The Right to Health is a Human Right:

Ensuring Access to Health for Homeless People in Hungary

Compiled for FEANTSA on the basis of the annual questionnaire of FEANTSA answered by homeless service providers and doctors working with the homeless

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*** Special thanks to those doctors working with the homeless who felt it important to answer the questionnaire besides their daily work**

Three fourth of the answers given to the questionnaire were sent by doctors working with homeless people. The data in their records can not be considered representative; however they are specifically valuable regarding the health condition of homeless people who accessed health care.

1.1: Please outline the common mental, physical and substance abuse related health problems of the homeless people bearing in mind the conceptual ETHOS categories. Some of the health problems will reoccur in several categories.

The bad health condition of homeless people can be characterized partly by psychic problems coming from the lack of accessing basic rights and services as well as impaired physical condition as a result of mental problems. As a result of the consolidation of the homeless lifestyle and the gradual impairment of the immune system the person is more and more exposed to different infectious illnesses.

Mental health problems:
Bearing the fact of becoming a homeless means different rate of psychic strain depending on the person's character, which first results mainly sleep disorder, anxiety, mood disorder, then may lead to more serious status such as depression and schizophrenia.
The regular consumption of non-evident origin alcohol as well as insufficient nutrition often leads to serious dementia. Arteriosclerosis associated with nicotine abuse also plays a significant role in the development of this status. Simultaneous use of alcohol and medicine can result in similarly serious mental problems.

According to the findings of a survey conducted in 1998 at the outpatient department of BMSZKI, 58% of the patients visited the consulting-hours mainly because of psychiatric diseases as well as psychic diseases, which make it probable that psychiatric morbidity of homeless people significantly exceeds that of the general population.

The most typical addictions are alcohol abuse and smoking. In many cases alcohol abuse is in connection with the psychic strain the person must bear to accept him or herself as a homeless. Then temporary or chronic mental disorders emerge as a result of the gradually developing alcohol addiction.

The incidence of drug abuse is very rare in the homeless population because of its high expenses. Among those falling under the first two categories of ETHOS it would definitely be too expensive. (In the other two conceptual categories there may be young people who have started to come down due to drug addiction but still can afford to buy drugs.)
Misuse of various substances (such as organic solvents) is less expensive and is mainly reported among young new clients leaving state care. One of the respondents reported on the incidence of burn in some cases when these highly flammable substances are used.

It occurs more often that homeless people cause themselves daze by sniffing in gas from cigarette lighters.

In terms of homeless people attending the outpatient department of BMSZKI the doctors reported that the incidence rate of alcohol abuse is between 50-80%, smoking is 80-90%, drug dependence is 10%, and only 1% of illegal drug addiction was reported due to the causes mentioned above.
Cigarette functions as a means of exchange among people experiencing homelessness. Therefore if somebody possesses enough of it to offer others it means his or her high status within the community.

On the basis of data collected by the doctors of BMSZKI the frequency rate of gambling associated addiction is 5-10%.
The incidence of subsidiary illnesses originated from the misuse of various substances increase directly proportional to the duration of the addiction and the frequency of use.

Major diseases

The Medical Crisis Service of BMSZKI reported on the following major diseases in their Annual Report 2004. [1]

Num.	Diagnosis of patients visited consulting-hours of the GP Total number of patients: 850 persons (more diagnosis belong to each patient!)	
1.	Hypertonia	466
2.	Depression	323
3.	Viral infection	239
4.	Tonsillitis	217
5.	Pain	209
6.	Lumboischialgia	207
7.	Acut bronchitis	162
8.	Flu	157
9.	Anxious personality	145
10.	Lumbago	143
11.	Epilepsy	134
12.	Pyrosis	122
13.	Influenza infection	105
14.	Ischemic heartdisease	100
15.	Chronic crural ulcer	98
16.	Cystitis acuta	96
17.	Asthma	96
18.	Alcohol related dependency	96
19.	Headache	84
20.	Gastroduodenitis	81
21.	Diabetes	81
22.	Chr. bronch. acut exacerbatio	76
23.	Diabetes mellitus with comorbidity	69
24.	Spondylosis	63
25.	GERD - Gastro Esophageal Reflux Disease	59
26.	Cardiac insufficiency	59
27.	Cardiac insufficiency (with stasis)	58
28.	COPD - chronic obstructive pulmonary disease	57
29.	Arthralgia	56

Note: Only diseases diagnosed in more than 50 cases were collected!

Secondary diseases:
Prominently frequent organic diseases owing to the toxicity of alcohol abuse: chronic hepar disease, cirrhosis, polyneuropathy, cardiomyopathy, alcohol withdrawal syndrome, delirium, encephalopathy, organic psycho syndrome.

The incidence rate of cardiovascular diseases was reported over 80% in the sick-list of BMSZKI. The most frequent of them are hypertonia, ischemic heart disease, ASO (arteriosclerosis obliterans) atherosclerosis, infarct, aortic stenosis as well as post stroke status.

Respiratory diseases such as asthma, COPD (chronic obstructive pulmonary disease) and bbronchitis are present with different severity among those visiting the GP's consulting-hours.

Due to bad hygienic conditions infectious wounds, crural ulcer and skin diseases associated with parasites such as louse and psora are frequently diagnosed among the roofless (ETHOS 1.1., 2.1.). Frequent skin-diseases are itch and dermatopythosis, which are often exacerbated by sluttishness, ectoparasitosis, head-louse and body louse.

