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VulnerABLE: Pilot project related to the development of evidence based strategies to improve the health of isolated and vulnerable persons

Literature Review

17 March 2017

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Introduction

This literature review assesses the health needs of people living in vulnerable and/or isolated situations in the EU. It is based on analysis of relevant literature, data and policy documents and aims to identify the following:

- Health challenges of isolated and vulnerable persons (including contributing factors);
- Evidence-based approaches to promote health and prevent health problems for isolated and vulnerable groups;
- Policy interventions to address health problems of vulnerable and isolated groups; and
- Other relevant literature, statements and initiatives by health, social and civil society organisations.

A methodologically rigorous approach was taken to conduct a systemic review of literature, which involved using a team of researchers who systematically identified, reviewed and evaluated literature relevant to the objects of the research. To do this, a multi-step process was developed and implemented to guide the research and included refining the research questions, setting the focus and parameters of the review, searching and scoping relevant literature and policy documents, extracting relevant information from scientific literature, policy document and data, and thematic analysis and synthesis of findings.

This document presents the results from the literature review and has the following structure.

Chapter 1 presents the wide range of cross-cutting issues in the EU that may influence individuals or groups that drive vulnerability and negatively impact health. This section will explore these issues in relation to health inequalities as a whole, as well as providing a foundation for understanding the main barriers and challenges faced by individual target groups (presented in Chapter 2). This section is broken down into four subsections and includes the following:

- Important definitions for the project, including defining health inequalities and vulnerability;
- The scale of the health inequalities in the EU, including inequalities in life expectancy, prevalence of health conditions and access to healthcare; and,
- A policy review examining approaches to address the general issue of health inequality

Chapter 2 present the review of evidence and literature related to nine target groups under study. These groups are:

- Older people
- At risk children and families (especially lone-parent families)
- People living in rural/isolated areas
- People living with physical and learning disabilities or poor mental health
- People experiencing long-term unemployment, and economic inactivity
- In-work poor
- Victims of domestic violence and intimate partner violence
- People in insecure housing situations (homeless)

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- Prisoners.

Chapter 2 is divided into nine sub-sections which corresponds to each of the nine target groups and explores the following:

- A brief overview of the EU policy context;
- Details of the scale of the problem facing the group, including health challenges and barriers to healthcare access;
- Evidence in relation to policies (at EU and/or national level) that aim to address the health needs of the group.

Chapter 3 presents the overall conclusions of the literature review.

Chapter 1: Conceptualising, measuring and addressing vulnerability in relation to health

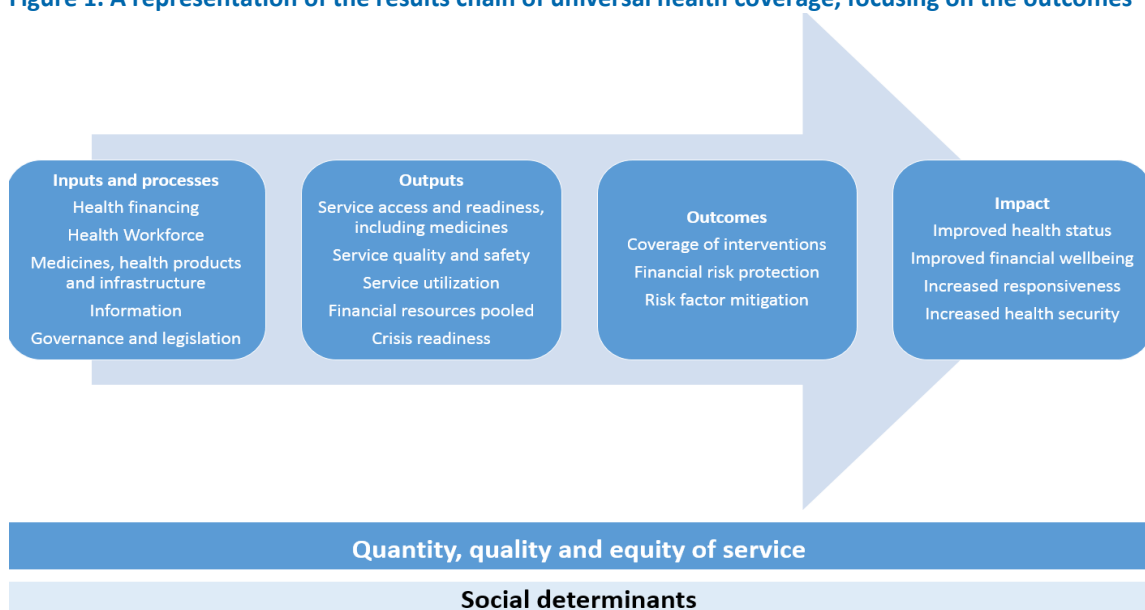
Due to specific individual and social characteristics, some groups or segments of a population are more likely to face poor health status and access to health care than the general population, contributing to the situation of health inequalities.

Factors that increase the prevalence of health problems for vulnerable and isolated individuals can be grouped into individual and social categories. For example, social factors can increase the probability that certain categories of population will have poorer health and engage in unhealthy behaviours, including: lower socioeconomic status; lower education levels; lower resources and incomes; lack of social and family support; living in an unhealthy environment and limited access to preventive health care (CSDH, 2008).

Individual characteristics present at birth also affect the prevalence of health problems for vulnerable and isolated people and include factors such as inherited genes, conditions in the womb, birth trauma and parental circumstances. However, the impact of these factors on vulnerability is modified by subsequent environmental factors (i.e. subsequent experiences and life events). Vulnerability can also be contextual, i.e. a product of determinants that can affect equity of access to healthcare.

Figure 1 shows the results chain of universal health coverage focusing on outcomes. Each outcome depends on inputs, processes and outputs, which have an impact on health.

Figure 1. A representation of the results chain of universal health coverage, focusing on the outcomes



Source: WHO (2013a)

People belonging to vulnerable and isolated groups often experience significant barriers in accessing health care, alongside shouldering the greatest health burdens. Whilst health inequalities affect everyone, the intensity to which people are affected differs. There are specific groups that experience particularly poor health outcomes. This literature review will discuss these groups in more detail below.

Important definitions for the project

Defining health inequalities

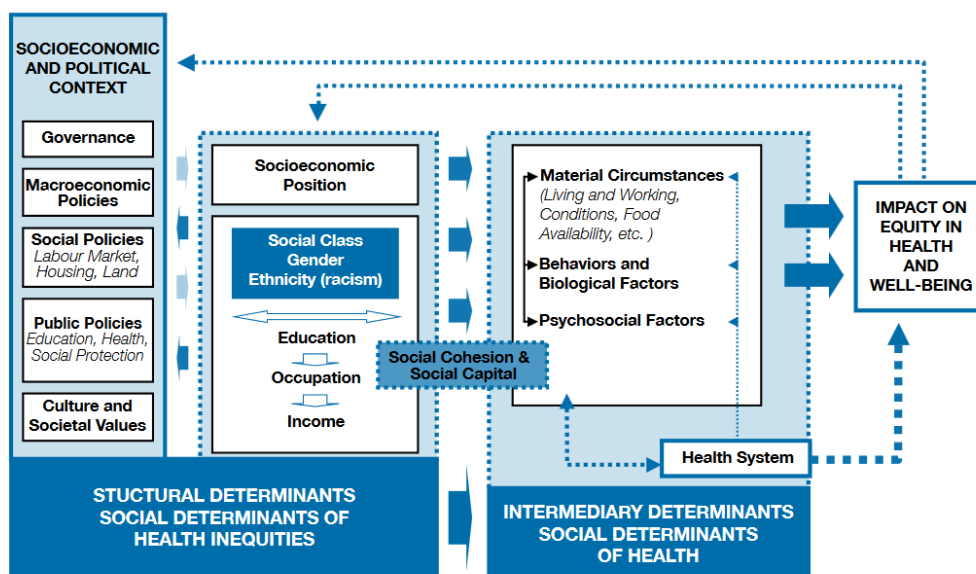
Health inequalities are broadly defined as 'differences in health status between individuals or groups, as measured by for example life expectancy, mortality or disease' that arise from 'avoidable differences in social, economic and environmental variables' (European Commission, 2009a). A key element of the concept of health inequalities is that they are 'unnecessary, avoidable, unfair and unjust'. Alongside focusing on health differences between social groups, analysing the 'social gradient' of health inequalities highlights the differences in health outcomes across socio-economic groups.

The Commission's communication 'Solidarity in Health: Reducing health inequalities in the EU' (2009a) marked a milestone in the analysis of health inequalities and policy recommendations to combat them. More recently, the European Commission study on 'Health inequalities in the EU' (2013a) outlined both health inequalities between Member States and social groups. Concerning the social gradient of health inequalities, the study found that general ill health and longstanding health problems are increasingly common as disadvantage worsens. The steepest social gradients were found for the relationship between material deprivation and adverse health outcomes. Furthermore, it is highlighted that health inequalities are increasing particularly in the Eastern Member States.

When speaking of health inequalities, an important distinction is to be made between inequalities in the determinants and risks of prevalence of health problems, or health status, and access to health care (CSDH, 2008). Concerning the prevalence of health problems, individual characteristics, environmental conditions and social factors vary for different groups and throughout the life course of individuals, causing disparities in their general health.

Concerning access to health care, organisational and institutional factors - as well as welfare systems and policies - affect health inequalities within Member States. This is illustrated in Figure 2, which shows how social, economic and political mechanisms result affect health determinants and access to healthcare.

Figure 2. CSDH conceptual framework



Source: Solar and Irwin (2010)

Defining vulnerability

Vulnerability is a social phenomenon, affected by multiple processes of exclusion that can lead to or result from health problems. Three notions shape the concept of vulnerability:

- 'Risk': vulnerability is a situation that anybody can experience at a point in their life and *'any individual may be at risk of physical, psychological and social health issues'* (Rogers, 1997).
- People's coping capacities with adverse situations (Zaidi, 2014).
- The outcome of this adverse situation on the individual's health: its impact *'in term of welfare loss'* (Alwang et al, 2001).

In addition, the WHO (2013b) International Classification of functioning, disability and health (ICF), demonstrates a broad view of vulnerability, acknowledging that all people may experience some degree of disability during their lifetime, through changes in health or in the environment. This experience of disability is universal and can be permanent or transient, but is not restricted to one particular sub-group of a population.

The concept of vulnerability is not considered static. Individuals appear to be more or less at risk of being in a vulnerable situation, depending on the interaction of personal (inborn or acquired) and societal and environmental factors. Those factors provide or deprive individuals from certain types of resources. The more personal resources (good mental and physical health, good coping skills, etc.) and the more environmental support a person has, the less likely that person is to be at risk of vulnerability (Rogers, 1997).

Social determinants of vulnerability are influenced by the political, historical, cultural and environmental context (Rogers, 1997). Building on these observations, Aday (2002) stated that vulnerability to adverse health outcomes is not related to a physiological condition only, but primarily depends on the amount of control individuals can have over their life. Thus, an important factor determining the degree of vulnerability is the availability and distribution of community resources, whether they are economic, social or environmental. An unequal distribution of societal resources predisposes people to vulnerability and to poor health.

Flaskerud and Winslow (1998) developed the 'vulnerable populations conceptual model' (VPCM) and defined vulnerable populations as *'social groups who have increased morbidity and mortality risks, secondary to factors such as low socioeconomic status and the lack of environmental resources'* (Nyamathi et al., 2007). The VPCM illustrates the interactions between:

- Resource availability, determined by human capital; social status; social connection and environmental resources, at both individual and community level;
- Relative risk, where risk factors may be behavioural or biological and refer to the differential vulnerability of specific groups to poor health; and
- Health status, including disease incidence, prevalence, mortality and morbidity rates in a community.

The VPCM is used to understand the barriers to health care access that some populations may face and to assess the potential impact of a public policy on the links between resources limitation, their effects on relative risks and health outcomes.

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The concept of accumulative processes of exclusion that drive vulnerability has been considered useful to study the specific barriers face by vulnerable groups. Vulnerable populations have specific attributes and needs that cumulatively influence their vulnerability to poor health and their access to health care. There is '*a gradient relationship (that) exists between vulnerability status and health care access, quality and health outcomes*' (Nyamathi et al, 2007).

The scale of health inequalities in the EU

Over the last decade, population health indicators have improved across the European Union. However, these indicators suggest that an increase in health has not been experienced equally. There are still widespread inequalities in health and access to healthcare between and within Member States, reflecting the different conditions in which people are born, grow, live and work (European Commission, 2013a).

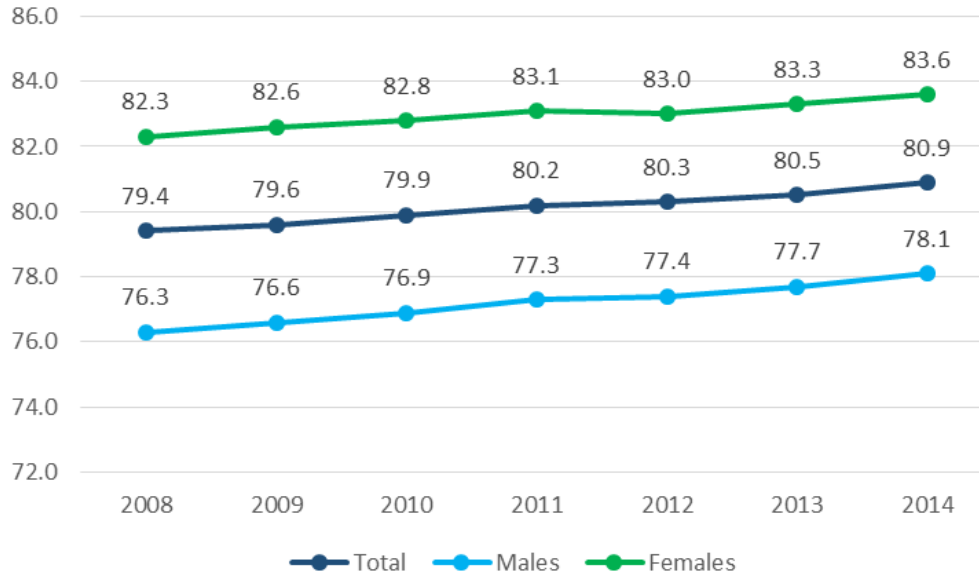
The following sections present the latest data on Eurostat on life expectancy, healthy life years (HLY), the prevalence of health conditions and the degree of reported unmet need. Where available, it provides data disaggregated by key characteristics (including age, gender, income quintile and others), in order to show the different health inequalities that exist amongst the EU population.

Life expectancy and healthy life years (HLY)

Consistent with the picture of improvements to overall health, the most recent data show that the average life expectancy at birth in the EU-28 was estimated to be 80.9 years in 2014: an increase in average life expectancy of 1.5 years compared to 2008. Average life expectancy for men was 78.1 years, compared to 83.6 years for women.

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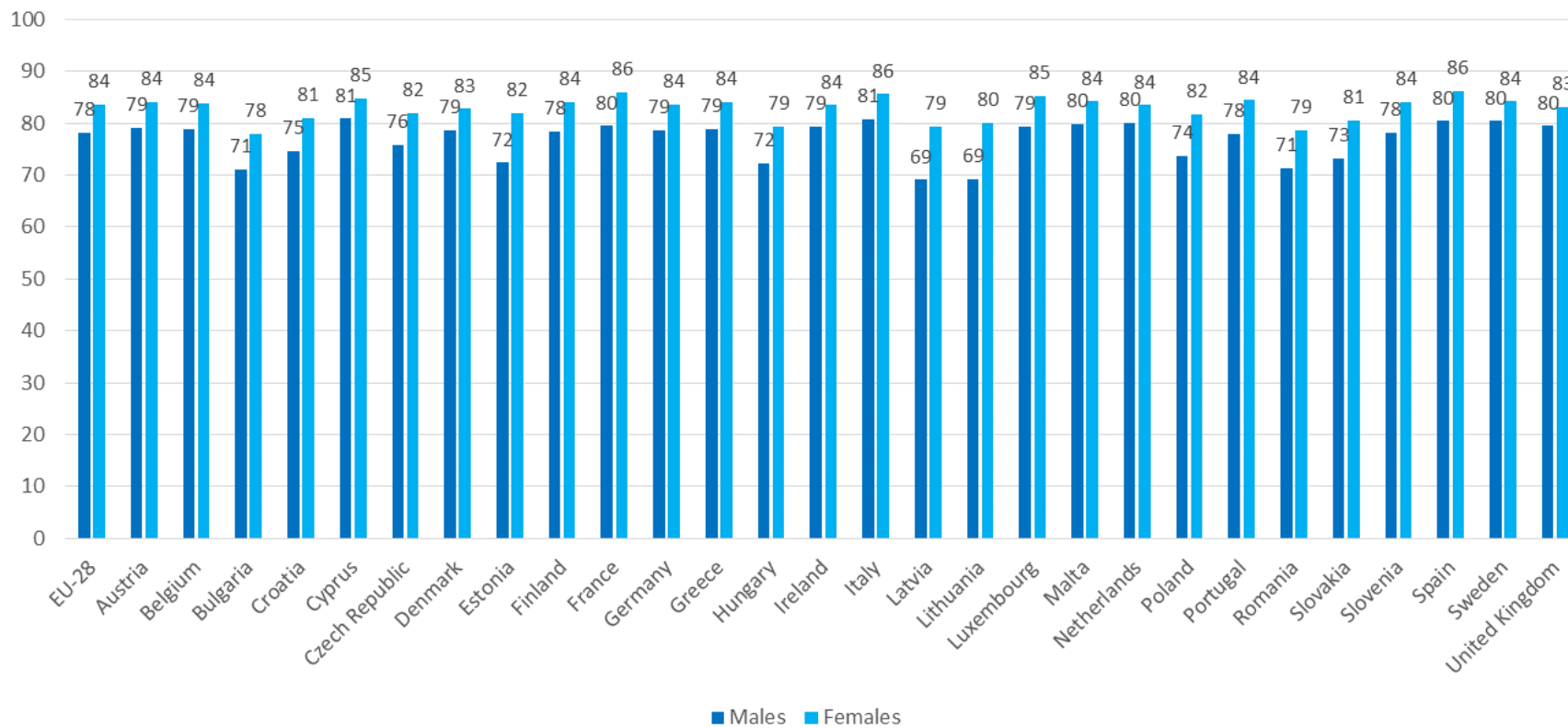
Figure 3. EU-28 average life expectancy at birth, 2008-2014



Source: Eurostat (2016a)

The same pattern can also be seen within each individual Member State: life expectancy for both sexes increased in each Member State between 2008 and 2014, but was consistently higher for women. Data for each Member State in 2014 are presented in Figure 4 below.

