FEANTSA

September 2010

Briefing Paper 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

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 people who are homeless and other hard to reach groups? Health care entitlements for homeless people vary depending on the country, as well as requirements to access the health care system, although similar features can be evidenced as well.

The purpose of the present briefing paper is to give an overview of existing legislation and policies relating to health care entitlements for homeless people at different levels and how these are implemented in some EU Member States. It also aims at highlighting issues which need to be addressed in order to allow everyone to access the highest attainable standard of health, in particular vulnerable groups such as people who are homeless.

Health as physical, mental and social well being

FEANTSA embraces the comprehensive definition of health set out in the preamble of the World Health Organisation's constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This definition goes far beyond considerations of access to health care services and implies that a joined up health policy will take account of prevention, promotion, treatment and reintegration issues. It also requires health to be taken into account across a range of policy areas, such as social welfare, housing, employment, education, agriculture, environment, etc.

Social exclusion and homelessness are complex and multifaceted realities, which have an unquestionable impact on people's state of health and well being. People who are homeless[1] often suffer from chronic and severe health problems, including issues related to physical health, mental health, substance abuse and dual diagnose (suffering simultaneously from mental illness and drug addiction). Rates of certain serious infectious diseases are significantly higher among the homeless population than the general population, including HIV, tuberculosis and hepatitis. There are also high levels of drug and alcohol abuse and far higher rates of mental ill-health among people experiencing homelessness than among the general population. However, access to health care for homeless people remains difficult for a number of reasons, including administrative and financial barriers.

International human rights framework and European action

The right to benefit from access to health care is recognised in human rights texts at international and European level. In particular, the Revised European Social Charter of 1996 enshrines the rights to protection of health, to social security, and to social and medical assistance in Articles 11, 12 and 13[2]. Equally, the Charter of Fundamental Rights of the European Union sets out a strong entitlement to access preventative health care and treatment in Article 35 on health care.[3]

The commitment to upholding these rights by policy-makers in the European Union (EU) was reinforced in 2006 by the Council Conclusions on the Common Values and Principles in EU Health Systems. The defining principles set out for health care systems in Europe were universality, access to good quality care, equity and solidarity[4].

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[1] 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 The 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. The four broad categories of housing situation identified are as follows: roofless, houseless, insecurely housed, inadequately housed.

[2] Article 13 defines medical assistance as the guarantee that "any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition." See Revised European Social Charter 1996: http://conventions.coe.int/Treaty/en/Treaties/Html/163.htm.

[3] "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." See Charter of Fundamental Rights of the European Union, Article 35: http://www.europarl.europa.eu/charter/pdf/text_en.pdf.

[4] These principles are explained as follows: "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." See Council Conclusions on

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While the Treaty of Lisbon has strengthened the EU's role in the protection on public health[5], the EU does not have any competency as regards organisation of health care services at national level, but it has created mutual exchange and learning mechanisms, as well as funding to support Member States to tackle the challenges facing their health care systems. Thus it is clear that there is agreement among Members States and at European level about the need to make progress on tackling health inequalities and ensuring equitable access to healthcare systems across the EU. However, it would still seem that there is much work to be done.

Health inequalities and the inverse care rule

Healthcare plays a role in population health, but access to healthcare is not evenly spread across the population. For a range of socio-economic reasons, people who are poorest tend to have the greatest healthcare needs, but also the worst access to care. This documented economic reality is known as the "inverse care rule" and it means that "the availability of good medical care tends to vary inversely with the need for it in the population served".[6]

There is a growing understanding of the correlation between socio-economic and health status[7] and political support to tackle health inequalities[8], 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 the care that they need is a crucial step towards improving health outcomes across the population and upholding basic human rights for all.

Why focus on access to healthcare for people who are homeless?

In the case of people who are homeless, 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. Among people who are roofless and houseless, one often finds an accumulation of health problems that have become very severe and add up to a high vulnerability across a range of areas. These are further complicated by bad nutrition and precarious living conditions.

Another important factor in the health situation of people experiencing homelessness is that the health problems they experience are usually complex and multiple and this usually constitutes a significant challenge to mainstream services. It also means that homeless people are highly vulnerable, as they frequently suffer from several problems concomitantly.

Yet despite these severe health needs, homeless people frequently go without the care that they need. Financial and administrative hurdles often prove insurmountable and there may be reluctance on the part of health services to engage with them. Moreover, homeless people cannot be considered as being consumers as they are without the financial power to command a good quality service. They are at the mercy of the baseline public provisions made for them and where even a small out of pocket payment is introduced for emergency or basic primary care, this can have a very negative impact in terms of access to health. It is highly unlikely, therefore, that market rules will ensure a diminution of existing health inequalities. The vulnerable status of people who are homeless is further worsened by the fact that they are not always informed about their rights and entitlements.

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the Common Values and Principles in EU Health Systems: http://www.eu2006.at/en/News/Council_Conclusions/0106HealthSystems.pdf.

[5] The Treaty of Lisbon entered into force on 1 December 2009. See http://europa.eu/lisbon_treaty/index_en.htm

[6] 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

[7] 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.

[8] 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. Concerning health inequaltieis, see also EC Communication "Solidarity in Health: Reducing Health Inequalities in the EU", published on 20 October 2009 and the Social Protection Committee's opinion on the Communication, which was published on 20 May 2010in view of the EPSCO Council of 7-8 June 2010: http://register.consilium.europa.eu/pdf/en/10/st09/st09960.en10.pdf

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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[9]. 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.