The consequences of falls and violence are fractures, ecchymosis, cerebral concussion, burn and freeze injuries as a result of sleeping rough in winter.

Malignant tumorous diseases:
Malignant growths such as larynx cancer, tumours of the oral cavity, bronchus cancer and lung cancer mean causes of death increasingly in the homeless population. The most probable trigger causes are the use of alcohol with precarious origin as well as smoking cigarette stubs. Among women gynaecological tumours are also frequently diagnosed.

However homeless people are not more often diagnosed with diabetes and hypertonia - which are considered as an endemic disease - than the general population.

1.2: Certain diseases, which are widespread among the homeless population, carry a clear public health risk. This is the case, for example, with tuberculosis. Tuberculosis incidence is much higher among homeless people than among the general population and there is a risk of the spread of this infectious disease and the development of multi-drug resistant strains. For this reason, some countries have put in place specific programmes or strategies to combat tuberculosis among homeless people. Please outline list any public health risks associated with the health of homeless people and actions taken to alleviate these risks.

Tuberculosis carries the biggest public health risk in the homeless population. According to research findings of the 90s more than half of the new tuberculosis patients were disadvantaged people. The most affected are alcohol addicts, drug users, the homeless and the unemployed. According to data collected in the capital there are 200 homeless people out of the approximately 900 recent patients in each year.[2]

After the multitudinous reappearance of tuberculosis one of the first surveys[3] in 1991 showed that 60% of those interviewed at the time of entering a shelter hadn't been screened for tuberculosis for years. The incidence rate of pulmonary diseases among homeless people was 11,5%.

The first control group survey studying the health condition of homeless people in Hungary was conducted in the spring of 1994.[4] . According to the findings of this survey the incidence rate of tuberculosis among homeless people was ten times higher than that of among the adult male control group in the capital.

Homeless people's weakened immune system and overcrowded shelters serve the spread of the disease. The non-homeless population is exposed to the risk of getting infected mainly in little closed air-space places (e.g. public transport means, subways, etc.). The TB germs emerge in the air and on objects in great quantities in places frequently visited by homeless people carrying the

disease, and it's only personal hygiene which limits its spread. Although every shelter requires regular certification of pulmonary screening, the isolation of those suffering tuberculosis doesn't always happen in practice. Naturally if a person appears at a shelter for the first time in the winter crisis period he can not be refused even if he has no document certificating the TB screening, thus he can only present it later.

The Hungarian Maltese Charity Service runs mobile buses with X-ray equipment for TB screening for the examination of those living in the street, which reduces public health risk. Street workers who know where to find the given client play an important role in the prevention of the spread of the disease. They discover the selected clients in order that their treatment can be commenced.

Body louse, head-louse and itch also carry public health risk for the non-homeless population. The possibility of becoming infected with parasites exists in the above mentioned places and public transport means visited or used by both the homeless and the non-homeless population. The transportation of a person infected with parasites means considerable problem for the ambulance service. In such cases the whole ambulance car must be disinfected, thus it drops out of service for 3-4 hours, which means big disadvantage regarding the low number of the available vehicles.

In these cases public health risk can be reduced with disinfection. In Budapest besides one of the institutions of the National Public Health and Medical Officer's Service, disinfection is also done in the 24-hour health centres. The situation is somewhat worse in the countryside and in numerous major cities where the disinfection of homeless people is unsolved.

In both cases the problem is the screening and delousing of those homeless who are excluded from the institution system or those who deliberately refuse to use the services (ETHOS 1.1).

1.3: Certain health conditions experienced by homeless people pose significant problems of treatment. (For example: tuberculosis treatment can be rendered difficult by a mobile and chaotic lifestyle and overcrowded conditions; there may be availability problems for mental health treatment and drug and alcohol treatment etc…) Treatment of mental health problems is evolving and deinstitutionalisation has taken/ is taking place in many countries, but this too has given rise to new challenges and problems. Multiple needs are another factor that can make treatment problematic. Please outline treatment problems encountered when trying to ensure access to health for homeless people.

<u>Personal causes:</u>
Homeless alcohol addicts have such strong dependency that the patients visit the doctor and undergo the essential treatment or control examinations only in the final stadium. Getting to the daily dose of alcohol is more important for the patients suffering from addiction than undergoing control examinations. (During the winter crisis period homeless patients are more willing to undergo the necessary treatments in order that they avoid freeze injuries.)
It is essential for the successful medical treatment for the patients to understand their situation, the seriousness of their condition, however in many cases willingness to recover is minimal among people experiencing homelessness. Thus the omission of their regular appearance at consulting-hours and that of the necessary control examinations prevents the improvement of their health condition and recovery.
It would promote to re-contact those homeless people who arbitrarily quit the treatment and would foster the continuation of their treatment, if the list of the diagnosed and that of those being treated was sent to all the organizations working with the homeless. Instead of the senseless and prioritized application of personal rights it is public interest what should be given priority (it is also the interest of the given person).