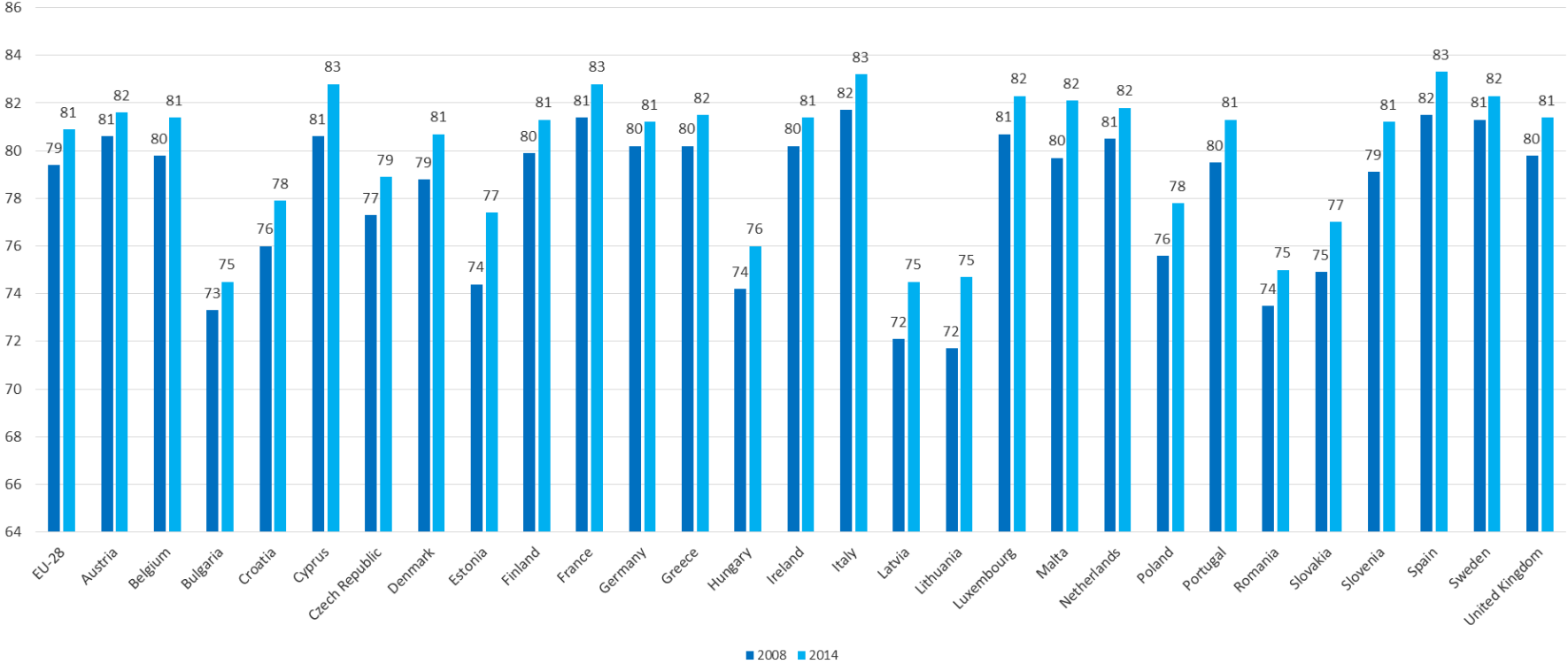
Figure 4. Life expectancy at birth by sex, 2014



Source: Eurostat (2016a)

The data also show persistent and significant differences in life expectancy between Member States. In 2008, the difference between life expectancy in the lowest Member State (Lithuania) and the highest (Italy) was 10 years. This gap had decreased slightly by 2014 although was still significant, with a gap of 8.8 years between the lowest life expectancies (Bulgaria and Latvia) and highest (Spain).

Figure 4. Life expectancy at birth, by country, 2008 and 2014



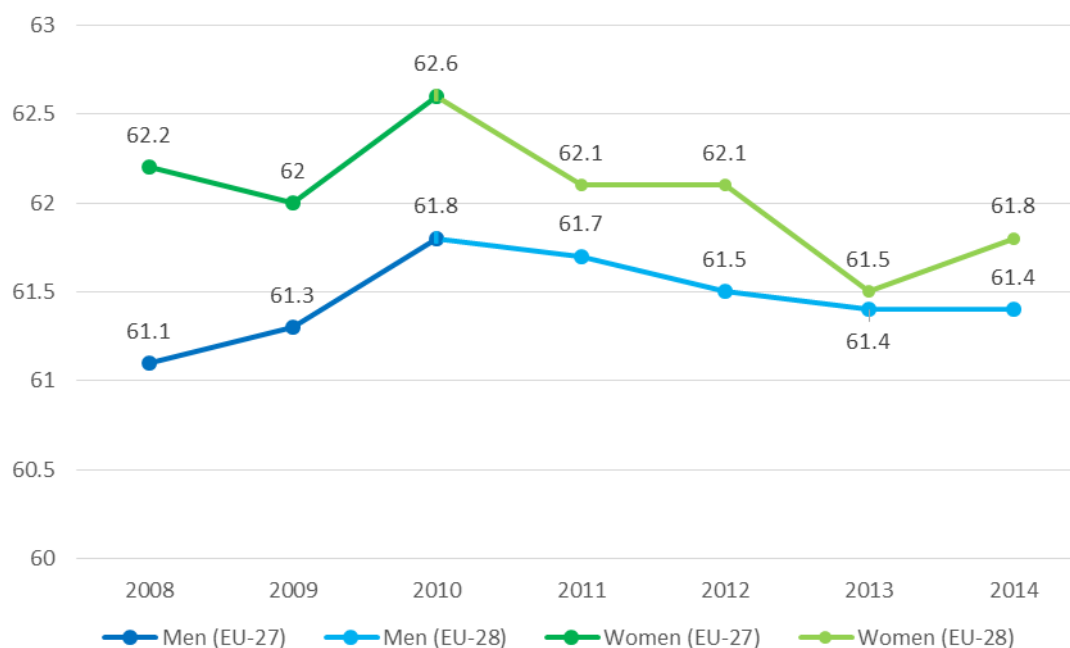
Source: Eurostat (2016a)

Data show that there are also differences in life expectancy by education within Member States. For example, data from Bulgaria show that the average life expectancy, at age 25, of men educated to lower secondary level or below (ISCED 0-2) was 40.8 years in 2013, compared to 52 years for men with a tertiary education (ISCED 5-8). There was a similar, although smaller, gap for women in Bulgaria as well: life expectancy at age 25 for women educated to lower secondary level or below was 50.1 years, compared to 56.9 years for women with a tertiary education (Eurostat, 2017a). For men (at age 25 in 2013), the lowest life expectancy in any country for those with tertiary education (ISCED 5-8) was 51.5 years (Romania), as opposed to 39.2 years for those with lower secondary level or below (ISCED 0-2) (Slovakia and Estonia) (Eurostat, 2017a).

In addition to life expectancy, measures of healthy life years (HLY) are also important. Unlike conventional life expectancy measures, which show the entire length of life that individuals of a certain age can expect to live, measures of HLY show only the number of years a person can expect to live without disability. This is an important distinction: an individual may live longer than someone from the preceding generation, but a greater proportion of that longer life might be spent in ill-health.

Unlike life expectancy, HLY at birth have remained broadly stable across Europe in recent years, as shown in Figure 5. For both sexes, HLY at birth peaked in 2010, before decreasing marginally. In 2014, although men were expected to live for less time than women (overall life expectancy), they were also expected to spend a greater proportion of their lives without disability, in good health.

Figure 5. Healthy life years at birth, by sex, EU-27 and EU-28

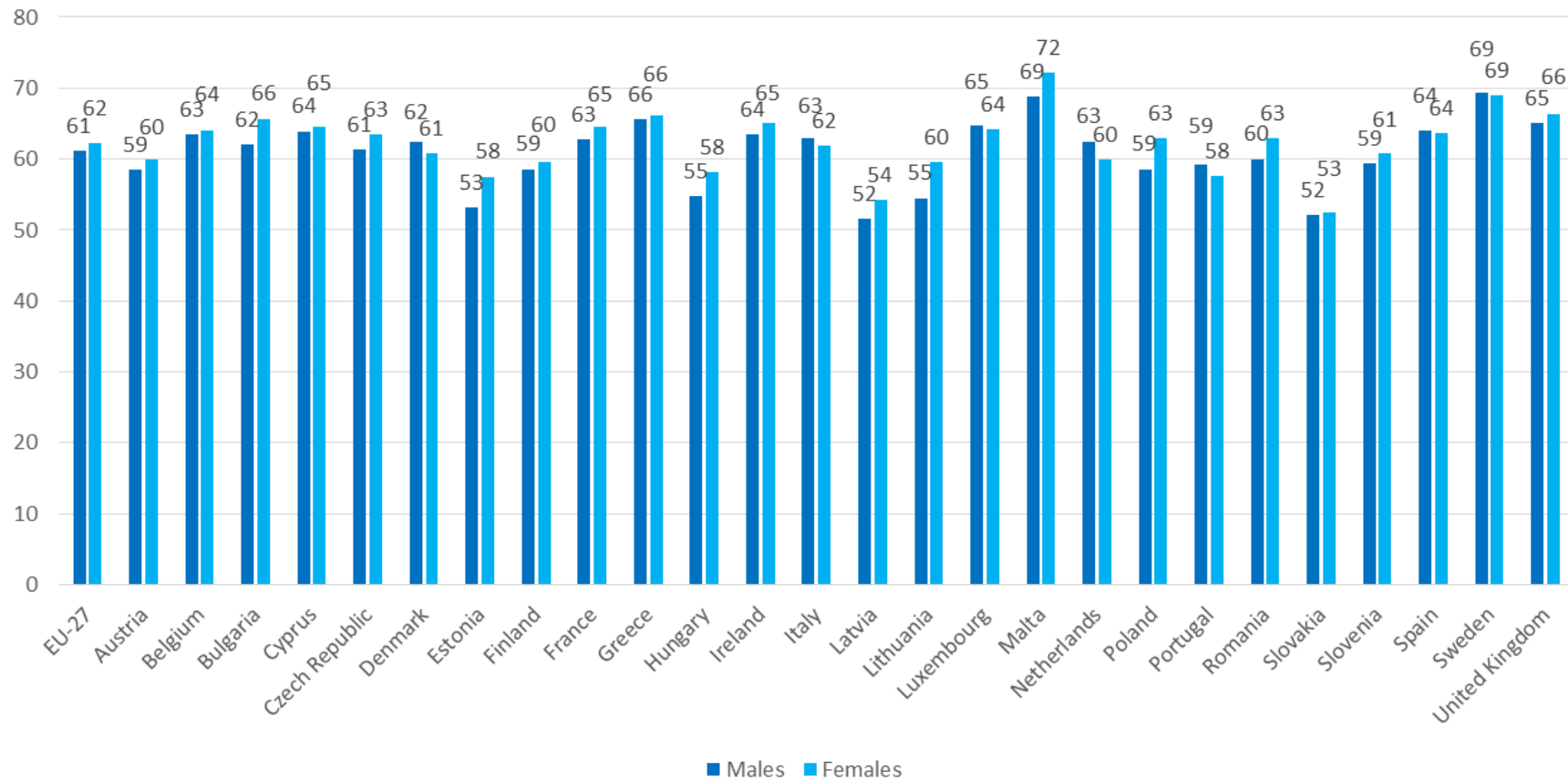


Source: Eurostat (2016b). EU-27 data available for 2008-2010, EU-28 available for 2010-2014. Figures for EU-27 and EU-28 are identical for both sexes in 2010.

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Within this, some variation is evident at individual Member State level. For example, between 2008 and 2014, the average HLY at birth increased significantly for both men and women in Sweden (4.2 and 4.6 years respectively). Other countries, however, saw both measures decrease: in the United Kingdom, for example, HLY fell by 1.6 years for men and 2.1 years for women during the same time. No consistent trend can be observed across EU-28 Member States.

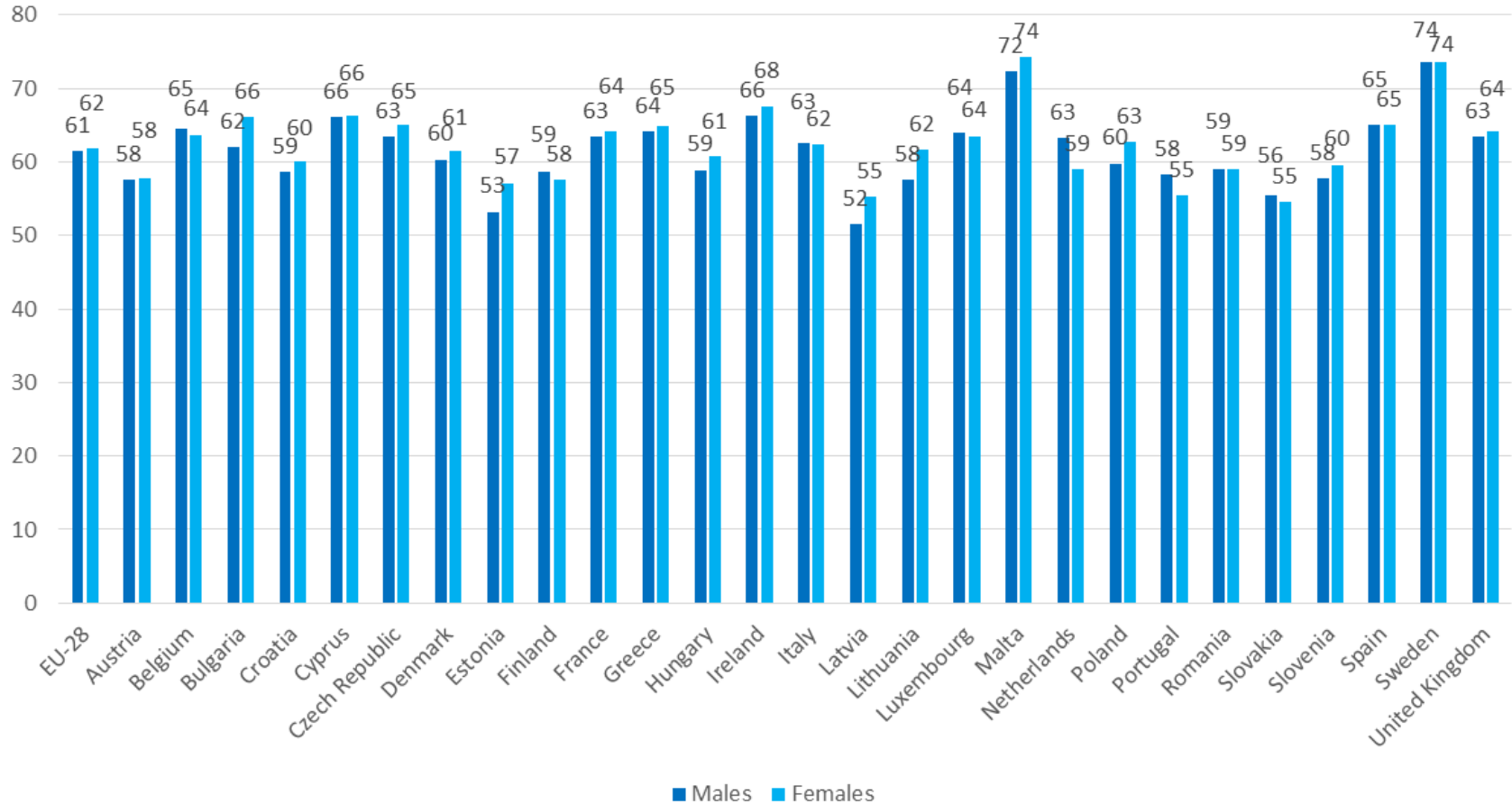
Figure 6. Healthy life years at birth by Member State, 2008



Source: Eurostat (2016b). No data available for Croatia or Germany.

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Figure 7. Healthy life years at birth by Member State, 2014

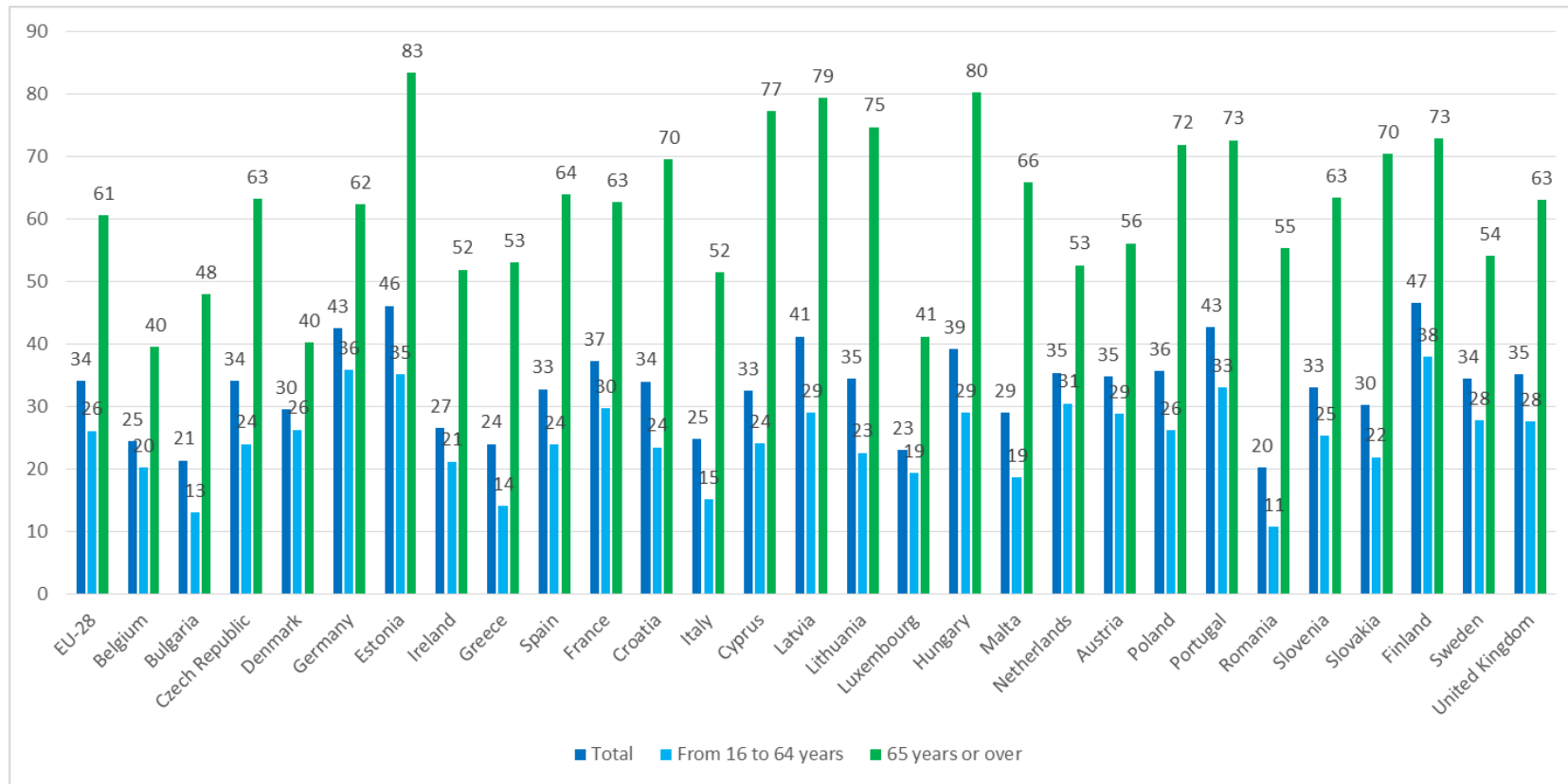


Source: Eurostat (2016b). No data available for Germany.

Differences in prevalence of health conditions

As well as life expectancy, the prevalence of ill health also varies across Member States and population subgroups. One particular difference is between different age groups. As Figure 8 shows, the prevalence of illness or health problems is higher among people aged 65 and over than people aged under 65. In 2015, 60.6% of the EU-28 population aged 65 and over had at least one long-standing illness or health problem, more than double the rate of among people under 65 (26.1%). Whilst the higher rates of long-standing illness or health problems among older people is not surprising, the data shows considerable differences between Member States. For example, Estonia reported the highest rates of long-standing illness or health problems (83.4%) among its population of people aged 65 and over in the EU. In contrast, Member States such as Belgium (39.5%) and Denmark (40.2%) reported rates of long-standing illness or health problem of less than half that of Estonia, highlighting the considerable differences across Member States.

