

# Tackling Health Inequalities Faced by People who are homeless

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## Introduction

The discussion paper by Cristina Masseria offers a clear overview of health inequalities in Europe today. It develops an understanding of how health differences emerge across the social spectrum. The health inequalities associated with the economic and social deprivation experienced by people who are homeless will be the focus of FEANTSA's contribution to this discussion. The severe poverty and the precarious and insecure housing situation experienced by people who are homeless have a direct negative impact on their health. These health problems may serve to further worsen their overall situation and cement them into exclusion. For this reason, it is vital that health systems take account of the specific needs of people who are homeless as part of an overall public health and social inclusion strategy. This paper will briefly outline the barriers to health faced by people who are homeless and approaches to overcoming these barriers.

It is also worth recalling at the outset of this paper what we mean by "homelessness". FEANTSA's members and researchers have spent several years developing a European typology of homelessness, which takes full account of the social, legal and physical dimensions of homelessness. This typology covers the range of situations of housing exclusion and identifies four conceptual categories: rooflessness, houselessness, living in insecure housing, living in inadequate housing. The present paper will focus essentially on the situation of people who are roofless and houseless; that is to say people that are living in public space or using low-threshold services and spending time in public space. The health needs of people in this situation were the main focus of FEANTSA's work on the theme of access to health in 2006. However, the health inequalities associated with living in insecure and inadequate housing are also significant. Indeed, the discussion paper highlights housing as a clear factor in relation to the health gradient along the social spectrum – though housing cannot always be described as a "life-style choice" as it is in the paper – many who live in insecure and inadequate conditions have no means of changing their living situation.

Dilapidated and deteriorating housing, such as the large multi-storey housing estates in Eastern Europe, is a major source of physical health problems. Damp and cold are a source of ill health in such conditions. Damp homes may lead to mould growth and increased prevalence of respiratory conditions such as asthma and skin problems. Overcrowding also gives rise to health problems. It may aggravate existing problems with the housing and interact with other factors to worsen overall conditions. Accidents and fires are also more prevalent in poor and overcrowded housing conditions. Indoor air quality is another factor that impacts on health and well-being. Older and deteriorating housing may contain hazardous substances like asbestos and lead. Clearly, the mental health and wellbeing of an individual is closely related to their physical environment. Overall, housing dissatisfaction, for whatever reason, has an effect on mental health. Housing insecurity is a significant stressor and worries over possible housing loss and lack of control over one's housing situation can lead to depression, stress, insomnia and anxiety. Neighbourhoods

without amenities and with inadequate public transport are also a source of health inequalities. A more indepth discussion of the way that health relates to insecure and inadequate housing is available in FEANTSA's 2006 paper "Exploring the Complex Relationship between Housing and Health through Consideration of the Health Needs of People who are Homeless", which is available on the FEANTSA website.<sup>1</sup>

## **Health Inequalities and Homelessness:**

In 2006, the annual theme of FEANTSA was on health and homeless and we undertook an in-depth examination of this issue with our members across the EU. On the basis of a questionnaire, members in all countries drew together a national report on the situation of homeless people in their country and FEANTSA drew up a European report on that basis. The points raised below are drawn directly from the findings of the annual theme. The discussion paper for the present peer review highlighted that a range of socio-economic factors can lead to greater health needs in some portions of the population and that these health inequalities may be further aggravated by inadequate access to services to meet those needs. Certainly it is true that roofless and houseless homeless people have urgent and pressing health needs that arise from their situation. 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.

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. The health problems experienced by people who are homeless are usually complex and multiple. Thus people experiencing homelessness frequently suffer from several problems concomitantly: so it might be possible that a person who is homeless could 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 whole situation must be taken into account. 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.

It is certainly true that this problematic health situation is worsened by difficulties in accessing quality healthcare. What is more, multiple needs challenge the very structure of the medical model of working in separate and specialised areas. This way of working exacerbates the

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<sup>1</sup> Exploring the Complex Relationship between Housing and Health through Consideration of the Health Needs of People who are Homeless  
[http://www.feantsa.org/files/Health%20and%20Social%20Protection/Reference%20Documents/WS\\_5\\_Murphy.doc#\\_Toc138071000](http://www.feantsa.org/files/Health%20and%20Social%20Protection/Reference%20Documents/WS_5_Murphy.doc#_Toc138071000)

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 main barriers that the healthcare system throws up for homeless people in Europe are outlined below.

## Barriers to Accessing Care:

### Administrative and financial barriers

People experiencing homelessness have differing entitlements to access healthcare according to their status, but even where there is a clear entitlement, the administrative procedures that must be observed in order to access it are often complex and constitute a barrier in themselves. Many of FEANTSA's members 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 without all of the necessary documentation etc. This is a significant problem, particularly where there is no flexibility in the system to allow for it.

As was also highlighted in the discussion paper, the out of pocket payment to be made by the person receiving care is also a major barrier to care for people with few financial means. 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 experience of FEANTSA's members shows that even a small charge to be paid up front by the person who is homeless can constitute an insurmountable barrier. The discussion paper highlights a recent reform in Germany (p.11) whereby a 10€ fee for first contact with the doctor or dentist has been introduced, though is unable to offer any information on the impact that this reform has had on lower socio-economic groups. However, FEANTSA's member in Germany has examined the impact of the reform on their homeless services users across Germany and has found the results to be disastrous:

“On January 1<sup>st</sup> 2004 a reform regarding health legislation has come into effect that led to a further deterioration of the already bad state of health of homeless men and women. Since January 2004 all welfare recipients and therefore also homeless persons have to pay a medical consultation fee (“Praxisgebühr”) of 10.00 Euros per quarter as well as a co-payment to medicaments, remedies and therapeutic appliances. In May 2006 the BAG W conducted a representative survey amongst the Wohnungslosenhilfe facilities regarding the effects of this reform in the health care sector. 54% of the Wohnungslosenhilfe facilities state that their clients' health status has further deteriorated. 82% of the facilities note an increased need for consulting and support activities because of the law and 62% of them support their clients financially (through donations) to enable them to get the most necessary medical treatments. Nevertheless, most Wohnungshilfe facilities will not be able to continue doing this on a long-term basis.