Health care entitlements for people who are homeless in several EU countries

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. 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. However, if this is true in theory, it does not always correspond to the reality, as people who are homeless are usually still faced with a number of hurdles to overcome. These include: lack of awareness of entitlements, need to provide necessary evidence for accessing rights, local connection requirement, 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[10]. Fear may discourage them from seeking medical help when necessary and this may have a public health impact. In recent years, homeless service providers have also witnessed and increasing demand from users from EU-10 countries[11] moving to EU-15 countries, who find themselves without work and destitute and have difficulty in accessing services due to lack of entitlements.

An 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** is available below. It is based on the experience of FEANTSA members active in those countries and will seek to provide answers to the following questions:

- How are entitlements and access to health care for people who are homeless in your country organised? How does this translate in practice? Where does access break down?
- What is the situation in terms of access to care for people who are homeless from another EU member state?
- What is the situation in terms of access to care for people who are homeless from a non-EU member state?

9 The Spanish national report on health and homelessness submitted in the framework of its annual theme mentions that: "processes of extreme exclusion can reveal the shortcomings of any system, including a health care system". See Spanish National Report for FEANTSA's Annual theme 2006 (The Right to Health is a Human Right: Ensuring access to Health for People who are Homeless). Available in the "Members' National Reports Section of the Health and Social Protection Page of FEANTSA's website: http://www.feantsa.org/code/en/theme.asp?ID=2.

10 See FEANTSA 2006 European Report and PICUM's "Access to Health Care for Undocumented Migrants in Europe", 2007 http://www.picum.org/?pid=210. See also the report published by Médecins du Monde in October 2009 on access to health for undocumented migrants in several European countries: http://www.mdm-international.org/index.php?id_rubrique=37.

11 This refers to Member States, 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 Member States 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, Spain. Further, France intends to lift restrictions gradually.

Austria

In Austria, people who are homeless, Austrian nationals and have a health insurance are entitled to health care as other insured citizens. However, in practice, access often breaks down due to several reasons and multiple barriers. For non-Austrian nationals access to health care depends on their legal residence and insurance status within Austria. Emergency care is provided to all people in need, regardless of their insurance status or residence permit.

Social Security

The Austrian social insurance system[12] is characterized by compulsory insurance. Mandatory insurance is based on membership of an occupational group or place of residence and includes practically all employed persons. The system is mainly financed by compulsory contributions paid by employers and employees, while close dependants are insured on a non-contributory basis. 98.7% of the Austrian population is insured, of which about 26% are family members whose insurance coverage is for free.

The Austrian Welfare System consists of three main components:

1. Social Insurance: includes health, accident, pension and, in a broader sense, unemployment benefits. The social insurance is mainly financed by contributions.
2. Public assistance, which is financed by general taxation and includes benefits such as child benefit, care benefit, maternity benefit and others.
3. Social welfare, including disability benefits, retirement and care homes, monetary assistance etc. The social welfare provides a minimum subsistence benefit in cases of emergency and is financed by general taxation.

Voluntary insurance for those who do not work is possible. Unemployment benefits provide money, support and advisory services in case of unemployment. Unemployed people are also insured in case of illness[13]. Those who do not have insurance have to pay for all medical services, they are only granted free access to services in case of emergency.

Medical aid

Entitlement to health care is managed through the E-card, which needs to be shown prior to any medical visit. People in need, who are registered at the Social Welfare Office, receive a substitute E-card, which allows them to receive free medical treatment. People without insurance do not have either the E-card or the substitute E-card and have to pay for their medical treatment. Emergency care is provided to everyone regardless of their insurance status.

In case of illness, the insured person can visit any doctor, who is affiliated to his/her insurance carrier. In this case the fee is paid by the insurance provider; the patient is charged an annual co-payment of 10€ to cover the costs of the E-Card. When consulting a doctor who is not affiliated with an insurance carrier, the health insurance fund will reimburse 80 percent of the amount which would have been paid by the insurance provider to a contracting doctor. The health insurance scheme for public sector employees, self-employed people and farmers generally requires a co-payment[13]. In general the following co-payments are required in the following cases:

- prescription fee for medication
- specific dental and dental-technical services
- grants for prosthetic materials and auxiliaries
- specialist services, such as physiotherapists and others
- contribution for hospitalization up to a maximum of 28 days per year, except in specific cases such as childbirth.

[12] See Main Association of Austrian Social Security Institutions, “Well insured. Social Security in Austria”, 2009 available at: http://www.sozialversicherung.at/mediaDB/554674_Gut_versichert_englisch_2009.pdf
[13] Federal Ministry of Health and Women (2005): Public Health in Austria. http://www.bmgfj.gv.at/cms/site/attachments/8/6/6/CH0713/CMS1051011595227/public_health_in_austria_2005_internet.pdf

Health Care for Homeless People

In Austria, people who are homeless, Austrian nationals and have a health insurance are entitled to health care as other insured citizens. However, even if most homeless people are entitled to health care services, in practice access to care is problematic due to several reasons and barriers:

- In general, the Austrian health care system is based on the patient's responsibility to solicit medical treatment and/or monetary assistance. As many homeless people suffer from psychiatric diseases, they often cannot "actively" access the system and therefore they do not receive medical treatment as other citizens do.
- Homeless people cannot afford financial contributions to the cost of medical treatment. As a result, in practice, they are excluded from medical treatment such as dental-technical services.
- It is possible to ask for financial support to cover out of pocket payments. For instance, people in need have the right to be exempted from the prescription fee. However, this does not automatically translate into practice, as they need to apply for the exemption, a bureaucratic obstacle for many of them.
- Sometimes out of pocket payments are reimbursed, but this means that they have to be paid first and then the person can ask for the money back. Many homeless people cannot afford to finance their medical treatment in advance.
- Most people in need, who receive social welfare benefits, have to organise their substitute E-card on their own. The substitute E-card entitles people in need to free medical treatment, but obtaining it may prove a hurdle for many of them.
- Moreover, receiving social welfare benefits or other monetary assistance may also be linked to *stigmatisation* of people in need, and having a substitute E-card shows that people in need of assistance.
- Some homeless people have no health insurance, they have to pay for all medical services and are only granted access to health care in case of emergency.