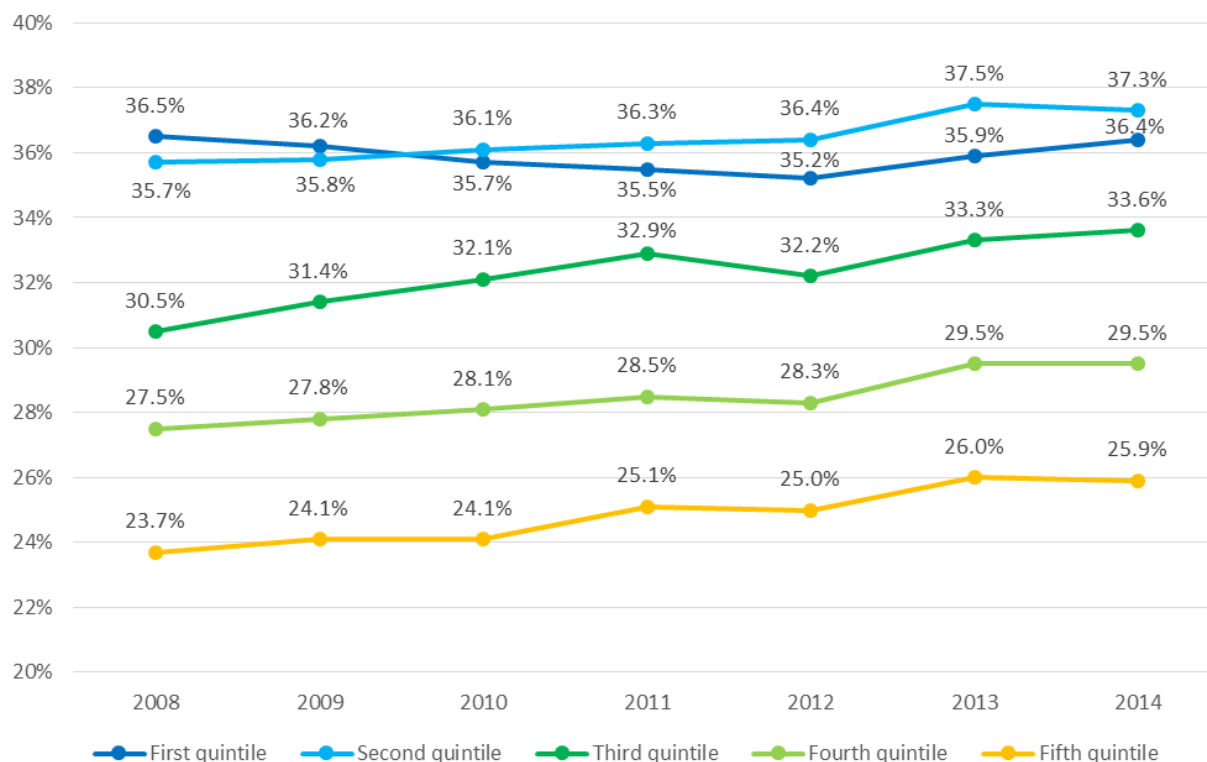
Figure 8. Proportion of people with long-standing illness or health problem, by age



Source: Eurostat (2016c)

Another significant difference is between people with different levels of wealth. As shown in **Error! Not a valid bookmark self-reference.**, EU-27 residents with the highest incomes (fifth quintile) have a significantly lower rate of long-standing illness or health problem than those with the lowest incomes (first and second quintiles). In 2014, the difference between people in the first and fifth income quintiles was 10.5 percentage points.

Figure 9. Proportion of people with long-standing illness or health problem, by income quintile



Source: Eurostat (2016c). All data are for EU-27 (excluding Croatia).

It is potentially of interest that, from 2010 onwards, individuals in the second quintile (i.e. the second lowest level of wealth) are slightly more at risk of having a long-standing illness or health problem than the lowest-income group (first quintile).

Inequalities in access to healthcare

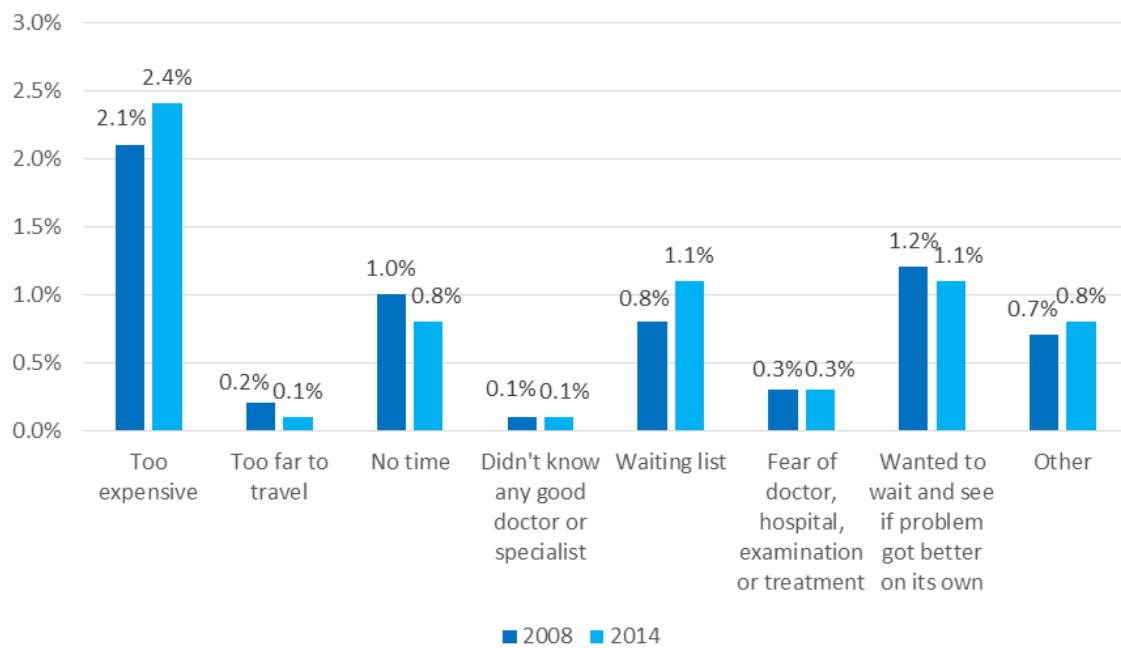
The EU endorses equality of access to healthcare for all people as an important policy objective. However, there are differences in access to healthcare across Europe. In Member States (such as Germany), access to social insurance (including public health care) is linked to employment or dependency status, whilst in other Member States (such as the United Kingdom) it is available irrespective of employment status.

One method of measuring to what extent the objective of equity of healthcare access is achieved is through assessing reports of unmet needs for healthcare, which are collected by the EU Statistics on Income and Living Conditions survey (EU-SILC). Inequalities in access are influenced by several key issues, including the cost of treatment, location and travel distance of healthcare services, and the quality of healthcare services (e.g. type of services provided, skill and capacity of health professionals, etc.). Data is collected based on common reasons for not receiving care: excessive treatment costs, traveling distance to receive care, long waiting lists or not being able to take time off work.

In 2014, 6.7% of Europeans reported having unmet healthcare needs. In this year, the adult population (aged 16 and over) with unmet needs for medical examinations ranged from 0.4% of the population in Slovenia to 19.2% of the population in Latvia (Eurostat, 2016d).

Figure 10 presents the reasons that Europeans with unmet healthcare needs give for not having accessed healthcare that they need. The most common reason given for not having received treatment was cost. The problems reported by people in need of obtaining care services reflect significant barriers to care.

Figure 10. Self-reported unmet needs for medical examination, by reason given, 2008 and 2014

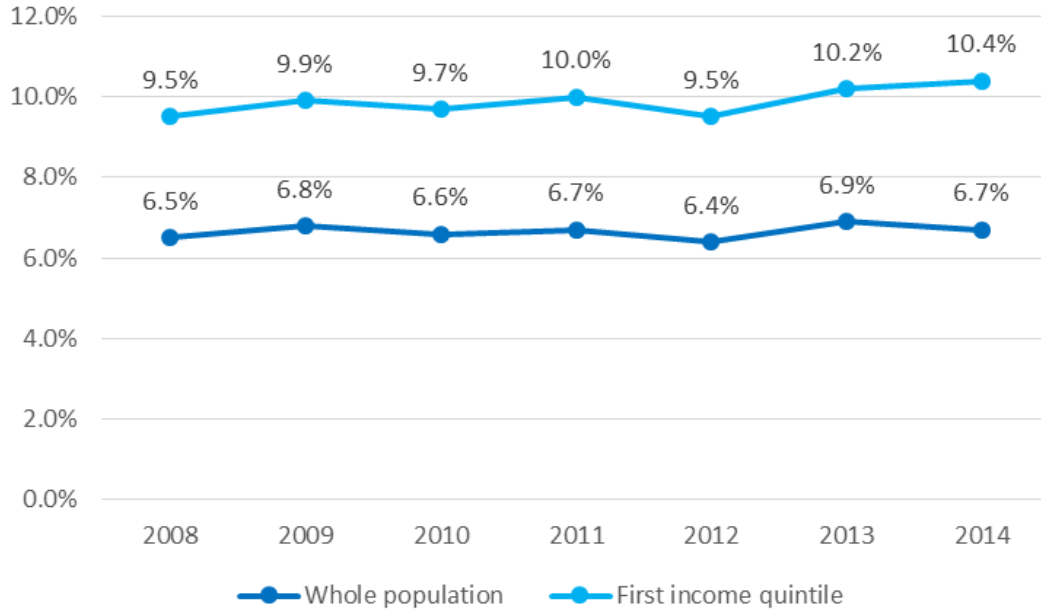


Source: Eurostat (2016e). All data are for EU-27 (excludes Croatia).

In the EU as a whole, people with low incomes are more likely to report having unmet healthcare needs than the population as a whole, as shown in

Figure 11. In particular, they are the most likely to report having unmet needs due to the cost of healthcare. Self-reported unmet healthcare need that occurs due to the cost of treatment is twice as prevalent among Europeans in the first income quintile (i.e. the least wealthy in society) as among the European population as a whole. Unmet needs due to treatment costs are also over eight times as prevalent among people in the first quintile (lowest income group) as among people in the fifth quintile (highest income group).

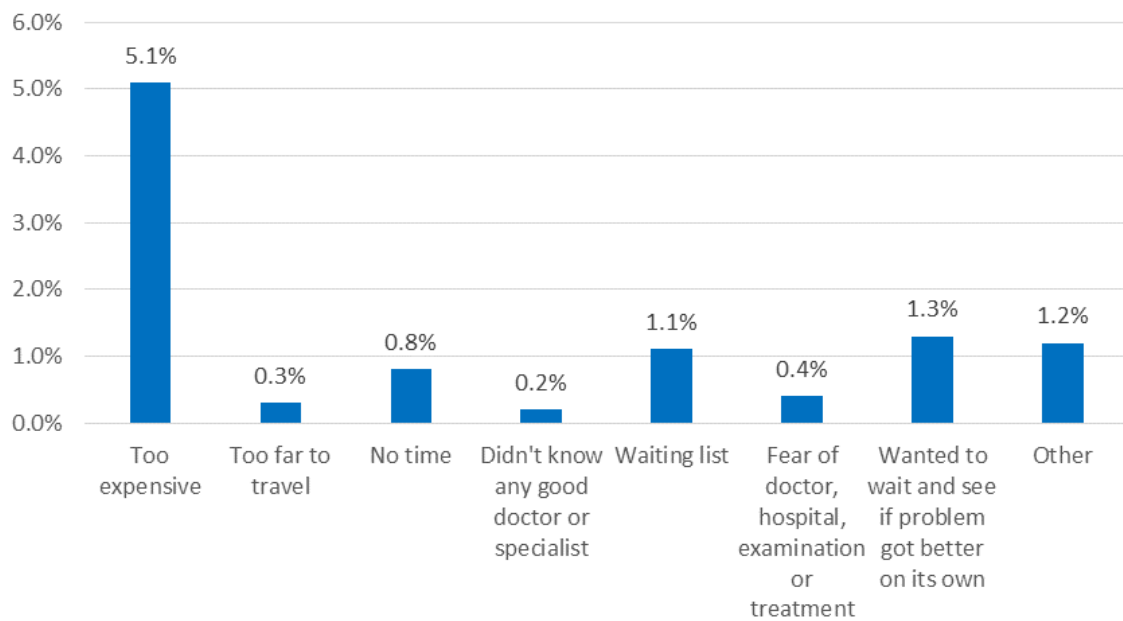
Figure 11. Self-reported unmet needs for medical examination, 2008-2014



Source: Eurostat (2016e). All data are for EU-27 (excluding Croatia).

Figure 13 shows that treatment being too expensive is by far the most common reason given by individuals in the first income quintile for having unmet healthcare needs.

Figure 12. Self-reported unmet needs for medical examination by reason: first income quintile (2014)

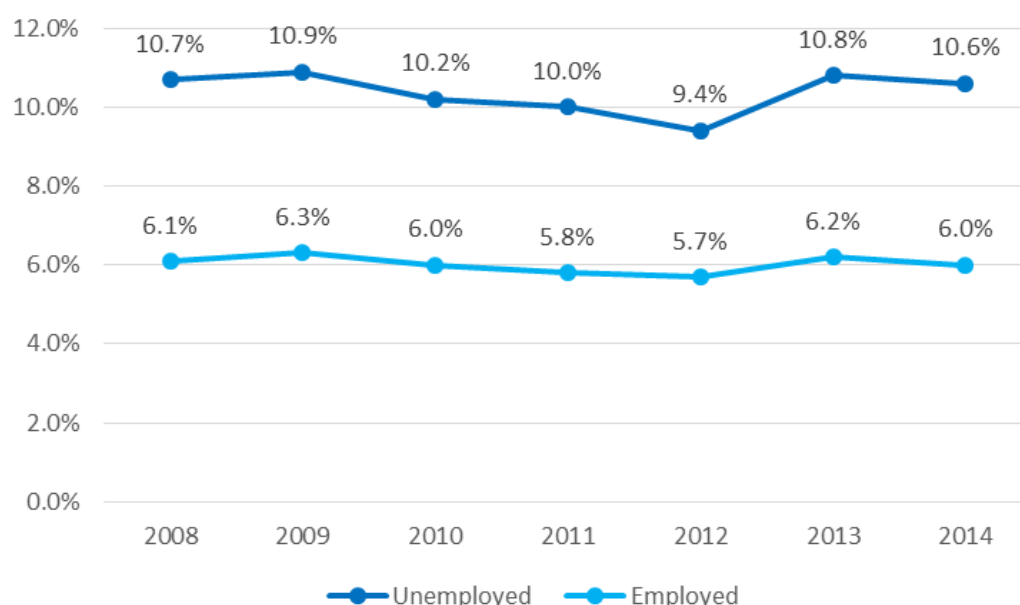


Source: Eurostat (2016e). All data are for EU-27 (excluding Croatia).

Differences in self-reported unmet needs vary widely between Member States: in Slovenia, Sweden and the UK, income level is not reported and is less of a barrier to accessing healthcare, while in Latvia the income level is reported as having a significant impact on access to healthcare (OECD, 2014). This income-related inequality of access to healthcare is likely a key determinant of the health inequalities, as implied earlier in Figure 10.

The prevalence of unmet medical examination needs also varies between other population subgroups. For example, Figure 14 shows that unmet needs among unemployed people have consistently been higher than unmet needs among employed people in Europe. The rate of unmet needs did not change significantly for either group across the period 2008-2014, with the prevalence of unmet needs among unemployed persons consistently between four and five percentage points higher.

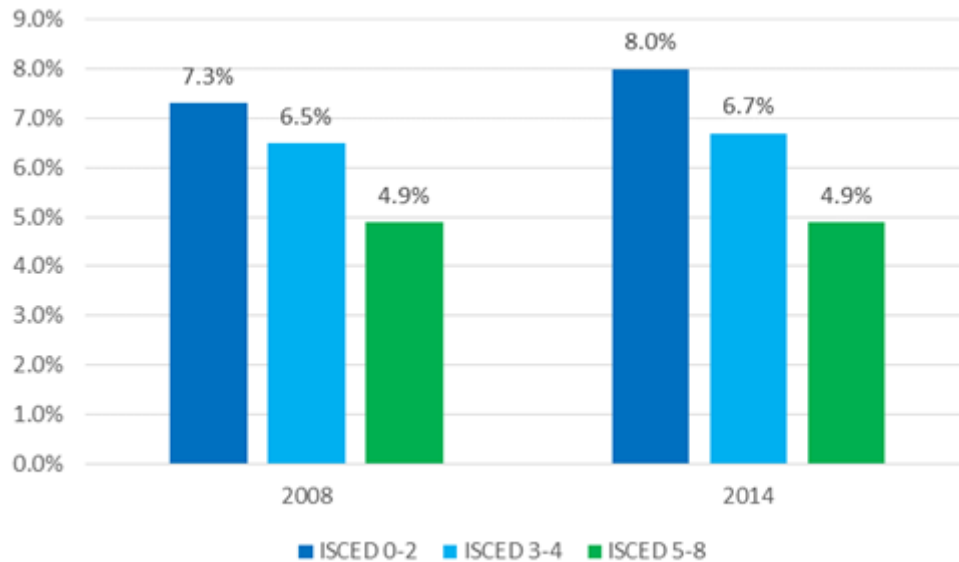
Figure 14. Self-reported unmet medical examination needs, by employment status



Source: Eurostat (2016f). All data are for EU-27 (excluding Croatia).

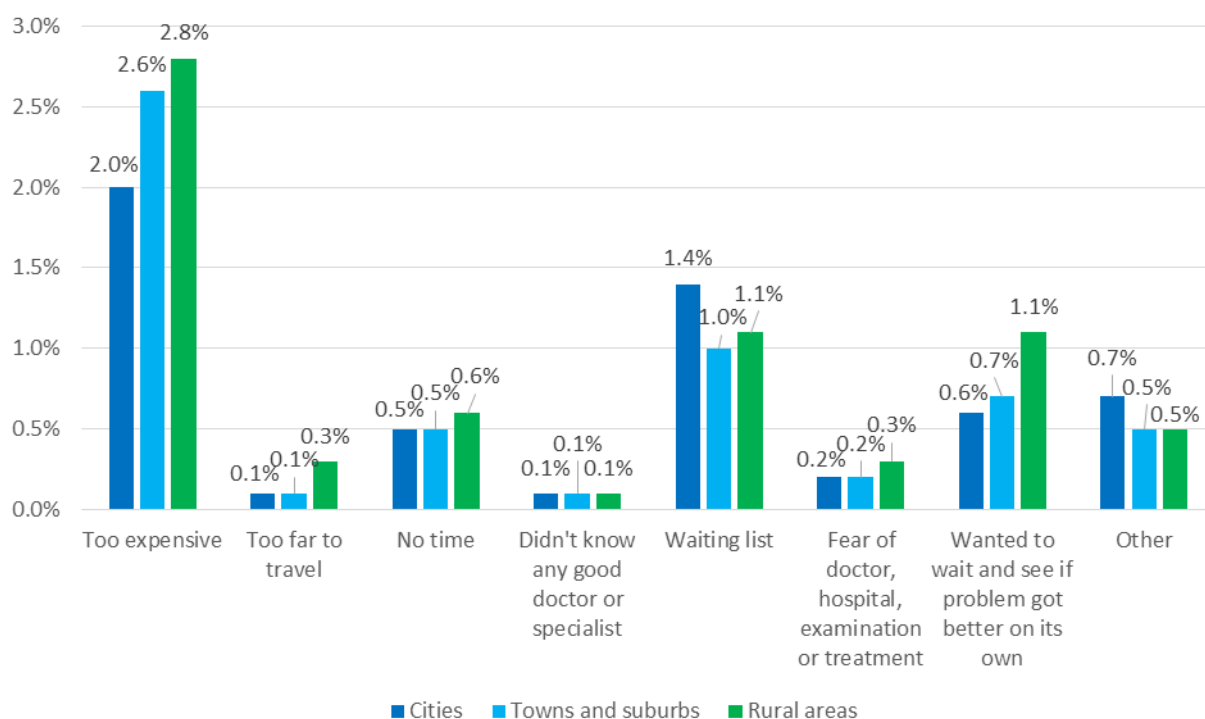
The level of educational attainment also correlates with access to healthcare. As shown in Figure 15, people with a higher level of education were consistently less likely to have an unmet healthcare need than people with a lower level of education. In 2014, 8% of individuals educated up to a junior high school level had an unmet need, compared to 4.9% of individuals with a tertiary education. This perhaps contributes to some of the differences in life expectancy depending on educational status, as discussed earlier.