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<sup>2</sup> German Report for FEANTSA's annual theme 2006, p. 2. Available at <http://www.feantsa.org/code/en/theme.asp?ID=2>

## **The gap between the hospital and homeless life**

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. 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. 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.

## **Lack of knowledge about entitlements**

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 people who are homeless. They may also be victims of discrimination.

## **Overcoming the barriers to access**

### **Alternative routes into care:**

All of the reports received by FEANTSA in 2006 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 rise to different kinds of low-threshold and outreach health services for people who are homeless across the EU. Such services can be a vital gateway into the mainstream healthcare system and can be tailored to have the flexibility and multi-disciplinary focus that is necessary to engage with people who are homeless.

## **The homelessness service sector as mediator and advocate**

Homelessness services across the EU 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 and help them to overcome apprehensions they may have about accessing healthcare. They 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. 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. It is clear that homeless services have an important partnership role in helping to ensure access to health for people who are homeless.

### **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.

### **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 up-front. 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.<sup>3</sup>

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<sup>3</sup> French National Report for the annual theme, pg 4

## Reducing and eliminating health inequalities faced by people who are homeless

FEANTSA's research observatory also undertook a study in 2006, looking specifically at the barriers that prevent homeless people accessing the healthcare system and how these can be overcome. This report will shortly be available on FEANTSA's website: <http://www.feantsa.org/code/en/pg.asp?Page=455>

The Observatory Report and the European report based on the input from FEANTSA's members clearly demonstrate that homeless people suffer from very bad health and face substantial difficulty in accessing the services that they need. The research shows that the health needs of very vulnerable groups such as people who are homeless need to be given special consideration within the overall public health and social inclusion strategy. Healthcare must be structured to meet the needs of homeless people to facilitate access and financial and administrative barriers have to be examined and overcome. Close cooperation with homeless services and all relevant sectors (housing, education, employment etc.) is vital.

All EU countries have expressed their support for building equitable access to health, underpinned by principles of universality and solidarity. The recent statement of common values and principles in European health systems by the European Council laid it out very clearly:

“The overarching values of universality, access to good quality care, equity, and solidarity have been widely accepted in the work of the different EU institutions. Together they constitute a set of values that are shared across Europe. Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay. EU health systems also aim to reduce the gap in health inequalities, which is a concern of EU Member States; closely linked to this is the work in the Member States' systems on the prevention of illness and disease by inter alia the promotion of healthy lifestyles. All health systems in the EU aim to make provision, which is patient-centred and responsive to individual need.”<sup>4</sup>

Equally, the European Social Charter and the Charter of fundamental rights of the European Union reinforce the commitment on the part of member States to ensure equitable access to good quality healthcare. The Council of Europe Recommendation Rec (2001) 12 of the Committee of Ministers to member states outlines how States must adapt their national healthcare systems in order to uphold the right to health for vulnerable and marginalised groups. The actions include the following:

- “1. 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;

<sup>4</sup> Council Conclusions on Common values and principles in EU Health Systems, 2733rd Employment, Social Policy, Health and Consumer Affairs Council meeting Luxembourg, 1-2 June 2006

- ensures supportive environments for the social integration of persons living in marginal situations or in insecure conditions;
- 2. strengthen and implement their legislation in order to ensure human rights protection, social solidarity and equity;
- 3. improve multisectoral co-operation to increase the ability of their social systems to participate in preventing health problems for persons living in insecure conditions.”<sup>5</sup>

## Conclusions

Thus, European countries have already set themselves the task of combating health inequalities. However, much progress is still needed. There is considerable expertise among civil society actors that could be built upon and the homeless sector can be a valuable partner in cross-sectoral working to ensure better access to health for people who are homeless.

It is clear that there is also considerable scope for European processes to influence health inequalities. The open method of coordination should help to promote mutual learning around the issue of equitable access to healthcare. DG Sanco’s work around health inequalities should also seek to generate political will to prioritise and tackle this problem.

It is also vital that European processes should guard against worsening health inequalities. It is vital that the work to improve quality and financial sustainability should not be at the expense of equity of access. As was mentioned in the preceding paragraphs and in the discussion paper for the peer review, increasing co-payments and co-insurance with the aim of reducing unnecessary health demands can also have the perverse effect of reducing very necessary health demands among vulnerable and marginalised groups, further worsening their situation. Careful consideration of the needs of vulnerable groups must be a part of healthcare reforms.

Equally, the European framework in which healthcare services operate will have an impact on how they meet the needs of vulnerable groups. The discussions on the draft directive on services in 2006 highlighted that healthcare services have a specific function that needs to be considered and safe-guarded when seeking to create an integrated market and open competition in this area. It is clear that healthcare services seeking to meet the needs of vulnerable groups have a general interest aim. Certain health services, such as outreach services to homeless people, drugs and alcohol rehabilitation etc. can also be considered as social services. When the future internal market framework for health care services takes shape, it is vital that the general interest aims of certain healthcare services not be placed in jeopardy.

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<sup>5</sup> 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, para 8