

ADDRESSING HOMELESSNESS IN EUROPE

**The Changing Role
of Service Provision:
Barriers of Access to Health Services
for Homeless People**

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November 2006



FEANTSA

European Federation of National Organisations Working with the Homeless

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- The changing role of the state
- The changing profiles of homeless people
- The changing role of service provision

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An overview of Health and Policy Issues

This section provides a framework for the paper by presenting an overview of the health issues affecting homeless people and a brief review of the policy issues involved. There is not scope here to present a comprehensive literature review of these issues. However, a selection of literature exemplifies the range of issues to be addressed which are developed throughout the paper.

1 Health Issues

There is an extensive literature on the nature of the health issues affecting homeless people. and this introduction provides a brief overview of some of the key findings in order to inform the discussion of the factors affecting access to health service for homeless people. A range of health issues are identified in the literature within the context in which homeless people have higher levels of morbidity and a greater prevalence of co-morbidity (Nordentoft and Wandall-Holm, 2003; WHO, 2005; Reinking et al, 2001; Ishorst-Witte et al, 2001). A common finding from research is that only a small proportion of homeless people generally (and rough sleepers especially) are registered with primary health care (i.e. general practitioners) and hence have difficulties accessing integrated care resulting in the fact that they present late in the pattern of illness with problems that could have been prevented or treated (ODPM, 2004; WHO, 2005).

MENTAL HEALTH

A great deal of research finds a high prevalence of assessed homeless persons having a current mental disorder (e.g. Salize et al, 2001. found 69% in Mannheim Germany). Thus, needs for mental health care are very common, with unmet needs predominating in all problem areas, supported by very weak service utilization. Even in regions with a comprehensive community mental health care network, mentally ill homeless people are widely under-provided (Salize et al, 2001). Salize et al (2001) conclude that the traditional shelter system for homeless people carries most of the mental health care burden for their clientele and must be supported by adequate interventions from community-based mental health care services.

A closer connection of both sectors and a better co-ordination of care appear to be a prerequisite for helping to reduce unmet mental health care needs in this specific high-risk group. There is also a fairly extensive literature on the impact of hospital closures and discharge procedures on homelessness in different countries (Greece - see Sapounakis, 2005; Ireland - see Seymour and Costello, 2005; USA - see Lamb R, 1984).

DRUG ADDICTION AND REHABILITATION

Drug addiction and alcohol addiction (or dependency) is often associated with homelessness. While there are related issues involved in drug or alcohol dependency, these need to be understood as two distinct aspects of research. The literature comes from the medical and psychiatric literature as much as from social sciences and homelessness literature. One much cited work (Johnson et al, 1997) suggests that drug but not alcohol abuse was associated with first homeless episode. Prior homeless experiences were found to be predictive of first symptoms of both alcohol and drug abuse. Other variables, including the availability of social and economic resources, were also associated with each of these outcomes. Models of both selection and adaptation processes are necessary to account for the association between homelessness and substance abuse, indicating that a multi-directional model is more appropriate. In addition findings suggest that, in recent years, drugs may have displaced alcohol as an important precursor of homelessness for many individuals.

2 Policy Responses

Policy responses to homelessness have been changing rapidly during the last decade. In many countries (in North America and Australia as well as in Europe) approaches to tackling homelessness have moved from dealing with the immediate crisis, to a focus on rehabilitation and re-settlement and thence to more recent approaches aimed at prevention. To some degree these changes have occurred in response to a change in the perception of homelessness as a socio-structural issue rather than an issue of personal crisis or individual pathology. Change has also occurred as a result of the way service providers operate in deploying, challenging and transforming resources, rules and ideas as they frame and pursue their own strategies. Importantly this change has also reflected a perception of homelessness as a manifestation of processes of social exclusion. This shift in perception has resulted in strategic approaches using co-ordinated action rather than policies relying solely upon individualised social work intervention. In crude summary the catchwords of the new policy paradigm are prevention, support and co-ordination which subsume rather than replace the catchwords of previous paradigms focussed on treatment and re-integration. In the context of health policies this shift in policy focus emphasises the need for outreach services, improved hospital discharge procedures, improved coordination and integration of services, adaptation of mainstream services and targeted specialist services.

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. The Council of Europe recommendations require member states, in the context of international rights charters, to develop a coherent and comprehensive policy framework that secures and promotes the health of persons living in insecure conditions and protects human dignity and prevents social exclusion and discrimination.

While the rights based approach is one response to address the health needs of vulnerable groups, policy response to health inequalities has also developed within the framework of policies on social inclusion. The outcomes of a project 'Tackling Health Inequalities and Social Exclusion in Europe' funded by DG Employment and Social Affairs (DG EMPL) included a compendium of good practice and a literature review on health, poverty and social inclusion in Europe. These reports argue that socially excluded people experience many complex and interacting problems with respect to accessing health care, such as inability to access services as a result of legal status, poor literacy, cultural beliefs and prejudice on the part of service providers (Tamsma and Berman, 2004). A number of good practices therefore aim to overcome these difficulties and contribute to social inclusion by providing health services that supplement mainstream services. They involve services and interventions that contact people directly in their environments (home care, intercultural mediators and experience experts) or the establishment of low threshold centres and/or specialized clinics. However, although the report identifies 52 areas focused on six main target groups, the homeless are not directly considered.

INTEGRATION OF SERVICES

The lack of coordination of health services (especially in relation to mental health and addiction services) with homeless services and housing services is well documented in the literature (see Bevan, 2002; Salize, 2001). Previous reports in this series provide information of inter-agency working or the lack of it (Wolf, 2005 - changes in legislation and local agreements; Schoibl, 2005 - youth addiction services in Tyrol). Research in the UK also evaluates services and calls for changes - "while calling for the integration of health services for homeless people with those of the rest of the population, the report recommends that special interim arrangements should be put in place for primary care, accident and emergency services, community care and discharge planning to improve existing services" (Royal College of Physicians, 1994; see also Pleace and Quilgars, 2003).



INSTITUTIONAL ISSUES

A range of issues related to the nature of provision or institutional factors are documented in the literature. These include issues related to procedures (e.g. release protocols), need for specialist provision (e.g. alternative residential care for older homeless people), coordination and delivery of community services (e.g. psychiatric care and support provision). Institutional release and the linked nature of support provision or (wards in the community) are well known (see Sapounakis, 2005; also Busch-Geertsema, 2002). The need for alternative residential care for older homeless people is documented in Danish research (Gleeson, forthcoming; Meert, 2005) and in UK research (Crane and Warnes, 2001). In addition the Danish longitudinal study on hostel dwellers gives detailed information on morbidity and mortality rates among that group (see Koch-Nielsen, 2005).

HEALTH AND HOMELESSNESS STRATEGIES

In Scotland the Health Boards are required to produce Health and Homelessness Action plans (Anderson, 2006). Some of the major challenges that have emerged are rural homelessness, mainstream versus specialist healthcare and the need for high-level support (Pleace and Quilgars, 2004). Health and Homelessness has featured in NHS Scotland's Performance Assessment Framework since 2001 and, from 2005, meeting the Health and Homelessness Standards was expected to form the Performance Assessment Framework indicator. However, a subsequent review of the performance framework was underway in 2006 and it is not clear if the priority in respect of the Health and Homelessness Standards will be maintained. Nevertheless, the health of homeless people has thus become a key indicator of health inequalities.