Figure 15. Self-reported unmet medical examination needs, by educational attainment



Source: Eurostat (2016f). All data are for EU-27 (excluding Croatia). ISCED levels 0-2 equate to a junior high school education or lower; ISCED 3-4 to a senior high school education; and ISCED 5-8 to tertiary education (undergraduate or postgraduate).

Data on rates of unmet medical examination needs (Eurostat (2016g)) show some slight variation depending on people's level of urbanisation: the proportion of rural residents with unmet health needs (6.8%) was one percentage point higher than the proportion of those who live in towns and suburbs (5.8%) or cities (5.7%). As Figure 16 shows, there is no one consistent reason for this difference, although residents in cities were noticeably more likely to cite waiting lists as a key factor in any unmet needs they had, while the cost of healthcare was more commonly cited in towns, suburbs and rural areas.

Figure 16. Self-reported unmet medical examination needs, by reason and level of urbanisation (2015)

Source: Eurostat (2016g). All data are for EU-28.

The quality of healthcare services provided constitutes a further factor causing inequalities in access to healthcare. A Eurobarometer survey, conducted in 2009, explored Europeans' perceptions on patient safety and their attitudes towards the quality of healthcare. Survey findings indicate that an average of 70% of people perceived the quality of healthcare provided in their country as 'good'. However, significant differences were observed among respondents: 97% of respondents from Belgium consider healthcare quality in their country as good, followed by respondents in Austria (95%) and Finland (91%). On the other hand, only 25% of respondents in Greece and Romania stated the same (European Commission, 2010a). These variations in perceptions of quality of healthcare may reflect differences in the quality of healthcare provision between Member States.

The 2008 financial crisis is likely to have had an impact on health inequalities and access to healthcare across Member States. Although the health sector has been relatively protected compared to other sectors, expenditure on health has typically been cut, frozen or its growth has slowed (The Health Foundation, 2014). There is some indication that this has had an impact upon population health and healthcare access. Although levels of long-term ill-health were rising across the European Union even before the financial crisis, Member States (such as Spain, Portugal and the Netherlands) have seen more significant rises than others post-2008. It is also notable that levels of self-reported unmet need for medical care were declining across the EU-27 prior to 2008, but have since consistently risen (largely due to rises in Greece and Italy). This is especially problematic, considering that health problems are particularly pronounced among vulnerable groups, including people with low incomes, unemployed, elderly, pregnant women and children, and those with mental health problems (Kentikelenis et al., 2014).

Key findings from the data review:

- Between 2008 and 2014, life expectancy at birth rose consistently in all Member States, for both men and women. Other health indicators generally remained stable across all populations during this period, although the prevalence of long-standing ill-health increased slightly for people in almost all income quintiles.
- The evidence highlights persistent health inequalities between different population subgroups. For example, men's life expectancy and healthy life years (HLY) were lower than women's throughout this period (although men were also expected to spend a greater proportion of their lives without disability, in good health).
- Rates of ill health were consistently higher among older and poorer population groups within and between Member States. For example, rates of long-standing ill health have consistently been higher among poorer population quintiles. Similarly, there are considerable differences in the prevalence of long-standing illness and poor health among individuals aged 65 and over between Member States.
- The evidence highlights differences in levels of access to healthcare between different population subgroups. Those with lower incomes, lower levels of educational attainment and those who were unemployed or lived in more rural areas were more likely to have unmet needs for medical examination than the general population.
- The reasons given by individuals for having unmet healthcare needs varied, although there was some variation between population subgroups. The vast majority of people in the first income quartile (i.e. the least wealthy) said their unmet healthcare needs were due to the cost of healthcare, although this varied from country to country.
- All of the inequalities found during this evidence review remained broadly stable during the period covered, although the proportion of people rose who cited the cost of healthcare as the primary reason for not seeking treatment.

Policy review: addressing the general issue of health inequalities

European action on health issues started in the 1980s with the development of a range of activities on health promotion, education, information and training. During this period the European Union also began developing EU level health data and specific-disease programmes.

The growing challenges identified at European level in the health sector convinced Member States to adopt gradually specific approaches. In 2006 Member States agreed common objectives on the accessibility, quality and financial sustainability of healthcare in the context of the Open Method of Coordination for social protection and social inclusion (Joint Social Protection Committee / Economic Policy Committee, 2006). These objectives included access to high quality health and long-term care, promoting quality of care and a rational use of resources. This constituted the first step for the development of an integrated policy strategy at the European level.

In 2007, the European Union adopted the first comprehensive EU Health Strategy through a consistent and integrated policy framework that sought to address health challenges combining legislation, cooperation and financing in its EU Health Strategy 'Together for Health' (European Commission, 2007). The strategy consists of three main objectives: improve citizens' health security; promote health and reduce health inequalities; and, generate and disseminate health information and knowledge. It supports wider EU action which has sought to actively engage in a range of policy areas to reduce health inequalities, including recognising the need to address the key drivers of vulnerability, such as poverty and social exclusion, as part of its Europe 2020 strategy (European Commission, 2010b). These policies transcend strategies which focus on health policy alone and recognise the importance of acting on a range of health determinants, lifestyle and health behaviours and health outcomes (European Commission, 2013a).

Recognising the close link between the health sector and the Europe 2020 strategy, in 2013 the Commission proposed a new policy framework entitled 'Social Investment Package for Growth and Cohesion', which includes a staff working document entitled 'Investing in Health'. The staff working document extends the previous EU Health Strategy and explains how EU action in the field of health helps to reach the Europe 2020 objectives. How achieving health outcomes is likely to have a positive impact in terms of productivity, labour supply, human capital and public spending. To achieve positive health outcomes, the paper suggests a combination of investments in three areas: sustainable health systems, people's health and in reducing health inequalities.

As a result, the Commission continued to support actions to address health inequalities identified in the Communication entitled 'Solidarity in Health: reducing health inequalities in the EU' and increased information and dissemination activities through exchange of best practices and sharing an understanding of the effects of health investments on social exclusion and poverty reduction (European Commission, 2013b).

In 2014, the Commission adopted a Communication on the 'Effective, accessible and resilient health systems', which focuses actions to strengthen the effectiveness of health care systems by developing indicators and increasing the accessibility and resilience of healthcare systems. In this respect the Commission has taken a number of actions to support Member States, such as providing guidelines, monitoring and evaluation tools.

The European Commission recognises the importance of measuring the health of vulnerable groups within the EU, including those at risk of poverty and social exclusion, as well as migrants and Roma populations and has taken important steps in this area (European Commission, 2013a).

Access to healthcare is also a focus of EU action. The EU Charter and the International Covenant on Economic, Social and Cultural Rights both advocate for the right of access to healthcare for all people within the EU, with particular reference to vulnerable and marginalised groups. Whilst Member States are primarily responsible for this policy area, the EU has a mandate for supporting national strategies to improve public health and healthcare provision. However, the monitoring of access to health care at the EU level is often limited. Some commentators argue that the EU could do more to improve understanding around barriers to accessing healthcare that focus on the costs associated with healthcare, health literacy, and ensuring that efforts to promote access to healthcare are relevant to people's needs, appropriate and cost-effective (European Commission, 2015a).

At the Member State level, as identified in a national policy review, inequalities in health status and inequalities in access to healthcare are both consistently recognised as priority issues, with a range of policies and initiatives in place to address these inequalities. Some of those policies are broader, population-wide action plans that target multiple vulnerable groups, such as:

- Strategies for addressing health inequalities experienced by multiple different vulnerable groups (such as France's City Health Workshops, which provide for multiple vulnerable population groups);
- Population-wide health strategies, not specifically addressing health inequalities but with some specific aspects focusing on vulnerable groups (such as Ireland's national cardiovascular health policy, or France's cancer plan); and
- Multi-faceted strategies targeting vulnerable groups, within which health is one component (such as anti-poverty strategies in the UK and Portugal that address health but also employment, housing and other poverty-related issues).

In most cases, Member States have strategies or programmes in place that address the health inequalities of multiple disadvantaged groups within one single plan. In Greece, for example, the National Health Strategy (2014-2020) includes an aim of improving healthcare access for all vulnerable groups, although makes a particular mention of individuals with lower levels of education or lower income. France's City Health Workshops also have a relatively broad health inequalities remit, offering healthcare to meet a range of needs within deprived urban districts (those needs identified by consultation with those local communities). Where plans such as these identify specific vulnerable groups within their remit, they most commonly identify children and young people, older people and deprived groups (those on low incomes or in isolated areas).

Most Member States have implemented policies that specifically focus on the health or inequalities in healthcare access of at least one particular vulnerable group, as well as policies targeting Roma communities and immigrants. However, evidence of such policy initiatives is inconsistent. None of these groups are consistently the focus of such actions plans across many Member States. Health inequality policies that are targeted at one specific group most commonly focus on children and young people, older people or those with mental health problems. Across all types of health policy, victims of domestic violence, prisoners and homeless people are the groups least likely to be targeted by interventions.

Chapter 2: Understanding the issues experienced by particular vulnerable and isolated groups

Target groups for this review

This Chapter reviews evidence and literature related to nine target groups, based on their vulnerability to poor health and susceptibility to the cumulative impact of specific risk factors. We explore the specific health needs and challenges of each individual target group, as well as the key drivers of vulnerability. We also explore evidence on strategies and initiatives to tackle vulnerability and health needs of these groups.

These groups, as agreed during the inception phase of this study, are:

- Older people
- At risk children and families (especially lone-parent families)
- People living in rural/isolated areas
- People living with physical and learning disabilities or poor mental health
- People experiencing long-term unemployment, and economic inactivity
- In-work poor
- Victims of domestic violence and intimate partner violence
- People in insecure housing situations (homeless)
- Prisoners.

Structure

For each group, Chapter 2 provides:

- A brief overview of the EU policy context;
- Details of the scale of the problem facing the group, including health challenges and barriers to healthcare access;
- Evidence in relation to the effectiveness of policies and actions (at EU and/or national level) that aim to address the health needs of the group.

Older people

The data review in Chapter 1 showed old age is associated with a greater chance of having a long-standing illness or health problem, relative to other age groups. This section focuses on vulnerability experienced during old age, describing the health challenges faced by vulnerable older people, issues relating to access to healthcare, and measures taken to address the health needs of older people experiencing vulnerability.

Overview of policy context

Over the last few decades, there has been a number of legal developments at the EU and international level focusing on the importance of promoting and protecting the rights of older people. Recognising that older people may face a range of challenges, including discrimination and barriers to accessing services and participation in mainstream society, a range of activities have taken place at the international level advocating for the rights of older people. This includes the following major milestones:

- The Amsterdam Treaty of 1997 provided the EU with the ability to fight discrimination based on sex, race or ethnic origin, religion or belief, age or sexual orientation.
- In 2000, European legislation was introduced to protect all people living in the EU from discrimination at work on the grounds of age, through the Framework Directive 2000/78/EC.
- The Charter of Fundamental Rights, which was given binding force in 2009 under the Treaty of Lisbon, dedicated Article 25 to the rights of older people and set out a wide range of political, civil, economic and social rights relating to older people, including the rights to non-discrimination, social security, healthcare and education.
- In 2011, the EU ratified the United Nation Convention on the Rights of Persons with Disabilities (UNCRPD) requiring the needs of the ageing population to be taken into account as part of its application.

At the EU level, there have also been important steps to promote active and healthy ageing, including through the European Innovation Partnership for Active and Healthy Ageing. This Partnership involves a collaboration between a wide range of stakeholders working towards promoting Active and Healthy Ageing within the EU. Overseen by the Partnership's Steering Group, established in 2011, it aims to implement the a range of action plans focusing on specific priorities relating to ageing and older people and has received backing from the European Commission (European Commission, 2012a).

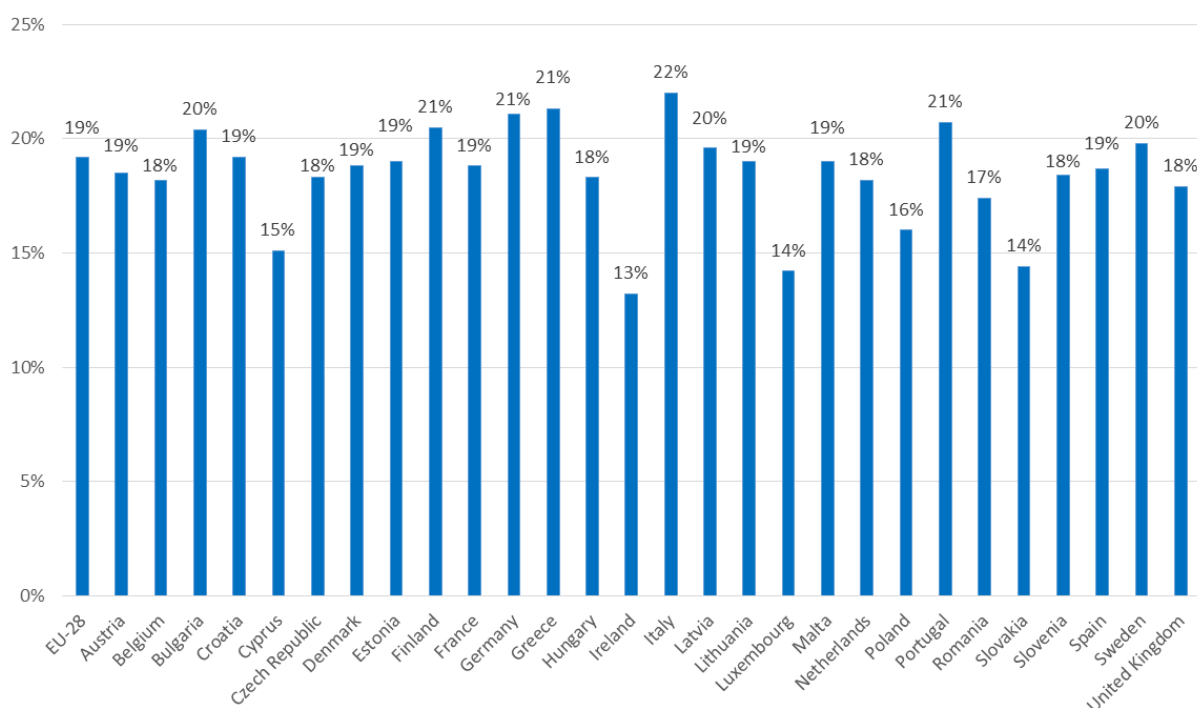
This is discussed in more depth in the "Evidence" section below.

Scale of the problem

Europe is the world's oldest continent by demography and its ageing population poses particular challenges for policymakers. Estimates suggest that older people (aged 65 and over) made up 19.2% of the EU population in 2016 (Eurostat, 2017b), and the proportion of older people in the EU is set to rise by 20% by 2020 (Eurostat, 2015a). However, the proportion of older people differs considerably from one Member State to another. For example, as shown in Figure 17, Member States such as Italy (22.0%), Greece (21.3%) and Germany (21.1%), whilst countries like Poland (16.0%), , Luxembourg (14.2%), Cyprus (15.1%) and Slovakia (14.4%) have low proportions of older people, with Ireland reporting the lowest proportion of older people in the EU (13.2%) (Eurostat, 2015a). Therefore, it is likely that challenges will differ across Member States and so will the level of vulnerability experienced by some older people.

Figure 17. Proportion of population aged 65 years and more (2016)

Draft Scientific Report: Literature Review



Source: Eurostat (2017b). All data are for EU-28.

Mortality rates between EU countries also vary considerably. Therefore, when considering vulnerability in old age, it is important to make a distinction between chronological age and biological ageing: *'the progressive decline in physiological ability to meet demands, that occurs over time'* (Adams, and White, 2004). It is likely that people who experience faster rates of decline in physiological ability may present health issues and/or vulnerabilities at an earlier chronological age than others, as the process of ageing is dynamic and the health status of older people varies considerably (Chatterji, et al., 2015). This requires consideration of a broad age range for the purposes of this review.

Health challenges

This section examines the health challenges faced by older people. Older people are often confronted with the long-term impacts of vulnerable situations experienced over their life-course, such as death of a partner, illness and disease, and long-term unemployment during active years of their life. In addition, due to age-related health deterioration, older people are more likely to be dependent on, and greater consumers of, healthcare services than the rest of the population. These things combine to have a cumulative impact on the key components of their quality of life and well-being, including financial well-being, health, social support and connectedness (Zaidi, 2014). The Lancet has published a series on ageing which highlights some of the major health challenges in relation to ageing. This includes a study which suggests that at the global level, around 23% of the total burden of disease is attributed to people aged 60 and above, and is highest in high-income countries (Prince et al., 2015).

Older people, as a group, are more likely to experience a wide range of health needs (including higher rates of morbidity and mortality) than the rest of the population. For example, a study conducted by Drozdak and Turek (2016) in Poland, using data from the Polish Edition of the European Social Survey (ESS), aimed to identify factors relevant to self-assessed health that also contribute to health inequalities in Poland's ageing population. The study found that overall age was associated with poor health. People in the 65-69 age group reported poor or very poor health seven times more often than people in the 45-49 age group; people in all age groups, on average, reported poorer health than the youngest age group. In addition, the study identified retirement as a predictor of poor health, which is linked to age, as well as other factors including income sufficiency, disability, low social activity and social position.

Socioeconomic factors are identified as a key determinant of health and vulnerability in later life, with those experiencing greater disadvantage experiencing poorer health and wellbeing (Knesebeck et al., 2007; Siegest, 2009). Education and wealth can have a direct and indirect impact on health. For example, access to greater material resources in early old age can facilitate individuals participating in cultural and leisure activities, contributing to autonomy and feelings of control (Pinquart and Sorensen, 2000). Welfare arrangements in individual Member States can also have an impact on vulnerability and health, as older people become dependent on support from fixed incomes (such as pensions) and families as they are no longer of working age (Eikemo and Bambra, 2008).

Access to healthcare

This section examines issues around access to healthcare experienced by older people. According to literature explored, there are a range of factors that may affect older people's ability to access healthcare. These are discussed in more detail below.

Low income has a negative impact on older people's access to healthcare. In some Member States (such as Latvia), where provision of healthcare is often linked to health insurance, level of income can have an impact on an individual's ability to access healthcare (particularly specialist healthcare) because the cost may be too high. This may also affect those who are approaching retirement age as older people are often at risk of being excluded from the labour market or may choose to retire early. For example, research in the EU-27 countries suggests that only three out of ten of those in the pre-retirement age cohort (60-64) are in employment (Eurofound, 2012).

Older women are particularly at risk of low income barriers when accessing healthcare. Gender inequalities in the labour market, accumulated over the life-course, transition into disadvantages in older age, exposing women to poverty and social exclusion. They receive, on average, lower pensions than men, and the gender gap in material deprivation (to the detriment of women) is greatest amongst those aged 65-74 and over 75 years old (Eurostat, 2015b).

Another barrier to accessing healthcare for this target group is low education and low health literacy. Data from the Survey of Health, Ageing and Retirement in Europe (SHARE) shows that older people with a lower level of education and lower income are more likely to experience functional limitations and have a higher prevalence of eyesight, hearing and chewing problems. In addition, low health literacy and reading problems are aggravating factors that affect the utilisation and access to healthcare and are often linked to bureaucratic procedures within healthcare systems (such as completion of forms). The increasing use of e-technologies for health services and information in the health care sector may also intensify this barrier (CPA, 2014).

