FEANTSA

Annual European Report 2006

The Right to Health is a Human Right: Ensuring Access to Health for People who are Homeless

FEANTSA

Annual European Report 2006

The Right to Health is a Human Right: Ensuring Access to Health for People who are Homeless

Table of Contents

Introduction

> "Processes of extreme exclusion can reveal the shortcomings of any system, including a healthcare system"[1]

FEANTSA is the European Federation of National Organisations Working with People experiencing Homelessness. Each year, FEANTSA draws on the expertise of its over one hundred members across the EU to carry out a European survey on a specially selected theme. FEANTSA then draws together the findings from the survey in a single European report. In 2006, the theme selected is the broad and challenging one of health and homelessness. FEANTSA's members felt that there was a real need to look at this area more closely and the main questions were brought to together in a detailed questionnaire[2]. This was circulated to all members and in each country, the FEANTSA Administrative Council member (who represents the members of that country in FEANTSA's decision-making structure), was responsible for drawing together the information in a single representative report. These reports are a detailed examination of the health situation of homeless people by country and are a valuable resource. They can be read on FEANTSA's website.[3] The present report seeks to offer an overview of the main findings across the EU as a whole.

When considering homelessness and the best ways to tackle it, one cannot fail to be aware of the close links between homelessness and a person's state of health and wellbeing. A very comprehensive definition of health is set out in the preamble to the World Health Organisation Constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Given that being homeless will certainly affect at least one of these spheres of health, homelessness may, by its very nature, be considered as a state of ill-health. Looking at health and how it relates to homelessness offers a view of homelessness in health terms that is very useful. It allows a better understanding of the importance of access to health for people who are homeless and serves to highlight how failure to ensure this access is a failure to allow them to enjoy their human right to the highest attainable standard of health and to a life in dignity.

Health is a vital factor for social inclusion. Good health is a prerequisite to reintegration and is a crucial factor in being able to access and maintain employment and housing. Conversely, having a home and a job are important to good state of mental and physical well-being. Thus the right to health underpins and reinforces the right to employment and to housing. What is more, the right of a person to enjoy the highest attainable standard of health has a strong place in international human rights law and is enshrined in international conventions and charters such as the International Convenant on Economic, Social and Cultural Rights and the European Social Charter. This right has been clarified in the General Comments of the UN Committee on Economic, Social and Cultural rights, where it is set down that "the right to health is closely related to, and dependent upon, the realisation of other human rights, including the right to food, housing, work, education, participation…" So it is clear that health is a good way of framing and approaching these other needs, which are particularly acute in the case of people experiencing homelessness. It is for this reason that FEANTSA has placed the right to health at the core of its reflection on health and homelessness and the title given to the annual theme of 2006 reflects that fact: "The Right to Health is a Human Right : Ensuring Access to Health for People who are Homeless."

There is a range of factors, which may lead to a person eventually becoming homeless and often health issues are among them. Health and homelessness have a relationship of both cause and effect: illness (such as mental illness, substance-abuse or illness leading to loss of employment) may be among the trigger factors that lead to homelessness. Once in a situation of homelessness, a variety of health problems may result, such as exposure to infectious illness, mental health problems, development or aggravation of substance-abuse and addiction, or health problems resulting from an unsanitary or overcrowded environment. These health problems may make it harder to break out of a cycle of homelessness. What is more, accessing healthcare is often very problematic for homeless people. Drawing on the

[1] Spanish National Report for the annual theme 2006, pg 11

[2] You can read the questionnaire on FEANTSA's website: http://www.feantsa.org/code/en/theme.asp?ID=35

[3] Page with national reports http://www.feantsa.org/code/en/theme.asp?ID=35

experience of its members, FEANTSA will set out a detailed overview of the health problems that are prevalent among people experiencing homelessness in this report. It will also examine closely the different barriers to accessing healthcare people who are homeless encounter across the EU.

This health perspective offers people a more accurate and nuanced understanding of what homelessness can mean and the challenges and hardships that people experiencing homelessness face. This in turn can serve to counteract stereotyped visions. It is perhaps for this reason that health is one of the elements that has been used to define homelessness in Australia, for example: in Australian legislation, homelessness is defined in the **Supported Accommodation Assistance Program Act 1994**. This act defines a 'homeless' person as follows: "For the purposes of this Act, a person is homeless if, and only if, he or she has inadequate access to safe and secure housing. "(Section 4) The Act goes on to define 'inadequate access to safe and secure housing' and the very first criteria that is used is that of health: "For the purposes of this Act, a person is taken to have inadequate access to safe and secure housing if the only housing to which the person has access: damages, or is likely to damage, the person's health; or threatens the person's safety…" This offers a concrete understanding of homelessness in terms of a threat to health and well-being that policy-makers are likely to be able to identify with and which is concrete enough to mobilise political will.

Thus it is clear that health has an important role to play in understanding homelessness and in communicating about homelessness. It is also true that health policy is a useful avenue for tackling homelessness in a preventative and also a holistic manner. Health services have a vital role in the fight against homelessness, as meeting health needs is an important step towards tackling homelessness and health services should be one of the gateways to get access to other services. Indeed, following the close study of the health situation of people who are homeless undertaken in Luxemburg within the framework of the annual theme, the authors of the report felt that a new understanding of homelessness had emerged, one that had political implications. They raised the question as follows:

> *"All of these conclusions lead us to think that it would be useful to consider those people experiencing homelessness, in the situations described in categories one to three of the ETHOS definition* (an explanation of the ETHOS definition is given below)*, as not only excluded from housing, but also as people suffering from illness. Such a conclusion may clearly lead us to question the distribution of political competencies in relation to the homeless people described in these three categories. Would it not be useful to give greater consideration to the medical dimension of the phenomenon instead of limiting ourselves simply to the housing dimension?"*[4]

It is the firm conviction that health considerations should have a central role in approaching homelessness, and that homelessness policies should reflect this, that has led FEANTSA to dedicate 2006 to exploring the theme of health and homelessness. This report will try to establish a broad overview of the issues relating to health and homelessness across Europe, on the basis of the reports gathered from FEANTSA's members. It will look at health profiles of homeless people, problems of access to healthcare, training of health professionals, inter-agency working and networking, data collection on the health of homeless people and the right to health of people experiencing homelessness.

It is also worth noting that the understanding of homelessness in the present report is rooted in FEANTSA's long-standing work on defining homelessness. This work has led to the development of a **European Typology of Homelessness and Housing Exclusion (ETHOS)**[5], which sets out four conceptual categories of homelessness: roofless, houseless, living in insecure housing, and living in inadequate housing. The present report generally focuses on people that are roofless or houseless: that is to say, rough sleepers and people who are spending some time in emergency services and centres for people experiencing homelessness, but also

[4] Luxemburg National Report for the annual theme 2006, pg 4

[5] To find out more about ETHOS, visit FEANTSA's ETHOS webpage: http://www.feantsa.org/code/en/pg.asp?Page=48

time in public space. The discussion of the health situation of people in insecure and inadequate housing was generally not treated in detail in the national reports, though it does feature in some and has also been discussed in other FEANTSA papers[6]. The main focus of the present report is therefore the health situation of people who are roofless and houseless, though other situations may be touched upon, where relevant.

[6] "Exploring the Complex Relationship between Housing and Health through Consideration of the Health Needs of People who are Homeless" (FEANTSA paper drawn up for the European Network of Housing Research 2006 – available on FEANTSA's website: http://www.feantsa.org/files/Health%20and%20Social%20Protection/Reference%20Documents/WS_5_Murphy.doc

Section 1: Health Profiles of People experiencing Homelessness: Mental and Physical health problems commonly experienced by People who are Homeless

1.1 General Health and Multiple Needs:

It is useful to begin the discussion of the health situation of people experiencing homelessness with an overview of the type of health problems that are prevalent among this population. Even a general review of the health of people who are roofless and houseless serves to highlight the chronic bad health and suffering that often accompanies this situation. And indeed it is impossible to look at the health of people who are homeless in isolation from their general situation, for, as the French national report pointed out:

> *"There are no illnesses specific to homelessness: rather the health situation of a person worsens in direct relation to their overall situation."*[7]

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. Thus, among people who are roofless and houseless, one often finds a cumulation of health problems that have become very severe and add up to a high aggregate of vulnerability across a range of areas. These are further complicated by precarious living conditions and bad nutrition.

Indeed, it must be borne in mind when examining the overall health situation of people experiencing homelessness, that the health problems they experience are usually complex and multiple. A strong agreement emerged from all the national reports of FEANTSA that this issue of multiple needs is a significant treatment problem. It also means that homeless people are highly vulnerable. Therefore, although various mental, physical and substance-abuse related illnesses and disorders are outlined separately in the paragraphs below, people experiencing homelessness frequently suffer from several problems concomitantly: so it might be possible that a person who is homeless might simultaneously have a physical injury, a physical illness, mental health problems and substance abuse problems. These multiple needs make it very difficult to redress the general state of ill-health, but although it is difficult, it is vital that the needs not be addressed in isolation to one another: rather the overall situation must be taken into account.

Multiple needs challenge the very structure of the medical model of working in separate and specialised areas. This way of working exacerbates the problems of people with multiple needs, as these must be met through a holistic and multi-disciplinary way of working, that is generally lacking. The definition below, drawn up through a consultation of homeless service providers in the UK may be a useful reference in understanding multiple needs:

A definition of multiple needs:
A typical homeless or ex homeless person with multiple needs will often present with three or more of the following, and will not be in effective contact with services:

- mental health problems
- misuse of various substances
- personality disorders
- offending behaviour
- borderline learning difficulties
- disability
- physical health problems
- challenging behaviours
- vulnerability because of age

If one were to be resolved, the others would still give cause for concern.[8] These needs may be further complicated by previous negative experience of the healthcare system.

Overall the national reports received left no room for doubt about the severe state of ill-health experienced by people who are roofless and houseless. Several of the reports highlighted the fact that people who are homeless have a significantly lower life expectancy than the general population and that their health compares very unfavourably to that of the general population. In the case of the Belgian report, a detailed study was available and closely cited, which

[7] French National Report for the annual theme 2006, pg 1

[8] Multiple Needs Briefing, Bevan P, Homeless Link 2002

compared the health of people experiencing homelessness with that of the general public in the Belgian town of Limburg, across a range of areas, highlighting the substantial discrepancy between them.[9] The area where the difference in health situation was greatest was that of mental health, prompting the Belgian author to note that there is a pressing need to develop better cooperation between homelessness services and mental health services. [10]

Physical Health Problems

Most of the national reports submitted noted that, due to their exposed lifestyle and living conditions, roofless and houseless people are very vulnerable to physical injury and violence and that they may have serious wounds from falls or attacks, often worsened by neglect and failure to seek treatment. Some reports also noted that people who are homeless are more likely to commit suicide. Serious physical health problems result from lack of hygiene and inadequate living conditions and include a range or severe dermatological and parasitic complaints. This includes such problems as louse infestations and scabies. Untreated wounds may ulcerate and several of the reports mentioned the higher prevalence of crural ulcers among people who are roofless or houseless. Chronic foot problems are also prevalent, affecting mobility. All countries cited the area of dental health as particularly problematic, due to poor dental hygiene and to the fact that dental care is particularly difficult to access for people who are homeless.

The reports from Scandinavian and Eastern European countries also highlighted physical problems arising from exposure to extreme cold. Frostbite is common among homeless people who spend time in extremely low temperatures and this may result in limb loss. However, amputations following frostbite may also often lead to further complications as it may not be properly followed up. Homeless people that lose contact with medical services in the aftermath of an operation will not benefit from proper follow-up care or physiotherapy.

The difficult living conditions and bad nutrition associated with homelessness mean that the general health of people who are homeless is greatly weakened and they are vulnerable to infection. Respiratory diseases are common and often worsened by smoking. Cardiac and pulmonary problems are prevalent. Rates of certain serious infectious diseases are significantly higher among the homeless population than the general population: these include HIV, tuberculosis and hepatitis. Indeed, the Danish report places levels of hepatitis among people experiencing homelessness as high as 50%.[11] TB is also a major problem in many countries and it gives rise to a host of treatment problems that will be examined more closely in the section on public health risks. Cancer is common, particularly so among women who are homeless. Women experiencing homelessness also frequently suffer from gynaecological health problems.

Substance Abuse Problems

All of the reports highlighted the problem of substance abuse among people who are homeless. There are generally high levels of drug and alcohol abuse and though this abuse is difficult to quantify, some countries submitted figures from various recent, limited-scale surveys, or made an estimate based on the experience of the service providers. A sample of these figures is below:

> In Ireland, a survey of 72 homeless people in Dublin in 2003 showed that 44 of them had used drugs such as heroin, cocaine, ecstasy, amphetamines or cannabis in the previous thirty days.[12]
>
> The UK report drew on a government commissioned report to offer figures of about 70% of people who are homeless misusing drugs and about 50% alcohol reliant.[13]
>
> The Danish report estimates that some 60% of roofless and houseless people in Denmark suffer from alcoholic liver damage.[14]
>
> The Belgian reports cites the results of the comparative study undertaken in Limburg as showing that 21% of the people experiencing homelessness surveyed abused alcohol, while 36% have tried ecstasy or amphetamines and 55% have taken cannabis.

[9] Belgian National Report for the annual theme 2006, pgs 11-13

[10] Ibid, pg 12

[11] Danish National Report for the annual theme 2006, pg 1

[12] Irish National Report for the annual theme 2006, pg 3

[13] UK National Report for the annual theme, 2006, pg 4

[14] Danish National Report for the annual theme 2006, pg 1

Many of the countries specifically highlight alcoholism as a chronic problem among people experiencing homelessness. Aside from the problem of the dependency itself, alcoholism brings a range of serious secondary illnesses. These are described in the Spanish National Report, drawing on the experience of Spanish organisation Rauxa, which works with alcoholic people who are homeless:

> "Rauxa posits that 50% of the homeless suffer from alcoholism and its consequences: hepatitis, alcoholic cirrhosis or alcoholic pancreatitis, the cause of mellitus diabetes... Rauxa asserts that alcoholism raises the risk of tuberculosis and hepatitis C and points out that among the homeless who suffer from alcoholism, 90% are also addicted to tobacco, which combined with alcoholism increases their risk of developing cancer, intermittent claudication or blindness caused by optic neuritis."[15]

What is more, Rauxa attributes a significant causal effect of homelessness to alcoholism among the vulnerable client group with whom it works. The UK report highlighted the fact that heavy drinking may come about among people who are homeless as a way of "self-medicating" unmet health needs – particularly mental health problems.