"The 'modernised' version of the Exceptional Medical Expenses Act (AWBZ) in the Netherlands, which began to take effect on 1 April 2003, is already having a major impact on the shelter and support sector. It was designed to give service users more control over the care they receive ('demand-driven service provision') and to remove the artificial barriers between the various care sectors" (Wolf, 2004).

HOLISTIC APPROACHES

AND HOUSING FIRST APPROACHES.

The FEANTSA policy paper (Feantsa, 2006) argues that a health policy that seeks to promote the good health of homeless people must address the wider questions of housing, employment and social reintegration. In this context there is a growing understanding that stable housing impacts on the health of an individual. Policies derived from the USA labelled as 'housing first' are gaining ground as part of the general strategy towards prevention and re-settlement.

On the other hand, Wolf et al (2001) in a study examining the effects of re-housing on homeless people conclude that "of all the covariates included as predictors at baseline, only two variables seemed to consistently predict changes in satisfaction; namely, self-assessed general health and self-assessed self-help skills". Their study suggested that becoming independently housed may improve some aspects of quality of life for homeless people, but not others. Their results perhaps indicate some limits to the concept of housing first. They suggest that homeless people prefer to be independently housed relative to remaining homeless or staying in a dependent housing situation, but that independent housing does not necessarily improve other aspects of their lives.

Health and the Pathways to Homelessness

Homeless people are a heterogeneous group who have experienced different pathways into homeless and who have different health needs. So, although it is an obvious point, it does need to be stressed that the health needs of people who have been sleeping rough for an extended period of time are distinctive and will differ from the needs of, for example, young homeless people or families in temporary accommodation due to eviction. Equally people with mental health or substance abuse problems have specific health needs. There is an extensive literature identifying the health care needs of specific groups of homeless people. The Health Evidence Network (WHO, 2005) provide a review of that literature and argue that “on a medical disease model, the most common needs of homeless people concern drug dependence, alcohol dependence or mental disorders, and dual diagnosis is common” (WHO, 2005 p7 citing Griffiths, 2002; Wright, 2002; Reinking et al, 2001; Thomson et al, 2000). Additional causes of ill-health, they assert, arise from injury (due to accident or violence), poor condition of feet or teeth due to self-neglect and infections or skin complaints.

Another approach to considering the health needs of homeless people is to consider the causes of homelessness. In recent years qualitative research has endeavoured to understand the nature of the pathways into and out of homelessness (Anderson, 2001; Edgar and Meert, 2006; MacKenzie and Chamberlain 2003). Equally, policies aimed at the prevention of homelessness have begun to promote research into the factors associated with repeat episodes of homelessness and on the longitudinal analysis of homelessness; though such research is limited in scale and of very recent origin (Stax, 2004; Pickering et al, 2003). Both strands of research have introduced new insights into the major causes of homelessness linked to structural factors, institutional factors, relationship factors and personal factors.

For example, structural changes in the housing market, associated with de-regulation policies (of the 1980s and 1990s) and with governance reforms, have led to significant barriers of access to affordable rented housing for poorer and vulnerable households (Edgar, Doherty and Meert, 2004). This change has been associated, for example, in many countries with a demonstrable rise in evictions as a pathway to homelessness. Repeat episodes of homelessness have also been associated with institutional factors associated with de-institutionalisation processes and with weak inter-agency working linked to institutional release protocols for, among others, young people leaving care and offenders leaving prison (Edgar et al, 2002; Dyb 2005). Relationship breakdown and domestic violence have long been understood as a major pathway into homelessness and, among women, for patterns of repeat homelessness (Hague and Malos, 1998). While research has moved our understanding from explanations based on individual pathology towards more structurally based explanations, it remains the case that factors associated with personal vulnerabilities present different and distinct pathways into homelessness. Research has described, on the one hand, differences in pathways into homelessness for young people compared to older people (Anderson and Tulloch, 2003; Crane and Warnes, 2002). On the other hand research has, more recently, considered the health needs of people (and dual diagnosis) as an explanation of the barriers to routes out of homelessness (Konstantakopoulos, 2003).

Taking this basic typology of the causes of homelessness, it becomes clear that different health issues may be identified (see Table 1). Table 1 suggests illustrative examples of different health issues for homeless people or people threatened with homelessness linked to the underlying causes of homelessness. These are presented here simply to illustrate the different types of health issue that can be identified and are not intended to be comprehensive in coverage. Structural causes of homelessness, for example, linked to eviction and relocation of the household can create difficulties in relation to registration with primary health care (general or family practitioner). Access to other parts of the health care system can also be affected in some countries (e.g. Portugal) if the place of registration is different from the place of current (temporary) residence. Research evidence in many countries demonstrates the link between institutional discharge and homelessness. This can occur in the sense that people remain in the institution or hospital longer than is required due to a lack of housing or support in the community. Equally, discharge from an institution or hospital without adequate planning can itself result in homelessness. In these situations an early or unplanned discharge can result in interrupted medical care leading to additional problems for the person concerned and extending the period of homelessness or delaying their re-integration into permanent housing.

Domestic violence and abusive family relationship is a common cause of homelessness among both young people and women. Research, in a number of countries, has examined the health needs of women and their children who find refuge in women's shelters (Malos and Hague, 1997; Hanmer and Itzen, 2000). Research has also shown that there is a lack of follow-on care for women when they leave temporary shelter to enable them to sustain their tenancy and that the lack of access to health care and counselling is a major factor in the failure to sustain a tenancy (Edgar et al, 2003; Mullender and Morley, 1994). The health needs arising from personal factors leading to homelessness have been referred to above (WHO, 2005). In addition, the health issues also involve the need for specialist supported or transitional accommodation (Edgar et al, 2003) and for residential care for older homeless people (see Meert, 2005).

Although there is limited research on the topic, it is understood by homeless sector practitioners that homelessness, especially among young people, can result from an undiagnosed health situation. This has been referred to in research in two contexts. First, young people with a mild learning disability who may receive support during childhood lose that support due to the structure of adult social services. Poor coping and life skills can then result in a tenancy breakdown. Second, the de-institutionalisation of mental health services, and the lack of concomitant community psychiatric services for people who have not been hospitalised, can result in the mental health condition of young people being undiagnosed.