Older people are also less likely to own private modes of transport and rely on public transport to access healthcare services. For older people who have particularly long distances to travel in order to access healthcare services, this may present a barrier in accessing healthcare if they do not have private transport and they live in areas where the public transport infrastructure is poor (Gartner, Gibbon and Riley, 2007; European Commission, 2008a). This confirms the impression from scoping interviews that the level of dependency on others is a key issue affecting older people's health status and access to services.

The barriers described above fall under the concept known as structural ageism. Structural ageism is often described as the systematic process by which society and its institutions perpetuate discriminatory attitudes, actions or language in legislation, policies, practices or culture based on age. This can result in the inadequate provision of services for older people in which their needs, experiences and aspirations are not taken into account during the process of decision-making (AGE Platform Europe, 2016).

Evidence of policies to address the health issues affecting older people

This section examines actions taken to address the health challenges faced by older people. Strategies targeted at promoting health in among older people in the EU have focused on a range of factors. Some seek to promote and prolong health in old age through policies around active ageing to prevent vulnerability, whilst others focus on the specific health needs of vulnerable older people. These are explored in more detail below.

Promoting healthy and active ageing

At the EU level, there has been an increased focus on policy to enable a greater proportion of older people to remain healthy and active in later life, partly driven by the high costs of health and social care associated with supporting Europe's ageing population. The concept of healthy and active ageing is described by the WHO as:

"...the process for optimizing opportunities for health, participation and security in order to enhance quality of life as people age. Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental wellbeing throughout the life course and to participate in society according to their needs, desires and capacities while providing them with adequate protection, security and care when they require assistance (WHO, 2002).

In 2012, the WHO European Region (2012) produced a set of strategic priority areas to support action on healthy ageing within Europe. This included the following:

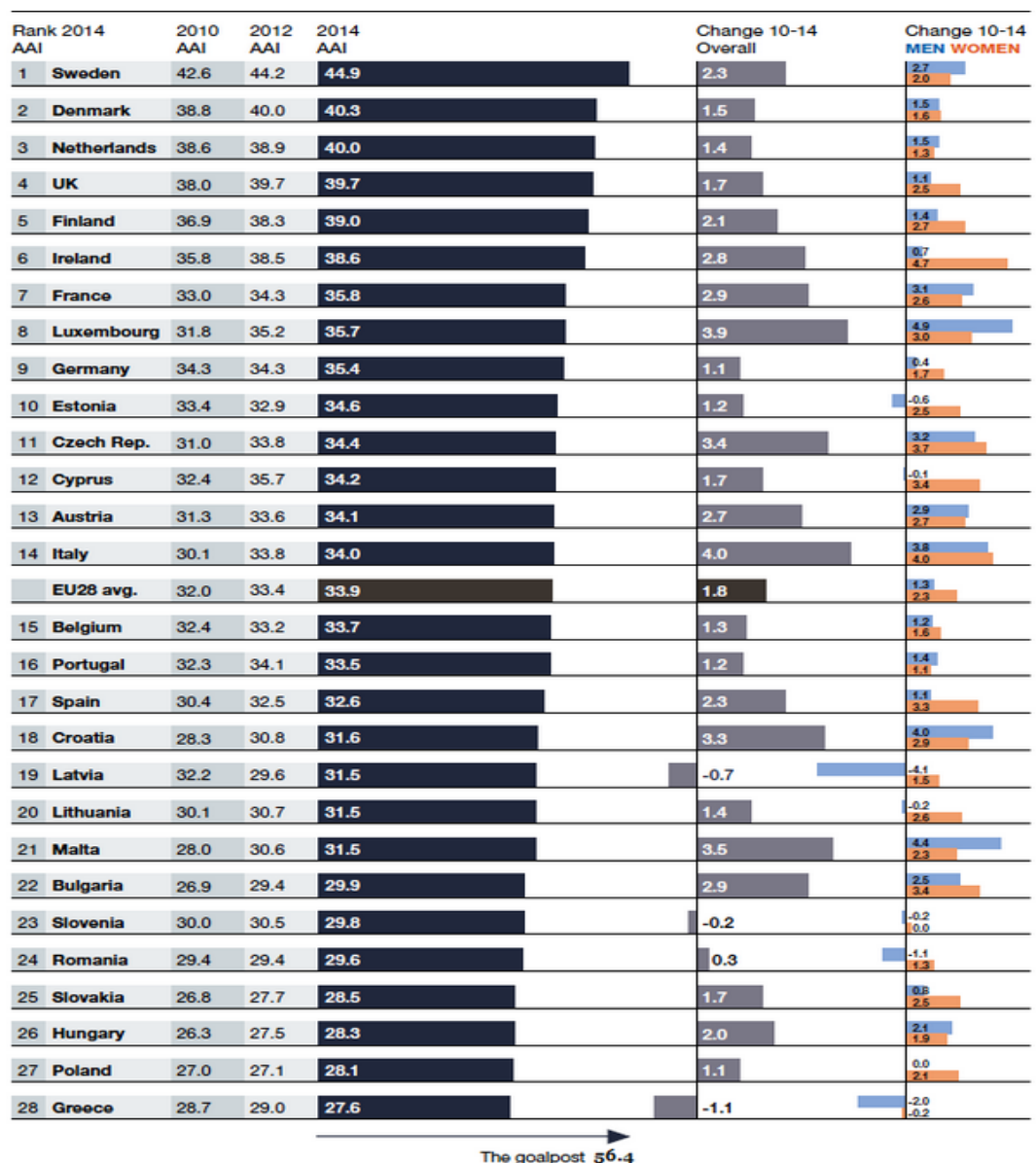
- Supporting healthy ageing through the life-course;
- Ensuring that health and long-term care systems are fit for ageing populations;
- Creating supportive age-friendly environments; and,
- Strengthening research and the evidence base to support policy on ageing.

In conjunction with the WHO, the European Commission has taken action to promote active and health ageing. In 2012, the EU devoted the year to promoting active ageing to improve solidarity between generations. The Active Ageing Index has also been developed to assess the untapped potential of older people across Europe (European Commission, 2012).

The index can be used to monitor active ageing across European countries and provide an indication of where Member States have taken action to improve their progress towards active and healthy ageing across four domains – employment, social participation, independent living and capacity for active ageing (Walker and Zaidi, 2016). The maximum score on the Index is 56.4, indicating that a country has taken substantial steps across these four domains.

Figure below shows the Active Ageing Index results for 2010, 2012 and 2014. It highlights that there is considerable difference in how Member States perform against the Index indicators across the EU. For example, Sweden (44.9) Denmark (40.3) and The Netherlands (40.0) have the highest indicators scores of EU-28 Member States in 2014, compared to Hungary (28.3), Poland (28.1) and Greece (27.6) who had the lowest indicator scores. The average score across all EU-28 Member States was 33.9. In addition, whilst most Member States have demonstrated improvements in their Index indicator score from 2012, the scores for Latvia and Greece have actually decreased.

Figure 18. Active Ageing Index results for 2010, 2012 and 2014



Source: UNECE Statistics 2016

The European Innovation Partnership for Active Ageing was also established in 2011 with the aim of increasing the average number of healthy life years in the EU by 2020, and improving the health status and quality of life of EU citizens. The partnership has also developed six action groups and produced action plans focusing on specific issues, including the following:

- Prescription and adherence action at regional level;
- Personalised health management and falls prevention;
- Prevention and early diagnosis of frailty and functional decline;
- Replicating and tutoring integrated care for chronic diseases, including remote monitoring at regional level;
- Development of interoperable independent living solutions; and

- Innovation for age-friendly buildings, cities and environments.

The partnership has since brought together more than 3,000 partners to contribute to this policy area and support good practice. Work has focused on improving information sharing, solutions on how to overcome bottlenecks, pooling knowledge and resources, acting towards shared goals and strategies for increasing the scale of good practice in the area of active and healthy ageing (European Commission, 2015a). An evaluation of European Innovation Partnerships found that there were sound reasons for the European Commission to continue promoting this approach, but stated that the partnership should perhaps reconsider its target of increasing healthy life years across the EU by two years, viewing this target more as a slogan compared to an objectively measurable target (European Union, 2014).

Alongside the European Innovation Partnership, other policies have also included aims to support ageing populations. Research into active and ageing suggests that lifelong learning, working longer and retiring later, as well as volunteering in old age is associated with improving or prolonging good quality of life in old age (Knesebeck et al., 2007; Siegreest, 2009). The EU's employment strategy has focused on encouraging Member States to implement active ageing policies to increase the participation of people aged 50 and over in the labour market, including incentives for employers to hire older workers and increased flexibility of work (through part time and temporary employment) (EuroFound, 2013).

Prevention and addressing drivers of poor health and vulnerability

The Health Ageing Supported by the Internet and the Community (HASIC) programme, a Europe-wide programme which ran for two years between 2014 and 2016 and funded through the 2nd European health programme. It sought to empower, and improve the lifestyle of, older people, through supporting older people to have healthier diets, engage in physical activity, moderate their alcohol consumption and provide opportunities for social interaction. These measures address some of the key factors that contribute to inequalities in health and vulnerability, such as poor diet and health behaviours, social isolation and low levels of physical activity. The programme also aimed to improve the cost-effectiveness and quality of older people's services through encouraging cooperation between regional service providers and making policy recommendations. The programme comprised four main activities, including: group and peer support activities; an online platform to provide information about healthy lifestyles for older people; a toolkit for healthy ageing comprising of self-management techniques and other activities to help older people lead a healthier lifestyle; and a network to improve cooperation between health and social care providers from the public, private and third sectors (HASIC, 2014).

In Poland, the Health promotion and prevention of risk – action for seniors (Pro-Health 65+) project is led by the Jagiellonian University Medical College and other partners in tertiary education, the project was funded under the first European Union Health programme (2008-2013) and began in 2014. The project aims to improve knowledge and use of evidence-based methods for promoting health among older people, increasing the possibilities for and reducing barriers related to health promotion services and activities. It also aims to improve health literacy among older people, support older people to lead healthy lifestyles and reduce the risks of chronic diseases and accidents, ultimately increase healthy life years for older people. To achieve this, the project is developing a manual to be used to support healthcare professionals to deliver better care for older people and sustain good health among the older population.

The manual will include practical information and recommendations regarding:

- The utility of health promotion interventions in improving the elderly population's health;
- Good activities and programmes for practitioners to prescribe;
- Funding mechanisms for funding health promotion interventions;
- The use of economic evaluations in measuring the success of health promotion interventions; and,
- Tools for conducting further research in this area.

This is based on research and analysis of relevant studies relating to health promotion for older people, an assessment of health workforce institutions and the incorporation of findings from the research and analysis into training materials to be delivered to institutions undertaking training on health promotion for older people (Golinowska, 2016).

Given the breadth of information covered, it is likely that institutions and individual practitioners receiving the briefs will see the value of the recommendations made by Pro-Health 65+ and result in practical changes to approaches health promotion for older people.

Improving the provision of health and social care for older people

Focus has also turned on the challenges facing health and social care services in terms of meeting the needs of vulnerable older people, particularly those with complex needs and high levels of service utilisation. To meet the health and social care demands of people with complex health needs, research and policy in some Member States (such as the United Kingdom) highlights the importance of person-centred care and personal budgets in providing adequate care for older people (Gridley, Brooks and Glendinning, 2014). However, to meet the growing demand on health and social care services of an ageing population, this will require the expansion of the health workforce (UKCES, 2015).

The Our Life as Elderly (OLE II) project¹ has been implemented in Member States such as Sweden and Finland, as well as other Scandinavian countries such as Norway, Iceland and the Faroe Islands. The project operated between 2008 and 2011 and was funded via the Northern Periphery and Arctic programme as part of the European Union regional development fund. Building on the work of OLE I, which aimed to identify the needs and care preferences of older people, OLE II aims to develop specific services to meet the need of older people through improving the quality and responsiveness of health and social care services available to older people. The project involves four main activities including:

- Competence development and staff recruitment to ensure that the health and social care workforce is suitably qualified and staffed to meet the increasing demand on services from a growing population of older people;
- Development of products for health and social care services to conduct home visits and risk assessments for older people, improve the safety of medication administration processes, and educate staff on how to appropriately hand patient medication;
- Recognising the importance of social connectedness, develop a web portal providing a platform for older people to communicate and organise educational and social activities.

¹ <http://www.ourfuture.eu/>

- Supporting older people to live in their own home through the provision of suitable housing through creative property solutions.

Although there is little evidence on the outcomes of the project, OLE II has demonstrated a good level of sustainability and replicability as it has been implemented in a range of countries and over two project phases.

Programmes such as SUSTAIN (Sustainable Tailored Integrated Care for Older People in Europe) consists of a range of international experts working in the field of care for older people, collaborating to improve integrated care initiatives within a number of Member States (including Spain, the United Kingdom, Austria, Germany, Estonia and The Netherlands). The project began in 2015 and is funded under the European Union Horizon 2020 programme for research and innovation. Recognising that care for older people is often poorly coordinated, preventing older people from receiving care that adequately meets their complex health needs, the programme supports existing initiatives by engaging a wide range of stakeholders in order to bring knowledge and experience to models of integrated care and ensure that learning and good practice is applicable and adaptable to other health systems and Member States (SUSTAIN, 2016).

At-risk children and families

This section focuses on the issues of vulnerability in relation to at risk children and families, including lone parents. This group is an internally diverse group whereby not all children are vulnerable and isolated, but where the vulnerability and isolation of children may result from specific characteristics or particular circumstances (e.g. growing up in poverty). Similarly, parents are also a diverse group and may experience vulnerability or isolation because of health and behavioural problems (e.g. substance abuse) or due to particular circumstances (such as poverty).

This target group sits within a context where, across many developed societies, the structure of the family has changed over the last few decades and the structure of the two-parent nuclear family has become less common (Eurostat, 2015c).

Overview of the policy context

The United Nations Convention on the Rights of the Child (UNCRC) was adopted by the United Nations in 1989 and sets out the civil, political, economic, social and cultural rights to which all children are entitled. The EU recognises children's rights are an integral part of human rights and is guided by the principles of the UNCRC. In 2009, the Treaty of Lisbon introduced legislation to protect the rights of children within the EU, and within the same year the Charter of Fundamental Human Rights of the EU became legally binding, ensuring the protection of children's rights by EU institutions and Member States. The importance of promoting children's health has been stressed by other international organisations, such as the WHO.

Under the EU Health Strategy, the Commission has also demonstrated its commitment to empowering young people to take an active role in efforts to improve their health. This includes the launch of the Youth Health Initiative in 2009, which aims to encourage young people to be more involved in the decisions and policies in around health, and support a wide range of projects targeting young people to improve health and prevent poor health (European Commission, 2009).

The WHO's Commission on the Social Determinants of Health (CSDH) (2008) emphasises the importance of experiences in early childhood – prenatal development to age eight – in setting the foundations for an individual's life-course, including their health. Therefore, ensuring that children have the right environment to develop and grow at the start of their life is very important.

The European Commission's Social Investment Package and Recommendation "Investing in children: breaking the cycle of disadvantage", introduced in 2013, aimed to tackle child poverty and social exclusion by calling on Member States to ensure that parents are: supported into the labour market; have access to affordable and good quality child care services; and, are able to access appropriate child and family benefits (European Commission, 2013b).

In 2014, Member States also agreed on a European Action plan targeting childhood obesity which provides a range of voluntary initiatives aimed to give every child the best start in life and promote healthier environments for children to grow and develop, through action in key areas such as schooling, advertising and marketing, physical activity, the family and research (European Commission, 2014a).

Scale of the problem

Within the EU, children are at a greater risk of poverty and therefore ill health than the general population. The AROPE indicator measures the share of the population at risk of poverty or social exclusion, which covers individuals who fall into one or more of the following categories:

- At risk of (monetary) poverty – below the poverty threshold;
- In a situation of severe material deprivation; and
- Living in a household with low work intensity.

According to this indicator, in 2014, the proportion of children living in households at risk of poverty or social exclusion in the EU-28 was 27.8%, ranging from 15% in Denmark to 51% in Bulgaria. Between 2010 and 2014, the AROPE rate for children in across 17 EU Member States rose, including in countries such as Malta, Greece and Luxembourg. Figures for other age groups suggest that poverty rates are lower among these groups; 25.4% for 18-64 year olds and 17.8% for people aged 65 and above (Eurostat, 2016h).

Employment is one of the most important sources of income for the majority of households in the EU. Families with low employment levels (including unemployment) are more likely to be at risk of poverty and social exclusion. Around 65% of households with dependent children with low and very low work intensity were at risk of poverty in 2014 (Eurostat, 2016h).

The risk of poverty and deprivation is also often associated with lone parent households, and so it is important to consider the circumstances of individuals raising children without a partner. Whilst the costs and time commitment may be similar, the lack of shared responsibility with a second parent can have a significant impact on the ability of individuals to provide for dependents while manage a household (RAND, 2014).

This situation can place lone-parent households at great risk of poor health, compared to two-parent families, to which socioeconomic factors contribute. Changes in family structure have resulted in an increase in lone-parent families, the vast majority of which (85%) are headed by lone mothers (EIGE, 2016). Lone parents with dependent children were found to be at the greatest risk of poverty or social exclusion in the EU. This is because family structure is associated with a negative impact on total household disposable income. In 2014, nearly one in two (46%) lone-parent households in the EU were at risk of poverty or social exclusion, as opposed to 20% of households made up of couples with children (EIGE, 2016). Lone mothers were particularly at risk of poverty and social exclusion (ibid)².

Health challenges

This section examines the health challenges faced by at risk children and families. There is limited literature specifically focusing on the health needs of at-risk children and families, including lone-parent families at the European level. However, there is a body of research that focuses on the relationship between vulnerable families, poverty and health.

Research conducted across 26 European countries found significant and positive correlations between income inequality and a country level childhood injury mortality rates (Sengoogle et al., 2013). In addition, poverty is also a risk factor adverse childhood experiences³, which can lead to a range of health needs including respiratory, circulatory and oncological diseases; mental health problems; drug abuse; and, risky health behaviours (UCL IHE, 2015).

A recent report published by the Royal College of Paediatrics and Child Health (2017) in the UK, provides a snapshot of infant, children and young people's health. The report found that children from deprived backgrounds have considerably worse health and wellbeing compared to children from non-deprived backgrounds. The findings also suggest there is a clear link between children growing up in low income households and the poor health management (such as Type 1 diabetes control) and the prevalence of special or additional education needs, likely to affect children in adult life.

Research has looked at the impact of lone-parenthood on the health status of mothers. For example, Rousou et al. (2013) conducted a systematic study of literature on the health implications of lone mothers and self-reported health. They found that lone mothers assessed their health lower than any other group of women, including mothers in two-parent families. Based on these findings, the study concluded that the family status was the main factor in explaining the inequality between lone mothers and other women. Similarly, a study carried out in Sweden by Westin and Westerling (2006), analysed the self-reported health and healthcare utilisation of respondents who were single or partnered parents. Among lone mothers, they found that as many as 51% rated their health as less than good; compared to 27% among partnered mothers. Single parents were also found to be less likely to utilise healthcare services, due to constraints on their time, caused by the strain of managing childcare and employment responsibilities. Less is known about the specific health needs of lone fathers.

² In 2014, 48% of lone mothers and nearly a third (32%) of lone fathers were at risk of poverty or social exclusion.

³ Situations which lead to an elevated risk of children and young people experiencing damaging impacts to health and social outcomes throughout the life-course.

