Questionnaire for the FEANTSA Annual Theme

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

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Christian Perl
Heinz Schoibl
Barbara Zuschnig

Preamble: health and homelessness:

When considering homelessness and the best ways to tackle it, one cannot fail to be aware of the close links between health and homelessness. Looking at health and how it relates to homelessness offers a view of homelessness in health terms that is very useful. A definition of health is set out in the preamble to the World Health Organisation Constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Given that being homeless will certainly affect at least one of these spheres of health, homelessness may, by its very nature, be considered as a state of ill-health.

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

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

Health is a vital factor for social inclusion. Good health is a prerequisite to reintegration and is a vital factor in being able to access and maintain employment and housing. Conversely, having a home and a job are important to good state of mental and physical well-being. Thus the right to health underpins and reinforces the right to employment and to housing. What is more, the right of a person to enjoy the highest attainable standard of health has a strong place in international human rights law and is enshrined in international conventions and charters such as the International Convenant on Economic, Social and Cultural Rights and the European Social Charter. This right has been clarified in the General Comments of the UN Committee on Economic, Social and Cultural rights, where it is set down that "the right to health is closely related to and dependent upon the realisation of other human rights, including the right to food, housing, work, education, participation…" So it is clear that health is a good way of framing and approaching these other needs, which are particularly acute in the case of homeless people.

Thus it is clear that health has a role to play in understanding homelessness and in communicating about homelessness. It is also true that health policy is a useful avenue for tackling homelessness in a preventative and also a holistic manner. Health services have a vital role in the fight against homelessness, as meeting health needs is an important step towards

tackling homelessness and health services should be a gateway to other services. It is for all of these reasons that FEANTSA has dedicated 2006 to exploring the theme of health and homelessness. This questionnaire will try to establish a broad overview of the issues relating to health and homelessness across Europe. It will look at health profiles of homeless people, access to healthcare, training of health professionals, inter-agency working, data collection on health and the right to health.

GENERAL FINDINGS[1]

In February 2005 BAWO has organised an expert workshop on health and homelessness in Vienna, attended by the competent minister of health, Maria Rauch-Kallat. One of the main findings of the expert meeting was that, to tackle the objectives more effectively, there has to be a better linking-up between the health and the homelessness sector. In order to perpetuate the networking, BAWO organised a workshop on health and homelessness in the framework of our annual conference in May 2006 in Wels.

Participants of this workshop were unanimous about the fact that homeless as well as other groups of the poverty-affected population can be characterized through their bad state of health and their similar restraints, accessing the assistance of the Health Service. Principally, it can be noticed that, even though all institutions working with the homeless are confronted with the health-related requirements of their clients and concerned with the task of supplying achievements, acquired strategies vary notably from institution to institution.

An important point made in the Workshop was that the Health care system as well as the Health welfare service for the homeless would only work with the support of the institutions working with the homeless. Indeed, they would need to strive for co-operation, to invite specialists, to accompany clients to lectures etc.

Furthermore the Workshop ascertained that, for the clients of the institutions, it would be necessary to develop offers of lowest requirements and to bring these offers to the clients, meaning that they should reach them before the clients seek them.

Regarding the homeless clients, the participants have pointed towards subjective and objective barriers whose actions hinder the access to the Health care service, therefore making the assistance through the social workers more difficult.

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[1] Wohnungslosenhilfe und Gesundheit, Dokumentation des Workshops BAWO Fachtagung 2006, Angela und Heinz Schoibl, translation by Achim Wolf.

Q1: Health profiles of homeless people:

This section aims to establish an overview of the main mental and physical health needs of homeless people in Europe; the public health issues that arise from them; as well as common treatment problems. When answering the questionnaire, it may be useful to refer to the ETHOS (European Typology of homelessness and housing exclusion) categories in order to ensure clarity and comprehensiveness. You will find the ETHOS typology in Annexe 1. It is also useful to bear in mind that many homeless people will present with more than one health problem and that these multiple problems across a range of areas may interact with each other and add up to a high aggregate of vulnerability. Please take multiple needs into account when answering these questions.