To sum up, it can be said that the access threshold to the Austrian health care system is too high for many homeless people. In practice some hospitals and NGOs provide free and low threshold medical services for homeless people, helping them to overcome bureaucratic hurdles and claim their right to medical treatment.

Need-oriented Minimum Security Payment (*Bedarfsorientierte Mindestsicherung*)

Recently, the Austrian federal government has decided to pool social welfare, unemployment and monetary benefits services in order to facilitate access to benefits for people in need. Instead of applying for all those different benefits, there will be a minimum security payment of 744€. This new policy is planned to be implemented as from September 2010 and will facilitate access to health care services, as people receiving social welfare benefits will not have to apply for a substitute E-card anymore and will receive an E-Card allowing them to access medical treatment more easily.

Health care for Non-Austrian homeless people

Foreign citizens who are homeless have free access to emergency health care. All other medical treatments depend on their administrative status, which is linked to their residence permit. *EU nationals* have the right of freedom of movement in Austria. They have to register within 3 months following their arrival to receive an official certificate allowing them to stay in Austria on a long-term basis. Proofs of health insurance and employment are required prior to registration. Health insurance allows for access to the same medical treatment options as Austrian nationals. Homeless EU-nationals in Austria have access to medical treatment as long as they have a health insurance. If not, they will receive free medical treatment only in case of emergency. Losing one's health insurance can also lead to the loss of residence permit. EU-nationals are entitled to health insurance as long as they work, if they are entitled to unemployment benefits or pay for voluntary insurance.

In order to receive a residence permit non-EU nationals have to prove that they are earning an income. To be able to do so, work permit is essential for them to access the labour market and finding a job. Unless they pay for voluntary insurance, in order to be health insured they need to work.

Transitional arrangements for workers from new EU member states[14]: in Austria transitional arrangements are still valid for all new Member States except from Malta and Cyprus. Therefore, as a rule, the citizens of these states are not allowed yet to be employed without permit. Despite these limitations, some things have become easier as certain persons or occupational categories are exempted from the Act on the Employment of Foreigners (*Ausländerbeschäftigungsgesetz*) and do not need any permit[15]. As most nationals from these member states do not have access to the labour market, they do not have a health insurance as a consequence. However, voluntary insurance in Austria or the migrant's home country is possible and allows for people in need (limited) access to free medical treatment.

Asylum seekers are people, whose asylum procedure are still ongoing and have not yet been accepted. According to the asylum act, they are entitled to a temporary residence permit and a basic care agreement, which includes health insurance and access to medical care. Nevertheless, there are several grounds for losing their entitlements, such as: leaving the accommodation for more than 3 days without notice, property damage, being convicted for committing a crime and other reasons.

Refugees are foreign nationals who have been granted asylum. Once this is the case, there is a transitional period of four months where they are entitled to access the health care system based on a basic care agreement. After that time period refugees have the same rights and entitlements to health care as Austrian nationals.

As undocumented foreigners are not legally residing in Austria, they are not eligible to access the social security system. Uninsured and undocumented persons have to pay for all medical services, they are only granted access to emergency services.

Czech Republic

All Czech citizens including homeless people are entitled to health insurance, which is compulsory for all legal residents. People, who are not employed and registered as being unemployed, as well as retired people, have to pay their own insurance themselves. If a person does not pay the insurance, he/she will be treated anyway. The insurance company will cover the treatment and then claim back the payment from the client.

Since 2008, a regulation provides for all doctors to charge their patients with a fee according to a price list. There is an exception for people registered as being unemployed or retired whose income is lower than the poverty threshold. If the person does not the pay fee foreseen in the regulation, the doctor has to urge them to pay. Some local authorities allow for patients not to pay the fee for a medical consultation in their health facilities, although there is currently a pending case at a Czech court, which will have to answer the question of whether such an exemption is legal.

Denmark

In Denmark, homeless Danish citizens have the same access to health service as other citizens. There are no formal requirements beyond a Danish CPR number. People have to pay medicines if they are not hospitalised, but reimbursement increases with increasing expenses. In-patient treatment is paid for, while this is not the case for outpatient services unless there are specific situations where

[14] During a transitional period of up to 7 years after accession of 10 Member States to the EU on 1 May 2004 (Czech Republic, Estonia, Cyprus, Latvia, Lithuania, Hungary, Malta, Poland, Slovenia, Slovakia) and of 2 Member States on 1 January 2007 (Bulgaria, Romania), specific conditions restricting the free movement of workers from, to and between these Member States may be applied by former EU member States. These restrictions only concern the freedom of movement for the purpose of taking up a job and they may differ from one Member State to another. See European Commission: Employment, Social Affairs and Equal Opportunities: http://ec.europa.eu/social/main.jsp?catId=466&langId=en

[15] For Further Information: Beratungszentrum für Migranten und Migrantinnen http://www.migrant.at/aktuell-rechtliche-infos-2006/eu-erweiterung1/eu-erweiterung1-eng-2009.pdf

public health is at stake, such as tuberculosis and HIV. Medical staff can choose to hand out the prescribed medicine in specific cases, but it is not a part of the usual service at GP or emergency departments. If someone cannot afford paying, either the treatment should be paid for by the social system or the patient must be admitted to inpatient treatment[16].