The structure of the family also has socioeconomic implications that can impact health. The observed health inequalities in the Rousou et al. (2013) study were associated with socioeconomic disadvantage due to either unemployment or insufficient welfare support. Unemployment is associated with a lower income and increased risk of material hardship, linked to increased levels of stress that can be damaging to health (Ala-Mursula et al., 2013).

The effect of growing up in a lone-parent household has also been linked with poor outcomes in adult life. Suavola et al. (2000), explored links between family background and physical illness in adulthood based on a general population birth cohort connected to a national hospital discharge register which included information on all diagnostic groups of physical diseases. The findings suggested that family background may impact on physical illness in early adulthood. Personal relationships and problems related to health behaviours emerged, such as induced abortions and accidents, considered important issues for psychological and public health perspectives. Women from lone-parent families were more likely to be treated for any physical condition in hospital wards compared to women from two-parent families (61% versus 57%). The study also suggests that people from a lone-parent family backgrounds tend to be less able to protect themselves against accidental injuries and poisoning.

Similarly, Miller and Plant (2003) examined the importance of family and peer variables in predicting adolescent substance abuse, based on data from the UK part of the European Schools Project on Alcohol and other Drugs (ESPAD). The study found that participants from lone-parent families were more likely to engage in petty theft and vandalism, develop higher rates of depression, have lower self-esteem, poorer family finances and poorer self-reported health.

Access to healthcare

This section examines issues relating to access to healthcare for at-risk children and families, including lone parents. There is limited literature examining the barriers in access to healthcare for at risk children and families across the EU and it is evident that more research is necessary to understand the specific barriers this group may face. Research by Katz, La Placa and Hunter (2007) explores parents' experience of engaging with mainstream support services. The study examined the physical and practical barriers (e.g. travel, cost, geographical), social barriers and stigma experienced by parents accessing services.

The research suggests that a major barrier for parents accessing services include physical and practical barriers in accessing services. Practical barriers include a lack of knowledge about the support available through services on offer, whilst physical barriers include a lack of affordable or adequate transport and physically inaccessible services. The research also suggests that social barriers, such as poverty, disability, ethnicity and being a father can pose a barrier to accessing services. In addition, the research suggests that time the pressures of managing a household and childcare can affect single parents accessing services.

Evidence of policies to address the health needs of at-risk children and families

This section describes approaches to address the needs of at risk children and families at the EU level as well as Member State specific initiatives.

Action at the EU level seeks to reinforce children's rights and lift people, including children and families, out of poverty

There are a range of strategies and initiatives at the EU level that seek to directly or indirectly address the needs of at risk children and families. The European 2020 Strategy aims to lift 20 million people out of poverty and social exclusion by 2020 (using 2008 as the baseline). This recognises that almost one in four people in the EU are at risk of poverty and that there is a need for Member States to reduce the number of people who experience disadvantage, low work intensity and material deprivation, many of whom are disadvantaged families (including lone parents).

To support the implementation of the Social Investment Package and Recommendation for Investing in Children (through providing guidance for Member States), the European Platform for Investing in Children (EPIC)⁴ (an evidenced-based online platform) was used to collect and disseminate examples of innovative and evidence-based practices through measures including family support and benefits, good quality childcare and early-childhood education. The Platform is also used as a tool for monitoring progress in response to the Recommendation.

Alongside these strategies, organisations such as Eurochild aim to position children's rights at the centre of policymaking. Forming a network of organisations across the EU, Eurochild has aimed to influence policies at the EU level that impact on children, particularly children and young people, who experience vulnerability and are exposed to poverty and social exclusion (Eurochild, 2011). The organisation claims a number of achievements in advancing children's rights, which include the following:

- **Securing the European Commission Recommendation on Investing in Children:** the recommendation stresses the importance of early intervention and preventative approaches to break the cycle of disadvantage, poverty and social exclusion experienced by children across the EU. It calls on Member States to support parents into paid work and improve access to affordable early years childcare, education and healthcare (European Commission, 2013b).
- **Enlisting support from 100 Members of the European Parliament to support Child Rights Champions:** the Child Rights Manifesto was launched in 2014 and aims to build commitment to children's rights, including promotion and protection of children's rights across the EU (Child Rights Intergroup in the European Parliament, 2014).
- **Securing the commitment of the EU to end child poverty and institutional care:** through the distribution of European Structural Funds (Eurochild, 2013).

⁴ <http://ec.europa.eu/social/main.jsp?catId=1246&langId=en>

Initiatives to improve the reduce poverty and improve the economic circumstances of the family

Access to childcare for families at risk of poverty has been linked with better wellbeing outcomes and life chances (Eurostat, 2016h), and good quality childcare is also associated with better child development and breaking the cycle of disadvantage. Policy recommendations at the EU level state that Member States should encourage the participation of disadvantaged families by breaking down the barriers to childcare, such as through subsidised childcare (European Commission, 2013b). In addition, welfare payments to vulnerable families, including single-parent families, are important in reducing risks of poverty as they increase household incomes. Universal approaches are considered particularly effective, in comparison to more selective approaches; the former tend to be associated with higher rates of family spending (Cantillon, Collado and Van Mechelen, 2015).

Policies that promote paid parental leave have been shown to ensure stronger links between parents and the labour market after childbirth, offering job protection and financial support during the break from work (Eurostat, 2016h). Well-paid parental leave, subsidised childcare and cultural support for employment soon after childbirth are associated with a smaller gender employment gap and smaller gaps in working hours between mothers and childless women (Boeckmann et al., 2014).

In terms of lone-parent families, the majority of policy responses relating to lone-parent families tend to focus on supporting lone parents to manage their childcare responsibilities and overcome barriers to the labour market and paid work. This approach emphasises the importance of employment in increasing the income of households and reducing the risk of poverty (and its consequences), but also the essential role that childcare plays in ensuring that lone parents are able to return to work (RAND, 2014).

Research conducted by Saraceno (2011), examined the wide range of childcare packages offered across EU Member States. It showed that Member States adopt different approaches to childcare provision, as well as levels of funding, including formal childcare provision, leave arrangements and the level of financial compensation during leave. In addition, it was clear that there was no consensus across EU Member States on how best to deliver childcare services. The national differences in childcare arrangements, leave entitlements and workplace flexibility as well as their impact on children's health were reflected more recently in research carried out for a European Peer Review on the topic (Mantouvalou, 2015).

Supporting disadvantaged families to give children the best start in life

Good practice examples from EU Members States focus on increasing access to a range of services for at-risk children and families. These services include improving access to healthcare, but often they are also combined with social welfare, education and recreational activities.

Family Centres were set up in the 1970s in Sweden and remain a longstanding initiative aiming to support parents and children through helping parents develop caring skills and social networks, identify social, physical and mental risk factors, and develop multi-sector collaboration and partnerships between local organisations to support the initiative. The Family Centres also provide access to healthcare and other targeting families and children all in one place, promoting universal and simplified access to services. The Family Centres operate within each member state independently and form part of their social care budget. These services include maternity healthcare services, child healthcare service, kindergarten and activities aimed at improving the

socioeconomic situation of the family, including employment support (Abrahamsson et al., 2009). The Sure Start programme supports families with young children through children centres. The Sure Start model has been implemented in Member States such as Hungary and the United Kingdom. In Hungary, centres have been operating since 2004 and were initially funded by the European Social Fund and Norwegian Fund financing and then in 2012 became state funded. They have been set up in deprived areas to engage mothers and their children in a range of capacity-building activities, delivered by trained staff. The programme aims to reach families from diverse backgrounds to promote mutual learning, strengthening parental capabilities to ensure optimal child development, establishing good relationships between child, parent and service staff, and strengthening cooperation within local communities. In addition, the programme seeks to support mothers to return to employment (Morrison et al., 2015).

In Germany, the Schutzengel (Guardian Angel) project, which launched in 2000 and is still in operation, aims to give young children from deprived families and communities the best possible start in life. The project is funded half through central, and municipality and half through donations and fundraising. The project helps to improve health-related behaviours and enhance the social resources of parents through supporting them to prepare for pregnancy and childbirth and providing social counselling to deal with problems such as stress, violence and debt. It also helps to encourage participants to become more involved in their communities by engaging in community activities and promoting networks and peer support group through local day centres (Field, 2010).

Addressing the direct needs of disadvantaged families

In Greece, the Programme on Food Aid and Promotion of Healthy Nutrition (DIATROFI) aims to provide free, daily, healthy and nutritious meals to pupils in participating public schools located in disadvantaged areas across Greece, and to encourage healthy eating among children and families. The programme began in 2012 and is still in operation funded via a charitable institution and further donations. The programme tackles food insecurity and hunger, which is proven to have a negative impact on children health and development as healthy diets, are essential to good health and cognitive development. An evaluation of the programme found that the participants reported a significant reduction in food insecurity, healthier weight and improved dietary choices (Kastorini, 2016).

People living in rural/isolated areas

The data presented in Chapter 1 shows that people living in rural areas are more likely to have self-reported unmet healthcare needs than those living in towns or cities. This section focuses on issues of vulnerability among people living in rural/isolated areas.

Overview of policy context

The EU supports rural areas through its rural development policy (2014-2020). This sets six EU priorities, one of which is to foster social inclusion, poverty reduction and economic development in rural areas⁵. Each Member State and region must draw up rural development programmes (RDPs), in line with this focus area (and others). The regional development policy is also accompanied by the European Agricultural Fund for Rural Development (EAFRD), from which all EU Member States receive an allocation of financial aid. In all, 15% of rural development funds have so far have been allocated to RDPs that focus on this priority area of social inclusion in rural areas⁶.

The EU has also taken important steps to support Member States to recruit and retain and healthcare professionals: a particular issue within rural areas. For example, the EU-funded Joint Action on Health Workforce Planning and Forecasting has released methodologies and guidance on assessing/forecasting the necessary number and types of health workers in individual regions (European Commission, 2015b). This type of action is discussed in more depth under the "evidence" section below.

Scale of the problem

⁵ http://ec.europa.eu/agriculture/rural-development-2014-2020_en

⁶ See slide 5, in this presentation from DG Agriculture and Rural Development, European Commission (year not specified, accessed 30 January 2017): https://ec.europa.eu/agriculture/sites/agriculture/files/rural-development-2014-2020/country-files/common/rdp-list_en.pdf

Data collected at EU level shows that there is an unequal distribution of healthcare services in Europe. It has been demonstrated that location, and especially physical isolation, is a major determinant of vulnerability (Mechanic and Tanner, 2007). In 2013, around 27.6% of the EU-28 population lived in rural areas compared to 72.4% of the population who lived in urban and suburban areas (Eurostat, 2016i). Although rural and urban residents experience the same illnesses and injuries, there can be differences in their particular health needs, based on the groups within the populations. For instance, in some Member States (such as the United Kingdom), a crucial demographic distinguishing rural areas from urban is the greater share of older people in the former (Davies et al., 2008) – potentially resulting in higher rates of chronic illness and multi-morbidity in these areas.

Data and research on the quality of life of rural populations paints a mixed picture. On the one hand, EU-wide data indicates that a higher proportion of people living in rural areas of the EU were at risk of poverty and social exclusion (27.4%) compared to those living in cities (24.4%) in 2013. People living in cities are more likely to report their self-assessed health and educational opportunities positively, compared to rural populations. Data also demonstrates that there is an unequal distribution of healthcare services in Europe. Location, and especially physical isolation, is a major determinant of vulnerability (Mechanic and Tanner, 2007). A report by WHO (2010a) into poverty in rural areas of the WHO European Region highlights that rurality is often neglected as a factor that influences health status and the provision of health services.

On the other hand, people living in rural areas were more likely than those living in urban areas to report better accommodation satisfaction and use of time, as well as lower crimes rates and pollution. EU-level research indicates that there is often little variance in the life expectancy of rural populations compared to urban populations within EU Member States and in the majority of Member States, particularly those from Northern and Central Europe, people living in rural areas enjoy greater life expectancy than those living in urban areas (European Commission, 2008b; Kyte and Wells, 2010).

In addition, there are differences between Member States who joined the EU since 2004 and those who joined prior to 2004. People living in cities in Bulgaria, the Czech Republic, Croatia, Cyprus and Romania (as well as Portugal) were more likely to have higher quality of life compared to those people living in rural areas. Member States who were members prior to 2004 were more likely to find higher quality of life among people living in rural areas compared to those living in urban areas (e.g. Ireland, Denmark, UK, Netherlands and Austria) (Eurostat, 2015d). The level of rurality and risk of poverty amongst rural populations varies considerably across member states.

Note on the scope of the group

Estimating the population of the EU that live in rural and urban areas is complex. Whilst these two concepts have a common understanding, there is no clear definition among policymakers and definitions vary between Member States, which can make comparability within the EU a challenge.

Common geographical and economic parameters used to define rural populations include: the proportion of population living in rural areas; population density; the degree of isolation; the level of economic activity; spatial composition; and others. However, there are also social and cultural dimensions to rurality (Deaville, 2001). Key features for understanding rural general practice include not only spatial elements but also socio-economic and service characteristics, such as out-of-hours cover and the profile of the workload (Ibid).

There are different types of health inequities that can be considered in relation to rural areas: inequities between rural and urban areas, inequities between places within rural areas and/or inequities between different socio-economic groups in rural areas. However, finding quality data to demonstrate differences within rural areas can sometimes prove challenging, due to differences in the scope and quality of data collection across different areas (Davies et al., 2008).

Health challenges and barriers to service access

The literature on specific health needs of rural populations at the EU level is limited; most studies focus on factors that drive vulnerability and problems accessing healthcare.

Access to quality healthcare is central to citizens' wellbeing, life expectancy and social protection, but inequities of access persist. As shown below, limited accessibility of healthcare remains a particular issue in many rural areas in the EU, due to a range of demand/supply factors⁷. According to the literature, key barriers to healthcare in rural areas can include travel times and limited access to transport, distance, expense (both in terms of the costs of delivering services and the costs of accessing them), a lack of health facilities and professionals, and/or other factors. Office hours, rural culture, a lack of anonymity and stigma can also act as obstacles (Deaville, 2001). Despite widespread recognition of this issue, there are some signs that the issue has worsened in recent years. Indeed, in most EU Member States, the share of those in rural areas who reported unmet health needs rose between 2009 and 2014⁸.

Specific inequalities in health provision between rural and urban areas include the following:

- **Health services in rural areas commonly struggle to recruit and retain qualified health care workers** in order to provide healthcare for the local populations (WHO, 2010a). Research conducted by the Rural Strategy Group Scotland (2014), identified issues with recruiting and retaining general practitioners in rural areas. This included: lack of connectivity; transport limitations; fragility of services; high workload; lack of professional development, education and training opportunities; professional and social isolation; and, adverse effects on family life. There can also be key **differences in the type of workload of general practitioners in rural and urban areas**.
 - *Example:* Research in Bulgaria found that there is often a single general practitioner providing services to local rural populations. This limits the patient's ability to exercise their right to choose who provides them with health services, as well as presenting difficulties in obtaining a second opinion (Georgieva et al., 2007).

⁷ For example, demand-side factors could be the difficulties that poor people in rural areas face in trying to reach remote facilities (thus reducing demand), whereas the supply-side factors would relate to the costs/resources involved in delivering services to sparsely populated areas.

⁸ See Eurostat, 'Self-reported unmet needs for medical examination by sex, age, detailed reason and degree of urbanisation' [hlth_silc_21]. These figures covers the adult population (16 and over) and those who reported unmet needs for medical examination, either because it was too expensive or too far to travel, or due to waiting list issues. Note that reported unmet need is not equivalent to actual unmet need. Actual unmet need is measured by avoidable or preventable morbidity or mortality.

- Research into the profile of rural health in Wales reported **difficulties for people accessing health services who did not have access to private transport**. In particular, this affected the elderly population who were least likely to own private transport. **Distance from health services** was also found to affect negatively the ability of people to maintain and improve health, including the ability to attend appointments and health screenings and for health services to respond to patients in an emergency (Gartner, Gibbon and Riley, 2007). In the UK, rural residents are less likely to receive thrombolysis and defibrillation within set time limits (Davies et al., 2008).
- There is **evidence from some Member States that pharmacies, essential medicines and specialised services are more difficult to access in rural areas**. For example, in Romania, there were three times as many pharmacies registered in urban areas compared to rural areas, despite the fact that a large proportion of the population lives in rural areas. (Vladescu et al., 2008). Other research suggests that some rural residents may have lower levels of access for breast screening, treatment for acute myocardial infarction, asthma and cancer (Deaville, 2001). In some cases, a greater distance to specialist services can reduce survival rates from some cancers and asthma (Davies et al., 2008).
- There can also be **inequalities in access to maternal care, mental health services, rehabilitation services and childcare services in rural areas**. A study conducted by Katz et al. (2002) across 34 European countries (including EU Member States), found that children were more likely to be seen by a family doctor, rather than a paediatrician, in rural areas. Whilst it is not clear what the full consequences of this may be, it is likely that this could have an impact on the quality of specialist care available to young children in rural populations.

The literature – in particular a study by the European Commission (2008b) – also revealed key factors affecting the level of vulnerability of individuals in rural/isolated areas, including:

- **Poor transport infrastructure and distance to services:** transport links are often poorer in rural areas and can affect people's access to employment and other services. In addition, key services tend to be concentrated in urban areas, particularly health services that are for the elderly and childcare services (which can negatively impact on carers as well as these groups themselves).
- **Demographic issues:** rural areas tend to have an outward migration of young people and a higher percentage of elderly people than the national average. This can have a negative impact on the labour force of rural areas, as the population of working people may be smaller than that of the elderly population.
- **Problems in the labour market:** employment rates are often higher in rural areas compared to urban areas, as both a consequences of lower employment opportunities and lower qualifications among rural populations (Copus et al., 2006).
- **Educational differences:** children of pre-school age in rural areas are less likely to attend pre-school compared to urban children (e.g. in Poland the share of children between 2 to 5 educated in nursery schools was 59% in urban areas and 8% in rural areas). This has been attributed to a lack of pre-school structures. It has become more common for schools to be grouped in rural areas; primary and secondary schools are less accessible as commutes to schools have become longer at a greater cost to families.

Evidence of policies to address the health needs of rural and populations

This section examines approaches that may address the health challenges face by rural populations. The issue of inequalities in health between rural and urban areas and rural poverty was highlighted in by the WHO's Commission on Social Determinants of Health in its report, *Closing the Gap* (2008). The report called on Governments around the world to:

"Promote health equity between rural and urban areas through sustained investment in rural development, addressing the exclusionary policies and processes that lead to rural poverty..." (CSDH, 2008, p. 4).

Assessing the policies and strategies aimed at addressing rural vulnerability across EU Member States is complex. Each Member State follows different approaches according to the physical environment, political, economic and cultural factors affecting the issues experienced in rural areas. In addition, a research gap exists, whereby evidence of policy responses to improving the health needs and provision of healthcare among rural and isolated populations is limited across the EU.

Existing literature on policy approaches to improve healthcare and health outcomes for rural populations are limited; however, some literature provides an insight into how governments may go about addressing these issues. The WHO (2010a) has called for policies to improve access to health care and better meet the needs of rural populations. This includes action towards the following: improve the level of human resource within rural populations; improve the regulation and monitoring of rural areas; improve the service delivery in rural areas; and improve access to healthcare through financial measures.

Each of these approaches is explored in more depth below.

Improve the level of human resource within rural populations

Healthcare in rural populations is often understaffed and lacks human resources. Using policies to recruit and retain staff; develop and train staff; and, increase professional support to staff has been cited as one way to support improving the provision of health services in rural areas (WHO, 2010b; Rural Strategy Group Scotland, 2014).

