements to what?

People who are homeless often suffer from chronic and severe health problems, including issues related to physical, mental health, substance abuse and dual diagnose[5]. Life expectancy is far lower for homeless people than for the general population and when comparing the incidence of certain serious diseases, homeless people and other vulnerable groups are faced with significantly higher morbidity rates[6]. Another important factor is that the health problems they experience are usually complex and multiple and this constitutes a significant challenge to mainstream services. It also means that homeless people are highly vulnerable, as they frequently suffer from several problems concomitantly.

In most of the countries reviewed, homeless people have usually access to emergency and basic health care services. Preventative measures are seldom referred to, while dental health care, mental health care and specialised treatment (for instance alcohol or detoxification treatment) do not usually fit the basic basket of services homeless people are entitled to. In this context, it should be highlighted that although a frequent entry point, the emergency department is not the most appropriate or more cost effective service to respond to homeless people's health needs, as it only addresses acute situations, does not allow for a comprehensive approach to health and well being nor tackle chronic conditions.

Preliminary requirements

Even to access basic health services, in most cases users need to show that they are entitled to care. To do so, they usually have to provide proof of residence, local connection, employment and financial means. Paper work and administrative procedures might prove insurmountable when people are facing difficult and precarious circumstances. Also, depending on the personal status[7] the situation might be even more complicated. Other obstacles include: lack of awareness of entitlements, lack of information on available services, etc.

If the homeless person is not a national of the country he/she is living in, entitlements usually depend on a number of conditions, including administrative and employment status. Undocumented migrants are in a problematic situation as minimal provisions usually lead to a lack or insufficient access to subsidised health care, which is becoming increasingly restrictive throughout the EU, due also to contradicting provision in different policy areas[8]. Fear may discourage them from seeking medical help when necessary and this may have a public health impact. It is worth mentioning that in recent years, homeless service providers have witnessed and increasing demand from users from EU-10 countries[9] moving to EU-15 countries, who find themselves without work and destitute and have difficulty in accessing services due to lack of entitlements.

In many countries, there seems to be an increasing tension between individual rights, public health considerations and broader policy options (for instance those related to migration policy). In some countries, first line health professionals are forced into a situation where they will face ethical

[5] See FEANTSA European Report "The right to health is a human right: ensuring access to health for people who are homeless" (2006) ; FEANTSA Briefing paper on homelessness and alcohol (2009); FEANTSA-MHE joint statement on homelessness and mental health (2009):

[6] See FEANTSA contribution to the consultation on EU action to reduce health inequalities (2009):

[7] Differences depending on whether a country national, EU citizen, A8, third country national, asylum seeker or a refugee.

[8] See FEANTSA 2006 European Report and PICUM's "Access to Health Care for Undocumented Migrants in Europe" (2007). See also the report published by Médecins du Monde on access to health for undocumented migrants in several European countries (2009).

[9] This refers to Member States (MS), which joined the EU in 2004 (apart from Malta and Cyprus), and to Romania and Bulgaria. When the Accession countries joined the EU in May 2004 the existing MS were given the option of implementing transitional arrangements to the freedom of movement of workers from these countries for up to 7 years. In May 2004 the UK, Ireland and Sweden were the only European countries to allow A8 nationals free access to their job markets. Other European countries applied work permit systems under the transitional arrangements. The European Union allowed transitional measures for an initial period of two years after which member states had to inform the European Commission of whether they intended to continue or amend their regulations as regards to free movement. The initial 2 year period ended in April 2006 and additional countries have decided to lift their restrictions. These include Greece Finland, Portugal and Spain. Further, France intends to lift restrictions gradually.

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dilemmas on a daily basis (unconditional duty of care versus legal constraints), while in other countries they are officially being given the right (and power) to either register or refuse vulnerable patients depending on their ability to pay for their treatment (unconditional duty of care versus financial considerations).

Affordability

In several countries the modernisation of health systems has lead to the introduction of compulsory health insurance schemes or out of pocket payments for a doctor's visit. As for the insurance schemes, when failing to pay for a certain number of months patients are usually not covered anymore. Concerning the out of pocket payments, even if the amount to be paid does not seem to be very high and can be partly claimed back, this remains a barrier for very poor people. Due to the precarious situation they live in, they might have to struggle for survival and will prioritise their needs. As a result, they have no choice but not to go to the doctor.

Access to and delivery of care

Access to healthcare is not evenly spread across the population. People who are poorest tend to have the greatest healthcare needs, but also the worst access to care ("inverse care rule"[10]). The situation faced by homeless people is therefore a valuable indicator in terms of how accessible a given health system is and whether a new development is likely to have a negative impact in terms of access for vulnerable groups[11]. To reverse this thinking, one may consider that a system that meets the health needs of people who are homeless will be one that ensures equitable access to health care to the most excluded and which has successfully tackled the barriers of access affecting the poor and marginalised.

Delivery of care aimed at vulnerable group seems to be structured in different ways depending on the country, ranging from an attempt to mainstreaming general primary care services to a more targeted approach, for instance through outreach work and specific services aimed at vulnerable groups. Apart from the administrative and financial hurdles mentioned above, there are still many obstacles for homeless people to access care: socio economic and health inequalities, the need for appropriate information, the fact that the care demand is not always expressed, difficulty in attending appointments and following up the treatment, etc. Another problem may be the reluctance on the part of health services to engage with them. As concerns the quality of care delivered, it should be mentioned that homeless and very vulnerable people cannot be considered as being consumers as they are without the financial power to command a good quality service.

Multidisciplinary settings and multiple needs

In general, there seems to be a tendency towards a sectorialisation of health care services, whereas multiple needs would be more efficiently addressed in the framework of multidisciplinary settings. As a matter of fact, basic health care entitlements do rarely take into account the usually multiple and complex needs of people who are homeless.