As for drug-treatment, there is officially a general right to receive treatment within 14 days. But there is no clear definition of "treatment" and this means often the only possible treatment within two weeks will be an interview with a social case manager. Many communities in Denmark have a waiting list for medical treatment of 3 or more months.

Regarding alcohol treatment there has been a general right to alcohol treatment equal to the right describes for substance use for about two years. Homeless people will usually not be offered treatment for alcohol-related disorders, as it requires a medical recommendation and since they very often have only a sporadic and at best non-coordinated access to healthcare, a comprehensive treatment will not be proposed. Usually, the only treatment offered is short term out-patient detoxification and dispensing of Antabuse.

The general access to drug- and alcohol treatment has become less standardized as a new structural reform at community level has taken treatment from the regional to municipal level. This means that that there is an increased competition among the different municipal duties and related budget lines, and drug- and alcohol treatment depends on priorities.

Non-Danish nationals

Homeless foreign citizens have free access to *emergency* health-care. As long as the care is delivered for an acute need, they will not be asked to pay a bill. If the service given in an emergency room leads to further in-patient treatment, the patient will be moved to his home-country as soon as the condition is stable. There is no possibility for longer term out-patient treatment unless it is paid for by the home country or the patient himself. Medicines are provided for to foreign citizens within the same limitations as there are in relation to Danish citizens. Homeless foreign citizens have no right to treatment for alcohol- or drug-related disorders.

It has become the official policy to actively refuse treatment, which collides with the Hippocratic oath and therefore most will provide acute care.

France

People who are homeless and French nationals can benefit from a supplementary universal medical cover - CMU. Every person entitled to basic health insurance and having an income lower than 598€ per month may apply for CMU[17]. This medical healthcare system allows for the person to receive free healthcare. No payment is required for hospital, doctor visit, laboratory tests or medication from the pharmacy.

Documents required for the application to the CMU are: a written proof of income received over the last 12 months and an address, which could prove difficult for people who are homeless. If they cannot give an accommodation certificate, homeless people can request an address from the social services of the town hall (CCAS) or from a habilitated association. However, these sometimes do not give a government-assigned address or ask for the proof that the person has been living three months in the town. French nationals, EU nationals, or non-EU nationals lawfully staying in France are entitled to CMU. People asking for CMU must be also residing in France for at least 3 months. The CMU is valid during one year and can be renewed every year. It should be mentioned that currently people entitled to CMU have to face the problem of doctors refusing patients with CMU/AME.

[16] The HealthTeam in Copenhagen usually provides people who are homeless with medicine for the first days/weeks and if the patient has no funding or it is likely that he/she won't buy the medicine, medicine is provided until the payment can be obtained through the social system.
[17] The minimum income is 897€ for 2 persons.

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For non-EU nationals entitlements depend on their administrative situation. Those legally staying in France for more than 3 months are entitled to CMU and have the same medical rights than French citizens. For those illegally staying in France and with an income under 598€, then can benefit of AME (State medical aid). This medical protection gives the beneficiaries the possibility to access hospital, doctor, laboratory or medication from the pharmacy without paying. In order to receive the AME, the person will be asked to show an identity certificate as well as an accommodation certificate, the procedure being the same as for the CMU to obtain a government-assigned address. The AME is valid during one year and can be renewed every year.

For both AME and CMU, two main obstacles must be pointed out: people are requested to give an address and doctor may refuse to register the patient.

Germany

In general in Germany everybody has the same entitlements, being homeless or not. However, in the German Health Care System several regulations make it difficult and often impossible for low income groups, including homeless men and women, to access the health care services they would need.

With the entry into force of the health care reform in 2004 patients with statutory health insurance had to bear a significantly greater financial burden. Since then, apart from some specific exceptions, patients need to pay a 10 € consultation fee for each first visit to the doctor by trimester.

When purchasing medicines, medical supplies and bandages a supplement of between 5€ to 10€ needs to be paid in addition, which should equal 10% of the price. As for treatment (physiotherapy, occupational therapy, speech therapy), 10 € will have to be paid for the prescription plus 10% of the actual cost of the treatment. Home nursing services are charged 10€ per trimester for the prescription and an additional 10% of the actual cost of the service for a limited period of 28 days.

In-patient hospital treatment or follow-up treatment are charged 10 € a day, this is for a maximum of 28 days or 280 € per calendar year. The contribution for services covered by the compulsory health insurance is limited to 2% of individuals' gross annual income and to 1% for people who are chronically ill. People are considered as being chronically ill when they have been treated for the same serious illness at least once every three months during a year. This needs to be proved to the insurance company and once this has happened, the insurance will exempt the patient from additional co-payments.

At the same time, since 1 January 2004, many medicines, which can be sold without prescription in pharmacies, are not reimbursed anymore by the health insurance and need to be purchased by the patient. This applies for instance to flu remedies, mild pain drugs, ointment preparations and vitamins. The cost of glasses will no longer be covered, except for very high level of visual impairment. As for teeth replacements, the health insurance only pays a flat rate contribution. However, if the situation is considered to be unbearable for the patient, the health insurance will cover the full costs.

Due to the "capping" hospital financing, many services which used to be provided in-house have now become outpatient services. The length hospital stays has been drastically reduced (keywords "discharge with open wounds" or "revolving door effect"). There is an increase in outpatient interventions at hospitals and doctors' practices, which is at the disadvantage of patients who are left alone without proper follow up care and feel overwhelmed.