It is also problematic that homeless people can not afford to buy their regular medication due to its expensiveness.
Certain diseases such as diabetes and hypercholesterinaemia would require special diet, the fulfilment of which on a daily basis for rough sleepers is impossible. (ETHOS 1.1) People receiving long-term residential care are in a much favourable situation in terms of the fulfilment of their treatment and the follow-up of their health condition. (ETHOS 3.1, 7.1)

Structural causes:
The territorial principle of health care overburdens the delivery of services especially follow-up care of homeless people due to their precarious residential status. As for emergency medical service, homeless patients are often sent from service to service and the affected actors resort to evasions refusing the responsibility. In comparison with the non homeless population, the delivery of the same quality services to homeless people much more overburdens health care both in working hours and expenditures. It would be necessary to make health service providers interested in delivering services to homeless people with multiple needs by rendering extra resources.

Drug dependants are present in great strength among homeless patients. The administrative control of this situation is hindered by the present practice that patients can ask even 5-6 doctors for the prescription of the same medicines.

It is problematic to find the adequate type of services meeting the health, social and mental condition of homeless patients. Since the referral of the elderly, ill homeless people to a residential home is not solved, and such institutions are only available in some major cities, thus the service provision of such patients who would require protected and permanent settlement in the above institutions is also devolved upon departments of health for months and years.
In most of the cases the barrier of transferring the needy to institutions providing permanent care is that arranging access to all the necessary papers, pension or other regular income is very time consuming. If sometimes it succeeds, homeless patients often drop out of nursing wards because of the lack of willingness to cooperate.
In certain cases it took several years of constant work of the staff of homeless service providers to arrange placement for an elderly, invalid homeless people in a residential home providing permanent nursing. Since the patients previously had been delivered complete service free of charge, when they yet gain access to residential home with permanent care, the charges for the services often move them to leave the institution. Even if they find themselves in the street again, sooner or later they will gain admission to a hospital ward where they will access to services free of charge again.
To promote their willingness to cooperate homeless patients would need psychic guidance and mental health care in order that they acknowledge when they are ill and have willingness to get well. In certain cases the psychic injury that the psyche must endure while the person is "coming down" and finally becomes homeless is reversible. The prevention of mental health injuries – the consequence of which is the bad physical condition and carry of various diseases – would be an extremely important responsibility in terms of public health.

The delivery of health services for the homeless due to the specific problems of the target group can only be implemented with extra workload and extra expenditure, which is nevertheless not financed by the National Health Insurance Fund. Additional resources for crisis wards and recovery wards are only available through call for proposals; however it makes the services very precarious.

Chronic psychiatric wards and specific rehabilitation wards would also need to be set up due to the high psychiatric morbidity of people experiencing homelessness.

Another important issue is to sustain the good health condition of those homeless people who have already recovered from their illness. To this end an even better organized social-health follow-up care would be needed where the mentally ill, people suffering from diabetes, the amputee, the old as well as the dement wouldn't mean extra hardship.

Q2: Social Protection: Healthcare entitlements of Homeless People

The healthcare entitlements of homeless people vary from country to country according to the social protection system in place. It may also relate to their administrative status (whether they have registered). It may also vary according to whether the homeless people are nationals or non-nationals. This question seeks to examine the impact on access to healthcare and quality of care available to homeless people.

2.1: What are the healthcare entitlements of homeless people in your country (for nationals; for non-nationals, including asylum seekers and undocumented migrants)? What are the registration requirements etc.?

Emergency health care and primary health services are available for everyone free of charge. Under the law on health (1997 CLIV.) every patient are entitled to access to life-saving services as well as services preventing severe or permanent damage of health. Specialist services are available free of charge for those having social insurance card. Homeless service providers can provide help in the supplementation of documents (identity card, social insurance card) necessary to get access to the services. The delivery of in-patient services to people with no permanent address takes place on the basis of a so called central bed register. The delivery of specialist services at outpatient departments for homeless people is unsolved and they often face refusal.
Homeless patients having no social insurance card can be provided 24-hour health care services at the health centres financed by the National Health Insurance Fund. So far there have been four such institutions operating in Budapest and two in the countryside (Pécs, Miskolc).
Asylum seekers and illegal migrants mainly receive health care in the refugee camps of the Migration Office.

2.2: Has the health system evolved in such away that it is getting harder for homeless people to access their entitlements?

Present trend lines show that it is getting more difficult for homeless people to access to health services. Primary dental treatments are also attached home address, since the state-financed dentist's surgeries are divided by home address. As homeless people have address card with no address therefore they have no appointed dentists.

The forthcoming "reform" of the health care system also foreshadows that the present free services will end. At present the details are under development, but it is certain that patients will have to pay for the prescriptions written by the doctor and a fixed amount will be charged for seeing the doctor. Soon citizens will be "screened" in terms of how much each person charged the social insurance system and how much they have paid for it.

2.3: What do you consider to be the main barriers facing homeless people in your country when they try to access healthcare (stigma, financial barriers, administrative barriers, etc.)?

Administrative barriers may occur in accessing healthcare. Mainly due to the lack of social insurance card, address card and identity card, that homeless people often lose.
Refusal and the lack of equal treatment occur mainly because of their neglected appearance, parasites or aggressive behaviour, thus they are not especially refused just because they are homeless. What is more many of the non homeless members of the society have to suffer from the lack of equal treatment. In Hungary the law income of health workers is supplemented by the patients, so the "principle of equal treatment" fails at this very point, since a thicker note-case may result more equal treatment. Naturally there are social classes which are not supposed to pay such extra contribution. In extreme cases homeless people have to face wrongful refusals as well.