Table 1 Health Issues Related to Causes and Factors of Homelessness			
CAUSES	FACTORS	TRIGGERS	HEALTH ISSUES
STRUCTURAL	Poverty Unemployment Housing	Debts Financial Crisis Eviction (arrears) Eviction (behaviour)	GP Registration
INSTITUTIONAL	Institutional Living Foster / State Care Prison Experience Armed Forces	Leaving care Leaving Care Leaving prison Forces discharge	Discharge Procedures
RELATIONSHIP	Abusive relationship (childhood) Abusive relationship (with a partner) Family Breakdown (death or separation)	Leaving family home Fleeing violent relationship Coping with living alone	After Care Follow-on Care (women and children)
PERSONAL	Mental Illness Learning Difficulty Drug Dependency Alcohol Dependency	Deterioration / illness episode Support breakdown Substance Misuse Substance Misuse	Undiagnosed condition Dual Diagnosis Housing and Support Specialist care / Residential care
<p><i>Note: this typology does not adequately cover immigrants where access to health care is dependent upon their immigrant status and the social welfare practices in different countries. Their situation could be included as a structural factor creating barriers to health care for non-nationals.</i></p>			

Health Service Structures

This section considers the nature of health services in relation to homelessness. First the section briefly describes the governance of health services (so far as this is relevant to homelessness). Second, the section describes health service policies and procedures so far as they impact on the provision of services to homeless people. Third, the section describes the use made of health services by homeless people.

1 Governance of Health Services

The common typologies of health systems reflecting an ideal set of macro-institutional characteristics are based on variations in the funding of health care and corresponding differences in the organization of health care provision (Barau et al, 2006). In 1994, based on the sources of financing and dominant service providers, the OECD suggested several types of health care systems as demonstrated by figure 1.

In 2004, the OECD suggested a simplified typology by deleting the mixed mode in health care provision and financing, thus finally narrowing health system down to three types: the public integrated; the public contract; and the private insurance-provider model (Figure 2). While the earlier model is useful to illustrate the mix of welfare regime countries in relation to health across Europe, it is this later simplified model that is used for the purposes of this paper. Health systems

can thus be reduced to three main types of health care models (Sang-Yi and Chang-Bae, 2005). First, the National Health Service (NHS) model is characterized by universal coverage, funding out of general taxation and public provision of health services. The UK and Sweden belong to this model. Secondly, the Social Health Insurance (SHI) model is characterized by contribution paid by employees and employers, the public and private provision of health care, as well as a compulsory coverage for the population. Germany and France are the main examples of this type. Finally, in the private health insurance (PHI) model, health care is funded by the individual and employer premiums and health delivery relies predominantly on private ownership. The Netherlands and Greece are examples of this type.

It has been argued (FEANTSA, 2006) that all three models make some form of provision for citizens (and those in a regular situation) without financial resources to access healthcare. However, the same report provides evidence to indicate that in practice, in all health provision models, the provisions often fail to translate into action for a range of reasons.

Figure 1 **Typology of health care systems (Europe)**

			Health care provision		
			Public provider	Mixed (public + private)	Private provider
Financing	Public	contribution		Belgium, France, Germany, Austria, Luxemburg	
		taxation	Ireland, Spain, Denmark, Finland, Greece, Portugal, Norway, Sweden, Italy, UK		
	Mixed (public+private)			Netherlands	
	Private			Swiss	

Source: OECD, *The Reform of Health Care Systems, 1994.*

Figure 2 OECD Typology of health care systems, 2004

		Health care provision	
		Public provider	Private provider
Financing	Public	public integrated model	public contract model
	Private		private insurance-provider model

Source: revised from OECD, Proposal for a taxonomy of health insurance, 2004

2 Health Service Policies

This section describes the nature of health service policies in each country that can affect access to health care for homeless people.

In the UK, national policy is developed at central government level. However, as with housing policy, health policy has been devolved to the Scottish Parliament and, to a lesser extent to the Welsh Assembly and Northern Ireland Office¹. Policy implementation and service delivery are the responsibility of the National Health Service (NHS), which is a UK wide institution but with complex regional and local structures which vary across the four jurisdictions. While there are differences in the detail for policy development and implementation, the broad direction of health policy is heavily influenced by the New Labour UK government. In theory, all of the freely provided services of the NHS should be equally available to homeless people in the same way as the general population. In practice, however, many research studies and policy documents cite evidence of barriers which homeless people face in accessing these services.

The key structures for health policy implementation are the strategic authorities and boards which commission and monitor services. These agencies generally cover geographical areas larger than the local government municipalities which have responsibility for housing and homelessness. Hence, partnership arrangements need to be co-ordinated across different geographical jurisdictions. The strategic authorities/boards also have the main responsibility for public health, health promotion and preventative services - though implementation will generally involve both partnership arrangements and commissioned services.

Health inequalities were made a key priority for the NHS in England in the Priorities and Planning Framework (PPF) for 2003-2006 and homeless people are identified as a vulnerable group. There is a target to reduce the gap in inequalities in health outcomes by 10% by 2010 (ODPM, 2004, p6). In Health Scotland (2004), the health needs of homeless people are recognised within Scottish health policy as part of the broad goal of reducing health inequalities. In 2001, Scottish Executive Guidance issued to NHS Boards placed a requirement on them to produce health and homelessness action plans, to be in place by 2002. These plans set out the actions that Boards will take to address the health needs of homeless people in the area. Some of these plans have led to the development of new services for homeless people, such as joint training and hospital discharge protocols to prevent homelessness. The plans are required to be linked to the local mental health and drug and alcohol strategies. Somerville et al (2003) clarify that Government publications on homelessness in Wales recognise the 'frequently complex health care and support needs of homeless people' (p7). In Wales, the National Homelessness Strategy (2003) emphasises individual needs assessments as fundamental to tackling/preventing homelessness and recognises health and access problems for homeless people. Commitments of the Welsh Assembly have included: issuing guidance requiring local health boards to address the health needs of homeless people; promoting and funding good practice initiatives; improving hospital discharge procedures; and a review of substance misuse strategy.

In Denmark, the health system is based on a universal right to services and is tax paid and non-insurance based. The provision of health care is a responsibility of the counties. With the upcoming reform of local government the responsibility for the health care system will be transferred to the newly established regions. Generally, the main entry to the health system is the general practitioners where all individuals with legal residence permit are entitled to a practitioner. Hence, the provision of health care for the homeless to a large extent relies on the mainstream services for the general population.

¹ The Northern Ireland assembly remains suspended and under threat of permanent dissolution if political differences among the parties active in the province cannot be resolved.

According to the Portuguese Constitution the right to health protection is fulfilled by the creation of a universal National Health Service free at the point of consumption (Constituição da República Portuguesa, 1976). Access to public health care services is made through a register in the local health centre which requires proof of identity and address (proof that you live in the area covered by the local health centre). Everyone is entitled to a family doctor through whom other services (medical specialists, medical examinations, treatments) are accessed. The 2007-2010 National Health Plan recognises that, in spite of the progresses registered in these last three decades in terms of health gains, *“there has also been a deepening of the health problems linked to poverty and social exclusion.* The 2005-2006 NAP Implementation Report also highlights the positive evolution of health indicators but also recognises that some important obstacles remain in terms of the access to health care, particularly *‘regarding the guarantee of access to health care among the most socially vulnerable groups’* (2005-2006 NAP Implementation Report).

Access to health care in the Netherlands is regulated primarily by the new Health Care Insurance Act (ZVW, which prescribes a basic health insurance package), the Exceptional Medical Expenses Act (AWBZ) and the Public Health (Preventive Measures) Act (WCPV). Collective prevention with respect to health risks is a municipal task, and it is usually assigned to the Municipal Health Services. In future, access to some services will be transferred to coverage under the new Social Support Act (WMO; see Netherlands Policy Report 2006).