Greece

In Greece, people who are homeless are subject to the same healthcare entitlements than the rest of the population. Usually Greek nationals are eligible to one of the three schemes mentioned below: the Certificate of Social Protection, or two social security schemes for the unemployed.

The Certificate of social protection (certification of pauperism) is issued by the National Providence Organization. The certificate entitles them to free medico-pharmaceutical care, provided that:

- They are not insured under some other National Insurance fund, which means that they are not employed, do not have revenue stamps and they do not receive a pension in Greece or abroad
- Their annual income does not exceed the 6.000 € mark
- The members of their family (if they exist) are not insured in any such or other National Insurance funds
- They are not over the age of 65 years (over 65 people are eligible for free medico-pharmaceutical care from the Farmer Insurance Fund).
- They declare some mailing address (it is imperative that they do so)

Social security (IKA) is aimed at people who are unemployed, provided that they have worked in total for at least 3 months in the current year.

Finally, there is social security scheme aimed at unemployed people, which which is organised in cooperation with the Organisation for the employment of the work force. People are insured if:

- They are registered at the Registry for the Unemployed people of the Organisation for the employment of the work force for two consecutive months and for up to 12 months.
- They attend subsidised seminar of the same Organisation, so they are insured for as long as the seminar lasts.

People who are homeless and national from another EU Member State are also eligible for the Certificate of Social Protection under the same conditions has the Greek nationals, but they must have residence permit in Greece. However, the medico-pharmaceutical care from the Organisation of social security in cooperation with the Organisation for the employment of the work force is provided only for the Greek and the Greeks living abroad.

The Organisation of social security in cooperation with the Organisation for the employment of the work force insures unemployed people if:

- They attend a subsidised seminar for Greek nationals (as described above). Participants will be insured for as long as that seminar lasts. However, they should also have residence permit.
- In order to be issued a residence permit, they have to be insured in an insurance fund. They also have to own a banking account in their name with 1000 €.

People who are homeless and from a third country have the right to free medico-pharmaceutical care. The Presidential Decree 668/18.5.2005 anticipates the free medico-pharmaceutical care of people who request asylum and refugees who are not insured or do not have the economic capability to cover their expenses. The medico-pharmaceutical care includes free hospitalization in public hospitals and free issue of medicines from the public hospitals. In order to have the right to free medico-pharmaceutical care, people who request asylum should have in their possession a special card which identifies them as applicants for asylum. On the other hand, refugees should possess an identity card of a political refugee. Undocumented migrants are not eligible for medico-pharmaceutical cover.
Homeless people's dental problems are not covered by the insurance funds, except in acute cases. This does not include full dental treatment and this is definitely an issue.

Lithuania

Although health problems are quite common for homeless people, there is no specific and established health care system catering for their needs in Lithuania. Homeless Lithuanian citizens have the same access to health service as other citizens. However, since they rarely have documents and social security coverage, they usually do not receive full medical assistance, as there is no doctor working exclusively for the homeless people.

A Health Insurance Law was passed in 1996. It provides compulsory health insurance for all people residing permanently in Lithuania, irrespective of their nationality. All Lithuanian citizens, citizens of other countries and stateless persons permanently residing in Lithuania are provided with compulsory health insurance (this includes Lithuanian citizens permanently or temporarily residing in a country with which Lithuania has signed a contract for the compulsory health insurance).

The compulsory health insurance fund covers personal care services: preventive health care, medical care, medical rehabilitation, nursing, social services and services for personal health care.

The following people are insured through the compulsory health insurance system:

- those who pay the compulsory health insurance contributions;
- those for whom the compulsory health insurance contributions are being paid;
- persons, who are insured through State funds.

There are a range of different categories of the population who are entitled to State funded health insurance, including recipients of any kind of pension, working-age people registered in employment agency and their incapacitated family members, unemployed working-age persons having obligatory working experience of receive social insurance old-age pension; pregnant women on maternity leave; disabled persons of group I and II, unemployed disabled persons of group III; persons under 18; full-time students, state support for people entitled to receive social benefits, parent to their children under 8, parent with 2 and more children under the age of majority, persons with dangerous infectious diseases mentioned on a specific list issued by the Ministry of Health.

People not insured through the compulsory health insurance system receive only emergency medical assistance, while they have to pay for other services. Emergency medical assistance includes emergency first aid and related personal care facilities (inpatient or outpatient). Such measures need to comply with conditions laid down by Health Protection Ministry. Emergency medical assistance in public health facilities is free of charge to all residents, regardless of whether they are insured by compulsory health insurance or not, and regardless of the place of residence. Health care institutions have to ensure the necessary medical assistance, physician‘s referral being unnecessary.

The government provides for a number of (free) health care services, including:

- Emergency medical assistance;
- Health care services for people, who are insured through the compulsory health insurance system;
- Limbs, joints and other body prostheses;
- Public health care provided for under the Health Ministry necessary public health measures;
- Reimbursement of medicines and medical assistance included in the list approved by the Ministry of Health and compensated for from the compulsory health insurance;
- And other health care (including personal health care for prisoners, undocumented migrants, persons suffering from tuberculosis, sexually transmitted diseases and HIV/AIDS).

Hospitals provide inpatient and outpatient services, emergency as well as scheduled, free personal care services, as well as services for which the patient pays. Specialist care can be accessed for free by patients who are insured through the compulsory health insurance system. Emergency health care services for patients permanently residing in Lithuania are provided for by hospitals, regardless of whether they are insured by compulsory health insurance or not, and regardless of whether the patient has been referred from the physician or not.