For reference, here is a definition of multiple needs:

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

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

If one were to be resolved, the others would still give cause for concern."
(Definition from Homeless Link Good Practice Briefing "Multiple Needs" August 2002)

It should be noted that these multiple needs may also be complicated by previous bad experience of health or social services and a mistrust of health and social workers.

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

health problems of homeless people category 3 houseless
in 3.1. homeless hostel
Every patient (100%) of this category has multiple needs.

Misuses various substances

- misuse of alcohol
- misuse of nicotine
- i.v. drug use

physical health problems

- malnutrition
- CVD - cardiovascular diseases
- peptic ulcers
- zoonoses
- dermatitis - skin diseases
- COPD – emphysema
- pneumonia
- epileptic convulsions

mental health problems

- stress

- dementia
- personality disorders
- offending behaviour
- challenging behaviour
- depressions

health problems of homeless people category 3 houseless in 3.2. temporary accommodation

misuses various substances
- misuse of alcohol
- misuse of nicotine
- drug abuse
- i.v. drug use

physical health problems
- epileptic convulsions

mental health problems
- stress
- personality disorders
- offending behaviour
- challenging behaviour

specific women's health problems
- depressions
- eating disorders
- PTSD - posttraumatic stress disorders

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

The fight against Tuberculosis in Austria is regulated by the Tuberkulosegesetz which is a federal law. The responsibility to implement this law lies in the hands of the Länder. According to our members in the Länder, there is no regularly structured check-up of homeless people there. According to the Viennese public tuberculoses agency, there are quarterly checkups in the facilities for homeless people in Vienna, which are done on a voluntary basis. Every homeless who wants to sleep in a shelter in Vienna has to do a tuberculoses check-up on an obligatory basis.

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

Treatment problems for homeless people arise especially with mental and psychological problems. Some of the specific problems encountered are:

- Revolving door psychiatry, meaning that the crossover from short term inpatient treatment to long-term treatment does not work satisfyingly. Problems are caused partly by a lack of bed capacity in supervised housing and partly by a breakdown in referrals.
- There is not enough qualified medical and psychotherapeutic help available especially for traumatised refugees but also for traumatised homeless Austrian
- Homeless people often fail exceeding barriers for non-stationary psychiatric services. These health problems have then to be dealt with in the institutions working with the homeless.
- Besides the problem of missing comprehension of the clients our members in Bregenz see the biggest problem in a lack of psychiatrists in the area.

Q2: Social Protection: Healthcare entitlements of Homeless People

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

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

The legal entitlements of national homeless are the same as for other Austrian citizens.

In case of emergency every person in Austria is entitled to the necessary health care, not depending on the citizenship or residence status or if a person has social insurance or not. Above that, it depends if a person has social security or not. Homeless people normally have social security or social welfare pays for the medical services. In the latter case the access to the social welfare system for the homeless usually only works with the support of the institutions, as there are complicated administrative procedures to be handled. Since the beginning of 2006, every person who has social security has a so-called "E-card" that proves his entitlement. For homeless Austrian citizens with an E-card it is more of a practical access problem to health care institutions and private medical practices than an administrative problem. But for homeless who's health care is paid by social welfare, members report that there still is a very complicated and discriminating procedure.

The same applies to conventional refugees, asylum seekers in the specific care system and more or less to long-term residents.

Migrants who do not fulfil these requirements and undocumented migrants, if they are not entitled to social security, are not entitled to health care unless they pay for it themselves. The evangelic deaconry set up a centre for ambulant health care (http://amber.diakonie.at) in Vienna called Amber-med. Target group are exclusively persons without insurance protection.

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

The discussion about the overflowing costs of the health care system has brought a quite noticeable rising of retentions (Selbstbehalt). Although there are exemptions according to the income or specific social facts, these retentions do have a noticeable effect on low income persons for instance in the field of long-term medication.

The in principle positive developments of high standards in the healthcare system lead, on the other hand, to higher barriers for homeless people. They usually have a satisfying access to emergency medical aid but not to long-term treatments.