Drug use, particularly intravenous drug use, also carries a great many secondary risks. Drug users are vulnerable to transmission of serious infectious illnesses such as hepatitis and HIV through the sharing of syringes. Lowered inhibitions and control may also lead to high risk behaviour such as unprotected sex, resulting in greater vulnerability to sexually transmissible diseases. Both drug and alcohol abuse, particularly long-term abuse, carries a significant risk of the development of significant mental health problems. Existing mental health problems may be aggravated or disorders may be directly provoked by abuse of drugs and alcohol.

Mental Health Problems

All of the reports received point unanimously to far higher rates of mental ill-health among people experiencing homelessness than among the general population. Some of them pointed to mental health problems predating the loss of tenancy as a trigger factor of homelessness. For example, a survey undertaken in the North of Ireland, which is cited in the UK report, showed that one in five people experiencing homelessness cited mental health problems as a factor that had led to their situation. A clear picture emerges from the reports concerning the state of mental health of people experiencing homelessness. Even where there is no mental illness as such, there is a clear lack of mental wellbeing among most people who are homeless. This manifests itself in general feelings of anxiety, stress, strain and inability to cope; in feelings of depression; and in difficulties sleeping.

Levels of mental illness are also high and it is common for people who are homeless to have several psychiatric problems at once. As was mentioned above, these problems may be provoked or aggravated by substance abuse. Some of the mental illnesses that the reports show are significantly higher among people who are homeless include schizophrenia, personality disorders, depression, and learning difficulties. Mental health problems also lead to a higher risk of suicide and self-harm.

Dual diagnosis, where a person is suffering simultaneously from mental illness and drug addiction is also significantly more prevalent among people experiencing homelessness. It renders each problem all the more difficult to treat and the addiction and illness aggravate each other in a very problematic way.

Social Health Problems

Although it may seem strange to talk about "social health", it is nonetheless beyond dispute that a person's state of social wellbeing is closely connected to their overall state of health and some of the reports submitted specifically examine the social problems that impact on the health of people experiencing homelessness. The Belgian report, for example, offers the following list of problems to illustrate the lack of social wellbeing:

> "Lack of self-confidence and self-respect; lack of privacy; insecurity; discrimination; shortage of secure storage space for personal belongings; street noise; lack of access to medical care; avoidance of contact with authorities, with public services or government bodies; unbalanced and chaotic lifestyle; family problems; truancy among children; necessity of finding other (potentially criminal) methods of paying for healthcare."[16]

[15] Spanish National Report for the annual theme 2006, pg 3

[16] Belgian National Report for the annual theme 2006, pg 8

Many of the reports cite the problems created by the loss of a social network. The lack of support from friends and family has an impact on mental health and wellbeing and can give rise to feelings of loneliness and isolation. It is also true that social networks have an impact on health, as it is often through the encouragement of their network that people seek the care that they need and support from this network that makes treatment adherence possible. Therefore, where contacts with friends and family have broken down through homelessness, this has a non-negligible effect on their state of health.

1.2 Illnesses that pose a serious public health risk among people who are homeless

Almost all of the reports mention the problem of the prevalence of tuberculosis among roofless and houseless people particularly. In the Scandinavian countries, the levels are far lower than in other countries, though there has been some resurgence. This disease is a very problematic one. Tuberculosis is a disease that is historically associated with poverty and indeed it is a disease that has a great deal of stigma attached to it. The reason that TB has been associated with poverty is that inadequate and unsanitary housing, overcrowded conditions and deficient nutrition greatly raise the risk of infection with TB.

The exposure that rough sleepers experience places them at risk, as do the conditions in hostels and shelters. TB spreads easily in closed and crowded conditions. This risk is further increased by the greater likelihood that homeless people will be carrying TB. This is because they are less likely to have accessed healthcare recently or to have been included in generalised public scans. Crowded or poorly ventilated accommodation with little natural light makes the spread of infection more likely. These characteristics are often found in squats and sub-standard accommodation or in places where people congregate to use drugs and alcohol. Alcohol abuse has a negative impact on the immune system that can make people with a high intake susceptible to infection.

The increasing number of migrants who are using homelessness services across Europe have also had an impact on TB levels among the homeless population. Some of them come from endemic TB zones and may be infected without being aware of it. In Finland, immigrants from such zones account for almost all the annual cases of TB in the country.[17]

Homeless people are also harder to treat. The nature of the treatment for TB makes it particularly difficult to administer to homeless people. It lasts at least six months and needs to be taken very regularly – either every day or three times a week, depending on the type of treatment. Incomplete treatment is worse than none, because of the risk of multi-drug resistant strains developing. These MDR strains pose a significant public health risk.

Due to this problem some countries have adopted public health measures in order to reach homeless people with TB. Austria and Hungary have made a TB test an obligatory step in order to access shelters. In some countries, there are mobile, outreach services offering X-rays in order to diagnose cases of TB among people who are homeless.

The reports also highlight the public health risk posed by the higher levels of hepatitis and HIV among people experiencing homelessness. The risk of contracting these illnesses is much higher for people who are homeless, due to risk behaviour such as intravenous drug use. People engaging in prostitution are also at severe risk. This is a significant and growing problem highlighted by service providers across the EU. In some countries, measures have been put in place to reduce the spread of these severe and debilitating illnesses. These preventative measures are often referred to as 'harm-reduction' measures as they seek to reduce to the degree of harm attached to drug abuse, by at least reducing the risk of infection with serious disease. Measures highlighted in some reports include the creation of safe injecting rooms for drug users, needle exchange schemes, condom distribution and vaccination.

In the Spanish report gave examples of some very comprehensive schemes that have been put in place to screen people who are homeless for contagious illness:

[17] Finnish National Report for the annual theme 2006, pg 5

> "The "Luz Casanova" shelter (Caritas Diocesana de Granada) carries out exams for tuberculosis, syphilis and hepatitis on everyone who checks into their centre for a certain amount of time: blood count; biochemistry; urine; HIV, Hepatitis B and Hepatitis C serology; mantoux reactions and direct smears for bacilli and its cultivation. At the same time, the centre is in constant contact with the corresponding epidemiological services and carries out all pertinent obligatory declarations. The control extends to the professionals who work in the centre, as well, who are tested yearly for all possible illnesses that could be contracted through contact with the service users."[18]

Several reports voiced a similar concern for staff and volunteers in shelters and other homeless services and the need for care and vigilance in order to safeguard their health and safety also.

The organisation Rauxa in Barcelona is responsible for a system of TB testing in the soup kitchens that it runs in an effort to come to terms with this problem. On the basis of this experience, the system has now been adopted in all of the soup kitchens in Barcelona.

It is certainly true that certain public health measures, such as harm-reduction measures to reduce the risk of infection through intravenous drug use or early detection and treatment of serious infectious diseases, have a positive impact on the health of people who are homeless. However, it is not clear whether there would be widespread support for measures such as obligatory testing for all those wishing to use low-threshold services, which are in place in some countries or individual organisations, as it is possible that these might constitute a further barrier to access.

1.3 Treatment problems associated with homelessness

Section 2 of this report will closely examine how the healthcare systems in EU countries exclude homeless people and the different types of barriers that the systems throw up, preventing homeless people from accessing the care that they need. The aim of the present section is different, though related. This section seeks rather to examine the barriers to good treatment that being homeless creates. A situation of homelessness creates numerous treatment problems, many of them common across the whole EU and which require attention if homeless people are to derive benefit from medical treatment.

Negative experiences, failure to recognise ill-health and competing needs

Day to day living in a situation of homelessness gives rise to a set of experiences that may constitute a barrier to care. Several reports mentioned the fact that many people who are homeless have had previous negative experiences of the healthcare system that make them less likely to turn to it when they are unwell. They may also feel shame and embarrassment in relation to their situation and an inability to go through the procedures necessary to get access to health. Several reports highlighted the fact that homeless people may have developed a relationship with their own bodies that makes it hard for them to realise that they are actually in need to medical care. The Belgian report describes this difficulty as follows:

> A roofless person will rarely address a medical service directly for a medical problem, unless it is very urgent... This can be explained by their discomfort at discussing medical problems. They regard their bodies as the only and last thing they still have some control over, and this makes it difficult for them to entrust themselves into the care of professional carers. [19]

In many cases, reports cited studies where a majority of people experiencing homelessness described their state of health as good, despite clear medical evidence to the contrary. Negative past experiences and an inability to recognise the need for care, as well as possibly mental health problems in some instances, can give rise to negative and challenging behaviours that make treatment very difficult and there is no real engagement between health services and the person who is homeless. Thus the Czech report highlighted as significant treatment problems both the:

> "negative and rejecting attitude of doctors" and the "irresponsible attitude of clients to their own health"[20]

[18] Spanish National Report for the annual theme 2006, pg 7

[19] Belgian National Report for the annual theme 2006, pg 22

[20] Czech National Report for the annual theme 2006, pg 1

Another aspect of homelessness that makes it difficult to treat people in that situation is that homelessness gives rise to a host of severe and pressing needs – the need to obtain food, shelter and in some cases drugs or alcohol - and the prioritisation of these needs, means that medical problems do not receive sufficient consideration. This also means often medical problems have become chronic and disabling by the time that people experiencing homelessness look for care, making treatment significantly more complicated and difficult.

Failure of treatment to take account of the lived reality of homelessness

As was discussed in the introduction to this report, promoting good health cannot be achieved unless all the areas that impact on a person's health are taken into account: housing, diet and nutrition, access to good sanitation facilities, employment and income, support from others and so on. The living situation as a whole will determine the state of health. Failure to take account of the living situation of homeless people leads to failure to comply with treatment and may make it impossible for treatment to be successful. Much successful treatment of health problems is based on the premise that the person will be able to ensure a certain amount of "self-care" – that is to say, that they will observe certain standards of hygiene and that they will comply with a certain diet, for example. In the case of people in a situation of homelessness, such assumptions cannot be made. People who are homeless are likely to be badly nourished and to be unable to adhere to the type of strict diet necessitated, for example, by diabetes.

Where the treatment of illness requires regular medication, it is hard for homeless people to adhere to this strict treatment plan. They may be in a chaotic situation where they are unable to observe the treatment. This makes medicating problems like TB, certain mental illnesses, epilepsy or diabetes very problematic. This has led to a situation where in some countries, medical professionals simply do not prescribe these medicines to people who are homeless. It would seem that there is a clear role for homeless service providers to coordinate and oversee the distribution and taking of this medication. However, it is vital that they receive the support and training they need to take up this role. In some countries, medication is predispensed in specially designed dosage boxes ("dosset boxes") to facilitate the distribution and dispensing.

At an even simpler level, people who are homeless are unlikely to be able comply with a doctor's order to rest and stay in bed. Indeed, most of the reports highlighted gaps in the health system, whereby there are few facilities to allow people who are homeless to recuperate in a supported environment, whether from a mental, physical or substance abuse related problem. And where these facilities exist, they may not be properly adapted to the needs of those using them. For example, in Finland:

> **"The results of treatment can not be effective when there are not enough suitable housing facilities available. If a person has multiple problems and also mobility disability the situation is even more difficult. A wheelchair can be an obstacle to accessing services or living in supported housing or shelters, simply because they are situated in old buildings."[21]**

Some countries also feel there is insufficient awareness of the fact that people who are homeless may not be able to pay for medicines that are prescribed and that this financial barrier will prevent them from complying with treatment.

Several countries also cite a lack of, or inadequate development of, those services that people who are homeless have particular need of, as a significant factor that creates treatment problems for people who are homeless. Drug and alcohol services are inadequate in many countries and have long waiting lists. Mental health services too fail to meet the needs of this group and there is very little available in the area of outreach treatment for hard to reach groups in many countries. Spain and Germany also mention a lack of low-threshold "gateway" services. German research has repeatedly shown these to be an effective way of bringing homeless people into the mainstream healthcare system and helping them to engage with services and yet they remain underdeveloped and underfunded.[22] There is a desire among many people who are homeless to see more services provided in a hostel setting, but this remains unusual.

[21] Finnish National Report for the annual theme 2006, pg 6

[22] German National Report for the annual theme 2006, pg 1

Section 2: Social Protection: Healthcare Entitlements of People experiencing Homelessness

2.1 What are the healthcare entitlements of people experiencing homelessness across the EU?

This section looks at the provisions made within healthcare systems across Europe to ensure that vulnerable groups such as homeless people can get access to healthcare. In general, in light of their situation, people experiencing homelessness (particularly those in a situation of rooflessness or houselessness) fall into the administrative category of people without the financial means to pay for healthcare, like any person who is unemployed and living on social welfare payments or minimum income payments. Thus they theoretically have the entitlements that have been provided for this group, though they may not access them successfully. At least, this is the case for nationals and most EU citizens, but for non-nationals in an irregular situation and undocumented migrants who are homeless, the provisions are different and generally far less. For this reason, the two situations will be looked at separately below.

Healthcare entitlements for people experiencing homelessness residing in their country of origin, or as EU citizens in another EU country

People who are homeless residing in their own country generally have clear entitlements in the area of healthcare. In some countries, all citizens, regardless of their income status, share the same entitlement to free primary and secondary healthcare and hospital treatment, provided free of charge at the point of access. This is the case in the UK and in Denmark for example. In other countries, healthcare is not free for all citizens, but there are provisions which entitle low-income vulnerable groups to access the care they need for free, or at a minimal charge.

In many countries, this is organised by giving people who are unemployed and living on social welfare payments access to the State health insurance that workers access through employment. In Luxembourg most people who are homeless access the State health insurance through their eligibility for the minimum income payments. A recent survey in Luxemburg placed the percentage of homeless people with the state health insurance at 90.4%. [23] In Germany and Austria, the system is similar. People who are homeless are entitled to access the State health insurance system and most of them do. However, in other countries applying a similar principle, numbers of homeless people who actually have the insurance is lower, due to more complex and drawn-out administrative processes. In Poland, for example, the duration of the administrative process for people who are homeless to get health insurance means they may miss out on care that they need.[24]

In other countries, the system provides free access to healthcare for people who have acquired a special card or status because they fall into a low-income bracket. In Ireland for example, when means-testing places a person within a set low-income bracket, they are entitled to a "medical card" which should ensure free and full access to medical care of all kinds. Similar provisions exist in Hungary, where a person who is homeless is entitled to a "social insurance card", and in Portugal. In Belgium, if one is unemployed it is easy to fall out of the health insurance system, based around "health care funds" that workers pay into and which reimburse their medical costs. People who are homeless are often in such a situation and can turn to special social help centres called "CPAS" (Centre Public d'Aide Sociale – Public Centre for Social Welfare) and these will help them to get access to their entitlement to healthcare.