The Dutch Municipal Health Services have developed a wide range of activities over the years aimed at providing care to socially vulnerable groups. Examples are needle exchange programmes for injecting drug users (as part of the infectious diseases prevention programme) and walk-in social and medical surgeries for the homeless in large cities, which have both curative and preventive aims, such as preventing outbreaks of streptococcus or clothing lice.

The functions that the MHSs organise and carry out are best characterised by the terms ‘safety net’ and ‘bridgehead’. As a safety net, MHSs pursue objectives such as alleviating neighbour nuisance and unsanitary living conditions, averting evictions and providing social and medical assistance. Through such practices, MHSs manage to reach people who have often long been out of touch with relatives, neighbours, and even professionals from social and health care services. As a bridgehead, MHSs stand out in their efforts to bring stakeholders together, mediate between them, coordinate interventions, and guide clients towards mainstream services, which are then to take over responsibility.

Differences have historically arisen between different MHSs in how such practices are carried out and labelled. More consistency exists in the specific public mental health tasks assigned to them. In terms of clients, these involve: (1) outreach in response to detected or reported problems; (2) screening (triage); (3) initial interventions, if needed; (4) guidance to mainstream services; and (5) maintaining client registers. These MHS tasks are carried out by PMH outreach teams, embodying a range of disciplines. The teams work both with people who (still) have accommodation and with those who are already homeless.

In its most recent yearly State of Health Care report (*Staat van de Gezondheidszorg 2005*), the Netherlands Health Care Inspectorate reported improvement in the past few years in the safety net function provided for people with care or service needs who, for various reasons, do not utilise mainstream curative services.

Although most homeless people in the Netherlands are officially eligible to utilise all general health care services², in practice they make the most use of care provided or arranged by homeless services, municipal health services, mental health services and addiction services. All four sectors have services that specifically target homeless people with physical, mental or addiction problems, albeit in varying degrees. Although the boundaries between sectors are increasingly blurring, we shall briefly outline what the different sectors have to offer to homeless people with health problems.

In Greece, health services are categorized into primary health services ('out of hospital treatment'), hospital treatment and specialized hospital treatment. Furthermore, there are also public and private health services, the former of which are accessible to homeless people. Lastly, several specialised services, particularly addressed to vulnerable target groups with complex needs, have very recently started to develop mainly organised by non governmental organisations.

Due to the Greek institutional lack of the "family doctor" or general practitioner as a supporting structure, almost every hospital has an outpatient department where primary nursing takes place. Health centres are located in villages and in provincial areas that are distant from hospitals. Nevertheless, health centres are connected to the nearest hospital in an administrative and medical manner. Recently, the urban health centre has developed which is located in specific municipalities and aims to substitute the outpatient hospital departments. The prevalence of the urban health centre over the hospital outpatient service is a significant component of health policy in Greece. Every municipality has its own medical units which address their citizens' health needs. The size of the units depends size and financial situation of the municipality. Access to municipal medical units is free for all citizens. Some of the social security services in Greece have their own health services to address the health needs of their beneficiaries who are entitled to treatment free of charge. Although they belong to the private sector, a number of doctors cooperate with social security services which do not run health services of their own. Thus, beneficiaries are entitled to free of charge primary medical

Mainstream hospital treatment occurs in public and private hospitals. In the Greater Athens area, 40% of the hospitals are public and 60% private. However, public hospitals own the 70% of the hospital beds. Nevertheless, the total number of hospital beds is not adequate for the population's health needs. People who face an urgent health problem are taken by EKAB (National Centre of Immediate Help) to the nearest public hospital free of charge and receive immediate medical treatment. Private clinics are small, financially independent, medical units who often cooperate with social security services.

People who need to receive medical treatment by mainstream secondary health services are obliged to have social security benefit in order to be treated free of charge. If this is not available, the 'poverty leaflet' issued for people who are poor, or the 'humanitarian status' issued for refugees is equally valid. In all other cases patients are expected to pay for their medical treatment.

Tertiary health services include specialized hospitals and clinics which deal with specific medical fields (e.g. HIV, cancer). Most specialised medical services are public. Accessibility to the specialised medical treatment mentioned above follows the same principles as in the case of mainstream services. Preventative medical care takes place only in very few municipal medical units. Despite its significance especially for vulnerable target groups like homeless people, its scope remains limited as it constitutes a novelty for the national health system in Greece.

The National Centre of Immediate Social Help (EKAKB) offers intervention on social issues when needed. The medical staff is composed of psychologists, social servants and sociologists who provide: consultation on social issues, psychological support to people in need, temporary accommodation in shelters, referrals for access to public or NGO's social services.

The Austrian Health System is based on the principle of insurance and is mainly funded by specific contributions from employees and employers. Persons without employment or in precarious working conditions have to pay the monthly costs of insurance or to claim subsidies from the social benefit (Sozialhilfe). About 2% of Austrians are not insured and do not have adequate social security. Access to health care and treatment is accessible to all citizens (with or without social insurance) apart from retention for administration and the hotel costs of hospital care.

The Austrian health system is highly segmented and fragmented into different services including family doctors, practitioners in special branches of health care, hospitals and psychiatric wards and outpatient treatment facilities. Mobile services have developed since the 1980s to provide for people on release from stationary treatment.

² *The Dutch health system is differentiated into preventative care (via MHSs), outpatient care (via GPs, clinics, paramedics and home care organisations), provision of medication (via pharmacies), hospital and specialist care, elder care, disabled care, mental health care (via psychiatric hospitals, outpatient mental health services and addiction services). See van der Maas P.J., Mackenbach J.P.(1998) Volksgezondheid en gezondheidszorg. Elsevier/Bunge, Maarssen.*

In Estonia, on the other hand, (a country based on the social health insurance model) the main form of medical aid accessible for the homeless is the ambulance (the ambulance speciality is basic first aid and the service is free of charge for everyone in Estonia; irrespective of social security). The number of calls of Tallinn ambulance on the homeless increased from 353 in 1999 to 1,499 in 2005 (see Table 2).

Table 2 Emergency health care services in Tallinn

	Total calls	Including hospitalised	hospitalised %	Calls to homeless	Including hospitalised	hospitalised %
2001	53927	19421	36.0	619	195	31.5
2003	51189	20365	39.8	1014	371	36.6
2005	60662	23757	39.2	1499	421	28.1

Data: Tallinn Ambulance (<http://www.tems.ee>)

In Denmark, in relation to the use of the mainstream health services, there are no statistics available of how many homeless persons are actually registered with a general practitioner. However, a study on former users of homeless hostels shows that the average number of contacts to a general practitioner is higher for the former hostel users than for the general population (Geerdsen et al. 2005)³:

Table 3 Contacts with general practitioners among hostel users and the general population

Number of contacts with general practitioner	Hostel users %	General population (1% sample)
0	16	16
1 - 2	16	21
3 - 4	12	16
4<	56	47
Total	100	100
N	2,938	44,000

Source: Geerdsen et al. 2005: 68), Register data, p < 0,001

In particular, the frequency of more than 4 contacts to a practitioner per year is higher among the former hostel users (56% compared to 47%) than among the general population.