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

The main barriers homeless people are facing are stigma, especially when sleeping rough. Administrative barriers are occurring when trying to obtain special treatments. Undocumented migrants and asylum seekers who are not in the Bund – Länder care scheme do face high financial barriers, as they have to pay the treatments by themselves.

Retentions for dental or optical devices or prosthesis and high prescription retentions are high financial barriers to a proper access to the healthcare system.

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

There are specific programs by NGOs to overcome these barriers (see also Q 3.1).

In Vienna the FSW (Fonds Soziales Wien; www.fsw.at) has started pilot projects together with the neunerHaus and the PSD (Psychosozialer Dienst), beginning to offer special medical treatment in the institutions of the FSW in Vienna. neunerHaus is providing consultation hours by general practitioners in the houses. Occupants who are not able to see a doctor outside or who do not want to overcome the numerous barriers can make use of this offer. The PSD is offering psychiatric treatment in the same way. This pilot project, financed by the FSW, has been so successful that it is now offered in all of the institutions in Vienna. There is a special offer for woman in the field of psychosocial care by neunerHaus and FEM (www.fem.at). Wiener Hilfswerk will open in November a special house for woman with psychic and multiple problems (50:50) in Bürgerspitalgasse in Vienna (www.wiener.hilfswerk.at).

As none of these institutions are specialised on the work with drug abusers, there is a special health care centre run by Ganslwirth competent for the specific health care problems of these clients (www.vws.or.at/ganslwirt/ambulatorium.html).

Q3: Ensuring Access to quality healthcare

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

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

There are quite some specialist and/or outreach healthcare programs especially for homeless people. In nearly all regions there are special dental services for homeless people.

Some best practices: neunerHaus in Vienna is practicing a low barrier approach by scouting treatment. see also (Q2.4; http://www.neunerhaus.at/neunerambulanz2.htm), Caritas Vienna offers with the Luise Bus a specific structure for mobile treatment (http://www.caritas-wien.at/221.htm) and special medical treatment for elderly homeless in the Haus Allerheiligen (http://www.caritas-wien.at/5995.htm).

Marienambulanz in Graz (http://www.caritas-graz.at/home.php?cakt=einr&id=68) is a low barrier clinic fulfilling the basic and primary needs of people in need of low barrier access to the health care system or who are without health insurance.

B 37 (http://www.b37.at) is offering a wide range of low barrier psychological services for homeless in Linz.

The evangelic deaconry set up a centre for ambulant health care in Vienna called Amber-med (http://amber.diakonie.at). Target group are exclusively persons without insurance protection.

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

B 37 in Linz is also doing quite some interesting preventive health care programs especially in the field of nutrition and personal hygiene (http://www.b37.at).

Wiener Hilfswerk offers in the Tivoligasse a specific program to fight dementia (www.wiener.hilfswerk.at).

DOWAS Bregenz is starting to employ a nurse for health promotion without prescription of medicaments (www.dowas.at).

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

The access for homeless people to the healthcare system in rural areas is more difficult than in cities, as there are less institutions working with the homeless in these areas. The social barriers are higher as everybody knows everybody and therefore anonymity is not guarantied as much as in larger cities. The provision for healthcare in rural areas usually works with general practitioners and there is a much higher barrier here than there is in ambulances in larger cities.

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

Discrimination of homeless people can be observed in the health system as well as in other areas of society. Also the health care system is not value free. The problem can be considered two sided as being influenced negatively by both sides. Homeless persons usually confront themselves very late with a health problem and then they often experience severe discrimination. As a result they start their treatment even later.

Rough sleepers without social care generally do have only access to medical treatment of very low quality. Usually homeless people will not be able to access special long-term or expensive treatments.

In our opinion there is big lack in the field of psychological or mental disorders.

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

No, as far as we have experienced, there is nearly no specific policy framework or action plan on this topic.

First attempts are undertaken in Vienna as described in Q 2.4. In Vienna, the city also starts to open up smaller institutions for senior homeless persons, in order to get them out of antiquated geriatric institutions. This will have positive side effects on the health care for these persons.

Q4: Training of health professionals

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

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

Such trainings are not included in the regular educational system for the health personnel. If they exist, it is only selectively at the level of internships. We know of no such plans.