2.4: Have attempts been made to overcome these barriers? Have they been successful?

In order to overcome the above barriers 24-hour health centres started to develop besides the integrated system in order to supplement the lacking services and meet the specific needs of homeless people. These institutions make possible the disinfection of those homeless people who would supposedly be refused by hospitals with reference to their condition. Then after they are prepared for hospital treatment, they are referred either to hospital or other institutions providing health services.
As it was mentioned above hospitals can not 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 homeless people the street or the shelter don't offer the adequate possibility for nursing, therefore health centres try to meet this need by setting up recovery wards.

In these health centres homeless people don't face disadvantages because of administrative barriers. Social workers of homeless service providers help them get the necessary documents free of charge.

Another way of counteracting the above barriers is that homeless service providers seek to develop close cooperation and good relationship with health institutions and health workers through the social workers of hospitals. (Unfortunately in many cases hospital social workers are in a peripheral situation in the health institution.) Besides keeping in touch with hospital social workers, certain organizations (Hungarian Red Cross, Miskolc) seek to develop personal relationships with other health workers responsible for the given client. Social workers regularly visit their client, inquire about his or her well-being briefly try to substitute the relatives. They send cards at the end of the year to say thank you to health workers for their work. In this case the psychology of personal intercourse counteracts the existing structural barriers in the health care system. Perhaps it sounds strange to counteract structural barriers with such a cheap PR contrivance, but according to the respondent it yet succeeded.

Q3: Ensuring Access to quality healthcare

This question will explore why homeless people across Europe have difficulty accessing the good quality healthcare that they need. There is a range of services that homeless people should access in order to enjoy good health: these include medical treatment; but also preventative services (screening, check-ups etc.); specialised services such as dental services; and health promotion services.

3.1: Are you aware of specialist and/or outreach healthcare centres that have been put in place specifically for homeless people? Do you consider that this is a good way to meet the health needs

of homeless people? What are the costs and benefits of targeting homeless people in healthcare provision?

Under the government regulation (43/1999. III.3) County Health Insurance Fund can support the establishment of health services delivering 24-hour health care to homeless people. In the capital there can be four such services while in the countryside one in each major city (Debrecen, Győr, Miskolc, Pécs, Szeged, Veszprém). In the countryside there are only two cities which met the requirements while in the capital all the four health centres operate. The establishment of the services is only possible with the recommendation of the National Methodology Centre. It also means guarantee that they are operated especially for the homeless. The advantage of the centres is that it saves the patients from being sent service to service and secure nursing for homeless patients until their full recovery.
The same regulation defines that one General Practitioner's Office with no territorial obligation must be set up in each shire-town and 15 of them in the capital.

TÁMASZ Foundation in Pécs delivers one of the most complex health services:
- complete medical service (including mental illnesses)
- 24-hour medical attendance with mobile service
- providing care for users of homeless services
- employment related medical services
- delivery of sick-allowance
- Pre-care and follow-up care by operating a recovery room
- free medication to some extent
- organization of different preventative programs and bringing them into services (e.g. preventative inoculation against influenza)

For the initiative of TÁMASZ Foundation the National Public Health and Medical Officer's Service provides 22 beds at the disposal of the homeless in the hospitals of the county.
The Foundation works on the basis of a service contract and is financed by the National Health Insurance Fund with 6,5 million HUF/months. Besides fixed financing there are calls for proposal to support the sustainment of health centres.

Mobile health services which contact homeless people directly have proved to be really effective. One of these mobile medical services is run by the Hungarian Maltese Charity Service in Budapest that reaches out homeless patients in the evenings for the mobilization of the Crisis Phone Line Service. BMSZKI also operates such mobile medical service which regularly visits night shelters in the capital every week.

Practice has proved that these specialized health care systems are needed, because they approach homeless people with maximum loyalty and their staff is prepared for the specific needs of homeless people and their disadvantageous health condition.

3.2: Are you aware of any health promotion/ preventative health initiatives that are accessible to homeless people? Do you think that these impact positively on access to employment?

Prevention of diseases and preventative approach, which should manifest in health-conscious nutrition, means problems for the non homeless population as well. Due to the lifestyle of homeless people such wide-scale prevention can not even be mentioned. Therefore prevention mainly ranges from protecting inoculation, taking blood-pressure, measuring blood-sugar level to regular pulmonary screening. The inoculation and screening program of the Medical Crisis Service operating in BMSZKI have been providing protective inoculation against hepatitis,

pneumococcus and influenza for 4 years. In Debrecen homeless people can regularly receive protective inoculation against influenza at the GP's Office of homeless people.

BMSZKI introduced the delivery of dental treatment for the homeless as well, right because of promoting their access to employment. Certain institutions such as the Hungarian Red Cross in Miskolc improve the knowledge of homeless people on the prevention of diseases in the frame of trainings, free counselling, courses and regular lectures. Naturally they all have a positive impact on access to employment.

3.3: How do homeless people in rural areas access health care?

There are hardly any homeless people present in villages, who can visit the local GP. If they are refused at local level then they travel to major cities or the capital in the hope of better services and easier livelihood.

3.4: Do you consider the healthcare received by homeless people in your country to be comparable, in terms of quality of care, to that received by the general public? In what health areas is there the greatest lack of access to care and why?