In general, in EU countries, EU citizens enjoy the same entitlements as nationals in relation to healthcare, provided they have observed the correct administrative procedures. However, this is not yet the case with EU10 nationals residing in EU15 countries. They may find themselves in a problematic situation if they are without employment in their country of residence, as they may then find themselves in the same situation as non-nationals who have inadequate means to pay for care. This situation is examined in greater detail in the next section on "healthcare entitlements for people experiencing homelessness who are non-nationals in their country of residence".

[23] Luxemburg National Report for the annual theme 2006, pg 5

[24] Polish National Report for the annual theme 2006, pg 5

Even the brief and general overview of the system of entitlements to healthcare for vulnerable groups across the EU sketched in the preceding paragraphs, serves to highlight that all countries have made provisions for vulnerable groups of the national population to access healthcare, for free, or at minimum cost. However, it fails to capture the reality as it is experienced by people living in a situation of homelessness, and by the service-providers that seek to help them to access the care that they need, and thus it paints too rosy a picture. Many of the reports echoed one another in the expression of a shared frustration that entitlements that exist in theory, or on paper, simply do not correspond to the very real difficulties homeless people face when seeking healthcare. In many countries, homeless services help people to get their administrative requirements and obligations in order, but access still remains problematic. To quote but a few examples:

Ireland: "The issue now is not so much access to the medical card itself, as access to GPs who will actually include people who are homeless on their register of clients."[25]
Germany: "Law regulates the assumption of the treatment costs of homeless people who are not insured under the state health insurance plan… Nevertheless, in reality, the enforcement of this legal claim is not always guaranteed."[26]
Belgium: "In theory the whole Belgian population is covered by an obligatory insurance for medical care. In practice, however, some people prove not to be covered."[27]
Portugal: "Despite the favourable legislation, in practice many obstacles to the provision of services exist."[28]
Austria: "Homeless people normally have social security or the medical services are paid by social welfare…it is more a practical access problem to healthcare institutions or private medical practices."[29]

[25] Irish National Report for the annual theme 2006, pg 6

[26] German National Report for the annual theme 2006, pg 2

[27] Belgian National Report for the annual theme 2006, pg 20

[28] Portuguese National Report for the annual theme 2006, pg 5

[29] Austrian National Report for the annual theme 2006, pg 6

Given this problematic disparity between theory and reality, **section 2.2 below will offer a detailed examination of the type of barriers homeless people encounter when seeking to access care.**

Healthcare entitlements for people experiencing homelessness who are non-nationals in their country of residence

In general, where non-nationals are documented and their administrative situation is in order, they are eligible to access healthcare in much the same way as the general population. In some countries, certain groups such as refugees and asylum seekers, who are in a regular situation are entitled to healthcare but access it through specific structures and centres, run by the same administration that handles their immigration status. In general, for non-nationals, being in a regular situation implies compliance with requirements such as a residency permit or visa, a work permit or visa, and registration with the local or national administration. In general, non-nationals who find themselves in a situation of rooflessness or houselessness are not (or no longer) in a position to comply with such requirements. This makes them especially vulnerable. This group is known as undocumented migrants. It includes, for example, failed asylum seekers, who have lost their entitlements, as their request for asylum was not granted.

In many countries, the provisions for this group are minimal with an entitlement only to emergency care for urgent health issues. And indeed, the report from the Czech Republic noted, that while such care cannot be refused to them, they will be asked to pay for it.[30] It would seem that there is a charge for emergency care for undocumented migrants in several EU countries and that this charge can constitute a very significant barrier to care. Emergency care is however provided free of charge to undocumented migrants in many EU countries, but what is understood to be covered under emergency care varies a great deal from country to country. It generally covers life-threatening injury or illness and in some countries it also covers childbirth and post-partum care. Vaccines administered in a national programme may also be available. In some countries free emergency care also includes treatment for illnesses that are a public health threat, such as TB or HIV and in Italy it includes addiction treatment, such as methadone. In the UK a very problematic situation has arisen in relation to the treatment of a serious diseases for some non-nationals in an irregular situation:

[30] Czech National Report for the annual theme 2006, pg 2

> "When asylum seekers have reached the end of the process and been refused refugee status, they are only entitled to 'essential treatment' for prescribed diseases. This includes TB but not HIV. This is not a tenable situation, as there is a lot of co-morbidity."[31]

The Platform for International cooperation on Undocumented Migrants (PICUM) describes the situation as follows:

> "Undocumented migrants are very far from enjoying "the highest attainable standard of physical and mental health", as recognised to everyone by various international human rights instruments. Many undocumented migrants lack or have a very insufficient access to subsidised health care in Europe. Moreover, the entitlement to health care for undocumented migrants is becoming increasingly restrictive throughout the EU. Indeed, states are restricting access to health care as a way to fight illegal migration and there is a tendency to over-estimate the financial burden on the state. In addition to the huge amount of practical obstacles that undocumented migrants encounter when trying to get health care, there are still many important legal barriers. One big legal barrier is, for example, the duty that the German legislation imposes on public officials – including health care providers – to denounce undocumented migrants to the authorities."[32]

It is also important to note however that certain countries go far beyond emergency care in their provisions for undocumented migrants and that there is scope for exchange and mutual learning in this area to improve healthcare services to this very vulnerable group. However, in the many countries that offer very little to undocumented migrants, meeting their needs often falls to NGO-run medical services that are seeking to fill the gaps for very vulnerable and unhealthy groups. This will be examined in more detail in **section 2.3 on attempts to overcome the barriers that people who are homeless face when accessing healthcare.**

[31] UK National Report for the annual theme 2006, pg 13

[32] PICUM (www.picum.org) PICUM is currently undertaking a detailed examination of the entitlements and access to healthcare of undocumented migrants in 11 EU countries. For further details, see the picum website.

Are Healthcare systems evolving in such a way that it is getting more difficult for people experiencing homelessness to access care?

Although some of the reports felt that there had been little change in the system in relation to access to healthcare for people experiencing homelessness and others cited positive developments and recent improvements, there were still several examples of recent changes and reforms of the healthcare system, where the access to healthcare for homeless people suffered.

In countries where reforms have recently been introduced in an attempt to cut the high costs of the healthcare system, the impact on the access to healthcare for people who are homeless and other vulnerable groups without financial means, has been severe. A worrying and well-documented example was given in the German report. In January 2004 a health reform was introduced that has had a strong negative effect on the health of homeless people in Germany. A new charge of 10 per quarter for healthcare costs was introduced for social welfare recipients. They are also now obliged to participate in the costs of medication and therapeutic appliances. The umbrella of homeless service providers in Germany, the BAGW, conducted a survey in May 2006 among its members in order to investigate the impact that the reforms have had. The survey showed that 54% of respondents had noted a worsening in the state of health of the people experiencing homelessness using their services; 82% had noted an increased need for advice and support services in relation to the new law; and 62% had paid for medical treatment for their service users through donations – a solution that will be not be feasible in the long-term. [33]

Austria too has seen a recent increase in the participation in the costs of healthcare that people who are homeless have to pay and it has had a noticeable impact. It is particularly problematic for people who are on long-term medication.[34] In Hungary, a health reform is planned in the near future and though its full scope and implications are not yet clear, homeless service providers in Hungary fear that it will it have a negative impact. It seems certain that services that homeless people presently receive for free will become paying. It will be necessary to pay for prescribed medicines and there will be a set fee for doctors' appointments. [35]

[33] German National Report for the annual theme 2006, pg 2

[34] Austrian National Report for the annual theme 2006, pg 6

[35] Hungarian National Report for the annual theme 2006, pg 7

The Finnish report also expressed concerns in relation to reform of the healthcare system in Finland. There is a similar tendency towards reduction of resources for welfare services. The report notes that in Finland that situation for the provision of services to vulnerable groups such as people experiencing homelessness is being further complicated by the application of public procurement regulations. The report warns that

> "If public services are weakened, also the services to the most vulnerable homeless people are weakened, since there is not a real market of these services." [36]

Another problem for homeless people is a growing requirement in some countries for local residency status in order to access services. In Hungary, access to primary dental care is structured on the basis of address and places people who are homeless effectively outside the system. In England increased devolution of power to the local level within the health service, has led, among other things, to increased pressure on hospitals and specialised services to work only with "local" homeless people, meaning that many homeless people fail to get access to specialists or get referred to secondary care. What is more, social services are making access to certain types of care, such as rehabilitation and detoxification treatment more and more difficult, as they come under increasing budgetary pressure to "assess people as not needing a service".[37]

Although the examples that have been detailed are by no means common to all countries, they do serve to highlight some important points. It is clear that when cost-cutting reforms are undertaken in the healthcare system, it is common for the lowest-income and most vulnerable groups to feel a dramatic impact. If healthcare reforms are undertaken across the board, without special consideration for vulnerable groups who are already living on very reduced means, they will have a negative impact on their state of health. Health reforms need to include safeguards to ensure that this does not happen. Careful consideration also needs to be given to cost-cutting measures and new approaches to healthcare provision. Where there is a move from public provision of a service towards tendering it to the private sector, there is a real danger that vulnerable groups will lose out. As the Finnish report pointed out, people who are homeless are not powerful consumers who can command a good service or drive up standards. It is up to policy-makers therefore to safeguard the quality of healthcare that they can access with quality standards and special measures to ensure equal access, despite unequal means. The examples also serve to show how problematic it is for people who are homeless when care is tied to either a local residency requirement or an address. For rough sleepers, mobile homeless people or people moving between different homeless services, this creates a serious barrier.

2.2 The barriers homeless people encounter when seeking to access care

Administrative and financial barriers

As was outlined above, people experiencing homelessness have differing entitlements to access healthcare according to their status. Given the very limited entitlements of undocumented migrants in a situation of homelessness in relation to healthcare, it is not surprising that all of the reports name administrative and financial barriers as the chief problem for this group of people experiencing homelessness.

But even where people who are homeless are entitled to healthcare, the administrative procedures that must be observed in order to access that entitlement are often complex and constitute a barrier in themselves. Many of the reports indicate that homeless services often help people who are homeless to put these procedures in train, but even so, it frequently occurs that people who are homeless may seek healthcare with out all of the necessary documentation etc. This is a significant problem, particularly where there is no flexibility in the system to allow for it. For example, the Polish report notes that the administration of the healthcare system is becoming increasingly technological, with a system of chip pin cards being introduced etc. It is now obligatory to give one's personal ID number when seeking healthcare. Where this isn't given, the reimbursement system breaks down:

> "This means that any medical centre which gives help to someone without a Personal Identity Number (PESEL) is giving treatment "on the house" as there can't be any reimbursement"[38]

[36] Finnish National Report for the annual theme 2006, pg 7

[37] UK National Report for the annual theme 2006, pg 14

[38] Polish National Report for the annual theme 2006, pg 6

The complexity of administrative procedures also means that people experiencing homelessness can feel helpless in relation to them. Several reports highlighted the fact that homeless people sometimes feel that they don't really understand what their entitlements are or know how they might go about finding out more.

In other countries, the inability to produce a registered address is an equally large barrier. In Belgium, the lack of a legal residence makes one ineligible for health insurance.[39] In other countries, there may be a local residency requirement in order to get access to care, particularly secondary or specialist care.

The financial contribution to be paid by the person receiving the care varies from system to system and country to country. It may be nothing, or it may amount to participation in the costs of both care and prescribed medicines and appliances. In some countries, it is necessary to be able to pay some part of the costs upfront and be reimbursed afterwards. In any case, the recent experience in Germany and more long-term experience in countries like Belgium, clearly show that even a small charge to be paid up front by the person who is homeless can constitute an insurmountable barrier.

"The gap between the hospital and homeless life"

The above title tries to capture the fact for someone who has adapted to living on the streets and homeless shelters, the health centre or hospital environment is a difficult and challenging one. Almost all of the reports highlight that for someone in a situation of rooflessness or houselessness coming in to these services often brings feelings of shame and stigma. Previous negative experiences with administrative or medical personnel are a very real barrier to accessing the healthcare system. These negative experiences and perceptions, as well as feelings of being ill at ease, can sometimes give rise to difficult and challenging behaviours among people experiencing homelessness in their contact with the healthcare system, which in turn lead to further problems.

Healthcare services generally operate on the basis of fairly inflexible appointment procedures. These can be a problem for homeless people, who may not be able to adhere to them. People in a situation of homelessness often tend to seek care only when they are in urgent need of treatment. Rather than wait for an appointment, they may often fall back on emergency care. Many countries also report that certain services that people experiencing homelessness may be seeking, such as detox and rehabilitation services or low-threshold mental health services, are inadequate and may have long waiting lists.

Finally, several countries mentioned that the services offered may not be adapted to certain people experiencing homelessness. Thus there may be cultural or linguistic barriers, or gender-specific needs may not be taken account of. For undocumented migrants, for example, linguistic barriers may constitute a very significant hurdle, as the health system and medical professionals may not be equipped to understand their needs or explain their treatment to them, making it extremely difficult for them to engage with healthcare treatment.

"Lack of knowledge about entitlements"

Several of the reports highlight the fact that homeless people may feel dissuaded from trying to access healthcare through lack of knowledge about their entitlements. Homeless services may try to inform them and help them to access their entitlements, but in certain situations, these may not be at all clear. For example, in the case of undocumented migrants, their entitlements vary so greatly, and there is so little clarity surrounding them, that it may be extremely difficult to find out precisely what they are. What is more, given this lack of clarity, hospital administrations and healthcare professionals often tend to be inflexible and may seek to avoid engaging with them. They may also be victims of discrimination. Accessing healthcare services may be even further complicated for undocumented migrants by a fear of being denounced and having to leave the country. This fear may or may not be founded, depending on the country, but it is always a substantial psychological barrier and it is vital that it be addressed if access to care for undocumented migrants is to be improved.