Straume and Shaw (2010) conducted research in Norway examining challenges in providing sufficiently qualified healthcare staff in Finnmark County, in north Norway. In response to a shortage of staff in the late 1990s, the local authority undertook a survey to find out the key reasons why physicians stay in/leave the area. It found that a lack of chances for career development was the main reason why physicians omitted to stay (rather than pay or workload issues). As a result, interventions concentrated on setting up sustainable forms of professional development. Norway's specialised training programmes in general practice and public health use a decentralised model that can be introduced in all regions, focused on in-service training and group sessions, as opposed to bigger training centres and one-on-one tutorials. In Finnmark, this was used increasingly as a way of retaining professionals. The regional government also launched a new primary care internship initiative, which saw interns take up vacant positions to undertake full training in general practice and public health. Out of the 267 medical graduates who took part in the internship, the number of staff accepting their first fulltime licensed job in the region doubled between 1999 and 2006.

In rural Wales (UK), there have also been attempts to improve the coverage of rural health within the curricula of medical students, by introducing rural general practice placements (Deaville et al., n.d.). These increase in length as students become more senior/specialised. The student perspective was valuable in indicating how such placements can be designed to make students feel comfortable, including through putting in place shared accommodation, internet access, shared transport options and/or travel subsidies, group tutorials, and a short introduction to the realities of rural practice before the placement. The benefits of exposing medical students to the idea of working in rural practice at an early stage have been confirmed in other research focusing on nurses (Mbemba et al, 2013).

A recent report (European Commission, 2015b) examined effective approaches for recruiting and retaining health professionals (especially physicians and nurses) in Europe, including in rural areas. Its case studies revealed that "combinations of measures" may be most effective in attracting health professionals to areas where there is a shortage, i.e. not only financial incentives but also educational opportunities and chances for career growth. Whilst the former may lead to faster results, the latter is seen as more successful in bringing lasting change to an area. As a relatively unique example, the study looked at the Pacte Territoire Santé in France, an agreement between the Ministry of Health and other organisations that aims to attract more clinicians (mostly GPs) to rural parts of the country. As well as giving some financial incentives, this agreement also aims to establish some of the same conditions in rural practice as those that GPs find appealing in urban areas: in particular, greater team work and telemedicine. Implementation occurs at the regional level, where health authorities collaborate with doctors, medical associations, educational bodies and others to develop local action plans.

The report (European Commission, 2015b) also explores the steps that countries outside of the EU are taking. The University of Queensland Rural Clinical School in Australia has set up an alumni database to monitor graduates' career pathways and vocational choices, collecting follow-up data every two years. Graduates from the Rural Clinical School (RCS) are 2.5 times more likely to be employed in a rural region than medical graduates who were not part of the RCS.

There is an active discussion within the literature as regards the most effective ways of encouraging students into rural medical practice (Crampton et al., 2013; Rabinowitz et al, 2008; Barrett et al, 2011; Tesson et al, 2005; Viscomi et al, 2013; Maley et al., 2009; Ranmuthugala et al., 2007; Walters et al., 2012).

Improve the regulation and monitoring of rural areas

According to focus group participants, policies in Member States rarely take full account of the differences in needs between urban and rural areas when implementing national policies and often lack specific intelligence and information to support aligning the rural landscape with national priorities.

Some research from outside of the EU (conducted by the Rural Doctors Association of Southern Africa, the Wits Centre for Rural Health and SECTION27) has proposed the 'rural-proofing' of health policies as one solution (Rural Health Advocacy Project, 2015). Essentially, this involves considering the rural health context when preparing policies and budgets to check whether they will result in differential impacts for rural and non-rural areas (due to the characteristics of rural areas) and, if necessary, adapting the policy to meet rural needs and provide maximum, equitable access to public services in rural areas.

Improve the service delivery in rural areas

Member States (such as the United Kingdom and Germany) and non-EU countries (such as Norway) have implemented a wide range of strategies to guarantee health service provision in rural areas and address geographical inequities in access to healthcare. These include improved distribution of primary healthcare services, including increased number of GPs and family doctors in underprovided areas; increased ambulance services, including maximum response times for ambulances; improved transport networks; increased hospital capacity; and modernised health infrastructure (WHO, 2010b). Other research has also pointed to greater use of technology, mobile services, outreach services and an integrated transport system (Davies et al., 2008).

In Germany, the AGnES community medicine nursing programme ran from 2005 to 2008 and was largely funded by the Ministry of Health and Social Affairs. It introduced to provide support to GPs in rural areas. It aimed to reduce the travel time spent by GPs conducting home visits for routine procedures by training community medical nurses in treatment of chronic diseases, use of e-health equipment and operational procedures of GP practice. Once trained, the nurses could provide health information (under the guidance of a GP) to patients using electronic resources and video conferencing (OCED, 2010).

Methods of improving the delivery of other services – such as mammographic and other screening services – were explored in the Focus Group on 'Strategies to improve the health of people living in rural/isolated areas' (24 September 2016)⁹ and are discussed in more depth in the full report.

Improve access to healthcare through financial measures

Removing financial barriers of health services through universal coverage is important in ensuring that those experiencing rural poverty are able to access health services, including cost of travel and accommodation, as well as cost of medical care. Strengthening prepayment processes supports risk-sharing amongst the population and can significantly reduce the financial barriers associated with rural access to healthcare (World Health Assembly, 2005; CSDH, 2008).

⁹ Carried out by ICF as part of the VulnerABLE project, on behalf of the European Commission. This brought together rural doctors from across the EU to exchange their experiences/challenges. For more information, see either the full Focus Group Report (separate project deliverable) or the upcoming Scientific report (which pulls together all research strands).

People living with physical and learning disabilities or poor mental health

This section focuses on issues of vulnerability for people living with physical and learning disabilities or poor mental health. People living with physical disabilities, learning disabilities and poor mental health often experience vulnerability and isolation. They are at high risk of poverty, social stigmatisation and social exclusion, as well as unemployment and economic inactivity (WHO, 2012).

Overview of the policy context

The International Classification of Functioning, Disability and Health (ICF) defines disability as an umbrella term for impairments, activity limitations and participation restrictions (WHO, 2016a). The WHO defines mental health as 'a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community'. Those with poor mental health are then those not living in this state (WHO, 2016b).

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) was adopted in 2006 and entered into force in 2008. The convention focuses on empowering disabled people as autonomous individuals capable of making informed decisions for themselves rather than as 'objects' of charity or medical care. The EU adopted the (UNCRPD) in 2009 and it entered into force in the EU in 2011. The European Commission Disability Strategy 2010-2020 builds on the UNCRPD and supports its implementation.

Article 25 of the UNCRPD focuses on the health of persons with disability. It sets out the right to the highest standards of healthcare for those with a disability. In particular it highlights:

- The requirement that people with disabilities receive the same range of affordable or free healthcare;
- Persons with disabilities receive the health services they require as a result of their disabilities
- That these health services should be as close as possible to where people are living (including those that live in rural areas)
- Health professionals are required to provide the same standard of care for those with disabilities as to those without
- Discrimination of those with disabilities in terms of health insurance is prohibited
- Denial of any health services, food or fluid on the grounds of disability is prohibited.

The European Commission Disability Strategy 2010-2020 acknowledges that health services are the responsibility of each member state but reiterates the commitment to equal accesses to health services.

The EU joint action on mental health and wellbeing 2013-2016 launched the European Framework for Action on mental health in 2016. This framework will be promoted and disseminated by the EU compass for action on mental health and mental wellbeing. The compass focuses on seven priority areas (European Commission, 2017):

- Preventing depression & promoting resilience
- Better access to mental health services
- Providing community-based mental health services

- Preventing suicide
- Mental health at work
- Mental health in schools
- Developing integrated governance approaches.

Scale of the problem

Levels of physical and learning disabilities, as well as poor mental health, across the EU are difficult and complex to measure as data on the prevalence is either not collected or reported inconsistently. However, the latest available data from Eurostat (2012) shows that approximately 73 million people aged 15 and over people in the EU27 experience some kind of disability according to the International Classification of Functioning, Disability and Health definition. Of this number, around 41% are men and 59% are women (Eurostat, 2015e). The majority of this group are either retired or unemployed (Eurostat, 2016m). The proportion of people living with disabilities is substantially higher in the 45-64 age group compared to people aged 15-44 (Eurostat, 2016n).

An estimate of those experiencing mental health problems from 2010 suggests that 38.2% of EU citizens experience mental health issues – circa 164.8 million people (Wittchen et al, 2011). The most frequently reported issues include anxiety (14%), severe depression (6.9%), somatoform (6.3%), ADHD in youth (5%), issues caused by substance abuse (>4%), and dementia (1-30% depending on age group) (Wittchen et al, 2011).

The extent to which disability affects an individual's life is a function of the interaction between an individual's health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports) (WHO, 2016a).

Health challenges

This section examines the health challenges faced by people living with physical and learning disabilities or poor mental health. In general, this group tend to experience a shorter life expectancy and increased risk of early death compared to the general population (Hollins et al., 1998). They are also more likely to experience major health problems (e.g. obesity, circulatory and respiratory diseases) (Disability Rights Commission, 2007).

Research suggests many causes of the health inequalities between this group and the general population. These include the following:

- Greater risk of being exposed to poverty, poor housing conditions, unemployment, social disconnectedness and discrimination (Nocon, 2006). Research has found that disabled people are significantly more likely to be victims of abuse than non-disabled people (Plan, 2013) and therefore disproportionately likely to experience the negative health effects resulting from sexual abuse, exposing them to health inequalities.
- Communication barriers can affect how they engage with others, as well as access services (Emerson and Baines, 2010).
- Greater risk of negative health behaviours, including poor diet, lack of exercise and substance use (Emerson and Baines, 2010). Evidence from the United States shows the people with physical disabilities often face barriers in terms of accessing physical activity (Rimmer et al, 2004).

- People in this group may be more likely to developing chronic conditions than the general population related to lifestyle behaviours. For example, the increased risk of ill health related to a lack of physical activity (Rimmer and Rowland, 2008). There is also evidence from the US (Moorehouse et al, 2011) and Korea (Lee, et al., 2016) suggesting that people with a disability have significantly higher smoking rates than those without.
- People with disabilities are exposed to secondary conditions which further impact on health (WHO, 2011). For example, many people with disabilities experience depression as a secondary impairment (Prince et al, 2007; Khat et al., 2010; Ohayon and Schatzberg, 2010). Similarly, greater rates of osteoporosis are found in people with spina bifida (Dosa et al., 2007), and cerebral palsy (Turk et al, 2007).

In addition, for some people with learning and physical disabilities, they are also affected by genetic and biological factors and are more likely to experience congenital abnormalities (Tyrer and McGrother, 2009).

Access to healthcare

This section examines the issues relating to access to healthcare for people living with learning and physical disabilities or poor mental health.

People living with physical and learning disabilities or poor mental health experience significant barriers to accessing adequate healthcare. These groups are less likely to have their health needs met by health services than members of the general population are. As those in this group are more likely to experience material inequality, in that they are more likely to be exposed to poverty and unemployment (Nocon, 2006) they are therefore more likely to face the barriers to healthcare that accompany this. Furthermore, those living with physical or intellectual disabilities or mental health problems are more likely to be unemployed (Eurostat, 2016n) and therefore experience the difficulties with access to healthcare related to this including lack of access to employment based insurance.

People experiencing mental health problems are less likely to receive appropriate health care that best responds to their needs in terms of both addressing their mental health needs and other physical health needs. Nearly half of people across Europe in need of mental health treatment do not access formal health services (Walhbeck and Huber, 2008). Additionally, people with mental health issues often experience stigma in relation to their condition, which can act as a disincentive in accessing health services. A systematic review of studies found that rates of mammography screening were lower for women with mental illness than the general population but not for those who only exhibited distress; therefore, this inequality in preventative medicine was not ascribed to distress alone and was taken to indicate disparity in healthcare in general (Mitchell et al, 2014). The barriers mentioned above can contribute to the poor standards of physical health care among people with poor mental health and increase the likelihood of developing physical health problems, due to a lack of quality and appropriate healthcare provision (Tosh et al. 2010).

People living with a learning disability are also less likely to have their health needs met by health services. They are often reliant upon carers and support workers to assist them in meeting appointments and navigating their way through the health system, and often miss appointments if they are unable to find someone to accompany them. People with learning difficulties are also less likely to receive standard tests and health checks compared to the general population (DRC, 2007). For example, the uptake of women with learning difficulties was found to be 47% compared to 84-89% among the general population, which may also indicate some gendered inequalities (Samele, Seymour and Morris, 2006).

The quality and appropriateness of healthcare services for individuals living with physical and intellectual disabilities or poor mental health represent a serious problem in healthcare access. General healthcare professionals often lack appropriate skills to deal with mental health patients whilst patients are expected to use the same services as the general population (European Commission 2008c; Wahlbeck and Huber, 2008). Healthcare professionals in both primary and secondary care settings may also overlook the physical health needs of people with serious mental health problems. Research has indicated that physical health checks of mental health patients in primary and secondary care are low (Hardy et al., 2011). An example of this issue can be seen in the higher rate of potentially preventable hospital readmissions for people with learning difficulties seen noted in a 2015 UK study suggesting that those with learning difficulties are not receiving the best possible follow-up care (Kelly et al, 2015).

Those experiencing physical disabilities may face physical barriers to receiving appropriate and quality healthcare services. This may include the architecture of health buildings, lack of access due to transportation or lack of parking spaces, and other physical aspects of the space (WHO, 2011). For example, a 2005 survey found that 80% of orthopaedic surgeries and 90% of neurological surgeries in Essen, Germany were not accessible to wheelchair users and therefore they were limited in their choice of doctors (Trösken and Geraedts, 2007). Similarly, medical equipment may be designed for use by those without disabilities and not adaptable (WHO, 2011). Evidence of policies to address the health needs of people living with physical and learning difficulties as well as poor mental health.

Evidence of policies to address of people living with physical and learning disabilities and poor mental health

The needs of this group and underlying reasons behind health inequalities are diverse. Therefore, actions to address their health needs span a wide variety of interventions. At a policy level the DRC study (2007), from the UK, set out three recommendations for change that focus on national policies, these are:

- Reduce health inequalities among this group and improve access to primary care and equitable treatment;
- (For health commissioners) Identify and develop outreach services and new models of delivery to meet the needs of this group; and
- Have a specific focus on improving treatment within primary care through better collection and use of information on patients with learning disabilities or poor mental health. This, along with better engagement with local organisations representing the interests of this group, can shape how primary care engages with other services.

Improving the understanding of disability among healthcare workers

Literature on the specific policy responses to address the health needs of this group largely focus on improving the provision of health care services through training to increase the knowledge and skills (as well as change attitudes) of healthcare professionals in treating this vulnerable group (Devine and Taggart, 2008; Hardy et al., 2011). For example, a Chronic Heart Disease (CHD) education resource was piloted among a residential community support organisation working with adults with complex learning disabilities. The training was organised as a response to the fact that CHD is more common among those with complex learning difficulties. As a result of the training staff showed an increase in knowledge in CHD topics which could lead to increased understanding of cardiac health by those who are in regular contact with this group and thereby improve health outcomes (Holly, 2014)

Hardy (2009) argues that training healthcare professionals to have the right skills and competencies to conduct a comprehensive physical health check will provide the opportunity to screen for a range of health conditions as well as offer education regarding lifestyle choices that may help reduce the risks of developing poor health in the future.

Furthermore, working with health professionals to improve awareness of disability can help prevent situations where health needs are not identified due to the symptoms and health problems being viewed as part of their disability and therefore not treated (Alborz et al, 2005; Krahn et al., 2006; Smith and Pressman, 2010; Mason and Scior 2004, RCN, 2011).

One consideration is that whilst health care practitioners may be aware of the needs of this group on a general level, this understanding may not always be put into practice. A case study of the complications faced by a young boy with learning difficulties and his mother in obtaining a blood test highlighted the range of issues that can constitute barriers for people with learning difficulties to receive healthcare. The recommendations from this case study were that whilst the need for appropriate adjustments is understood it is not always fulfilled. The authors emphasised the need for health professional to take time to consider individual needs and any necessary adaptations to their care (Brown et al., 2013).

Approaches to tackle unhealthy behaviours among those with physical and learning disabilities or poor mental health

The approaches discussed above pertain to the increase of access to health for this group. There are also approaches that aim to tackle some of the health challenges that result in worse health among these groups than the general population. Two examples discussed here relate to increasing uptake of sport and improving health literacy. In both examples, the disadvantaged position of those with learning disabilities in society is challenged, ultimately leading to improvements in health status. . Although health interventions to promote healthy behaviours such as exercise tend not to be targeted at this group there is evidence that these are effective when practised (Allen et al, 2004; Durstine et al., 2000; Fragala-Pinkham et al., 2006). The first example is the Special Olympics Youth Unified programme, developed in 2005 and managed by a not-for-profit organisation, which aims to promote better a health status amongst children and young people with intellectual and physical disabilities by helping them to participate in sport. An evaluation of the practice was conducted by the University of Ulster in Northern Ireland in August 2010. The assessment covered five European countries: Serbia, Poland, Ukraine, Germany and Hungary. The programme involved both those with and without learning disabilities as 'athletes' and 'partners' respectively. This culture of inclusion was noted as a success factor by an evaluation. This culture challenges discrimination and supports individuals with learning disabilities in building self-confidence as well as challenging negative attitudes in the wider community (Dowling et al, 2010).

A further example of an approach to tackling these inequalities is in the programme, "I See! About Soul and Body for Women with Intellectual Disabilities". This programme, which ran in the Czech Republic from 2015 to 2016 funded via EEA grants, seeks to improve health awareness amongst women with learning disabilities by producing easily understandable information for them about sex and the female body. No evaluation of the project's outcomes has been published to date however. It is likely to have had some positive impact, given the previous lack of education or information on sexuality and sexual health previously available to mentally disabled women, as well as the use of the national network of the lead partner, the Society to Support People with Intellectual Disabilities in the Czech Republic's (SPMP) (with over 8,000 mentally disabled women and their families) (SPMP, 2015). This example demonstrates the role for networks with specialist experience on health promotion for these groups.

The focus of much policy on the health of those with physical or mental disabilities or poor mental health tend to focus on issues of discrimination and a lack of understanding which contribute to these inequalities. Work among professionals and individuals in this group is required to address their relationship to health care professionals and capacity to lead healthier lives in general.

Involving service users in service design has positive outcomes for access

Involving those with physical or intellectual disabilities or mental health issues in designing their own health care is an approach which has been shown to have benefits (Nilsen et al, 2006). Those who experience disability on a daily basis are best placed to examine these barriers and their involvement in planning services can lead to more effective services (WHO, 2011).

People experiencing long-term unemployment and economic inactivity

The data presented in Chapter 1 shows that people who are unemployed are significantly more likely to have unmet healthcare needs than those in employment. This section focuses on the issues relating to vulnerability experienced by people experiencing long-term unemployment, insecure employment and premature exclusion from the labour market.

Overview of policy context

The European Commission recognises the implications that long-term unemployment has on individuals and society as a whole and has a legacy of strategic policy to address long-term unemployment within the EU. The European Employment Strategy (EES) (introduced in 1997) sets out common objectives and targets for employment policies to create sustainable employment for the EU. The EES now forms part of the Europe 2020 Strategy, which has an Employment target of 75% of people aged 20-64 in employment and is translated into national targets for Member States.

The Strategy's targets are interrelated and reinforce once another, focusing on improving education to support the employability of individuals and reducing poverty (amongst other things), both of which can result in health improvements.

Scale of the problem

Long-term unemployment is one of the main concerns for policymakers in the EU as it negatively affects individuals as well as hindering economic growth. The long-term unemployed refers to people of working age who have been out of work and actively seeking a job for at least a year. Analysis of EU long-term unemployment data indicates that around 5.1% of the labour force is long-term unemployed in 2014, with more than half having been unemployed for more than two years. Levels of long-term unemployment were fairly equal between men and women at 10.8% and 10.9% respectively (Eurostat, 2016i).