The Hungarian health care system has been in need of financial resources for decades, therefore there are numerous things to criticize even in terms of services provided for the average population. In my estimation and partly on the basis of my own experience, in certain cases hospitals don't even meet quite elementary hygienic requirements, patients are placed in a humiliating position because of the inadequate circumstances and the right to human dignity is often injured. This is the environment where homeless patients with specific needs of care appear. Naturally if they access to health services then they are mostly delivered services of the same quality like the average population. However this does depend on the approach of the given doctor and on whether the homeless patients are groomed and willing to cooperate.

The standards of the consulting-rooms and consulting-hours are defined accordingly the regulations of the National Public Health and Medical Officer's Service, thus services are comparable and of similar quality in terms of General Practitioner's services. As a matter of curiosity TÁMASZ Foundation in Pécs considered the consulting-room of the health centre specialized for homeless patients of better quality in terms of equipment and medical instruments, than the consulting-rooms available for the non homeless population. They also remarked as an advantage that services are concentrated and are associated with each other.
Access to dental treatments for homeless people is one of the biggest deficiencies among health services. Although in the capital the opportunity is provided specifically for the homeless to access to dental treatments, this kind of service is rather "gappy" even in the major cities in the country.

3.5: In some countries, a specific policy framework and action plan around health and homelessness has been put in place in order to ensure that homeless people can get full access to quality care. Has such an approach been tried in your country?

With further development of the 24-hour health centres mentioned above, access to quality care could improve further.

Q4: Training of health professionals

Homeless people sometimes encounter a lack of understanding and reluctance to engage with them from healthcare professionals that might be overcome through training for health workers on how to work with homeless people, as well as on their specific health issues. The problem of homeless people presenting with multiple needs can also be professionally challenging for healthcare workers. This is another area where training would be useful.

4.1: Do you know of any such training courses (in all areas of healthcare – nurses and doctors, but also mental health workers, dentists, podiatrists etc.) or plans to put them in place, as part of medical training or as follow-up training?

No such initiative has started yet. The training of health care workers on the specific needs of homeless people is not part of the curriculum. However many of the questioned doctors would consider it very important and timely. 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.

A survey was conducted on the attitude of health care workers towards homeless people, which resulted in surprising findings. The non-representative survey was carried out with the participation of 181 graduate nursing students and 39 student ambulance officers at the Health Collage Branch of Semmelweis University.
The questioned student ambulance officers and men had more unfavourable attitude towards provision of services for the homeless. The majority considered homelessness rather as a social problem than a health problem. Many of them would refuse to provide care for the homeless and would be averse from advocate the rights of homeless people within health care. 23,2% of them didn't agree with the practice that homeless people could access to any services that the average population is entitled and only 57,3% of them would treat homeless people with the same way like their other patients.[5]

However there is an example of a positive initiative at local level in the frame of a follow-up training. In the frame of seminar training the Family Doctor Department of the General Medical Branch of the University of Pécs deals with social problems which healthcare workers encounter while providing care for the homeless. The seminar is held with the involvement of GPs.

Q5: Interagency working
Ideally, accessing healthcare should provide a route into other care and integration services, through referral and transfer practices between homeless services, social services and health services.

5.1 Are you aware of instances of this kind of networking in your country?

Networking between the different kinds of services, the nature and success of the contact vary depending on the approach of the partners concerned. In the capital Shelter Foundation compiled an information leaflet for homeless people. It contains the different types of hostels, GP's offices, mobile health services, crisis wards, recovery wards, legal counselling services. Besides it runs a crisis phone line service at local and national level, which supports to exploit free capacities in order that homeless people in crisis situation should access to adequate services.

The doctor's surgery of the National Public Health and Medical Officer's Service in Budapest is regularly in touch with organizations and institutions providing social services as well as health services. There are crisis-beds reserved for the homeless during winter months in certain hospitals.

At the Medical Crisis Service operating in BMSZKI the development of a patient referral system is being planned.

However, merely willingness and the existence of cooperation is not sufficient if there is no place to refer homeless patients. The situation of those cities (Budapest, Miskolc, Eger, Pécs, Győr) where there are residential homes for the elderly receiving specifically homeless people is more favourable. The situation of recovery wards providing very few beds at national level is aggravated by the fact, that the further referral of their patients to residential homes for the elderly takes a long time, thus it makes problematic to receive patients with temporary illness.

5.2: Are health and social services supportive of this type of working? Have administrative procedures or agreements been put in place to facilitate transfer and sharing of information and cooperation between different services? What are the discharge practices from hospitals in your country?

In January 2004 the National Ambulance Service, the Hungarian Police as well as advocacy organizations of homeless service providers such as HAJSZOLT and the Committee of the Ten made an agreement in order that people living in the street in crisis situation should access to the health and social services they needed. Under the agreement the staff of the National Ambulance Service and the Hungarian Police should contact the Regional Crisis Phone Line in their respective area, if while on duty they meet rough sleepers in crisis situation, but need no ambulance or police intervention in their case.

In good cases when discharging homeless patients from hospital there is cooperation between taking place between homeless service providers and hospitals. Nevertheless it occurs in many cases that the ambulance car simply put out the patient at the gate of the service provider, since its address is indicated in the patient's papers as his home address. 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.

5.3: Have you encountered instances where there is an obvious breakdown in this kind of networking? (e.g.: homeless people being retained in hospital because no other option has been found for them to move on to other services).