Citizens of other countries and stateless persons, who are not reckoned as residing permanently in Lithuania have to pay for personal health care services, including emergency medical service, except for emergency medical service to EU citizens, who holding an emergency E Card, Form E111, E106, E121.

Foreigners living in Lithuania are guaranteed the same rights to health care as those applying to them in their countries of origin. In practice this means that they receive health care services covered by the insurance, which was established in their country of origin. The State they come from has to guarantee the payment of the care provided.

Local municipalities support the territorial health care services available to residents, which are financed through local budgets. These include:

- Primary health care level emergency medical assistance;
- Health care aimed at pregnant women;
- Health care for unemployed and disabled family members;
- Health care for children under 16.

Citizens, who do not have compulsory health insurance and who require outpatient care and further treatment may apply to their municipality for outpatient treatment services in hospitals.

The Netherlands

Health Care Insurance Act (ZVW)

Current government policy in the Netherlands emphasises the self-responsibility of people in society. Recent changes to Dutch statutory health care insurance have considerably reduced the coverage in the basic insurance package. The cost of insurance has also increased, and policyholders are now responsible themselves for getting the premiums paid. Especially for socially vulnerable people, these new measures have raised the barriers to obtaining adequate health care insurance.

The new statutory basic health care insurance package *(basisverzekering)* was introduced on 1 January 2006 as part of the new Health Care Insurance Act (ZVW). The package is mandatory for all legal residents of the country. Previously, the premiums for national health care insurance (required for approximately the lower two thirds of the income scale) were withheld in large part from salaries or benefit payments; the people thus insured then paid an additional nominal premium of about €35 per month. In the new system, the bulk of the premium is paid directly by the policyholders, and a smaller part is paid via withholding. The basic package now averages about €100 per month, with supplementary coverage (e.g. dental insurance) available at extra cost.

If people fail to pay their premiums for three months, their insurance is suspended (first warning); they are still registered for the insurance, but remained uninsured until they pay up. If they have not settled three months later, the insurance is cancelled. As a result, the number of uninsured people in the Netherlands is expected to rise, with prognoses ranging from 500,000 up to 1,000,000. Insurance can be reinstated (with the same or a different company) after payment of a penalty fee.

Policyholders with incomes below a designated level may apply for a health care supplement to defray the costs of their insurance premium. The supplement is obtainable through the national Tax and Customs Administration.

In the Health Ministry's information campaign on the new statutory health care insurance, a special strategy has been developed to educate 'hard-to-reach and vulnerable target groups'. Intermediaries that have many contacts with such groups have organised gatherings and, if needed, have helped people apply for insurance policies and health care supplements.

To help keep social assistance beneficiaries from becoming uninsured if they default on their payments, the Inlichtingenbureau (benefits intelligence agency), a national databank on social benefit recipients, has begun notifying local authorities if beneficiaries fall into arrears. The local authority can then intervene to keep them from losing their insurance coverage.

A proof of identity requirement has been introduced as part of the ZVW. As from 1 January 2006, clients must show legal identification to obtain health care in hospitals, outpatient clinics and privately owned independent treatment centres. The requirement was introduced to combat health insurance

card fraud. If people not carrying a valid ID receive hospital treatment after an accident or health emergency, they are required to prove their identity to the hospital within two weeks.

Exceptional Medical Expenses Act (AWBZ)
The 'modernised' version of the Exceptional Medical Expenses Act took effect on 1 April 2003. It was designed to give service users more control over the care they receive ('demand-driven service provision') and to remove the artificial barriers between the various care sectors. An independent assessment board determines each client's need for care. The AWBZ modernisation has helped to improve access to essential care and supervision services for clients with severe mental illness or addiction. It has resulted in a substantial expansion of the number of places for supervised accommodation in the homeless sector. There are also more places for sheltered accommodation (RIBW). In 2005, homeless agencies and women's refuge agencies reached performance agreements with local care administration offices amounting to about €70 million. This has enabled significant improvements in the quality of services to clients. Some local governments have given priority to promoting case management. Amsterdam and Rotterdam have appointed staff to facilitate the transfer of clients to independent living arrangements or care facilities. The Hague, Utrecht, Rotterdam and Amsterdam are developing single entry points (CTMOs) for homeless services, to ensure that clients are referred to the appropriate services straightaway and do not remain in services unnecessarily long. The delivery of the more mainstream mental health care will remain unaltered in 2007, but will be fully transferred to the Health Care Insurance Act (ZVW) from 1 January 2008.

Health services for people who are homeless
Although most homeless people in the Netherlands are officially eligible to utilise all general health care services[18], in practice they make the most use of care provided or arranged by homeless services, municipal health services, mental health services and addiction services. All four sectors have services that specifically target homeless people with physical, mental or addiction problems, albeit in varying degrees. Although the boundaries between sectors are increasingly blurring, we shall briefly outline what the different sectors have to offer to homeless people with health problems.

Homeless services are funded mostly by local authorities, and partly by the AWBZ (and in future WMO) legislation. The core function of homeless services to provide shelter and support to homeless people. Sick bays and enhanced care units are operated specifically for homeless people with health problems. Physical care is provided there in cooperation with GPs, home care agencies, municipal health services and nursing care agencies.

Spain - Catalonia

Anyone has a right to be assisted in case of acute need in any hospital. Also, a sanitary card (*tarjeta sanitaria*) will be delivered to anyone residing legally in Catalonia. People who are homeless may obtain a specific "universal coverage" sanitary card: in order to do so, they have to ask the municipality to be given a residence as homeless as well as ask for the relevant social assistant to certify that they do not have economic means.