³ *Hostels users in 1997, register data from 2001.*

Further results from this study shows that former hostel users, on average, have twice as many contacts with a practitioner as the general population. Furthermore, the number of contacts increases rapidly for the older hostel users compared to the whole population. This increase sets in at age 40-44, reflecting that many homeless individuals develop severe somatic health problems from a relatively early age. Equally, the number of hospitalisations is also significantly higher among the former users of homeless hostels than for the general population (see Table 4).

Table 4 Hospitalisations among hostel users and general population

Hospitalisations 2001	Hostel users	General population
0	82	95
1-10	17	5
10 <	1	0
Total	100	100
N	2,938	44,000

Source: Geerdsen et al. 2005: 72), Register data, p < 0,001

In the UK, Anderson and Barclay (2003) identified a significant body of research evidence on health and housing and growing interest in health and homelessness as an area for research and policy. They identified that this research demonstrates that single homeless people, and those sleeping rough in particular, experience barriers to accessing basic health care and GP registration. Doctors experience problems in tracing the medical records of homeless people which affects follow up treatment. Importantly, many studies have identified a shortage of suitable detoxification and rehabilitation facilities (and suitable move on accommodation) for homeless people with drug and alcohol dependency problems. Policy and practice increasingly recognises the physical and mental health care needs of formerly homeless people along with their general need for resettlement support in moving into and maintaining settled housing. This is increasingly a key area for joint working between housing, health and social care professionals.

Griffiths (2002) looked specifically at health structures in relation to the needs of people sleeping rough. Their needs were not explicitly mentioned in policy documents from the Department of Health at that time and NHS and rough sleeper services were not routinely sharing information or working together to provide services. However, there was an implicit assumption that all social and health inequalities needed to be addressed.

Access Barriers

Given the volume of research evidence which consistently shows that homeless people experience poorer health than the general population across a wide range of indicators, it is extremely important to understand how barriers to accessing health care operate from the perspectives of both homeless people and service providers. A review of existing research in most countries suggests that access barriers operate at structural, institutional and agency level.

Somerville et al (2003, p20) identify four key barriers: inflexibility of bureaucratic procedures; negative attitudes of health staff; ignorance of existing community based services and reluctance to treat homeless people among some GPs. Other research in the UK (Pleace and Quilgars, 2004) also points to the main barriers to healthcare for homeless people to include the administrative factors linked in part to the patient's having a permanent address. Homeless people can also encounter attitudinal barriers, including negative attitudes or refusal of service by some administrative staff or medical professionals. In some cases, mental health problems, drug or alcohol dependency, or a combination of the two, can make it difficult for some homeless people to effectively access health-care or maintain contact to ensure continuity of care.

Location can also have a marked impact on the provision of health services for homeless people. Homeless people find it difficult to access mental health and drug and alcohol services in rural areas (Somerville et al, 2003). Pleace and Quilgars (2004) identified that rural locations are more challenging for specialist service delivery and that health services are not attuned to the needs of some groups (e.g. homeless women who have experienced domestic violence).

There can be particular problems for particular groups of homeless people. For example, homeless people with multiple needs (a drug/alcohol dependency and mental health problems) experience particular difficulties in accessing appropriate services. As mentioned earlier, research on the support needs of homeless women and children escaping domestic violence indicate problems of access to counselling and mental health services due to administrative delays and scarcity of provision (Edgar et al, 2003; Hague et al, 2000).

In the few available studies on the situation of homeless people in Portugal, poor health is clearly linked both as a precursor to and as a consequence of homelessness. The health trajectory and present condition of the individuals are presented as important factors linked to the triggering of marginalisation processes (linked to unemployment, lack of social protection, worsening of financial situation, unbearable costs, family ruptures) or to the persistence of reinsertion obstacles (impossibility to work, unmet health needs, loss of capabilities, loss of self-esteem, inadequate health care provision).

This section considers these structural, institutional and agency factors that can create a barrier to access to health services for homeless people.

1 Structural and Institutional Barriers

Structural barriers to health care can occur as a result of healthcare entitlements or the method of their implementation. Three different healthcare systems are described above. In some countries primary, secondary and hospital treatment (excluding dental services) are provided free of charge at the point of access with funding through the tax system (Denmark and the UK). In other countries access to health care is insurance driven (Netherlands, Greece). A third group of countries allows free access for those on low incomes (Portugal).

In countries (such as Denmark and the UK) where access is free at the point of delivery, barriers to access for homeless people concern issues of access to primary health care and to specialist services. Evidence in a number of countries identifies the need for a permanent address as a barrier to accessing primary health care services through the general practitioner (GP) system.

The structural and institutional barriers of access to health care for the homeless in Denmark mainly concern the organisation of health care services in relation to the homeless services and the lack of adequate integration of services. The tax paid health care system means that direct economic barriers to health care for the homeless are more or less absent which is probably a precondition for research results (quoted above) which show that the homeless use the health system more than the average citizen. However, health services for the homeless depend to a large extent on mainstream services.

In Greece, the National Health System (ESY) provides initial health care for everyone. Expenses are covered by the patient's social security. Poor people are entitled to attain what is termed a 'poverty leaflet' which gives them the benefits of full medical treatment. In most cases, social workers who either work in shelters for the homeless or by the Social Agency of mainstream hospitals usually help homeless people to issue this leaflet and receive the treatment they need being allowed to access mainstream and specialist health services. However, the situation is more restricted for immigrants and asylum seekers. In practice, access to the National Health System for immigrants and asylum seekers is delivered through the referral of a supporting body, as for example the Social Service or a non-governmental organisation like Praksis, the Red Cross or Doctors without Frontiers

This brief overview of the structural and institutional barriers to access to health care illustrate that such barriers exist in all three healthcare systems but that it is possible to identify distinct types of barrier. First, there are barriers of exclusion. The lack of an address, lack of insurance or lack of citizenship can prevent access to all but the most basic or emergency care. These barriers generally can be thought to relate to the manner in which the health system is funded and the links between primary healthcare (e.g. family practitioners), emergency healthcare and specialist care (drug and alcohol or mental health treatment). Second, there are rules based barriers. These relate to rules on registration with a general practitioner, and procedures for referral to hospital or specialist care (e.g. whether these are accessed through the general practitioner). Both sets of barrier affect the continuity of care as well as access to care and this can be important in affecting the re-integration or settlement of homeless people in permanent accommodation.

2 Agency Barriers⁴

Agency factors impact on access to health services both through the agency of the homeless person and the agency of staff in the various services involved. Agency factors of homeless people need to be discussed in the context of the heterogeneous character of the population. Agency factors related to staff in medical and social services are in part a reflection of institutional factors linked, for example, to training, line management and working procedures and in part they are a reflection of individual attitudes and professionalism.

Evidence from different countries confirms that the agency of the individual homeless person is important in, at least, two respects. First, the individual health situation of the homeless person can cause homelessness (e.g. mental health, voluntary discharge) and it can prolong homelessness (e.g. lack of self-esteem or acceptance of their health situation both of which can prevent continuity of care). The second respect in which agency factors play a role is partly affected by the current living situation. Issues related to self-harm, neglect or esteem are probably more important issues in access to health care among people sleeping rough or moving around. The willingness to keep appointments and continue medication is more likely to be sustained in situations where the individual has formal or informal support.