Due to the lack of capacity mentioned above it does occur that sick homeless people are retained at the chronic medical ward as well as the hospice ward of a hospital.

Q6: Health indicators, data collection and research

It is not always easy to access information on the health situation of homeless people. Yet such information can be crucial to making the case for political investment in healthcare for homeless people. This question seeks to establish possible effective ways of accessing reliable data on the health situation of homeless people.

6.1: Is data collected on any area related to the health of homeless people in your country? (such as the different illnesses suffered by homeless people, number of homeless people using specialist

health services, number of people using general services, causes of death, life expectancy, etc.) If so, who collects it? (hospitals, homeless service providers, A&E, youth care centres, psychiatric services, etc).

The collection and processing of data on the health condition of people experiencing homelessness chiefly takes place at local level. For this responsibility General Practitioner's Offices with no territorial obligation of delivering services are in the best position to fulfil this task, however, these data are neither used for national representative statistics nor for strategies aiming to prevent the most common illnesses. Health Centres specialized for delivering health services only for the homeless do register their patients, but data are rather sent to the National Health Insurance Fund.

6.2: Do you know of any research undertaken on the health of homeless people by academic or other bodies? (e.g.: Government reports, NGO reports, scientific reports, etc.)

Mainly research conducted by organizations working with the homeless dominates. Some of them have already been marked as references either in the report or under "References".

In December 2000 the Ombudsman drafted a report on the delivery of health services for homeless people in Budapest. The report stated that further placement of homeless people - after they had been delivered health services and not able to live in the street any longer - was unsolved, thus the right to social security (Constitution 70/E. §) and the right to the highest attainable standard of physical and mental health of the affected people were injured (Constitution 70/D. §).

Following the report for the initiation of the Ombudsman the Social Service Delivery Department of the Ministry of Social and Family Affairs commissioned the Methodology Department of the Foundation for the Homeless as a national methodology institution for homeless services to conduct an investigation on the capacity, development and need of institutions providing nursing and care as well as rehabilitation for the homeless. [6]

6.3: Do you know of data collection in the following areas that might be relevant in relation to the health to homeless people?
- Health determinants including lifestyle factors, drug and alcohol abuse and smoking
- Environment and health
- Access to health
- Mental Health

In the winter of 1995-1996 a pilot project of tuberculosis screening started in capital with the coordination of the Budapest Headquarter of the Hungarian Maltese Charity Service and with the cooperation of numerous organizations.[7] The report which was drafted on the basis of the pilot project provided data on the incidence rate of tuberculosis among the homeless population in the capital as well as other data related to the health condition of homeless people.

Six percent of the reached and examined homeless during the 1995-1996 screening program had to be selected with the aim of further examinations. On the contrary among the general public only 3,7% of the examined people had to be selected.
3,3% of the surveyed people answered "yes" to the question whether he or she had previously been treated for tuberculosis. This rate was 7,7% in the "non healthy" subgroup. The rate of those previously been treated for tuberculosis was the highest among those having been homeless for 4-6 years. The proportion of those who complained about other illnesses was 25% among "non-healthy" homeless people.

As a matter of curiosity 89% of all the surveyed homeless people answered "yes" to the question inquiring if they felt healthy.

91% of all the questioned homeless people smoke and 55% regularly consume alcohol on a daily basis. 74% of all the interviewed homeless people have been smoking for more than 10 years without reference to how long they have been homeless. In terms of alcohol consumption it was stated that the longer the person has been living in the street, the more likely he is to consume alcohol. While only 25% of those who had been homeless for less than a year consumed alcohol regularly, 45% of those having been living in the street for more than ten years drank alcohol regularly.

6.4: Do you know of any indicators used to measure the effectiveness policies/services in the following areas that might be used to get information on the health and well being of homeless people?
- Health determinants including lifestyle factors, drug and alcohol abuse and smoking
- Environment and health
- Access to health
- Mental Health

Sometimes "self-perceived health status" is used as an indicator to collect health data - do you think this is useful in relation to homeless people?

The regular annual survey conducted by Shelter Foundation on 3 February 2002 was amplified by questions on the health condition of homeless people. The questions in the questionnaire were literally identical with that of the National Population Health Survey 2000, in which 5500 adults representing the whole adult population of Hungary were questioned about their health condition. The questionnaire was adopted by Shelter Foundation with the aim of making comparisons between the health condition of the homeless and the non-homeless population.

They were mainly interested in such problems related with health condition, 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. The answers of the homeless and non homeless population didn't differ in certain questions as well as in certain groups the respondents. What is more in some cases the answers of the homeless were more favourable.

The first question measured the ability of self-care, in which the answers of the homeless and non-homeless population showed surprising similarity. As a matter of curiosity it must be highlighted that only slightly more than one third of homeless people who complained about problems of self-care were accommodated in a shelter providing also nursing, the majority of them was accommodated in a shelter or was sleeping rough.

Please, choose the statement which is RECENTLY true in your case!		
Self care…	**Non homeless (%)**	**homeless (%)**
is not a problem	96	93
is a problem	3	6
don't know	1	1
Altogether	100	100

One of the questions queried motility and concerned complaints associated with walking, which was found to be more frequent among people experiencing homelessness, although among people over 65 the frequency of complaints related to locomotor disorders were the same.