2.3 The efforts that have been made to overcome these barriers

Alternative routes into care:

All of the reports described special healthcare centres and initiatives that had come into being in an effort to reach people who are homeless and not in any kind of regular contact with the general healthcare system. This has given

[39] Belgian National Report for the annual theme 2006, pg 21

rise to different kinds of low-threshold and outreach health services for people who are homeless across the EU, which will be examined in detail in section 3 on ensuring access to quality care for people who are homeless.

The homelessness service sector as mediator and advocate

Many of the reports described how the homelessness services in their country have developed an important mediating role between the people experiencing homelessness that use the services that they provide and the mainstream healthcare sector. This mediation takes several forms. At a simple level, homeless services often try to help service-users to recognise when they need medical help. They may try and motivate them to make the effort that is required to go and see a doctor or healthcare worker and they try to help them to overcome apprehensions they may have about accessing healthcare, resulting from previous negative experiences, for example. They will also help them with simple problems like laundry, and access to clean clothes and offer them the facilities to be able to observe basic hygiene. This is generally important in relation to health, but it can also make the contact with doctors and health services easier if the person has the possibility to prepare in this way. The homeless services may also act as mediators by making appointments for people experiencing homelessness and accompanying them to the appointments and in this way helping them to navigate a system that may be alien and challenging.

Homeless services may also play a mediating role by seeking to build up a relationship with healthcare services, which will in turn help to facilitate the contact of homeless people with these services. This may be as simple as simply trying to get to know social workers within the hospitals or trying to forge a relationship with healthcare personnel or services with whom their service users come into frequent contact. This helps to foster better understanding and communication and may help to reduce exclusion of people who are homeless from the system. The Hungarian report describes how certain homelessness services have tried to build up a personal relationship with healthcare workers working with their service users. They stay in regular contact with them and try, for example, to send them cards thanking them for their help at the end of the year. The report states that these attempts have actually met with some degree of success and that :

> **"In this case, the psychology of personal intercourse counteracts the existing structural barriers in the healthcare system."[40]**

Homeless services also play a mediating role in relation to the administrative system. In many countries, centres and shelters for people experiencing homelessness try to offer their users advice and support to access their entitlements in the area of healthcare. They will try to help them to put the administrative processes in train to get necessary documents etc. and they will inform them about how the system works. In Germany and Luxemburg, some homeless services have even put in place systems in order to help homeless people to pay for their care. Where a payment up front is required, these services will shoulder the cost in order to ensure that the financial participation is not a barrier to care. In Germany the money comes from donations, while in Luxemburg it is provided for in the budget of the organisation and the Ministry of Health can also be approached for support, where the care is very costly.

Attempts to overcome the local residency requirement

As was mentioned previously, the requirement of a local, legal residence can exclude homeless people from care and some countries have come up with systems to try and bypass this problem. One way of doing this is to make it possible for a hostel address to be used. In Rome, a special address has been created in order to register roofless and houseless people:

> **"Even though a national law establishes the right to have residence (so that people can access health and social services) not all cities have endorsed it. However, in Rome, a "virtual street" has been created and all homeless people officially reside there. It is the "Via Modesta Valente "and is named for a homeless woman who died in the winter."[41]**

In Spain similar practices have been put in place in some cities and in Belgium the responsibility for providing a legal address to people experiencing homelessness lies with the local CPAS (Public Centre for Social Welfare).

---

[40] Hungarian National Report for the annual theme 2006, pg 8

[41] Italian National Report for the annual theme 2006

Overcoming financial barriers by tailoring the public health insurance to the needs of vulnerable groups

In some countries, special public health insurance packages have been put together for very vulnerable groups without financial means, in order to reduce or do away with the need to pay for care up front and await reimbursement or to reduce the financial participation required. An example of this type of measure has been put in place in France. In the French system, anyone who is living in a regular situation or a longer period than three months, and who is not covered by another form of health insurance (through their employment for example) is eligible for coverage under the basic public health insurance system, which is called the CMU (Couverture Maladie Universelle – Universal Health Coverage). This allows them to have a certain amount of what they pay for medical care and medication to be reimbursed to them through the public system. However, a further system has been developed, for those who are unable to shoulder their part of the cost or pay for care upfront. This system is known as the Complementary CMU and is accorded on a yearly basis, through a means-testing system. It allows people to access doctors and hospital care without any cost to them and without having to pay up front and await reimbursement. It is a third-party payment system and it covers 100% of the medical costs of those accorded it.[42]

In Belgium too a third-party payment system has been developed, though it is more complicated and less reliable than the French "CMU complémentaire". One significant difference is that the Belgian scheme does not cover the entirety of the costs – the personal financial participation of the patient not covered by the public health insurance is maintained. The third party payment system does not actually reduce the cost therefore, but it does away with the need to have the full price up front and to await reimbursement from the insurance system of the costs covered. However the patient has to organise this directly with the doctor and he or she may not always prove amenable as it means an added administrative burden. The surplus cost not covered by the insurance is still a problematic financial barrier for some people who are homeless, but some efforts have been made in this area too. It is possible to apply to have the surplus covered by the local CPAS (Public Centre for Social Welfare) though this has to be arranged by special request and actually go through the board of the CPAS and is generally granted more in the case of costly hospital stays, for example. A further system intended to reduce financial barriers is the "Maximum Invoice System". This is a means-tested system that sets a maximum ceiling for medical costs for low-income groups, beyond which medical expenditure is completely covered by the public insurance system. For people who are homeless and living on social welfare payments, this ceiling would be 450 a year. However, the Belgian report notes that certain types of expenditure are not taken into account (such as payment for certain medications, the cost of old folks' homes or supported housing).[43]

These types of provisions exist in many countries and have been developed in an attempt to do away with financial barriers to access to care, at least for people who are in a regular situation, which is certainly not the case for some people experiencing homelessness. Those outside the system can still only access emergency care.

[42] French National Report for the annual theme, pg 4

[43] Belgian National Report for the annual theme, pg 24

Section 3: Access to quality healthcare for people experiencing homelessness

What do we understand by quality healthcare? It is clear that having all of one's health needs met through emergency services does not constitute quality healthcare, no matter how good the emergency service provided. This is because properly taking account of a person's health requires going beyond treating pressing health problems on an emergency basis. Good quality healthcare requires a focus on prevention (screening, check-ups, vaccinations etc.) and also health promotion (good nourishment, smoking cessation etc.), and certainly primary care needs to be complemented with access to specialist services and good follow-up. How can homeless people get access to quality healthcare in this wider sense? This section will look at how different countries and organisations have tried to ensure that people experiencing homelessness enjoy high quality, holistic care.

3.1 Specialist, low-threshold care for people experiencing homelessness

Specialist care versus mainstream care

In all of the reports, the provision of some form of healthcare specially adapted to the needs of people experiencing homelessness was mentioned. These forms of care are provided in recognition of the fact that the people who use them may not be able to access mainstream care. This in itself makes them a problematic structure for some homelessness service-providers who feel that the creation of such services is based on acceptance of the fact that the mainstream healthcare provisions are, and will remain, inaccessible to people experiencing homelessness. This problem was raised in many of the reports and the Spanish report was particularly emphatic:

> "If we are discussing equality and, by the same token, the dignity of each individual, healthcare services – as established under law – should be equal for all, independent of the individual's personal situation."[44]

The Spanish report expressed a strong preference for working on existing services and adapting them to meet the needs of people who are homeless, rather than creating complementary services to fill the gaps. Indeed this is the approach adopted by several of the homelessness service providers there, who work to try and support homeless people to have their health needs met in the mainstream system. These fear that specialised services for homeless people will have stigma attached to them and be of inferior quality. Nonetheless, there is not agreement across the board on this question: there are still organisations in Spain that have developed certain services specifically aimed at people who are homeless.

In general, it would be true to say that most reports have a nuanced position on this issue. There was a shared feeling that, while ideally all the needs of homeless people would be met through the mainstream healthcare system, specialist services can help to bring them in to mainstream care. What is more, specialist services can be tailored to meet the real needs of homeless people based on a good awareness of their situation, making them more effective. They can reach greater numbers of homeless people who might otherwise go without care and they can respond in a holistic way by bringing several services together. Thus there is a recognition of an important role for specialist services, as long as they do not become an alternative healthcare system for homeless people or foster a culture of dependency. The UK report summed up the Scottish debate on this issue as follows:

> "The conclusion was that homeless people are entitled to receive the same range of health and well-being services as the general population, though their circumstances may make it more difficult to participate equally in a range of health-related programmes, or to receive the continuity of care experienced by the housed population. Specialist services may be appropriate for homeless people for a period of time, but the existence of such services should not mean that everyone who is homeless is automatically channelled through this route; the aim must be to incorporate homeless people within mainstream services and to ensure these services are designed in ways which meets their needs."[45]

[44] Spanish National Report for the annual theme, pg 13

[45] UK National Report for the annual theme, pg 17

Low-threshold care for people experiencing homelessness

In general, in all EU countries, some form of low-threshold primary care is available for vulnerable groups. Often this kind of care is provided through clinics and mobile services. Medical NGOs are sometimes responsible for this kind care service. The NGOs "Médicins du Monde" and "Doctors without Borders" were mentioned in several reports as offering a primary care service for those in an irregular situation and unable to access mainstream care. In Belgium an NGO called "Medimmigrant" caters specifically for the needs of migrants in an irregular situation who are excluded from all but emergency services in the mainstream system.

Homeless service providers also have a role in coordinating the provision of low-threshold healthcare to their service users. In many cases, homeless service providers have lobbied and worked with policy-makers to convince them of the need for such services and in several countries, services for people who are homeless have funding to ensure the provision of some form of health or health-related services. In Ireland, money has been made available for emergency shelters in Dublin to employ a nurse and pay for the services of a doctor. Some had even been able to secure the services of a counsellor and a nurse. While service providers in all countries did not have this level of care available in their services, it is quite common for a nurse to be available and for doctor's consultation to be held on a regular basis – perhaps once a week or once a month. Other services commonly provided in the homelessness services setting include tests for contagious diseases such as TB or HIV. Some of the reports observed that this kind of facility led to better rates of take-up of care and that there is a demand for this type of service.

Homeless services have also been involved in setting up specific services, outside the hostel setting, which are tailored to the needs of people who are homeless and with which the homeless services work closely. A type of health service that was mentioned in several reports is outreach, mobile medical services. These are specially equipped vans or ambulances and they go out and actively try to make contact with people who are homeless and try to see to their health needs on the spot or begin a process of care. These services try to meet health needs, but also more generally to encourage people experiencing homelessness towards services that will be able to help them to address their general situation. Several reports mentioned that it was desirable to have multi-disciplinary teams working in this outreach capacity in order to take account of the needs of people experiencing homelessness in a holistic way. It is useful to include a mental health worker and a social worker if possible. In some countries, there are also low-threshold services that are offered in special clinics and centres, which are not mobile, but which are adapted to the needs of homeless people. For example, in Hungary, a network of low-threshold clinics offering services on a 24 hour basis has been developed, with four centres in the capital city and others in other cities around the country.[46] As was noted in the Belgian report, such clinics and centres have a role to play in data collection on the health needs and situation of people who are homeless.

It is useful to look at the ideal model for mobile and outreach health services to homeless people that has been developed by the homelessness sector in Germany. It is elaborated both to meet the real needs of people who are homeless and also to help them back towards mainstream care. Thus it serves to show how most countries would ideally like low-threshold health services to homeless people to operate. The model is a "graded treatment model":

A graded treatment model seems the most appropriate in view of the different access circumstances of the target group.
The following areas can be differentiated:

- Street visits (medical street work)
- Use of a mobile ambulance
- Consultations in facilities of the Wohnungslosenhilfe (Homelessness services)
- Treatment in short-term care units („Krankenwohnungen")
- Cooperation with partners of the regular health care system

The individual grades differ regarding their intensity, structuring, treatment situation and their access barriers. While medical street work requires little motivation on the part of the patient, the visit to the surgery of an aid facility necessitates at least a minimum of initiative or acknowledgement of the disease by the patient. According to the grades, the shift of

[46] Hungarian National report for the annual theme, pg 9

> the individual treatment contacts to the facilities and the integration of the patients in the regular health care system differ as well. The objective of such a graded model is the development of services that finally lead the patients to use regular health care services. [47]

As well as this model, a set of criteria has been developed for these services to ensure that the treatment is of the appropriate standard and that it responds holistically to the needs of homeless patients:

> **Criteria for an appropriate service standard:**
> - Street visits (medical street work)
> - Treatment according to medically accepted methods and guideline
> - Consideration of the requirements of patients in multiple problem situations
> - Consideration of the patients' individual circumstances in definition of treatment
> - Continuous development of the measures according to the conclusions drawn through communication with the patients, documentation and communication with other specialists
> - Networking with corresponding facilities for psychiatric and social care[48]

Filling the gap – meeting the needs that are not met in mainstream health services

As well as low-threshold, accessible primary care, many of the reports described specific services that have been created for homeless people in order to fill a care gap in an area where their needs are generally not met. As was mentioned previously, people who are homeless have particular difficulty accessing mental health care which is adequate to their needs. The reports contained some examples of special mental health services that had been created in order to get to this hard to reach group. In some countries, there are special outreach mental health teams. These services operate by going to homeless people directly where they are. They try to establish contact and build up a relationship and gradually help the person towards mental healthcare. Thus, they aim to fill a gap in access to care and to reach groups that are outside the system by going out to them. Special dental health clinics for people experiencing homelessness also exist in many countries. These too are provided in recognition of the fact that dental care seems to be a type of care that is particularly difficult for people who are homeless to access.