In the UK, Lester (2003) suggests that homeless people, accepting of their health problems, may simply defer seeking care. Pleave and Quilgars (2004) found some research evidence that staff training can improve patient satisfaction. A Scottish case study found that, while homeless people were broadly satisfied with health services, attitudes of health service professionals could be improved upon (Anderson, 2006). Some service users perceived hostility from service providers, for example with assumptions being made about drug use. Some individual NHS staff were perceived as sensitive to homeless households and caring in their work. However, the NHS was more generally perceived by other stakeholders as operating a tighter medical model of health rather than a more flexible social approach. Similar findings are quoted in research in Portugal (Baptista, 2002).

⁴ Note: the term agency in this context refers to the active agency of the individual in determining action or change in their situation. It can relate to the individual homeless person or individual decision-makers or practitioners. It does not connote organisational structures.

Policy Responses

1 Context of Policy Response

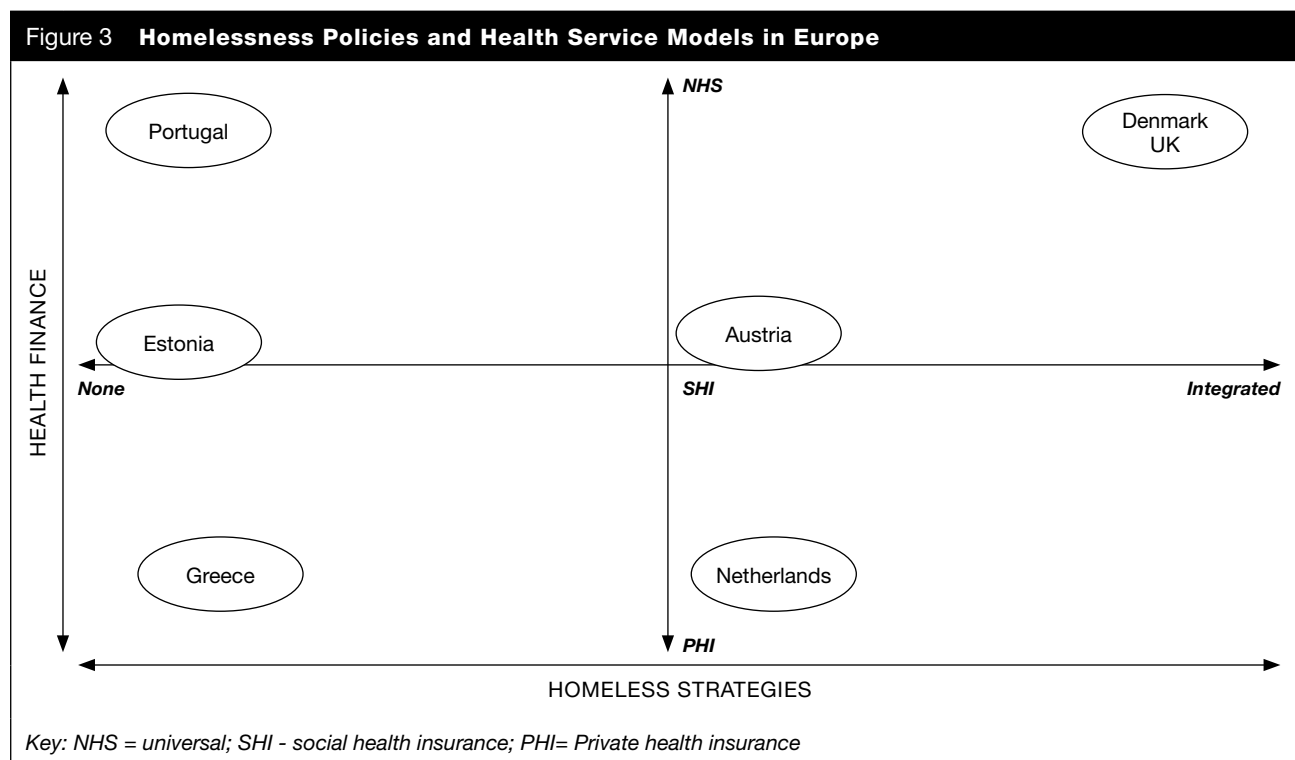
In order to appreciate the diversity of response to the health care needs of homeless people across Europe, it is necessary to understand the nature of homeless policies generally and how these interact in the specific health service structures. The diagram in Figure 3 locates countries on the axes of homelessness strategies and health service models. Hence, there are countries with universal health care systems and well developed homelessness strategies (e.g. Denmark and the UK). On the other hand, there are countries with constrained access to health care (via social insurance or private health insurance models) and very limited or weakly developed homeless policies where homelessness is not a priority of government action (e.g. Greece, Estonia). In between these situations there are countries in which homelessness is a policy priority operating within a private health care insurance model (the Netherlands) and where homelessness is not a priority operating within a universal health care model (Portugal). This simple classification forms a backdrop against which the description of policy responses in the following sections is discussed.

2 Policy Responses

Our review of the research evidence in the study countries suggests that there are broadly three main responses to improve the health care of homeless people. These relate to action taken to enhance mainstream services, the provision of alternative services and action to improve access to specialist services (see Box2). These approaches are described in relation to a selection of evidence from the study countries.

Box 2 Policy Responses to Improve Access to Healthcare for Homeless People

- Enhance Mainstream Services
 - > within GP practices, Hospitals
 - > within Hostels
 - > within Specialist units
- Provide Alternative Services
 - > Hostel based provision
 - > Walk-in centres
 - > Outreach and mobile services
- Improve Access to Specialist Services
 - > Co-ordination / Partnership / Joint Working
 - > Discharge and aftercare
 - > Referral and Tracking



In Portugal, in the absence of any kind of homeless strategies, the policy responses to improving access to health care depend basically on initiatives put forward by organisations working with the homeless population (usually NGO's) and more rarely by local health services. Concern with the provision of health care for homeless people has arisen mainly from the initiative of NGOs working with this population and from the more rare involvement of the health sector. Improvements in the delivery of services are basically centred on the direct delivery of urgent physical health care through outreach teams and through a continuing concern in promoting access to mainstream and specialist services through informal and personalised contacts. Apart from the specific domain of drug addiction there has been no sign of any policy developments in the domain of health and homelessness in a consistent and strategic way.

In the case of the former, most initiatives are focused on the provision of alternative services, the most common of which are the implementation of outreach services (already referred to) and the reinforcement of health care provision within shelters. It must be stressed that this type of initiative is very limited and the main outcomes of such efforts are basically centred around improving access to primary physical health care needs of the homeless, by directly delivering low-threshold care and in some cases by referral procedures towards mainstream health care services, usually hospitals.

In the latter case, the focus is placed on enhancing mainstream services and the only two initiatives of this kind, that it has possible to identify for this paper, are both located in Lisbon and involve local health centres. In one initiative, the mainstream local primary care services has established a protocol between a specific local health centre and a temporary shelter for homeless people which has improved access. The objective is to overcome some of the already identified obstacles (e.g. waiting times, referral procedures to specialised services) and to provide a better continuity of care by creating a privileged link between the homeless population and specific doctors and other health professionals at the local health centre.