Please, choose the statement which is RECENTLY true in your case!						
Walking…	**Age group (%)**					
	18 - 34		35 - 64		65 +	
	Non homeless (%)	**Homeless (%)**	**Non homeless (%)**	**Homeless (%)**	**Non homeless (%)**	**Homeless (%)**
is not a problem	97	92	81	70	55	55
is a problem	3	7	18	30	44	45
don't know	0	1	1	0	2	0
Altogether	100	100	100	100	100	100

It turned out from the answers given to the question on sight, that every fourth people and every second homeless people had problems with their sight. Among those under 35 the difference was not measurable yet, however in the age group of the old, the disadvantage of homeless people is very visible. The causes of the difference are not known, perhaps lifestyle factors may have such effect, or simply the lack of glasses, the omission of treatment results it.

Please, choose the statement which is RECENTLY true in your case!						
Vision	**Age group (%)**					
	18 - 34		35 - 64		65 +	
	Non homeless (%)	**homeless (%)**	**Non homeless (%)**	**homeless (%)**	**Non homeless (%)**	**homeless (%)**
Can see well enough	83	79	70	47	58	29
Can see well with glasses	16	20	26	50	35	59
Hard of seeing	1	1	4	3	7	12
Altogether	100	100	100	100	100	100

If we ask about pain in general, we find that there are significantly more people complaining about some pain among those experiencing homelessness. However in the case of people over 65 the difference changes in favour of homeless people: there are more people complaining about some physical pain among those living in a flat.

Please, choose the statement which is RECENTLY true in your case!						
Pain	**Age group (%)**					
	18 - 34		35 - 64		65 +	
	Non homeless (%)	**homeless (%)**	**Non homeless (%)**	**homeless (%)**	**Non homeless (%)**	**homeless (%)**
have no pain	90	80	68	41	36	51
have pain	11	18	29	35	51	46
have strong pain	0	2	4	6	9	4

The mental condition of the questioned persons was concluded from the measure of anguish. It turned out from the answers given to the question that homeless people reported on anguish in a bigger proportion than those living in a flat. Every third person complains about his or her general condition among the non-homeless population, while in the homeless population every second homeless people do so. However in the "over 65" age group the frequency of complaints indicating the mental condition of those living in a flat in Budapest again shows nearly the same rate measured among homeless people. On the basis of detailed studies this difference can only partly be explained by the fact that those living in a flat are generally older.

Please, choose the statement which is RECENTLY true in your case!		
Anguish	**Non homeless (%)**	**homeless (%)**
not anxious	68	54
anxious	28	38
very anxious	3	7
Altogether	100	100

A quite concrete indicator of health condition can be the number of days spent in hospital as an in-patient. When it was studied 84% of those living in a flat in Budapest answered "zero" while 64% of homeless people answered the same. Figures show in every age group that less homeless people were able to avoid hospital treatment than members of the non homeless members of the population.

How many days did you spend in hospital as an in-patient in the last 12 months?								
Days	**Age group (%)**						Total (%)	
	18 - 34 years old		35 - 64 years old		65 +			
	Non homeless (%)	**homeless (%)**	**Non homeless (%)**	**homeless (%)**	**Non homeless (%)**	**homeless (%)**	**Non homeless (%)**	**homeless (%)**
0 day	88,2	75,4	87,9	61,7	70,5	62,7	84,4	63,8
1 - 5 days	8,0	2,2	3,7	3,2	5,8	1,5	5,4	3,0
6 - 10 days	1,3	5,6	2,7	4,7	4,8	8,2	2,7	5,0
11 - 15 days	1,3	4,5	1,2	3,9	5,1	3,7	2,0	4,0
16 - 20 days	0	,8	0,7	1,5	2,4	3,0	0,9	1,5
21 - 25 days	0,5	1,7	1,7	2,2	4,7	3,7	1,9	2,2
26 + days	0,8	9,8	2,1	22,7	6,6	17,2	2,7	20,4
Altogether	100	100	100	100	100	100	100	100

In the original survey the study of smoking and alcohol consumption was questioned with the use of a self-completed questionnaire, namely in an anonymized way. However, Shelter Foundation had no possibility to do so. Therefore the answers (especially in terms of those questioned at a shelter) must be handled carefully.
It turned out from the answers given to questions on the frequency of alcohol consumption that there was much more homeless people who considered themselves an abstinent (no alcohol at all in the last 7 days) than among members of the general public. However contradictory it is to the general preconception formed about homeless people, according to our findings the proportion of heavy drinkers among homeless people are the same as in the general public.

The average measure of alcohol consumption in the general public was 4 glasses per week, while in the population of homeless people it was 7 glasses per week. When the type of the drink was studied it was found that the vast majority of the homeless drinks wine and much less of them consume beer as well as distilled liquor. It is especially because of financial reasons, after all 41% of those interviewed in a public place had no money at all at the time of the survey.

How many days did you consume alcohol in the last seven days?					
		Non homeless (%)		**homeless (%)**	
		male	female	questioned at a hostel	questioned in the street
Day	0	26,2	59,9	46,5	29,4
	1	19,3	29,6	9,8	12,0
	2	2,4	6,8	9,6	11,4
	3	6,8	0	6,5	5,5
	4	8,8	0	3,4	4,1
	5	2,5	1,7	2,6	4,1
	6	0	0	1,3	1,5
	7	33.9	1,9	20,2	32,1
Altogether		100,0	100,0	100,0	100,0

It can be stated from the answers concerned smoking that there are more smokers among the homeless than among members of the non-homeless population.