Another point at which care for people experiencing homelessness breaks down is at the recuperative stage. When people who are homeless are recovering from illness, surgery or treatment, recuperative care can become a major problem. The hospital may not wish to retain them in a hospital bed, but it is clear that they may not be able to manage a situation of rooflessness or houselessness in their weakened state and emergency hostels and shelters are not adapted to offer the kind of care that they need:

"Hospitals cannot wait for the complete recovery of homeless people and they are not interested in keeping them in "expensive" hospital beds for long. Naturally hospital beds are expensive for the general population as well, but in their case, nursing can be solved at home. As for people who are homeless, the street or the shelter don't offer adequate possibilities for nursing so health centres [for homeless people] try to meet this need by setting up recovery wards."[49]

There was agreement in the reports that this is a particularly important service for health centres seeking to meet the needs of people who are homeless to provide. The identification of this gap in France has led to the mobilisation of funds in 2006 for a new type of structure, called the "Stopover Beds for Healthcare" (LHSS – Lits Halte Soins Santé). These beds are a low-threshold service, in that are available to all, regardless of their administrative situation and they have been created with the needs of people who are homeless in mind. They are a new service and designed specifically for those who are not ill enough to be hospitalised, but who need bed-rest and care in order to recover. They are a medical service, but they also have a strong social dimension and seek to meet the needs of those admitted in social areas also.[50]

Another care gap that was identified in some countries is access to healthcare for people who are homeless in rural areas. Homeless people face the same barriers to main-

[47] German National Report for the annual theme, pg 3

[48] Ibid, pg 4

[49] Hungarian National report for the annual theme, pg 8

[50] French National report for the annual theme, pg 5

stream care in rural areas as they do in urban areas, but the specialist services that can offer a low-threshold alternative, or fill gaps left by mainstream care, are generally located in urban centres. This means that people experiencing homelessness in rural areas are generally wholly dependent on emergency care. It may mean that people who are homeless are forced to migrate large urban centres to get access to the services that they need. However, it is not easy to measure the full scope of this problem and several reports mentioned that there is little data on the needs of people who are homeless in rural areas.

The need for a solid financial basis and for political support:

Despite the fact that a good understanding has been developed across the EU about how specialised services for people experiencing homelessness can be tailored to meet their needs and how these can serve to complete gaps left by the mainstream system and to help people back to mainstream care, the difficulty can be to mobilise political support for such services. Even though reducing dependency on emergency services makes financial sense, it can be very difficult to channel public funding into specialist services for homeless people. However, it is clear from the examples above, that low-threshold services that can offer quality care require investment. A quality specialist service can only be provided to people who are homeless where the means have been made available to do so. Thus the Polish report describes the frustration of the few specialist health services for homeless people there:

> **"There are a few specialist health centres for homeless people available, which accept everyone asking for support. They suffer from continuous financial and staff shortages."[51]**

It is clear from the reports that where political support is given to initiatives to improve the health of people who are homeless, this is a major vector of change. Political champions of people who are homeless and of the importance of ensuring that they can access their rights can be a huge driver of new developments and improvements.

[51] Polish National report for the annual theme, pg 7

3.2 Health Promotion and Preventative Initiatives for people experiencing homelessness

As was discussed above, holistic and quality healthcare should encompass both a preventative and a health promotion dimension. That is to say, that caring for health should not be purely reactive, but also that possible problems should be prevented through vaccination or screening for example, but also through early detection and regular treatment. Health promotion has to do with the lifestyle determinants of health. It encompasses efforts to improve health by encouraging and supporting healthy living. These forms of healthcare are not provided in reaction to urgent and pressing needs and on an emergency basis, therefore they are less likely to be accessible to people in a situation of homelessness. Nonetheless, the reports show that efforts have been made in many countries, generally within the framework of homelessness services, to try and ensure that prevention and promotion initiatives reach people who are homeless.

Prevention

As has been mentioned in previous discussions in the present report, preventative initiatives among people who are homeless have been developed in many EU countries around certain major contagious diseases. This is because people experiencing homelessness are at particular risk of contracting certain diseases that are a public health risk and particular vigilance is necessary to protect them from infection or try to begin treatment at an early stage. The reports most commonly mentioned tests for tuberculosis, for HIV and for hepatitis. Vaccines that are frequently made available to people who are homeless include the influenza vaccine and the vaccine for hepatitis B. Another area where prevention of disease for people who are homeless that has been developed is that of harm reduction for intravenous drug users. Examples from the reports included needle exchange programmes, safe user rooms, information distribution and distribution of condoms.

Promotion

A growing number of services for people who are homeless across the EU are trying to bring health promotion to the services they provide. Efforts are made in many hostels to try and provide nutritious food and to try and raise awareness about nutrition. Equally, services try to maintain high standards of hygiene and to provide hygiene facilities to the users. There were also examples from the reports of programmes to quit smoking that are made available in centres for people who are homeless.

Services across the EU also try to promote the mental and social wellbeing of their users. The UK report mentions recent research that shows that

> **"there are wide-ranging health benefits for people who are homeless from social and cultural activities especially in the area of mental health."[52]**

Services in the UK are trying to implement this finding. Most services also try and implement principles of user participation in decision-making that affects them. This is an important part of the philosophy of how many homelessness service providers across the EU operate, but it is also an important way of helping people who are homeless be more involved in services, which can have a positive impact on mental and social health and wellbeing.

3.3 How does the quality of the healthcare received by people who are homeless compare with that of the general population?

Of course the major theme of this report is to examine how and why the healthcare systems in EU countries fail to meet the needs of homeless people. It goes without saying then, that the quality of care received by homeless people does not compare favourably with that of the general population. However, the comparison does still serve to highlight some important points.

It is worth noting that the group who fares worst in health terms in comparison to the general population is that of people who are homeless and in an irregular situation – undocumented migrants or people whose administrative affairs are not in order. The care that they receive is limited to emergency treatment. There is little follow-up and no access to secondary care. They are dependent on NGOs who do what they can to provide some alternatives for them outside of mainstream care.

The homeless people who fare best in comparison to the general population are those who are in regular contact with a service that knows them and follows up their care. Where specialised services are in a position to look after the homeless people who come to them in a holistic way, including offering recuperative facilities and access to secondary care, as well helping them towards mainstream care, they are generally in a better state of health. It is also worth noting that where there has been government support and investment for specialist healthcare for people who are homeless, the services are generally of very good quality. In Hungary, for example, where the government has funded the development of 24 clinics for vulnerable groups, these services compare well in terms of quality with those available to the general population.

Thus it is encouraging to note that, while much progress is needed, good working models of healthcare for people who are homeless do exist in Europe. These seek to reach the most vulnerable groups who would otherwise be outside of care and by tailoring themselves to meet their needs, they can help them towards treatment and towards the mainstream health system.

[52] UK National report for the annual theme, pg 18

Section 4: Training courses to equip professionals to better meet the health needs of people experiencing homelessness

People experiencing homelessness often cite the negative attitudes that they encounter from medical professionals as a significant barrier to accessing healthcare. Healthcare professionals, for their part, find that people who are homeless are a difficult client group and they often state that they feel ill-equipped and ill-prepared to engage with them and to meet their needs. For this reason, this section will examine the attempts that have been made to empower healthcare professionals across Europe to work with people who are homeless through training of different kinds. Equally, some professionals working in the homeless sector feel frustrated with their contact with the health sector and feel that they need more knowledge about health care and certain health related issues in order to help their service-users more effectively. As the Hungarian report expressed it:

> "Experts working in both the health sector and the social sector feel that they don't get enough help from the other side. Homeless service providers don't have the adequate capacity for homeless people in need of long-term nursing, while health workers don't have the capacity to handle the social problems of homeless patients needing extra work in any case. At present it's conferences that play a kind of interdisciplinary role between these two sectors."[53]

This section will also look at the efforts that have been made in some countries to equip the homeless sector with these skills and knowledge.

4.1 Training courses on homelessness for healthcare professionals

The reports clearly highlighted that training courses of this nature would be a very new idea in many European countries. Several reports stated that the homelessness sector was unaware of any such initiatives in their country. This was the case for example in Austria, Portugal, Finland, Hungary and Luxemburg. The idea of such training courses was therefore a totally new one in these countries and the reaction to it was very positive. In general there was a very strong feeling that it could be a very successful way of improving the contact with the healthcare system for people who are homeless. What is more, where healthcare professionals were questioned on this idea, their reaction was generally to support it:

> **Luxemburg:** "It is clear that it would be advantageous to integrate basic training on the problems and health needs of people who are homeless both for doctors and social workers."[54]
> **Portugal:** "We are not aware of any project with this objective, which we believe would reduce the stigmatisation of this group…there is a case for investing in changing attitudes of healthcare professionals."[55]
> **Hungary:** "The training of healthcare workers on the specific needs of homeless people is not part of the curriculum. However many of the doctors questioned would consider it very important and timely."[56]

In many other countries, there are examples of such courses. In most cases, these are informal or once-off training sessions. In the Czech Republic the homeless service provider organisation *Nadeje* in Prague has been working with the local branch of the Red Cross there on a trial basis over the past few months to provide training on questions of communication and attitudes in working with people experiencing homelessness.[57] In Denmark, doctors (generally young student doctors) who were involved with the former outreach medical service for people who are homeless in Copenhagen received special training on working with this client group.[58] In Poland attempts are currently being made to integrate a focus on homelessness into the training of

[53] Hungarian National report for the annual theme, pg 11

[54] Luxemburg National report for the annual theme, pg 16"

[55] Portuguese National report for the annual theme, pg 8

[56] Hungarian National report for the annual theme, pg 11

[57] Czech National report for the annual theme, pg 4

[58] Danish National report for the annual theme, pg 5

some groups that may work with people who are homeless in a health or social capacity, such as dentists, social workers and mental health workers. [59] In Estonia, there is a possibility of following a course on the needs of marginalized groups and on working with specific groups, as part of the specialised training for the personnel of hostels, shelters and hospitals. The professionals working in this capacity have often opted to follow this course on vulnerable groups.[60] There was a strong feeling in the reports that such training courses are a useful and effective way of empowering healthcare professionals to work well with people who are homeless.

The UK report makes reference to the specific scheme of "peer training" where homeless people receive training in order to work themselves as trainers about homelessness, sharing and using their experience to build understanding of homelessness and to undo negative attitudes and perceptions. This model has been developed, for example, in relation to training homeless service providers in order to develop better models of service user participation and involvement. The UK report suggests that there is a strong case for investing in such training in order to enable people who are homeless to become peer trainers for healthcare workers. [61]

In two countries, specific training on issues related to homelessness has been developed in the homeless sector and made available as a course for medical professionals within the recognised university or training system. In Ireland, homeless service provider *Focus Ireland* has developed a ten module training course on homelessness to be used as part of the national nursing degree programmes.[62] In England, an academic course for healthcare professionals across the primary healthcare spectrum has been developed. It has been developed in cooperation between medical professionals and the homeless sector. The course is entitled 'Health care for people experiencing homelessness' and it is aimed at graduates. The aims of the course are:

- To raise awareness of the health needs of homeless people
- To develop an understanding of the experience of being homeless
- To encourage and enable work across disciplines to identify the barriers and solutions to health care needs in the homeless population
- To provide the foundation, through interactive working, for the development of a locally enhanced service for homeless people[63]

These courses have only recently been developed and it is not yet possible to gauge what the take-up will be or what impact they will have. However, it seems likely that this model of providing training for healthcare professionals is a useful and transferable one and the reports indicate that there would be support for developing it further. This type of training also helps to foster better contact and cooperation between the medical and homeless sector. Countries seeking to ensure access to better healthcare to homeless people and other vulnerable groups should certainly consider making this kind of training model part of the strategy to make services more accessible.

4.2 Training on medical questions and on the medical sector for people working in the homeless sector

As was discussed in the previous sections of this report, there is a desire among some people who are homeless to have greater access to health services in a hostel or day centre setting. It was also highlighted that some services for homeless people have developed recuperative wards or structures for homeless people who have been hospitalised and still need time and space to recover. Homeless services also have a role to play in screening their users for serious infectious illness. They may also be called upon to help to administer treatment, such as TB medication. In many countries they also offer health promotion advice and support on issues such as healthy eating and smoking cessation. Thus it is clear that homeless services providers in many countries play a health role in relation to their service users. It is simply a fact that many of those that come to homeless services

[59] Polish National report for the annual theme, pg 8

[60] Estonian National report for the annual theme, pg 9

[61] UK National report for the annual theme, pg 23

[62] Irish National report for the annual theme, pg 10

[63] UK National report for the annual theme, pg 23

are unwell in one way or another and it is up to homeless services to help them towards the support and care that they need.

Given this situation, it is not difficult to make a case for providing some basic medical training courses for people working with homeless people in homeless services. The German report makes this point very strongly in relation to homeless service providers and particularly volunteers, who may have no previous knowledge or experience of working with people with severe mental illness. The report emphasises that such training is vital and urgent in order to enable people to work well with people who are homeless and mentally ill:

> "Qualification and training regarding the contact with mentally ill persons should urgently be offered for volunteers and other employees. The basic fundamentals of the field should be imparted. In the scope of further trainings the following issues should be treated: learning of clinical characteristics, aids for handling persons with mental illnesses or problematic behaviour, information about the local or a close support system (addresses, telephone numbers, opening hours, emergency telephone numbers, contact persons), aids for handling acute pathological conditions like depressions, aggressiveness, violence and acute crises."[64]

The Luxemburg report also contained a strong recommendation from a doctor working with people who are homeless there to offer basic training to social workers and those working with people experiencing homelessness on those illnesses that are likely to encounter often among their service users, such as epilepsy for example, or various forms of substance abuse.[65]

Another form of training that the reports highlighted as potentially very useful and empowering is training on the medical sector. As was mentioned previously, service providers frequently play an advocating and mediating role in relation to the healthcare system in relation to people who are homeless. There was a strong feeling in some reports that service providers would be able to do this more effectively if they were better informed about the medical sector and knew how to find their way around it. Training could be a way of equipping people with this knowledge.

Thus it is clear that training courses could be an effective way of increasing understanding and cooperation between the health sector and the homelessness sector. Better knowledge about homelessness would enable health professionals to better engage with people experiencing this situation. Similarly better understanding of the health problems and needs of homeless people will equip service providers to support them to have these needs met. The reports strongly suggest that the investment in such courses would be well worth making, to enhance service quality, breakdown stigma and create better inter-sectorial cooperation.

[64] German National report for the annual theme, pg 6

[65] Luxemburg National report for the annual theme, pg 16

Section 5: Networking, cooperation and inter-agency working

The needs of people who are homeless span a range of areas and can generally not be entirely met within the sector of homeless services. This makes good cooperation and co-working with other sectors, such as the health and housing sectors, truly vital to meet the needs of homeless people in a holistic way. However, this has not been the traditional way that services operate. Though the need for inter-sectorial work is generally recognised, the structures to permit it to take place are only slowly emerging. The present section seeks to establish an overview of inter-agency working across Europe and to gauge the support among homeless service providers and other sectors for this kind of approach.