In the second initiative, it is the local health centre that initiated a specific outreach team in order to reach homeless people who were not accessing primary health care support. It is important to highlight that this is the only initiative we have been able to identify, directly stemming from the health sector and it is clearly linked to the will and the initiative of the Local Health Centre Director and the interest of the team involved in the project which has been operating since the beginning of 2001 on a completely autonomous basis and with no extra support.

The nature of policy responses in this specific area mostly addresses access to primary physical health care, promoting referral procedures and less often by ensuring continuity of care. In the latter two situations, the main strategies developed are clearly centred around the establishment of privileged contacts between outreach teams, shelters and NGO's with reference persons in the different health care structures (central hospitals, local health centres, mental care units), and not based on any kind of clearly defined partnership or joint working.

In the domain of addiction care a more systematic co-ordination of services has been emerging recently which, although not specifically addressing the homeless population, is also giving response to their specific needs in this area. The fact that there is a National Strategy for the Fight against Drugs and Drug Addiction since the late 1990s has enabled the development of services in this area and the enhancement of coordination and inter-agency working in the fields of prevention, treatment and rehabilitation.

A recent review of research in the UK (Pleace and Quilgars, 2004) identified a range of specialist services for homeless people, including: informal adaptations to mainstream services; specialist primary care services and specialist complementary services (e.g. alcohol and drug support, dentistry, podiatry, opticians). Specialist services were generally more comprehensive in urban areas with higher concentrations of homelessness.

With regard to enhancing mainstream services, Lester (2003, p58) has suggested that evaluation criteria for primary care services to homeless people might include: access (availability when required); quality (range and standard of services); environment (segregation/inclusion); and coverage (suitable to needs). However, Pleace and Quilgars (2004) found no evaluations to date of informal adaptations to mainstream services such as GPs allowing registration with a temporary address or address of practice or doctors visiting hostels. Their review did conclude that primary care services were increasingly integrated with other services aimed at jointly preventing homelessness and resettling homeless people. Flexible working could achieve high patient satisfaction and joint working was recommended - though had not been evaluated for clinical effectiveness.

ODPM (2005) guidance to hospitals states that they should have formal admission and discharge policies which allow homeless people to be identified on admission and relevant housing agencies notified when discharge is imminent. Four real examples are given including having specialist co-ordinators for homeless patients; information sharing protocols; employing a hospital discharge homelessness prevention worker and having a hospital discharge protocol.

Provision of alternative services in the UK, as in many other countries, has included the development of outreach teams. Pleace and Quilgars (2004) found that mobile/outreach services appear to be effective as a contact point - but there could be difficulties with subsequent referrals.

The need for specialist mental health and substance abuse services was particularly identified by outreach teams working with people sleeping rough (Pleace and Quilgars, 2004). Flexibility, being adaptable to needs and joint working were all seen as important features of specialist service delivery. As early as 2002 the government departments responsible for housing and health policy produced a joint policy on drugs services for homeless people (ODPM, 2002).

Those who are roofless are likely to experience both the poorest health conditions and the most severe barriers to accessing services. Consequently services have been developed which specifically target people sleeping rough (Griffiths, 2002). Griffiths found that some specialist rough sleeping services were available in 28 out of 45 areas responding to the survey, mainly through Primary Care Teams. However in 17 out of 51 areas there was no out of hours' service. Specialist services were concentrated in areas with highest levels of rough sleeping and specialist provision was highly variable nationally (Griffiths, 2002).

Lester (2003) has summarised the pros and cons of specialist and mainstream health service provision for homeless people in the UK. Proponents of separate/specialist services argue that homeless people prefer separate services. Lester noted 13 dedicated primary care homelessness centres in England as at 1996, and this had increased to 25 (p59) with the introduction of Personal Medical Services pilots in England. Specialist services also helped overcome the structural time/cost disincentives to GPs, having 'the potential to replace or complement the capitation system of payment which forms a significant proportion of GP independent or contractor pay' (p59). However, limitations included possibly absolving many GPs of their general duty to provide services to the whole population and ghettoising homeless clients.

On the other hand, integrated/mainstream service use had the advantage of offering access to the full range of ordinary services in a non-segregated environment with out of hours cover (Lester, 2003). Problems included the inherent lack of flexibility (e.g. appointment systems) and funding constraints, such as the impact of registering a significant number of homeless families on, say, target payments for cervical smears and immunisations. Lester adds (pp59-60) that deprivation locality payments that may help to offset the additional workload would be difficult to calculate since homeless people can be difficult to define and enumerate.

Evidence to date suggests that specialist projects are good at providing care, but less good at achieving reintegration (Lester, 2003). Consequently this process needed to be better supported with NHS funding and training. Lester concludes that while there will remain a need for some specialist services, there are also opportunities for new and innovative approaches. Further, there remains a need for primary health service providers to reflect on how they can better meet needs of homeless people. Somerville et al (2003) argue that drop-in services are popular with homeless people (p21) and can be integrated with other specialist services for homeless people. However, people who are homeless and do not use services will still miss out. Importantly, Somerville et al (2003, p22) argue that homeless people should not be assumed to be a homogeneous group in this respect.

In the Netherlands, a range of initiatives have been developed in recent years to reach vulnerable people through dedicated medical services. However, a more recent trend is to try to reach vulnerable people through mainstream primary care practices. Arguments for this are that health care to this group is currently too fragmented (with the risk that serious problems of individual patients will be recognised too late), that insufficient coordination exists between the various practitioners and agencies, and that greater continuity of care is needed.

One illustration of an initiative to mobilise mainstream health care services is the Domzorg scheme in Utrecht. The Utrecht MHS organises and coordinates social and medical care to homeless people under an umbrella scheme called Domzorg. The scheme is implemented directly by the MHS and the Centrum Maliebaan addiction service, and indirectly by representatives of the Regionale Huisartsen Vereniging (regional general practitioners' association). MHS public health nurses provide outreach care to members of the target group, without regard to their insurance or residency status. Four nurse surgeries and one GP surgery are provided to address the estimated demand. During office hours (except during the public health GP surgery), a mainstream GP practice is available to the nurses for medically related advice and support. Centrum Maliebaan provides GP surgeries twice a week in Zorgcentrum de Stek (a 24-hour walk-in care centre for drug-dependent homeless people). A nurse is present at other times to help with social and medical problems of target group members. Outside office hours, mainstream GPs are available to provide medical care. All homeless facilities (including the walk-in care centres) make use of these services. The Utrecht MHS has made special arrangements for this with an out-of-hours medical service called Nightcare. Recently Utrecht has opened 4 hostels to accommodate drug-dependent, mostly homeless people. Each hostel has its own associated GP, and residents attend the ordinary GP surgeries. Primary care is also provided by a team of nurses affiliated with the GP practices. They hold surgeries in residential and other homeless shelters. The nurses serve as either practice nurses or nurse practitioners, thus supporting the GPs in their mainstream tasks as well.