Smoking	Age group (%)					
	18 - 34		35 - 64		65 +	
	Non homeless (%)	homeless (%)	Non homeless (%)	homeless (%)	Non homeless (%)	homeless (%)
heavy smoker	18,1	54,0	20,9	62,0	3,3	35,5
regular smoker	23,2	27,8	16,1	21,6	4,7	25,4
doesn't smoke	58,7	18,3	63,0	16,4	92,0	39,1
Altogether	100,0	100,0	100,0	100,0	100,0	100,0

It also turned out about the questioned population that 13% of them had some wound or hurt at the time of the survey, 9% of them had already had been infected with tuberculosis, 26% of them had already been a subject of psychiatric treatment, 61% of them had already been operated on and 8% of them reported on previous freeze injuries.

On the one hand the conclusion to be drawn is that in Hungary the health condition of the general public is also very poor. People don't pay enough attention to their health, in many cases they can't find time to see the doctor through fear of losing their job.
On the other hand it is important to mention that the answers of homeless people on their health must be handled with some provision. The astonishing figures measuring the ability of self-care serve as a good example. 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.

6.5: In relation to housing, are you aware of any comparisons undertaken between the health of the well and poorly housed populations? In relation to employment, do you know if comparisons between the health and well being of homeless or formerly homeless people who have access too employment and those who don't?

Q7: The Right to Health

The right to health is enshrined in several international human rights texts. You can find the articles on health brought together in FEANTSA's brief on the right to health. It is further strengthened by the right to non-discrimination in the area of access to health. Tackling health inequalities is an ongoing priority at European level. For this reason, expressing homelessness in terms of health has the potential to be a powerful political tool. The right to housing, the right to employment and to access to the services you need are all underpinned by the right to be healthy and to enjoy a state of well-being.

7.1: Do you know of any examples where a rights-based approach has been adopted in relation to health for homeless people or other vulnerable groups, whether in the form of court cases or campaigns?

7.2: Is the health of homeless people a political issue in your country? Could it be a useful campaigning point? Why? Why not?

None of the political parties have made a promise so far regarding the solution of the health situation of homeless people. Obviously none of the important political parties take into account this segment of the electors. One of the possible causes can be that self-blame attitude towards people experiencing homelessness is rather considerable in the general public, thus positive discrimination of homeless people would probably repugn many members of the society.

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Further Internet resources
http://www.ce-review.org/01/24/csardas24_2.html

Annexe 1: ETHOS TYPOLOGY

ETHOS
European Typology of Homelessness and housing exclusion

Homelessness is one of the main societal problems dealt with under the EU Social Inclusion Strategy. The prevention of homelessness or the re-housing of homeless people requires an understanding of the pathways and processes that lead there and hence a broad perception of the meaning of homelessness.

FEANTSA (European Federation of organisations working with the people who are homeless) has developed a typology of homelessness called ETHOS.

The ETHOS typology begins with the conceptual understanding that there are three domains which constitute a "home", the absence of which can be taken to delineate homelessness. Having a home can be understood as: having an adequate dwelling (or space) over which a person and his/her family can exercise exclusive possession (physical domain)*; being able to maintain privacy and enjoy relations* (social domain) *and having a legal title to occupation* (legal domain)*. This leads to the 4 main concepts of Rooflessness, Houselessness, Insecure Housing and Inadequate Housing all of which can be taken to indicate the* absence of a home*. ETHOS therefore classifies people who are homeless according to their living or "home" situation. These conceptual categories are divided into 13 operational categories that can be used for different policy purposes such as mapping of the problem of homelessness, developing, monitoring and evaluating policies.*

ETHOS European Typology on Homelessness and Housing Exclusion

Conceptual Category		Operational Category		Generic Definition
ROOFLESS	1	People Living Rough	1.1	Rough Sleeping (no access to 24-hour accommodation) / No abode
	2	People staying in a night shelter	2.1	Overnight shelter
HOUSELESS	3	People in accommodation for the homeless	3.1 3.2	Homeless hostel Temporary Accommodation
	4	People in Women's Shelter	4.1	Women's shelter accommodation
	5	People in accommodation for immigrants	5.1 5.2	Temporary accommodation / reception centres (asylum) Migrant workers accommodation
	6	People due to be released from institutions	6.1 6.2	Penal institutions Medical institutions
	7	People receiving support (due to homelessness)	7.1 7.2 7.3 7.4	Residential care for homeless people Supported accommodation Transitional accommodation with support Accommodation with support
INSECURE	8	People living in insecure accommodation	8.1 8.2 8.3 8.4	Temporarily with family/friends No legal (sub)tenancy Illegal occupation of building Illegal occupation of land
	9	People living under threat of eviction	9.1 9.2	Legal orders enforced (rented) Re-possession orders (owned)

	10	People living under threat of violence	10.1	Police recorded incidents of domestic violence
INADEQUATE	11	People living in temporary / non-standard structures	11.1 11.2 11.3	Mobile home / caravan Non-standard building Temporary structure
	12	People living in unfit housing	12.1	Unfit for habitation (under national legislation; occupied)
	13	People living in extreme overcrowding	13.1	Highest national norm of overcrowding

For more information please see FEANTSA's *2005 Review of Homeless Statistics in Europe* (Edgar et al.) at www.feantsa.org