Non-Spanish nationals: immigrants residing legally in Catalonia benefit from the same rights as a Spanish citizen, provided that they work and that they have a social security number (this is both for EU and non-EU citizens). If they do not work, in order to be entitled to a sanitary card, they will have to prove that they do not have economic means. Those who do not work but have economic means will not receive a sanitary card. As for undocumented migrants, they are entitled to a "universal coverage" sanitary card as homeless people.

[18] The Dutch health system is differentiated into preventative care (via MHSs), outpatient care (via GPs, clinics, paramedics and home care organisations), provision of medication (via pharmacies), hospital and specialist care, elder care, disabled care, mental health care (via psychiatric hospitals, outpatient mental health services and addiction services). See van der Maas P.J., Mackenbach J.P.(1998) *Volksgezondheid en gezondheidszorg.* Elsevier/Bunge, Maarssen.

United Kingdom

"National Health Service services are available free to anyone who is ordinarily resident in the United Kingdom, including anyone who is homeless. Primary care trusts (PCTs), or NHS Boards in Scotland, and Local Health Boards in Wales have a duty to ensure appropriate and timely access to healthcare for everyone in their area, including the homeless and those living in hostel accommodation.
In addition, the new requirement on local authorities to carry out a review of homelessness in their area and develop a homelessness strategy with local partners, such as the PCT, will help to identify gaps in services and ensure that there is appropriate mainstream and specialist health care for homeless people.

We have in place a range of initiatives to improve access to primary care services for homeless people. These include the development of a model general medical service local development scheme for PCTs (not Scotland) and LHBs (local enhanced schemes in Wales) and the promotion of locally agreed personal medical services (PMS) contracts with a similar focus. There are now nearly 90 PMS pilot schemes in England (there are no PMS schemes in Wales) which include the homeless as a priority objective. In addition, we are generally trying to improve access to NHS services for all through a variety of different access routes, for example, through walk-in-centres, diagnosis and treatment centres and one-stop primary care centres."[19]

England

To illustrate what mentioned above, in Southampton, there is a Homeless Healthcare Team, which is a specialist team providing primary health care services and mental health care to homeless people. The service includes: registration, GP and nurse consultations in drop-in services and hostels, screening and immunisation (hepatitis, TB, HIV), sexual health and family planning, specialist health visiting service for homeless families (includes Gypsies and Travellers encamped illegally, women and children in refuge houses, asylum seekers and refugees, as well as families in temporary accommodation), community mental health service for homeless people (assessment, treatment and monitoring). In addition the team acts as a resource for staff from the voluntary and statutory agencies regarding homelessness and asylum seekers/refugees[20]. People can access the service through self referral, drop in at day centers or be referred from partner agencies.

Scotland

In Scotland, new standards were launched in 2005 to help homeless people get the health care they need[21]. Standards were designed to assist National Health Service (NHS) Boards to continuously improve their services to homeless people and those at risk of homelessness. In this context, NHS Boards should:

- ensure that homeless people in their area have the appropriate access to the health service and should also take an active role in reducing homelessness[22].
- ensure that homeless service users participate in the development of services.
- address the whole range of services provided, including primary and secondary care services covering both physical and mental health, the services of allied health professionals, and important services linked to wellbeing and the health improvement agenda such as health promotion, healthy eating, smoking cessation and physical activity.
- recognise that the improvements they make in both access to, and delivery of, services for homeless people will benefit a range of marginalised groups; likewise service improvements for other hard to reach groups will also bring benefits for homeless people.

[19] Reply of Hazel Blears to Mr Marsden, Hansard, 24 February 2003: http://www.parliament.the-stationery-office.co.uk/pa/cm200203/cmhansrd/vo030224/text/30224w94.htm.
[20] http://www.southamptonhealth.nhs.uk/local/homeless-healthcare-team.
[21] Health and Homelessness standards, section 4, Scottish Executive 2003 http://www.scotland.gov.uk/Publications/2005/03/20774/53761.
[22] See Standards and performance requirements for NHS Boards in support of the planning and provision of services for homeless people, Scottish Executive, Edinburgh 2005 , ISBN: 0-7559-4442-9.

- be clear that homelessness involves an intensive set of compound risks to health and wellbeing which make it much harder for homeless people, compared to the general population, to maintain good health in the sense of physical, mental and social well-being.
- ensure effective and timely access to services such as maternity services, child health screening, surveillance and immunisation, and should also take account of the impact of homelessness or living in temporary accommodation on the mental health, self esteem and emotional development of children in these circumstances.

In all cases delivering the Health and Homelessness Standards will involve working with partners in related fields (e.g. housing, social work and the voluntary sector) to address the whole needs of households, in order to reduce health inequalities and promote well-being. NHS Boards will have an increasing role to play in inspection and performance management in relation to Community Health Partnerships as the primary means of delivering Boards' strategic priorities. The Health and Homelessness Standards should therefore assist Boards in developing appropriate reporting mechanisms.

In practical terms, some Boards will have in place specialist services for homeless people, others will not, depending on local circumstances. However, all Boards must provide mainstream services to homeless people and should be able to identify that such services are appropriate and accessible for those who are homeless.

The household composition and health-related needs of homeless households are so diverse that Boards should policy proof all strategies to take account of their needs. Boards will need to ensure that homeless people's needs are addressed in a wide range of strategies and plans, for example the Local Health Plan including the Joint Health Improvement Plan, the Equality and Diversity Strategy, Health Inequalities Strategy, Community Plans, Drug and Alcohol Plans, Mental Health frameworks and Community Health Partnership plans.