Given the above considerations, FEANTSA would like to put forward the following recommendations.

[10] Christina Masseria, LSE Health: "Access to Care and Health Status Inequalities in a Context of Healthcare reform", available on the Peer Review Website: http://www.peer-review-social-inclusion.eu/peer-reviews/2006/Access-to-care-and-health-status-inequalities-in-a-context-of-healthcare-reform

11 See FEANTSA European Report of 2006 mentioned above; see also Spanish National Report, which mentions that: "processes of extreme exclusion can reveal the shortcomings of any system, including a health care system", available in the Members' National Reports Section of the Health and Social Protection Page: http://www.feantsa.org/code/en/theme.asp?ID=2.

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Recommendations

1. Cross-sectoral approach and cooperation: homelessness needs to be tackled in a cross-sectoral and comprehensive way at different levels. This requires coordination across a range of different policy areas, levels of competence and responsibility and stakeholders. Some countries have embedded specific provisions regarding health in wider homeless strategies. This seems to be a good way forward to tackle sectorialisation. In general, cross-sectoral contacts and networking should be encouraged and supported.

2. Addressing structural factors: there is a need to address structural factors leading to both homelessness and ill health. These include socio economic inequalities, the housing situation, living environments, lack of appropriate prevention strategies, etc. When assessing cost effectiveness of the different types of measures, prevention should be seen as an investment for the future.

3. Tackling health inequalities: there is a growing understanding of the correlation between socio-economic and health status[12] and political support to tackle health inequalities[13], which prevent part of the population from accessing their fundamental rights, enjoying better life conditions and meaningfully participating in society. Ensuring that everyone can access preventative measures as well as the care that they need is a crucial step towards improving health outcomes across the population and upholding basic human rights for all.

4. Implementing targeted measures: as regards access to health care, in some countries, outreach health services support homeless people in accessing mainstream services. In other countries, a single point of contact, which can be health related or managed by general homeless services, facilitates their access to a range of different health services, including by supporting the users with the relevant administrative procedures. Whatever the option chosen, it is important that targeted support measures are available to vulnerable users/patients and sustained in the long term, including financially.

5. Children and young people: there is a need for specific measures aimed at children and young people. It is well known that difficult life circumstances and bad health in early life have an impact on later life. There should be targeted efforts addressing children's health needs, in terms of prevention, promotion and treatment, as well as appropriate policy measures supporting young people who leave care institutions, including in the area of health. High rates of youth unemployment and discrepancy in terms of entitlements might lead to higher vulnerability and the risk of entering a vicious circle of poverty, exclusion and ill health.

6. Avoid modernising health systems at the expense of the most vulnerable: ongoing reforms of health systems, which include cost cutting measures, privatisation of risks and efficiency considerations, need to be assessed in the light of the problems experienced by the most vulnerable. Introducing even a small fee aimed at ensuring a short term financial impact, might actually contribute to prevent vulnerable people to access health care services, thus worsening their general health condition, contributing to both perpetuating health inequalities and increasing the burden of disease and related costs in the long term. Cost effectiveness needs to be assessed in the long term.

7. Ensure consistency across policy areas: there is a need to address potential discrepancies between legal and policy provisions, which have a direct or indirect impact on access to health care for the most vulnerable groups in society. There are examples of (potentially)

[12] Including the WHO Commission on social determinants of health Final Report "Closing the Gap in a Generation: health equity through action on the social determinants of health" (2008).

[13] When referring to "health inequalities" we understand "health inequities", meaning health differences that are unfair and unjust. See M Whitehead, G Dahlgren, "Levelling up (part 1): a discussion paper on concepts and principles for tackling social inequities in health", WHO, 2006. See also EC Communication Solidarity in Health: Reducing Health Inequalities in the EU (2009), the Social Protection Committee's opinion on the Communication and the Council conclusions on Equity and health in all policies: solidarity in health (2010).

contradictory provisions in policy areas such as migration, security and public health policies, which need to be addressed. Some groups of the population cumulate a number of vulnerability factors[14], which will have an impact on their health. Consistency between different policies needs to be better ensured.

8. Ensure follow up and support measures for vulnerable users/patients: policies relating to discharge from institutions, be it hospitals, care institutions or prisons should be better coordinated with general health and social policies. There is a need for appropriate measures aimed at ensuring that health, both physical and mental health, is part of the follow up once people go back to the community. Short term budget cuts or political options can have an impact on public health and might affect both the most vulnerable and, in the longer run, the whole population[15].

9. Provide adequate training to relevant professionals: front line personnel should be aware of the specific hurdles faced by homeless people, which may be related to procedures, administrative or financial barriers, as well as of practical solutions to overcome the lack of care. There is a need for adequate training aimed at both health and non health professionals, allowing them to better address situations involving very vulnerable users and patients with multiple needs. It would be important for both health and non health personnel to have basic health skills.

For more details, visit FEANTSA web site www.feantsa.org or contact Stefania.delzotto@feantsa.org.

FEANTSA is supported by the European Community Programme for Employment and Social Solidarity (2007-2013).

This programme was established to financially support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields.
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For more information see: http://ec.europa.eu/social/main.jsp?catId=327&langId=en

FEANTSA is supported financially by the European Commission. The views expressed herein are those of the authors and the Commission is not responsible for any use that may be made of the information contained herein.

[14] For instance undocumented migrants or women faced with domestic violence. Gender based violence is among the main causes of homelessness among women, see FEANTSA contribution to the Consultation on an EU Strategy for combating violence against women 2011- 2015 (2010) .
[15] See also FEANTSA Ending homelessness campaign : http://www.feantsa.org/code/en/pg.asp?Page=1252

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