5.1 Networking and cooperation across Europe between the homeless sector and health and other relevant sectors

Networking and cooperation as a guiding principle of the strategy on homelessness

It is clear from the national reports that levels of cooperation and networking vary a great deal from country to country. However, there were a small number of examples where networking and interdisciplinary cooperation had been used as the guiding principles to structure the work with people experiencing homelessness. This is the case, for example, in Finland, where networking across sectors is one of the most important values in the work with people who are homeless. The need for involvement and cooperation of health services, social services NGOs and the housing sector in meeting the needs of homeless people is clearly recognised and the role of facilitating and coordinating this way of working falls to local authorities:

> "Local authorities have the legal obligation to arrange services and cooperation is demanded between social and health services as well as with the housing sector. Also the strong NGO-sector must be mentioned since these organisations have been active in developing new services and they work as partners to the public authorities."[66]

[66] Finland National report for the annual theme, pg 12

In Scotland too, the principle of networking is central to the whole approach to homelessness and has shaped the strategy that has been developed there. In Germany there is also a good recognition of the vital role of cooperation between the homeless and health sectors in order to work holistically to meet all needs. Homeless services and health services for people who are homeless closely coordinate their work – by adapting their opening times for example. A social worker is also included in the "inter-disciplinary teams" that work with homeless people in an outreach health capacity.

Emerging structures to facilitate networking and intersectorial working – the role of local authorities

Few other countries felt that cooperation and networking across sectors was presently a guiding principle of the work on homelessness, however, there were other examples highlighted where better inter-agency working is slowly being developed. Several countries highlighted discussion and exchange forums that had been developed in order to allow the different sectors to come together periodically to exchange information and experiences. In Poland, where, generally speaking, there is a large divide between the different sectors, meetings to bring them together are organised during the winter emergency period to better coordinate the working at this time.[67] In Madrid, the Health Board, which works under the auspices of the Centre for Primary Healthcare and which has branches in every district, is working to create spaces for community intervention. Essentially these are forums bringing together the organisations and social services active in that area and they aim to:

> "to analyze trends in social-health needs that appear in each district and to develop programs and actions to confront them."[68]

In Luxemburg too, some structures to facilitate cooperation and networking across the different sectors have emerged in relation to people who are homeless. Structures have

[67] Polish National report for the annual theme, pg 9

[68] Spanish National report for the annual theme, pg 17

been created to bring together social services working on a range of areas together in a single network. In Luxemburg city, a range of services have been brought together in a single access point. In the case of organisations active in the area of homeless services to people with a drug addiction, addiction services and mental health services have been integrated into the offer. Administrative agreements and structures have been developed to facilitate this cooperation. In Spain and Austria too more systematic networking has been developed with the mental health sector.

In Ireland, the "Homeless Agency" - which is the statutory body created by the Irish government to plan, fund and co-ordinate the delivery of services to homeless people in the Dublin area - has developed a computerised client database to facilitate inter-agency working. This is intended to:

> "facilitate transfer and sharing of information and cooperation between different services. Information collected includes services such as assistance in applying for medical cards or referral to medical services/detoxification facilities"[69]

In Hungary too attempts are being made to develop a shared referral system.

In almost all the above examples, the facilitating role of local authorities was strongly emphasised. Local authorities generally have the resources to bring the different sectors together in a way that they don't manage to develop themselves. They often further have the possibility of making the cooperation into a systematic procedure facilitated by administrative structures and agreements, as well as by instruments such as shared databases or information sharing agreements. Thus in the countries where networking and cooperation are most developed and central to the approach to homelessness, it is generally due to a strong recognition at national or local level of the value of this way of working and a concerted political effort to facilitate it and drive it forward.

Support for cooperation and networking in the homelessness sector

The reports serve to highlight the fact that there is a strong recognition in the homeless sector of the importance of having good cooperation with the health sector and health-care services. In the absence of structured cooperation, individual initiatives are made to build up contacts and to share information. Many reports described how homeless services will seek "sympathetic" doctors and health workers to build up cooperation with them for their clients. There are sporadic examples in many of the reports of where a single organisation has sought to establish a strong framework of cooperation with healthcare services. However, such individual attempts are often isolated and are necessarily fragile: where the individuals involved move on, the cooperation that has been established may break down.

There was also a feeling in many of the reports that the efforts to reach out and cooperate with the health sector are well developed in homeless services, but that they are not necessarily reciprocated. Several reports echoed the sentiment expressed in the UK report that:

> "[In England] it would be a fair generalisation to state that the making of links and the referral and transfer practice is mainly from homeless sector agencies into mainstream health and social services and that referral in the other direction from mainstream health and social services to the homeless sector is less developed and less effective"[70]

5.2 Breakdowns in networking and cooperation between the homelessness and health sectors

Unacceptable discharge practices

The most frequently cited instance of breakdowns in the cooperation between the sectors in the reports was in relation to discharge practices from various institutions, particularly from general hospitals, although discharges from psychiatric hospitals and prisons or care institutions may also be problematic. Almost without exception, the reports

[69] Irish National report for the annual theme, pg 10

[70] UK National report for the annual theme, pg 25

described examples of unacceptable discharge practices that put homeless service providers in an impossible position. The reports from Hungary and Poland described how ambulances arrive at homeless services, without any prior check to see whether there are beds available, and simply leave homeless people at the door. The Polish report describes the experience as follows:

> "There is a procedure of "delivering" homeless people to shelters. The homeless person is left there without even an inquiry as to whether the shelters have free places or not."[71]

As bad as this may be, an even worse practice is where hospitals simply discharge recovering patients into the street, as was described in the Hungarian report:

> It is even worse if the patient is discharged from hospital directly to the street, which does happen according to homeless service providers. Patients discharged from hospitals in this way would require home care for quite a long time. The relation between hospital social work and homeless service providers needs improvement.[72]

A less extreme form of the same problem was highlighted in almost all of the reports: the fact that hospitals and other institutions systematically discharge people who are homeless and recovering following hospitalisation into the care of homeless services that are simply not equipped to meet their needs. There was a painful awareness in many of the reports that hostels and shelters are the wrong environment for recuperating patients and that they may have a negative impact on their recovery, but there is a very problematic lack of better structures and systems available to people experiencing homelessness. This comes back to the problem highlighted elsewhere in the report of a "care gap" where the system is simply not adapted to the needs of those who are not ill enough to be hospitalised, but who need bed-rest and care in order to recover. Where there is a refusal on the part of hospitals to retain people who are homeless through the recuperative stage and simply discharge them to homeless services, the latter find themselves obliged to try and cobble together a solution.

The UK report offers some explanations as to why, in their experience, referral, discharge and transfer of homeless people between medical services and between medical and homeless services is so often fraught with problems and breakdowns of care:

- Restricted budgets leading to defensive practice where local authorities, housing and social services act to prove that a homeless person is not their responsibility[…]
- Responding to homelessness is not part of the training for health practitioners; they are ill equipped to understand the needs of homeless people or to know where to refer them […]
- There is not a tradition of holistic services which cater to the whole needs of a person.[73]

There was a frustration in some reports that bad discharge practices essentially constitute a missed opportunity, as the rest period in hospital away from homeless services and the street can be a valuable release from the competing needs that dominate the homeless lifestyle and can give the person a chance to take stock and identify possibilities open to them. It could be an important moment for them to make progress with regard to their situation, given the right support.

This problem of unacceptable discharge practices clearly shows that action is needed to improve the cooperation and networking between homeless services and the health sector. Some of the reports indicate, for example, that when there is a responsive social worker in the hospital, who is in touch with homeless services, that there are fewer problems with discharges. There are also examples of discharge planning with the homeless patient or resident to explore the different options with them and work towards a good solution. However, it is clear that if real change and progress is to be made in relation to this problem, it is fundamental to make structures available that constitute a viable option for recuperative patients in a situation of homelessness. Funding and support are necessary for such structures, whether run and administered by the voluntary sector or by the statutory sector.

[71] Polish National report for the annual theme, pg 9

[72] Hungary National report for the annual theme, pg 12

[73] UK National report for the annual theme, pg 28

A "siloed" way of working

Several reports traced back difficulties in networking and inter-agency working to a high-level reluctance to work outside the traditional 'silos' of responsibility. Several of the reports used personal stories to reflect the problems present in the system. All of these served to highlight cases where people who are homeless do not get access to the service that they need because the authority responsible for administering it refuses to accept that their needs fall within the strictly defined category that they consider themselves responsible for. The Irish report describes the problem as follows:

"Midlands Simon Community have experienced a number of cases where people are being discharged from hospital with no appropriate accommodation. In each case a 'turf war' has arisen between the local authorities and H.S.E., with either agency accusing the other of not taking up their responsibilities."[74]

In Luxemburg, the report highlights the difficulties in establishing coordinated services between the homeless sector and the health sector. It states that all progress made in this area is directly due to initiatives coming from the sector itself and that the division of responsibilities at high political level is a significant barrier:

"The essential brake on structured collaboration and coordination is the division of competencies at national level between the Minstry for the Family on the one hand and the Ministry of Health on the other."[75]

Thus it is clear that close cooperation at policy-making level between the different ministries and/or regional and local authorities with responsibility for services needed by people who are homeless, is a vital prerequisite for good coordination and inter-agency work between the various organisations and bodies that work with homeless people across a range of sectors.

[74] Irish National report for the annual theme, pg 12

[75] Luxemburg National report for the annual theme, pg 18

Section 6: Data Collection on the health situation of people experiencing homelessness

6.1 A generalised lack of systematic data collection on the health situation of homeless people

The reports described how data on the health situation of the general population and on public health trends is collected at national level, often through national statistics institutes, but without any specific account being taken of the situation of homelessness. Without this "homelessness variable" it is not possible to relate health data to the experience of homelessness. There were no examples in the reports of homelessness being integrated into the general data collection on the health situation of the population.

Some socio-economic variables are included however, which it makes it possible in some countries to collate data on the relationship between poverty and health and the problem of health inequalities. In Belgium and Ireland data is collected and analysed in this area and it clearly highlights the problematic relationship between poverty and health. The Irish data does take account of the specific situation of the travelling community, who often live in inadequate housing conditions. Among other things, it serves to highlight the lower life expectancy in the travelling community and the significantly higher rates of sudden deaths of infants. In Brussels, Belgium there is an Observatory on Welfare and Health which publishes an annual report on health for the Brussels region with specific information on poverty and its impact on the health situation. Again the analysis of the data serves to highlight the relationship of certain severe health problems to poverty and deprivation, but a specific examination of the situation of homeless people is not a part of this.

Equally the reports highlight that where data is collected by emergency services, the situation of homelessness is generally not recorded and so the data can not be analysed using this specific variable.

The reasons cited for this lack of data on the health situation of homeless people is generally attributed to heterogeneity of the group of people who are homeless and the difficulty of establishing in a consistent way whether a person is really homeless or not. Certainly there are significant difficulties to be surmounted in relation to data collection on the health situation of people who are homeless, but given that systems for collecting this data has been developed in NGOs (as will be outlined below) it would seem that these difficulties are not insurmountable. This conclusion leads the Luxemburg report to posit that the reason why data collection in this area has not developed is because there is no political will to drive it forward. It is not a type of information that policy-makers wish to be confronted with and this is the principle barrier to collecting it:

> **"The reasons for this absence of data collection are primarily political…To give the services concerned the possibility of systematically collecting detailed data on this target population, among other things on their state of health and access to healthcare services, would mean risking the possibility of highlighting a situation that is very deficient and which would force politicians and public administrations to propose, or even impose, solutions that the "general public" would not support."[76]**

6.2 Data collection in NGOs working with people who are homeless

When asked to give examples of data collection on the health situation of people who are experiencing homelessness, some of the reports pointed to the systems developed in the large homelessness networks in their country – such as the Tellus client registration system used in the organisations of the Flanders umbrella organisation of service providers, or the system being developed in the SAD network of hostels in the Czech Republic. These systems can be used to get some data on the health situation of a person using the service, though they generally are not a very detailed resource on health questions, as their main aim is to provide an overview of a range of questions related to the person's general situation.

[76] Luxemburg National report for the annual theme pg 22

Some organisations have run specific data collection projects on the health of their service users. An interesting example was described in the Hungarian report, where the NGO "Shelter Foundation" used the national health survey format to conduct a survey of the health of its service users, in order to arrive at a result that, though obviously limited in scale, would be in some way comparable to the findings of the survey of the general population.

> They were mainly interested in problems related with health situation, which might be relevant in terms of housing. The questions were extremely simple and inquired whether the interviewed person was hindered by his physical condition in doing everyday activities (getting up, going to bed, standing, walking, etc.) Questions aiming to measure the extent of smoking and alcohol consumption were also adopted from the original questionnaire.
>
> The data more or less met their previous expectations, thus the answers of people experiencing homelessness differed from that of the general population in a disadvantageous way. However, little differences and occasional surprising identities revealed much subtler (and perhaps more important) interrelations than we had expected. [77]

Organisations and projects that work with homeless people specifically in a health capacity were also named in the report as a source of data on the health situation of homeless people. Doctors' surgeries and clinics specifically targeting homeless people often collect some data on the health situation of those using the services. The health NGOs "Doctors without Borders" and "Médicins du Monde" run such services and were cited in some of the reports as a source of information. However, the use that can be made of such information is necessarily limited by the fact that it cannot be considered as a representative sample reflecting the situation of all homeless people across the country as a whole. Indeed it is recognised in some of the reports that data collection undertaken in an ad hoc way within NGOs is necessarily not as rigorous, comprehensive or representative as that undertaken by bodies whose sole function is the collection of information.