Q5: Interagency working

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

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

In the Land of Vorarlberg there is regular networking between social psychiatry and the homeless sector. In all of the other Länder this works selectively on a more personal level. In February 2005 BAWO organised a workshop on the topic which was attended by the competent minister for health Maria Rauch Kallat and led to the (further) development of specific projects such as the neunerHAUS health initiative. In May 2006 BAWO took on the topic in the annual symposium.

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

In hospitals where there are competent social workers, there is a satisfactory discharge policy. For instance, in Viennese hospitals we do have positive reports on this topic. In Salzburg, members have reported that there is no systematic policy.

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

No, but the retaining of homeless is also depending on the bed capacity. We do have an obvious shortage for psychosocial treatments for refugees.

Q6: Health indicators, data collection and research

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

6.1: Is data collected on any area related to the health of homeless people in your country? (such as the different illnesses suffered by homeless people, number of homeless people using specialist health services, number of people using general services, causes of death, life expectancy, etc.) If so, who collects it? (hospitals, homeless service providers, Accident & Emergency, youth care centres, psychiatric services, etc).

neunerHaus in Vienna is starting to collect specific data on health of homeless persons (eg. Gender specific data, diagnoses, referrals, special treatments).

Wiener Hilfswerk has accompanied clients of one institution for senior homeless (Tivoligasse; www.wiener.hilfswerk.at) for a year and collected specific data (Sylvia Hofmann, 2004, Gesundheit und Lebensqualität ehemalig obdachloser Frauen).

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

According to the FSW no such specific research is done in Vienna, with the exception of project related data collection as mentioned in Q 6.1. Neither the ÖBIG (Österreichisches Bundesinstitut für Gesundheitswesen, www.oebig.at) nor the ministry for health know of such research undertaken.

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

Of course there is research into the areas named above, but in our opinion it is necessary to undertake specific research into health of homeless people.

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

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

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

Q7: The Right to Health

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

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

We have not experienced any rights-based approaches in relation for health of homeless people in Austria up to now.

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

The health of homeless people up to now – with the exception of the BAWO attempts already mentioned - has not been a broadly discussed political issue in Austria. In principle the health of homeless people is a useful campaigning point in Austria. But right now there is a broad political discussion on availability and costs of home care for elderly people, so that a campaign on this issue would fail by all means.

Please return your completed questionnaires to dearbhal.Murphy@feantsa.org before End of August 2006.

Annexe 1: ETHOS TYPOLOGY

ETHOS **European Typology of Homelessness and housing exclusion**

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

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

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

ETHOS European Typology on Homelessness and Housing Exclusion

Conceptual Category		Operational Category		Generic Definition
ROOFLESS	1	People Living Rough	1.1	Rough Sleeping (no access to 24-hour accommodation) / No abode
	2	People staying in a night shelter	2.1	Overnight shelter
HOUSELESS	3	People in accommodation for the homeless	3.1 3.2	Homeless hostel Temporary Accommodation
	4	People in Women's Shelter	4.1	Women's shelter accommodation
	5	People in accommodation for immigrants	5.1 5.2	Temporary accommodation / reception centres (asylum) Migrant workers accommodation
	6	People due to be released from institutions	6.1 6.2	Penal institutions Medical institutions
	7	People receiving support (due to homelessness)	7.1 7.2 7.3 7.4	Residential care for homeless people Supported accommodation Transitional accommodation with support Accommodation with support
INSECURE	8	People living in insecure accommodation	8.1 8.2 8.3 8.4	Temporarily with family/friends No legal (sub)tenancy Illegal occupation of building Illegal occupation of land
	9	People living under threat of eviction	9.1 9.2	Legal orders enforced (rented) Re-possession orders (owned)
	10	People living under threat of violence	10.1	Police recorded incidents of domestic violence
INADEQUATE	11	People living in temporary / non-standard structures	11.1 11.2 11.3	Mobile home / caravan Non-standard building Temporary structure
	12	People living in unfit housing	12.1	Unfit for habitation (under national legislation; occupied)
	13	People living in extreme overcrowding	13.1	Highest national norm of overcrowding

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

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