Non-UK nationals

In 2004 the UK decided not to restrict the free movement of workers, but did introduce a Workers registration scheme (WRS) to monitor the impact of EU enlargement on the UK labour market. Further social security legislation was amended to restrict access to certain means-tested benefits. In response to uncertainty over the entitlement to health care for certain A8 nationals[23] the Department of Health clarified the rules regarding access to NHS services:

- Any person living lawfully in the UK on a settled basis will be entitled to free primary medical services.
- Lawful residence in the UK rather than UK Nationality, payment of UK taxes and National Insurance contributions is the main qualifying criterion for receiving free GP treatment.
- The same rules apply whether someone is from an EEA (all necessary) country or non-EEA country (immediately necessary).

On that basis, anyone is free to approach a GP practice near to where they live and request acceptance as a patient. Practices are free to decide which patients they accept on their lists of NHS patients and may use their discretion to accept (overseas visitors as) either registered NHS patients or with their consent, as patients on a private, fee-paying basis. When registering, GPs may request some proof that the prospective patient intends to stay in the UK for a settled period. Mental health and detoxification services are available upon referral by a GP if the treatment is deemed to be clinically necessary[24].

[23] The A8 countries are: the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.These represent 8 of the 10 countries that acceded to the EU in May 2004. Cyprus and Malta also joined at this time but nationals from these countries are not covered by the exceptions to entitlements applicable to A8 nationals. Guidance on the accession of Bulgaria and Romania to the EU, and on overseas visitors' rights to primary care treatment under European and other reciprocal healthcare agreements. See: EU enlargement and overseas visitors' rights to primary care treatment in the UK,

[24] For further information visit http://www.dh.gov.uk/PolicyAndGuidance/International/OverseasVisitors/fs/en

All treatment given by staff at a hospital or by staff employed by a hospital may be subject to a charge with the following exceptions:

- Treatment given in an accident and emergency department
- Treatment given in a walk in centre providing similar services to those of an accident and emergency department of a hospital; (N/A in Wales)
- Treatment for certain communicable diseases (excluding HIV/AIDS where it is only the first diagnosis and connected counselling sessions that are charge free);
- Treatment under the Mental Health Act
- Meet one of the exemptions as outlined in the NHS (Charges to Overseas Visitors) Regulations 1989 as amended.

In the case of treatment given in an Accident and Emergency department or Walk-in Centre the exemption from charges will cease to apply once the patient is formally admitted as an in-patient or registered at an outpatient clinic[25]. A person who is regarded as ordinarily resident in the UK is eligible for free treatment by a GP. A person is 'ordinarily resident' for this purpose if lawfully living in the UK for a settled purpose as part of the regular order of his or her life for the time being. Anyone coming to live in this country would qualify as ordinarily resident. Overseas visitors to the UK are not regarded as ordinarily resident if they do not meet this description.

The following NHS treatment is available to anyone:

- Treatment in an emergency (but not follow up treatment) in an Accident and Emergency Facility or treatment if immediately necessary
- Treatment of certain communicable diseases
- Compulsory psychiatric treatment.

Foreign nationals from non-EU countries have no automatic right to NHS healthcare (other than those outlined above)"[26]. There is a breakdown of care in the case of destitute asylum seekers whose claims have failed. There are increasing numbers of people who are destitute (not supported by the Home Office). Their access to healthcare is restricted also.

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Conclusions

As it appears evident from the different examples set out previously, although homeless people seem to be entitled to basic health care in the majority of the reviewed countries, there are still a number of uncertainties and hurdles they have to face when accessing health services and which need to be addressed. These include the following:

- **Entitlements to what?** In most of the countries reviewed, homeless people have access to emergency and basic health care services. As highlighted in a number of studies however, the emergency department is not the most appropriate or more cost effective service to tackle homeless people's health problems as it only addresses acute situations and does not allow for a comprehensive approach to health. Mental health care and specialised treatment do not usually fit the basic basket homeless people are entitled to, nor does dental health care. Considering the fact that many homeless people suffer from a combination of health problems, it is unlikely that chronic conditions are properly addressed. Also, preventative measures are usually not mentioned.

[25] Homeless Link Briefing, 13 April 2006
[26] http://www.admin.ox.ac.uk/uohs/services/visitors.shtml

- **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 circumstances. Also, depending on the personal status (citizenship, being an EU citizen, A8, third country, asylum seeker or a refugee) the situation might be even more complicated. There is clearly a tension between individual rights, public health considerations and broader policy options (in particular those related to migration policy). In some countries, first line health professionals are forced in a situation where they face ethical dilemmas, while in other countries they are officially being given the right to register or refuse vulnerable patients.

- **Affordability:** in several countries the modernization 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 care**: delivery of care aimed at vulnerable group seems to be structured in different ways, ranging from an attempt to mainstreaming general primary care services to a more targeted approach, for instance through outreach work and specific services. Apart from the administrative and financial hurdles mentioned above, there are still many obstacles for homeless people to access care: socio economic inequalities 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.

- **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. It would be important for both health and non health personnel to have basic health skills. Front line personnel should also be aware of the specific hurdles faced by homeless people, which may be related to procedures (attending appointments, medication follow up, need for support to allow for continuity of care, etc.) or financial barriers (out of pocket contributions, compulsory private health insurance, etc.), as well as of practical solutions to overcome the lack of care.

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FEANTSA's recommendations concerning this issue can be found in the **Policy statement on Health Care Entitlements for People who are Homeless** (October 2010).

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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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.