[77] Hungary National report for the annual theme pg 14

6.3 The use of "self-perceived health status" indicator when gathering information on the health situation of homeless people

Although this is a very common indicator used in data collection on the health situation of a given group or population, many reports expressed doubts about using the self-reported health of homeless people as a real indicator of their health situation. Some of the reservations about this indicator that emerged in the reports include the following:

> **Spain:** "The majority of the organizations that responded to our survey consider the use of one's personal perception of health is not a good method for gathering information about the health of the homeless. The RAIS Foundation reported that when, in its experience, when asked such a question people tended to report being in good health, although later it became clear that this did not correspond with reality."[78]
> **Belgium:** "we wonder if such an indicator would be much use for the homeless. We suspect that people with a low opinion of themselves have a tendency to minimalise their health problems and to adjust their standards downwards to fit their circumstances."[79]
> **Portugal:** "The criterion "self-awareness of the health condition" is bound to be used by the individual to present himself towards other people the way it suits him the most."[80]
> **Hungary:** "In many cases they considered their health condition good, even if they were suffering from a serious illness. One of the reasons can be that their pain threshold has increased during the years they spent in the street, and if they feel only little pain, then they may think they are well."[81]

[78] Spain National report for the annual theme pg 3

[79] Belgium National report for the annual theme pg 35

[80] Portugal National report for the annual theme pg 10

[81] Hungary National report for the annual theme pg 18

It is clear therefore that results gained using this indicator to measure the health situation of people who are homeless may lead to overly positive results. In spite of this fact, some of the reports feel that, particularly in the absence of better objectively compiled indicators, self-perceived health status may provide interesting and useful results. However they caution that such data is not suitable to be used alone for development or evaluation of policy.

6.4 Academic research – qualitative studies

The reports make clear that despite the lack of systematic data collection, there is a developed and growing body of research into the health of homeless people. In many cases the research studies are qualitative in nature and explore the experience of a small sample group. Some academics draw on the data collected by NGOs for use in their research. Many NGOs also conduct research among their service users and analyse the data collected in this way. A large body of reports and studies from across the European Union were brought to FEANTSA's attention in the national reports received from its member organisations. Clearly these constitute a valuable resource and for this reason, FEANTSA has compiled the lists received into a separate database of titles, with abstracts and links provided where possible. You can access this database on FEANTSA's website at:
http://www.feantsa.org/code/en/pg.asp?Page=616

6.5 Emerging attempts at the level of authorities with responsibility for homeless strategies towards developing indicators

While there are no very developed examples of data collection at national or local authority level, there were indications in some of the reports that work is underway in some countries to develop systems to collect data on the health of homeless people. This was noted in both the UK report in relation to Scotland and in the Irish report in relation to the Dublin area. In both cases, a statutory framework for homelessness strategies has placed an obligation on the statutory body with responsibility for implementing those strategies to measure and evaluate their progress. In Scotland, the application of Health and Homelessness standards, to which health authorities must adhere, requires them to measure their progress on meeting the health needs of homeless people and systems are being developed in response to this, though they are not yet very sophisticated. In Dublin, the statutory body called the Homeless Agency, which was created to oversee and coordinate the government's homelessness strategy in Dublin, has begun the process of measuring access of homeless people to services that they need, but equally this work is at an early stage. Still, it is clear that there will be an emerging body of experience in this area in the coming years and there will be scope to learn from the structures and systems developed to find more effective ways of gathering data on the health situation of people experiencing homelessness.

Section 7: Some Reflection on the Right to Health for People experiencing Homelessness

The right to health, or at least to the highest attainable standard of mental and physical health, is a right that European states have committed themselves to upholding. This commitment has been outlined and reiterated in a range of international declarations and treaties. Among others, it is enshrined in the ***Article 25 (1) of the Universal Declaration of Human Rights (UDHR), Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR),*** in the ***European Social Charter, aim 11, articles (2), (11) and (13)*** and ***Articles 34 and 35 of The Charter of the Fundamental Rights of the European Union.***

7.1 What does upholding the right to health mean for European States?

When States ratify international covenants and treaties that recognise the right to health and agree to be bound by them, this act constitutes a recognition of the state's responsibility to promote the health of its citizens, to reduce health inequalities and promote equity of access to healthcare. The commitment by states to safeguard the human rights of their citizens creates a duty and a responsibility towards all citizens, without exception. This notion resides at the very heart of European political culture, where the concept of the welfare state is deeply entrenched.

It is useful at this point to reflect on the use of the term "citizen". It is very important in the context of this discussion on the right to health for people who are homeless, that this term should not be used to distinguish inappropriately between the nationals of a given country and non-national groups, such as undocumented migrants, who are resident in that country and also suffering marginalisation, ill-health and housing exclusion. FEANTSA strongly emphasises that universal human rights cannot be limited by States to apply only to a specific group of people. Thus, we must urge caution in the reading of the term 'citizen' so that it does not get misused as an opportunity to further exclude marginalized people. "Citizen" in the present text describes all of the people living in a State, all of whom are entitled to full enjoyment of their human rights.

The European Union has repeatedly called on its member states to take action to reduce health inequalities, as part of a public health shift from treating bad health to promoting good health. This notion is central to the Programme of Community Action in the Field of Public Health:

> "People in the EU are living in better health than ever before. But good health for all is far from a reality. The health gap across the EU between those in good health and those in ill-health is widening. Good health still depends on where you live, what you do, how much you earn. The poor, the socially excluded and minorities are particularly affected by ill-health… To achieve good health, we need to look at the grass root problems – poverty, social exclusion, healthcare access. We need to understand how different socio-economic and environmental factors affect health. And then we need to make all these factors work together for good health. Good health must become a driving force behind all policy-making."[82]

The drive to tackle health inequalities and promote equality of access to quality healthcare has also become a part of the European Commission led "Open Method of Coordination" – a soft policy method of taking forward target setting and policy development in the area of social policy. A strand on "access to healthcare and long-term care" has also become a part of this action. Within the framework of this exchange and mutual learning process, there is a recognition of the vital importance of good health – for social inclusion – but also for productivity and economic growth.

What does it mean for people experiencing homelessness?

Adequate healthcare is one of the primary rights that states must secure for their citizens. The experience of FEANTSA's members on the ground, which has been presented in the present report, is that people experiencing homelessness

[82] Former European Commissioner for Health and Consumer Protection David Byrne: "Enabling Good Health for All: A Reflection process for a New EU Health Strategy" 15 July 2004, Pg 3.

do not have equal access to adequate healthcare and that chronic mental and physical illness is rife among the homeless population across Europe. In light of their exceptional vulnerability, states need to adopt a proactive stance in relation to homeless people. Having recognised their responsibility towards them, they need to transmit this duty to the relevant authorities, whether they be regional, local or municipal authorities. A sense of duty and a recognition that they are a part of society, must exist between the community and people who are homeless and marginalised. This is the first fundamental step towards meeting the needs of homeless people.

It is also worth recalling how the Council of Europe frames the duties of states toward their more socially vulnerable citizens in the field of health. On the basis of commitments made in international rights charters, the Council of Europe has called on its member states to adapt health care services to the demand for health care, and health care services of people in marginal situations. It made the following recommendations in Recommendation Rec (2001) 12 of the Committee of Ministers to member states:

"i. develop a coherent and comprehensive policy framework that:
- secures and promotes the health of persons living in insecure conditions; - protects human dignity and prevents social exclusion and discrimination; - ensures supportive environments for the social integration of persons living in marginal situations or in insecure conditions;

ii. strengthen and implement their legislation in order to ensure human rights protection, social solidarity and equity;

iii. improve multisectoral co-operation to increase the ability of their social systems to participate in preventing health problems for persons living in insecure conditions. This approach should clearly specify the role, responsibilities and co-ordination of the various agencies and social institutions involved in order to prevent these persons from falling into marginal situations;

iv. develop comprehensive, effective and efficient health systems for a timely and adequate response to health needs in order to ensure equity and equal access to health care services, taking into account health needs and available resources, and to be able to identify, assess and treat health problems of persons living in marginal situations"[83]

The present report offers states access to much of the knowledge and experience on the health needs of homeless people emerging from the homeless sector across Europe. This experience can facilitate states in their efforts to tailor their systems to meet the needs of their vulnerable, marginalized, homeless citizens, as they agreed to do when they committed themselves to upholding the right to health. What is more, it is clear that States would have willing and able partners in the implementation of this process across Europe in the homeless service providers who have long sought to improve the access to health for people who are homeless.

7.2 Recognising People who are homeless as citizens

Many of the reports submitted to FEANTSA from its members stated that they feared there would be little support for campaigning and lobbying on the right of homeless people to good health, despite their severe and chronic needs in this area. This is due to the fact that the negative perceptions of people who are homeless mean that there is little support from the general public for actions targeting their needs. What is more, people who are homeless are a group with little political clout; as they do not represent a strong vote, they do not garner strong support from the general public and meeting their needs generally implies long-term and far-reaching actions, which are usually costly in the short term and therefore politically unattractive.

For this reason, there is a strong need to promote the recognition of people who are homeless as citizens with the same rights as all other citizens and to raise-awareness about their unacceptable health situation. It is vital to break down

[83] Council of Europe Recommendation Rec (2001) 12 of the Committee of Ministers to member states on the adaptation of health care services to the demand for health care and health care services of people in marginal situations: Recommendations.

the tendency to blame homeless people for their own situation and to see them as having somehow forfeited their rights by becoming homelessness. There is a need to raise awareness on the structural and macro-economic causes of homelessness and to recognise that the vulnerable and marginalized situation of people experiencing homelessness makes it all the more vital that they be able to access their human rights.

As this report has shown, the health situation of people who are homeless is a particularly pressing one – and indeed a damning one as far as the commitment of states to uphold the right to health is concerned. For this reason, the right to health for people experiencing homelessness should be at the heart of the actions taken by states to improve the health of their citizens, reduce health inequalities and provide a good standard of healthcare to all citizens without distinction.

Conclusions / Executive Summary

These conclusions seek to bring together the main findings of the report and can therefore equally be read as an executive summary of the report as a whole.

Health profiles of people who are homeless

Multiple needs:

There are no illnesses specific to homelessness: rather the health situation of a person worsens in direct relation to their overall situation. 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. Thus, among people who are roofless and houseless, one often finds a cumulation of health problems that have become very severe and add up to a high aggregate of vulnerability across a range of areas. This problem of multiple and complex needs is also a challenge to the medical model, which is not adapted to working holistically across a range of separate specialised areas. Thus a homeless person may present with several of the mental and physical problems briefly outlined below, giving rise to a problematic co-morbidity.

Physical health and substance abuse

Homeless people often have severe physical health problems. Common problems cited include: serious wounds, severe dermatological and parasitic complaints, chronic foot problems and severe dental health problems. Respiratory diseases are common, as are cardiac and pulmonary problems. Rates of certain serious infectious diseases are significantly higher among the homeless population than the general population: these include HIV, tuberculosis and hepatitis.

All of the reports highlighted the problem of substance abuse among people who are homeless. There are generally high levels of drug and alcohol abuse and though this abuse is difficult to quantify. Aside from the problem of the dependency itself, alcoholism and drug use can give rise to a range of serious secondary illnesses. Drug use exposes the user to transmission of serious infectious illnesses such as hepatitis and HIV through the sharing of syringes.

Mental health and dual diagnosis

The reports received point unanimously to far higher rates of mental ill-health among people experiencing homelessness than among the general population. There is a clear lack of mental wellbeing among most people who are homeless. Levels of mental illness are also high and it is common for people who are homeless to have several psychiatric problems at once. Some of the mental illnesses that the reports show are significantly higher among people who are homeless include schizophrenia, personality disorders, depression, and learning difficulties. Dual diagnosis, where a person is suffering simultaneously from mental illness and drug addiction is also significantly more prevalent among people experiencing homelessness.

Treatment problems associated with homelessness

A situation of homelessness creates numerous treatment problems, which require attention if homeless people are to derive benefit from medical treatment. Day to day living in a situation of homelessness gives rise to a set of experiences that may constitute a barrier to care. Previous negative experiences of the healthcare system, the necessity of managing competing needs and a reluctance or inability to recognise the need for care constitutes significant treatment barriers.

Treatments often assume a certain amount of "self-care" – that the patient will eat well, maintain certain hygiene standards or that he/she will rest and stay in bed - which may be impossible for people who are homeless. Many reports highlighted gaps in the health system, whereby there are few facilities to allow people who are homeless to recuperate in a supported environment. Where the treatment of illness requires regular medication, it is hard for homeless people to adhere to this strict treatment plan. This makes medicating problems like TB, certain mental illnesses, epilepsy or diabetes very problematic.

Healthcare entitlements of people who are homeless:

Nationals and those in a regular administrative situation

The reports received by FEANTSA offered an overview of the different healthcare and social protection systems in Europe and the provisions that have been made for vulnerable groups, such as people experiencing homelessness, who don't have the means to pay for healthcare. There are generally clear entitlements when the homeless person is a national of the country where they are living or when they

are in a regular administrative situation. The reports made clear that EU countries have made provisions for vulnerable groups of the national population to access healthcare, for free, or at minimum cost. But the reports echoed one another in the expression of a shared frustration that entitlements that exist in theory, or on paper, simply do not correspond to the very real difficulties homeless people face when seeking healthcare. In many countries, homeless services help people to get their administrative requirements and obligations in order, but access still remains problematic.

Non-nationals in an irregular situation

The situation of non-nationals in an irregular administrative situation is very problematic, as the provisions for this group are minimal in many European countries. Many undocumented migrants lack or have a very insufficient access to subsidised health care in Europe. Moreover, the entitlement to health care for undocumented migrants is becoming increasingly restrictive throughout the EU. Indeed, states are restricting access to health care as a way to fight illegal migration and there is a tendency to over-estimate the financial burden on the state. The healthcare system in many countries offers little to non-nationals in an irregular situation and meeting their needs often falls to NGO-run medical services that are seeking to fill the gaps for very vulnerable and unhealthy groups.

Evolution of the Healthcare system

While not all the reports described a situation where the access of homeless people was worsening as the healthcare system evolves, there were still several examples of recent changes and reforms of healthcare systems, where the access to healthcare for homeless people has suffered. In countries where reforms have recently been introduced in an attempt to cut the high costs of the healthcare system, the impact on the access to healthcare for people who are homeless and other vulnerable groups without financial means, has been severe. If healthcare reforms are undertaken across the board, without special consideration for vulnerable groups who are already living on very reduced means, they will have a negative impact on their state of health. Health reforms need to include safeguards to ensure that this does not happen. Where there is a move from public provision of a service towards tendering it to the private sector, there can also be a real danger that vulnerable groups will lose out. People who are homeless are not powerful consumers who can command a good service or drive up standards. It is up to policy-makers therefore to safeguard the quality of healthcare that they can access with quality standards and special measures to ensure equal access, despite unequal means. The examples also serve to show how problematic it is for people who are homeless when care is tied to either a local residency requirement or an address. For rough sleepers, mobile homeless people or people moving between different homeless services, this creates a serious barrier.