To improve the accessibility and the interagency coordination of the medical and pharmaceutical services provided in the homeless sector, agencies in Amsterdam and Utrecht have initiated projects to draw up field standards, now formulated in *Recipe for Effective Action*⁵. The 'recipe' initiative was prompted by the lack of clarity that existed about which providers were to deliver medical and pharmaceutical care, under what terms and with what authority. The projects have resulted in local sets of field standards and cooperative agreements between the various partners in the local service continuum. The aim was to ensure that clients would get the right help faster and that treatment outcomes would be better monitored. The field standards set quality requirements for medical and pharmaceutical care to clients of homeless services with specific regard to:

- > medical and pharmaceutical care tasks carried out by the staff of the homeless facilities
- > consultation or cooperation in relation to the medical and pharmaceutical care tasks performed *within* homeless facilities by external providers (MHSs, mental health services, addiction services, home care agencies, GPs, pharmacists, dentists)
- > arrangements to ensure the coordination and cooperation between homeless facilities and external care providers with regard to the medical and pharmaceutical care of clients delivered *outside* the facilities.

In Denmark most §94 homeless hostels incorporate a health dimension into the services. In almost all hostels nurses are part of the staff. In some larger hostels there are sick wards usually in the form of beds reserved for users with a need for care and with a more intensive staff norm of nurses. The sick wards are not an alternative to a stay in a hospital but aim at giving care to individuals who if they were not homeless would be able to live in their own home with the assistance of for instance the municipal home care.

⁵ *Recept voor goed handelen [Recipe for Effective Action]. City of Utrecht, Utrecht MHS, Agis Zorgkantoor. Amersfoort: Veltkamp and Partners. September 2004.*

Denmark has also introduced outreach teams to reach the most excluded segment of the homeless population. One initiative is the 'Health Team' (consisting of a unit with a doctor and four nurses) at 'Sundholm' which is part of a larger facility of services for the homeless including a hostel, a day centre and an emergency night shelter. The team provides primary health care for the most marginalised among the homeless, those who often go in and out of shelters and/or sleep on the street. The target groups for the team are those with complex problems involving substance use, and severe somatic and psychiatric problems. Outreach health teams are not part of the general service provision for the homeless. However, teams have been established in some cities and towns. In the general funding programme for the socially vulnerable ('satspuljen') funding has been set aside in the period 2006-2009 for projects aiming to expand such services to more cities and towns.

However, Denmark has also been pioneering in the development of alternative residential health care services for older homeless people. These alternative nursing homes, which involves a holistic approach by providing the residents with a place to live and staff trained at providing somatic health care (e.g. nurses), and with a more intensive staff to user ratio, have been identified as an example of good practice (Meert, 2005). However, a lesson learned is that emphasis must also be placed on the extent of physical handicaps and somatic care demands in terms of staffing (e.g. the number of caretakers in the night) and facilities such as the size of bath rooms to allow for assistance (Benjaminsen et al. 2006). By bringing a solution to both the housing and the health problems the alternative nursing homes and similar residences provide an integrated solution to the multiple problems of the most marginalised groups of the homeless. In this way there are good examples of integrated solutions but often not enough places are available to cover all those who could benefit from such intensive services.

In Greece there is no global strategy to combat homelessness. This absence of an organised approach to tackle the issue is responsible for the absence of official statistics of its dimensions and characteristics and consequently an organised approach to deal with the health needs of the homeless population. For this reason there is no institutionalised coordination of service provision towards the health problems of homeless people.

Thus, the health care needs of homeless people are met by NGOs and the Church (see above) or are attended through an informal cooperation network between professional of the health and NGO sectors. A view of such networking is currently practiced in the case of the de-institutionalisation programme, 'Psychargos', in which mental health services cooperate with other sectors in order to attend to the needs of former patients of psychiatric hospitals (Sapounakis 2005). Still, in most cases this takes the form of referrals of homeless patients to hospitals, municipal medical units and specialist's practices.

The recent workshop on health and homeless in Austria identified (at least) three different types of health related services:

1. The homeless service providers create new health services – explicitly for their clients as an integrated part of the services for the homeless;
2. The homeless service providers cooperate with external health services and together they build up a new health service line - explicitly for their clients, in many cases these health services take place in the facilities for homeless persons;
3. Some service providers for homeless refuse to build up a specific health service line for their clients because they are eager to prevent additional stigmas and ghettos. Instead they focus on strategic cooperation with external health service providers and try to motivate their clients to use these services in the regular frameworks (in the hospitals, in doctors' practices and / or therapists). Cooperation between health services and services for the homeless relies then on exchange of information as well as cooperation according to the individual needs.

Conclusions

Homelessness has long been associated with relatively poor health. Our review indicates that, in a number of countries, there has been an increased recognition of the health needs of homeless people and positive and specific initiatives to address these and the barriers that prevent access to more appropriate of sustained care. There is, however, variation as to what is known on the subject across the countries considered here. There are barriers to accessing health care in all the countries studied and these relate to structural and institutional barriers as well as to agency or attitudinal barriers. Policy responses to improve access to health care for homeless people are clearly more developed where homelessness is itself perceived as a priority of policy. This is evident not least because access to good health care provision requires joint working across health, housing and social care agencies.

While there is evidence of change in many countries it is less easy to identify the factors that have driven change or improvement in access to health services for homeless people. Improved planning of services and planning for improved co-ordination of services is clearly important. Developing new services or specialist services requires an evidence base upon which to determine needs and agencies and finance to implement. However, improved access to health care also requires improvements in the delivery of services which will require new structures of co-ordination and inter-agency working as well as adaptation of existing services.

Box 4 Drivers for Change

- Developments in Policy
 - > Positive: health and homeless action plans
 - > Negative: insurance debt and recovery
- Improvements in Service Provision
 - > NGOs: in hostel services
 - > Finance for supported housing: long-term care
- Improvements in Delivery of Services
 - > Targets: family doctors
 - > Local Projects: innovation, coordination
 - > Improved Training and attitudes

There have been developments in policy. For example, the UK has a sound evidence base on housing/homelessness issues in relation to health and relatively well-developed policies for joint working to increase access to health services for homeless people. Central Government has taken a strong lead on co-ordinated policy development. However, there is limited evaluative evidence as to how well co-ordination of service is working and, indeed as to how effectiveness should even be measured? The challenge is for local agencies to deliver on implementation and for central authorities to ensure effectiveness is robustly monitored. On the other hand the new Health Care Insurance Act in the Netherlands is a development in policy that is likely to impact negatively an access to health care for homeless people and other uninsured groups especially as medically essential treatment is drawn more narrowly in areas such as mental health.

Improvements in service provision are evident in a number of countries. In many countries, especially where homelessness strategies are less well developed, improvements in health services for homeless people rely upon initiatives undertaken by NGOs. Problems in effectively dealing with the relatively poor health of homeless people arise in all countries due both to the reliance on hospital or emergency care and to the lack of continuity in treatment resulting from poor coordination between services. Initiatives are reported, however, in dealing with the long term care needs of older people whose history of homelessness requires specialist residential accommodation (see the experience in Denmark and the Netherlands). Funding for support service that targets the individual rather than the accommodation project can have a positive impact on access to appropriate health care.

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