Barriers to care for people who are homeless:

The most commonly cited barriers to care for people who are homeless were the following:

- Administrative and financial barriers: even a small upfront charge for care can be significant barrier. Administrative procedures to access entitlements tend to be complex and difficult and become a barrier in themselves.
- The "The gap between the hospital and homeless life": this refers to the fact for someone who has adapted to living on the streets and homeless shelters, the health centre or hospital environment is a difficult and challenging one. People who are homeless may not be able to adhere to inflexible appointment procedures. They may have previous negative experiences that give rise to difficult and challenging behaviours. The services offered may not be adapted to certain people experiencing homelessness. There may be cultural or linguistic barriers, or gender-specific needs may not be taken account of.
- In addition to the practical obstacles that undocumented migrants encounter when trying to get health care, there are also substantial legal barriers. The duty to denounce undocumented migrants that is placed on public officials including healthcare providers in certain countries is a major barrier.

Efforts to overcome these barriers:

- Special healthcare centres and different kinds of low-threshold and outreach health services have come into being in an effort to reach people who are homeless and not in any kind of regular contact with the general healthcare system.

- Many of the reports described how the homelessness services in their country have developed an important mediating role between the people experiencing homelessness and the mainstream healthcare sector. This mediation takes several forms. Homeless services often try to help service-users to recognise when they need medi-

cal help. They may organise appointments for people experiencing homelessness and accompany them to the appointments and in this way help them to navigate a system that may be alien and challenging. Homeless services may also play a mediating role by seeking to build up a relationship with healthcare services, which will in turn help to facilitate the contact of homeless people with these services.

- The requirement of a local, legal residence can exclude homeless people from care and some countries have come up with systems to try and bypass this problem. One way of doing this is to make it possible for a hostel address to be used.

- In some countries, special public health insurance packages have been put together for very vulnerable groups without financial means, in order to reduce or do away with the need to pay for care up front and await reimbursement or to reduce the financial participation required.

Access to quality health care for people who are homeless:

Specialist care for people experiencing homelessness:
In all of the reports, the provision of some form of healthcare specially adapted to the needs of people experiencing homelessness was mentioned. These forms of care are provided in recognition of the fact that the people who use them may not be able to access mainstream care. There was a shared feeling that, while ideally all the needs of homeless people would be met through the mainstream healthcare system, specialist services can help to bring them in to mainstream care. What is more, specialist services can be tailored to meet the real needs of homeless people based on a good awareness of their situation, making them more effective.

Homeless service providers also have a role in coordinating the provision of low-threshold healthcare to their service users. In many cases, homeless service providers have lobbied and worked with policy-makers to convince them of the need for such services and in several countries, services for people who are homeless have funding to ensure the provision of some form of health or health-related services. Another type of health service that was mentioned in several reports is outreach, mobile medical services. These are specially equipped vans or ambulances and they go out and actively try to make contact with people who are homeless and try to see to their health needs on the spot or begin a process of care.

Mental health care and dental care
As well as low-threshold, accessible primary care, many of the reports described specific services that have been created for homeless people in order to fill a care gap in an area where their needs are generally not met. As was mentioned previously, people who are homeless have particular difficulty accessing mental health care which is adequate to their needs. The reports contained some examples of special mental health services that had been created in order to get to this hard to reach group. In some countries, there are special outreach mental health teams. These services operate by going to homeless people directly where they are. There are also examples of dental clinics that offer a low-threshold service to people who are homeless

Care gaps and breakdowns that still persist
Another point at which care for people experiencing homelessness breaks down is at the recuperative stage. When people who are homeless are recovering from illness, surgery or treatment, recuperative care can become a major problem. The hospital may not wish to retain them in a hospital bed, but it is clear that they may not be able to manage a situation of rooflessness or houselessness in their weakened state and emergency hostels and shelters are not adapted to offer the kind of care that they need. There was agreement in the reports that this is a particularly important service for health centres seeking to meet the needs of people who are homeless to provide. Another care gap that was identified in some countries is access to healthcare for people who are homeless in rural areas. Homeless people face the same barriers to mainstream care in rural areas as they do in urban areas, but the specialist services that can offer a low-threshold alternative, or fill gaps left by mainstream care, are generally located in urban centres.

The need for political support
Even though reducing dependency on emergency services makes financial sense, it can be very difficult to channel public funding into specialist services for homeless people. However, it is clear from the examples above, that low-threshold services that can offer quality care require investment. It is clear from the reports that where political support is given to initiatives to improve the health of people who are homeless, this is a major vector of change. Political champions of people who are homeless and of the impor-

tance of ensuring that they can access their rights can be a huge driver of new developments and improvements.

Training courses to equip professionals to better meet the health needs of people who are homeless:

Training of healthcare professionals on homelessness

The aim of such training is to empower healthcare professionals across Europe to work with people who are homeless and in many countries, there are examples of such courses. In most cases, these are informal or once-off training sessions. The UK report makes reference to the specific scheme of "peer training" where homeless people receive training in order to work themselves as trainers about homelessness, sharing and using their experience to build understanding of homelessness and to undo negative attitudes and perceptions. There could be scope for investing in such training in order to enable people who are homeless to become peer trainers for healthcare workers. In two countries, specific training on issues related to homelessness has been developed in the homeless sector and made available as a course for medical professionals within the recognised university or training system. In Ireland, homeless service provider *Focus Ireland* has developed a ten module training course on homelessness to be used as part of the national nursing degree programmes. In England, an academic course for healthcare professionals across the primary healthcare spectrum has been developed. These courses have only recently been developed and it is not yet possible to gauge what the take-up will be or what impact they will have. However, it seems likely that this model of providing training for healthcare professionals is a useful and transferable one and the reports indicate that there would be support for developing it further.

Training in homeless services on certain health issues and on the medical sector

A better understanding of the health problems and needs of homeless people will equip service providers to support them to have these needs met. There was a feeling in many reports that training homeless service providers and particularly volunteers, who may have no previous knowledge or experience of working with people with severe mental illness is vital and urgent. Equally, basic training on those illnesses that are likely to encounter often among their service users, such as epilepsy for example, or various forms of substance abuse would enable them to work better with them. Another form of training that the reports highlighted as potentially very useful and empowering is training on the medical sector. There was a strong feeling in some reports that service providers would be able to mediate and advocate for homeless people more way around it. Training could be a way of equipping people with this knowledge.

Networking cooperation and interagency working

The needs of people who are homeless span a range of areas and can generally not be entirely met within the sector of homeless services. This makes good cooperation and coworking with other sectors, such as the health and housing sectors, truly vital to meet the needs of homeless people in a holistic way. However, this has not been the traditional way that services operate

Emerging systems of cooperation and networking – local authorities as facilitators

Levels of cooperation and networking vary a great deal from country to country. However, there were a small number of examples where networking and interdisciplinary cooperation had been used as the guiding principles to structure the work with people experiencing homelessness. However in most countries better inter-agency working is only slowly being developed. Several countries highlighted discussion and exchange forums that had recently come into being in order to allow the different sectors to come together periodically to exchange information and experiences. The facilitating role of local authorities was strongly emphasised. Local authorities generally have the resources to bring the different sectors together in a way that they don't manage to develop themselves. They often further have the possibility of making the cooperation into a systematic procedure facilitated by administrative structures and agreements, as well as by instruments such as shared databases or information sharing agreements. Thus in the countries where networking and cooperation are most developed and central to the approach to homelessness, it is generally due to a strong recognition at national or local level of the value of this way of working and a concerted political effort to facilitate it and drive it forward.

Breakdowns in networking and cooperation between the homelessness and health sectors

The most frequently cited instance of breakdowns in the cooperation between the sectors in the reports was in relation

to discharge practices from various institutions, particularly from general hospitals, although discharges from psychiatric hospitals and prisons or care institutions may also be problematic. Examples included ambulances arriving at homeless services, without any prior check to see whether there are beds available, and simply leaving homeless people at the door. As bad as this may be, an even worse practice is where hospitals simply discharge recovering patients into the street. A less extreme form of the same problem was highlighted in almost all of the reports: the fact that hospitals and other institutions systematically discharge people who are homeless and recovering following hospitalisation into the care of homeless services that are simply not equipped to meet their needs. Hostels and shelters are the wrong environment for recuperating patients and that they may have a negative impact on their recovery, but there is a very problematic lack of better structures and systems available to people experiencing homelessness.

This problem of unacceptable discharge practices clearly shows that action is needed to improve the cooperation and networking between homeless services and the health sector. Some of the reports indicate, for example, that when there is a responsive social worker in the hospital, who is in touch with homeless services, that there are fewer problems with discharges. There are also examples of discharge planning with the homeless patient or resident to explore the different options with them and work towards a good solution. However, it is clear that if real change and progress is to be made in relation to this problem, it is fundamental to make structures available that constitute a viable option for recuperative patients in a situation of homelessness. Funding and support are necessary for such structures.

Several reports traced back difficulties in networking and inter-agency working to a high-level reluctance to work outside the traditional 'silos' of responsibility, leading to a situation where people who are homeless do not get access to the service that they need because the authority responsible for administering it refuses to accept that their needs fall within the strictly defined category that they consider themselves responsible for. Thus it is clear that close cooperation at policy-making level between the different ministries and/or regional and local authorities with responsibility for services needed by people who are homeless, is a vital prerequisite for good coordination and inter-agency work between the various organisations and bodies that work with homeless people across a range of sectors.

Data collection on the health situation of people who are homeless

A lack of general systematic data collection in this area

The reports described how data on the health situation of the general population and on public health trends is collected at national level, often through national statistics institutes, but without any specific account being taken of the situation of homelessness. Without this "homelessness variable" it is not possible to relate health data to the experience of homelessness. There were no examples in the reports of homelessness being integrated into the general data collection on the health situation of the population. Some socio-economic variables are included however, which it makes it possible in some countries to collate data on the relationship between poverty and health and the problem of health inequalities.

The reasons cited for this lack of data on the health situation of homeless people is generally attributed to heterogeneity of the group of people who are homeless and the difficulty of establishing in a consistent way whether a person is really homeless or not. Certainly there are significant difficulties to be surmounted in relation to data collection on the health situation of people who are homeless, but given that systems for collecting this data has been developed in NGOs it would seem that these difficulties are not insurmountable. This lead some reports to posit that the reason why data collection in this area has not developed is because there is no political will to drive it forward. It is not a type of information that policy-makers wish to be confronted with and this is the principle barrier to collecting it:

Data collection in NGOs

When asked to give examples of data collection on the health situation of people who are experiencing homelessness, some of the reports pointed to the systems developed in the large homelessness networks in their country. Some organisations have also run specific data collection projects on the health of their service users. Doctors' surgeries and clinics specifically targeting homeless people often collect some data on the health situation of those using the services.

The use of the "Self-perceived health status indicator"

Although this is a very common indicator used in data collection on the health situation of a given group or population, many reports expressed doubts about using the self-reported health of homeless people as a real indicator of

their health situation. They felt that people who are homeless tended to report being in good health, although later it became clear that this did not correspond with reality. Homeless people can have a tendency to minimise their health problems and to adjust their standards downwards to fit their circumstances. There was a shared feeling that homeless people often refuse to recognise or acknowledge their own bad health and so results gained using this indicator may lead to overly positive results. In spite of this fact, some of the reports feel that, particularly in the absence of better objectively compiled indicators, self-perceived health status may provide interesting and useful results. However they caution that such data is not suitable to be used alone for development or evaluation of policy.

Academic studies on health and homelessness

The reports make clear that despite the lack of systematic data collection, there is a developed and growing body of research into the health of homeless people. In many cases the research studies are qualitative in nature and explore the experience of a small sample group. Some academics draw on the data collected by NGOs for use in their research. FEANTSA has compiled the studies highlighted by its members into a separate database of titles, with abstracts and links provided where possible. You can access this database on FEANTSA's website at: **http://www.feantsa.org/code/en/pg.asp?Page=616**

Reflection on the Right to Health of People who are Homeless

The Right to Health

When States ratify international covenants and treaties that recognise the right to health and agree to be bound by them, this act constitutes a recognition of the state's responsibility to promote the health of its citizens, to reduce health inequalities and promote equity of access to healthcare. The commitment by states to safeguard the human rights of their citizens creates a duty and a responsibility towards all citizens, without exception. FEANTSA strongly emphasises that universal human rights cannot be limited by States to apply only to a specific group of people. Thus, we must urge caution in the reading of the term 'citizen' so that it does not get misused as an opportunity to further exclude marginalized people. "Citizen" in the present text describes all of the people living in a State, all of whom are entitled to full enjoyment of their human rights. This notion resides at the very heart of European political culture, where the concept of the welfare state is deeply entrenched. The European Union has repeatedly called on its member states to take action to reduce health inequalities, as part of a public health shift from treating bad health to promoting good health.

The Right to health for people who are homeless

Adequate healthcare is one of the primary rights that states must secure for their citizens. The experience of FEANTSA's members on the ground, which has been presented in the present report, is that people experiencing homelessness do not have equal access to adequate healthcare and that chronic mental and physical illness is rife among the homeless population across Europe. In light of their exceptional vulnerability, states need to adopt a proactive stance in relation to homeless people. Having recognised their responsibility towards them, they need to transmit this duty to the relevant authorities, whether they be regional, local or municipal authorities. A sense of duty and a recognition that they are a part of society, must exist between the community and people who are homeless and margin. This is the first fundamental step towards meeting the needs of homeless people.

The present report offers states access to much of the knowledge and experience on the health needs of homeless people emerging from the homeless sector across Europe. This experience can facilitate states in their efforts to tailor their systems to meet the needs of their vulnerable, marginalized, homeless citizens, as they agreed to do when they committed themselves to upholding the right to health. What is more, it is clear that States would have willing and able partners in the implementation of this process across Europe in the homeless service providers who have long sought to improve the access to health for people who are homeless.

As this report has shown, the health situation of people who are homeless is a particularly pressing one – and indeed a damning one, as far as the commitment of states to uphold the right to health is concerned. For this reason, the right to health for people experiencing homelessness should be at the heart of the actions taken by states to improve the health of their citizens, reduce health inequalities and provide a good standard of healthcare to all citizens without distinction.

DESIGN: WWW.BEELZEPUB.COM

European Federation of National Organisations working with the Homeless

194, Chaussée de Louvain
1210, Brussels
Belgium

Tel: +32 (0)2 538 66 69
Fax: +32 (0)2 539 41 74
Email: info@feantsa.org