Similarly, people who are inactive¹⁰ from the labour market are also a concern for policymakers. The concept of an economically inactive population encompasses people with varying degrees of attachment to the labour market, specifically those who are neither employed nor seeking employment. For the purposes of this review, we are focusing on inactive people of working age. The most recent data on this group indicates that the share of the economically inactive population within the working age population was around 27.7% across the EU-28 in 2014. There was higher rate of inactivity among women (33.5%) than men (21.9%) in 2014 (Eurostat, 2015f).

Long-term unemployment and inactivity is associated with poverty and social exclusion. Households with higher levels of unemployment are more likely to experience poverty and social exclusion due to the lower levels of household income (Eurostat, 2015b). The causes of long-term unemployment and inactivity are complex and often associated with a lack of qualifications, employment opportunities and poor health (including mental health), as well as distance from the labour market due to, for example, familial responsibilities (Lotters et al., 2012).

Health challenges

¹⁰ According to the International Labour Organisation definition, a person is economically inactive if he or she is not part of the labour force. The figures represented here correspond to the number of inactive persons of working age population (15-64) who are not part of the labour force.

This section examines the health challenges facing people experiencing long-term unemployment and economic inactivity.

Participation in the labour market or exclusion from it has a significant impact on life chances, risks of material deprivation and well-being that may influence or determine people's health throughout the life-course. Levels of unemployment tend to occur unequally across society and are more likely to affect those in lower socioeconomic positions, with lower levels of education (Donkin et al., 2014).

Academic literature indicates that long-term unemployment and inactivity is associated with a range of poor health outcomes. These include the following:

- **Premature ageing:** a study by Ala-Mursula et al. (2013) explored whether unemployment in early adulthood is associated with shorter leukocyte telomere length (LTL), a potential biomarker of premature aging. The study found that unemployment exceeding 500 days during three years was associated with increased stress linked to numerous poor health outcomes, including mortality and potential premature ageing.
- **Poor mental health:** mental health problems are often experienced due to job loss and loss of income, causing higher rates of stress, anxiety and depression (Dubois and Anderson, 2013).
- **Negative health behaviours:** Bosque-Prous et al. (2015) conducted a longitudinal study based on two waves of the SHARE project, looking at hazardous drinking in middle-aged people during an economic recession in order to understand whether individual jobs loss and contextual changes in unemployment influence the incidence rate in that period. The study found that 505 people became hazardous drinkers, with cumulative incidence of 6.6 per 100 persons between 2006 and 2012. At country level, an increase in the unemployment rate during the study period and greater increases in the household disposable income were associated with risk of becoming a hazardous drinker. The study concluded that, job loss among middle-aged individuals during the economic recession was positively associated with becoming a hazardous drinker. Changes in country-level variables were also related to this drinking pattern.
- **Low levels of self-reported health:** Friedl et al. (2007) conducted research exploring the specific impact of long-term unemployment and the perception of social justice, and the impact this had on health (including self-reported health, health behaviours, and resources in marginalised groups). The study found that duration of long-term unemployment and low perceived social justice are strongly associated with self-reported poor health and low personal (internal) and social (external) health resources.

In addition, unemployment is also associated with an increased risk of mortality (Moser et al., 1987; Montgomery et al., 2013).

Access to healthcare

This section outlines issues in access to healthcare for by people experiencing long-term unemployment and economic inactivity. This group are likely to experience barriers in accessing healthcare in relation to cost, particularly within Member States where access to healthcare is reliant on in-work benefits or insurance coverage, or where there is a direct financial cost involved in accessing care, and there is no state provision or subsidy (Crepaldi et al., 2009).

For example, in the Netherlands, there is a gatekeeping system, whereby people are required to access healthcare through their general practitioner. Consultation with the general practitioner is free, but people are required to pay all medical expenses up to the value of 350 euros per year. As a result, some patients who see a general practitioner do not proceed to access medical care after this stage, as they will have to pay for it (Dubois and Anderson, 2013). A survey conducted by the Dutch national GP association with over 1,000 general practitioners found that 94% of general practitioners surveyed reported that some of the patients they saw did not follow their advice for further medical treatment due to financial reasons (LHV, 2013).

Addressing the health challenges of people experiencing long-term unemployment and economic inactivity

This section outlines approaches to address the health challenges of people experiencing long-term unemployment and economic inactivity.

EU level policy has focused on creating sustainable job opportunities for the unemployed

At the EU level, the European Commission's Employment Package aims to address the major challenges posed by unemployed in the EU and its Member States, looking at how EU employment policies intersect with other policy areas. This includes activities to support job creation, restore labour market dynamics and improve governance at the EU level (European Commission, 2012b).

The European Council has also adopted a Recommendation on the integration of the long-term unemployed into the labour market calling on all Member States to improve the provision of information and support available to people experiencing unemployment to encourage them to register with employment services, and provide specially tailored and personalised support to this group with an emphasis on getting people to re-engage with the labour market (European Union, 2016).

However, there is little evidence indicating how these policies address the health issues associated with long-term unemployment.

Activities promoting good health and employment

Across the EU, welfare states have focused efforts on trying to get those claiming unemployment benefits, many of whom have long-term health conditions, back into work.

In Belgium, the *Sortir de soi, sortir de chez soi* programme aims to support women who have been inactive or unemployed for a long period of time, through improving their employability. The programme began in 2008 and funding was provided by the Brabant Wallon Province. The main activities of the programme include the delivery of training sessions and information over a three-month period (Adrieanssens, Et al., 2007). Whilst there is no evaluation evidence of this programme, there is a general evidence base that supports this type of programme; this suggests that improving self-esteem can lead to better physical and mental health, whilst also improving the employability of participants (Mann et al., 2004).

The Action nutritionnelle dans une épicerie solidaire (A.N.D.E.S) (Nutritional action in a solidarity store) programme in France aims to improve access to health foods for people on low incomes or at risk of poverty through the provision of healthy food products at an affordable price. It also aims to provide support the long-term unemployed back into employment by providing employment opportunities and work placements to unemployed people in the community (A.N.D.E.S, 2009). The programme has been running since 2008 and is self-funded. Research studies suggest that providing subsidies and support for people on low incomes can improve the health and wellbeing, including an association between higher disposable income and better health outcomes, and proximity to stores offering fresh food linked to reduce rates of overweight and obesity and better health outcomes (Aron, et al., 2015; Bell et al., 2013)

An evaluation of the A.N.D.E.S programme identified 500 solidarity stores created nationwide to date, with a total of 85 previously unemployed people having engaged in work placements, with 67% of participants reporting that they had either continued to work within a solidarity store, found employment elsewhere or felt motivated to search for job opportunities. It also showed that programme has led to an increase in the consumption of fresh food (A.N.D.E.S., 2017).

Promoting positive mental health among unemployed people

Literature on actions to address the health challenges faced by long-term unemployed people indicates that there are a range of interventions which can support people to improve their health and also move them closer to the labour market.

For example, a study by Kreuzfeld et al. (2013) examined a 3-month long intervention programme for improving health of older, long-term unemployed people. The intervention was delivered through a job training centre specialising in re-employment support and was split into lectures for enhancing the individual health competence and a supervised physical training part in a fitness centre. The findings indicate that the improved both objective and subjective health. This was demonstrated by the reduction in cardiovascular risk factors (e.g. blood pressure), the increase in physical activity and fitness, as well as the reduction in chronic back pain symptoms and depression. In Portugal, the Emprego Saudável project developed a mental health network to promote positive mental, reduce inequalities in mental health associated with employment instability caused by the economic crisis. The project supports a range of activities aimed at capacity building, mental health promotion, and prevention within the workplace and among unemployed groups in receipt of unemployment benefits (INE, 2015).

A study by Limm et al. (2015) evaluated the effectiveness of a health promotion programme using a train-the-trainer approach on health-related quality of life and mental health of long-term unemployed persons. The intervention consisted of both individual sessions based on Motivational Interviewing and participatory group sessions. More than half of the participants had been unemployed for at least five years. The findings from the study indicate that within three months of the intervention, health-related quality of life had improved among participants and anxiety and depression had decreased significantly in the intervention group. The study concluded that the programme showed positive effects on health-related quality of life and mental health, particularly anxiety, of long-term unemployed persons. These findings are important as this was a highly burdened target group where improvements in mental health play a crucial role towards social participation and successful reintegration into the job market.

In-work poor

The data presented in Chapter 1 shows that poorer individuals are more likely to have long-standing ill health or unmet healthcare needs than richer individuals, and those with unmet healthcare needs most frequently cite the cost of healthcare as their main reason for not getting examined. This section focuses on issues relating to the vulnerability of in-work poor. The term in-work poor commonly refers to people who are in employment but who are at risk of being in poverty, perhaps due to the low pay and/or precarious nature of their employment. There is a lack of research on this group and it is not only difficult to identify the group because of a lack of information and data, but also because the concept incorporates two different levels of analysis:

- The individual level: the working status of an individual; and,
- The collective level: the income of the household (which that individual lives) being below the poverty threshold.

For example, an individual may be at risk of poverty, not simply because they are in low-paid employment, but because their level of pay is insufficient to maintain the income of the household they live in. Similarly, an individual may be paid far below the poverty threshold but may be living in a household where other individuals are sufficiently paid so as to raise the income of the household above the poverty threshold (Eurofound, 2010).

Overview of policy context

From a policy perspective at the European level, the EU has sought to take action the issue of in-work poverty by including as one of its goals for the 2003 European Employment Strategy, the aim to reduce the number of working poor and adding developing an indicator to measure in-work poverty (European Commission, 2010d). However, there is a lack of evidence that the Commission's recommendations for Active Inclusion under the EU 2020 Strategy has led to an increase in awareness or political debate about the issues of in-work poverty. Instead, the policy discourse has focused heavily on moving unemployed people into employment. This policy area also lacks consideration on the links between in-work poverty and health (Frazer and Marlier, 2010).

Scale of the problem

Despite employment greatly reducing the risk of poverty, data indicates that people in employment are at risk of poverty across the EU. The most recent data shows that 9.5% of the employed population in the EU-28 Member States were at risk of poverty in 2014 (Eurostat, 2016k). A breakdown of this data shows that:

- People in part-time employment (15.8%) are at a higher risk of poverty compared to people in full-time employment (7.7%);
- People in temporary employment (including zero hour contracts) (15.7%) are at higher risk of poverty compared to people in permanent employment (5.9%); and,
- Contrary to all other poverty indicators, men in employment (10%) are at higher risk compared to women in employment (9%). Research indicates that this disparity is due to family situations, such as men being more likely to be with partner who has no income of their own (Bennett and Daly, 2014).

Harkins and Egan (2013) state that there are three main drivers of in-work poverty. This are outlined in Table 1 below.

Table 1. Drivers of in-work poverty

Drivers of in-work poverty	Scale of problem across EU
Low-pay	Most recent data on low-paid ¹¹ employees across the EU-27 ¹² shows that 16.9% of people in employment were in low-paid jobs in 2010. The highest proportion of employees in low-paid work was in some Eastern European Member States (i.e. Lithuania and Latvia), whilst Member States such as Sweden, Finland, France and Belgium had the lowest proportions of employees in low-paid work (Eurostat, 2016l).
Households relying on a single earner	Most recent data shows that among households without dependent children, 25.1% of people living alone were likely to be at risk of poverty, compared to 11.2% of households with two or more adults. Similarly, 32.5% of single person households with dependent children were at risk of (monetary) poverty compared to two parent households (13.6% with one dependent child, and 26.9% with three or more dependent children) (Eurostat (2016k)).
Individuals not working enough hours	The lower the work intensity ¹³ of a household, the more likely the household is to be at risk of poverty. This is often associated with less stable working conditions and higher rates of part-time work. Most recent data shows that 11.1% of the population aged 0-59 in the EU-28 lived in households with very low work intensity in 2014. Member States including Ireland (21%), Greece (17.2%), Spain (17.1%), Croatia (14.7%) and Belgium (14.6%) had the highest proportion of households with low work intensity, compared to Member States such as Poland (7.3%), Slovakia (7.1%), Romania (6.4%), Sweden (6.4%) and Luxembourg (6.1%) (Eurostat, 2015b).

Health challenges

This section examines the health challenges experienced by the in-work poor. As has been highlighted above, employment is an important social determinant of health. Despite a lack of evidence directly examining the in-work poor and their health needs, it is possible to draw inferences from literature on the health needs of similar groups. For example, poverty can be detrimental to health and wellbeing in a variety of ways. In addition, it is likely that the types of employment that maintain in-work poverty are low-paid, insecure jobs (Harkins and Egan, 2013).

¹¹ Low-paid employees are defined as those employees earning two thirds or less of the national median gross hourly earnings in a particular country.

¹² Croatia was not included in the figures as it was not an EU Member State at the time of publication.

¹³ Work intensity refers to the ratio of the total number of months that all working-age-household members have worked during the income reference year and the total number of months the same household members theoretically could have worked in the same period. People living in households with very low work intensity are defined as people living in households where working-age adults have worked less than 20% of their total potential during the previous 12 months.

Literature on employment circumstances linked to the in-work poor indicate that this group are likely to have specific health needs. Low-paid jobs are often associated with stress, due to high psychological demands (Karlsson, et al., 2010). Research has found that there is a socioeconomic gradient in the distribution of job stress across the workforce, whereby increased job stress is associated with lower-paid and lower status employment (Stansfield et al., 1998). The findings in the Whitehall study (1991), conducted in the UK, identified an association between employment grade (which is also reflective of pay) and the prevalence of a range of health outcomes. Due to the nature of work that employers required of lower grade employees (e.g. low control and low satisfaction, as well as often low pay), these employees presented higher levels of respiratory and circulatory health conditions and were more likely to engage in risky health behaviours including, smoking, diet and exercise.

Literature also suggests a social gradient between job security and mental health. A study by Vives et al. (2013) assessed the association between job security and poor mental health, based on a cross section of 5679 temporary and permanent workers in Spain. The study found that people in insecure employment were more likely to report poor mental health, and the more insecure a person's employment status, the more likely they were to report poor mental health. In addition, the prevalence of poor mental health was more prevalent among men (29.4%) than women (22.5%) (showing a tendency to decrease with age among women and increase with age among men). Poor mental health was also significantly higher among workers with low educational attainment, low skilled workers, those who had been previously unemployed and female immigrant workers. Other research has also found that people in insecure employment are often unhappy with their jobs and pay, and experience greater stress and tension, which can affect physical and mental health, as well as negatively affecting their utilisation of health services (Broding et al., 2010).

Access to healthcare

This section outlines issues in relation to access to healthcare for the in-work poor, who face heightened risk of being deprived of access to appropriate healthcare (WHO, 2010c). There is little literature looking specifically at the in-work poor and access to healthcare in and across EU Member States; however, from the broader literature around work and poverty there are indications that this group often underutilise health services. This underutilisation is caused by three main factors:

- Low-paid and temporary employment is less likely to be accompanied by employment-related benefits, such as health insurance. This may require them to pay for health care services upfront where employment-based insurance is required or universal healthcare no offered.
- Member States with an insurance-based healthcare system (such as Germany and Poland) may require the costs of specialist healthcare treatments (e.g. mental health, reproductive, dental, ophthalmic and rehabilitation) to be paid upfront. The in-work poor may be unable to afford to access health services due to a lack of disposable income.
- The use of healthcare services varies according to labour market status. Some studies have found that people in temporary employment are less likely to use health services compared to people in permanent employment; however, more research is required to full understand the reasons behind this and whether it differs between Member States (Virtanen et al., 2006).

Evidence of policies to address the health needs of the in-work poor

This section examines the approaches and evidence of policies taken at the European level and Member State level to address the health challenges experienced by the in-work poor.

Policies to address issues relating to in-work poor has made little impact at the EU level

At the European level, the Europe 2020 strategy aims to lift 20 million EU citizens out of poverty and social exclusion through job creation and development and is accompanied by a range of other activities which aim to directly or indirectly address in-work poverty, including:

- The Commission's Annual Review on Social Developments in the EU stressed a need to address the increase of in-work poor;
- The European Parliament has sought to raise awareness of in-work poverty through resolutions, including 'Strengthening the social dimension to the EMU' which called on the Commission to monitor Member State compliance with Europe 2020 targets, specifically in relation to in-work poverty (European Parliament, 2013), and 'Employment and social aspects of the role and operations of the Troika' which expressed the Parliament's concern about the implementation of Member State economic policies on failing to protect those experiencing in-work poverty (European Parliament, 2014).
- There is limited recent research examining the impact of EU level initiatives to address in-work poverty and health. In 2010, the EU Network of Independent Experts on Social Exclusion (Frazer and Marlier, 2010) found no evidence that EU level initiatives had influenced Member States to focus more on policies to address in-work poverty and, as highlighted above, the European Parliament has continued to stress the importance of addressing in-work poverty in its communications. Data on temporary and part time employment can be a useful proxy for risk of in-work poverty. Trends show that, since 2012, the number of people in temporary employment increased from 12.8% to 13.3% in 2015. Likewise, there has been an increase in involuntary temporary employment (8.4% in 2008 to 8.8% in 2015) and part time work (4.4% in 2008 to 7.7% in 2015) (Eurostat, 2016o).

At the Member State level, policies indirectly influence the in-work poor

The majority of policies that relate to the in-work poor are often included in wider policies to tackle poverty and social exclusion (EuroFound, 2010). These policies can be grouped into two main types of responses:

- Welfare transfers, in the form of transfer payments and social benefits (such as in-work benefits and tax credits paid to those earning below a certain threshold), are given to households as a means of increasing the income of the households above a certain level to take them above the respective poverty threshold of the Member State; and,
- Labour market policies, in the form of minimum wages and wage policies in general, are set by governments to try to improve the income of households.

However, assessing the effectiveness of policies towards reducing the number of in-work poor is complex and research on these impacts is scarce, particularly in relation in-work poverty and health.

It is generally assumed that welfare transfers effectively reduce the risk of poverty by boosting the income of the household above the relative poverty threshold of a country. For example, analysis of EU statistics on income and living conditions data (EU-SILC) suggests that, in 2007, welfare transfers (excluding pensions) in Member States reduced the risk of poverty in Member States. Reductions ranged from 15.4% in Bulgaria to 60.7% in Sweden (European Commission, 2009d).

More broadly, a study was conducted by Lundberg et al. (2013) analysing the effect of social protection and income maintenance policies on health and health inequalities, examine the relationship between income, poverty and mortality, as well as social rights and subjective health in Europe. The results from the analysis indicated that social protection programmes are linked to health and health inequalities; however, these links are complex. For example, there are some instances where all social groups benefit from increases in social protection, but no major reductions in inequalities in health are achieved. The findings also highlight the importance of insurance based social protection systems in relation to population health, where populations with better coverage and higher replacement rates have better health. Increasing the threshold for minimum wage is another potential way for Member States to reduce the risk of poverty amongst the population of low-paid employees; however, in the majority of EU Member States, the level of minimum wage is often set well below the poverty threshold (EuroFound, 2010). Studies by Flint Cummins and Wills (2014) have examined the health and wellbeing benefits of increasing the minimum wage levels to meet the minimum income needed to cover the basic costs of healthy living relative to the locality (based on costs relating to nutrition, physical activity, housing, social interaction, clothing, transport, heating and hygiene), commonly referred to as the 'Living Wage' (Morris et al., 2000).

Flint, Cummins and Wills (2014) conducted a study of employees within the service sector in the UK and identified the benefits of the living wage on psychological wellbeing. They found that those earning the living wage scored on average 3.9 points higher out of a total of 70 compare to employees earning below the living wage. Another study by Wills and Linneker (2012), surveyed 416 employees in London with varying wage levels to establish the costs and benefits of the living wage. They found a significant difference in the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) score among employees earning the living wage; the average score for living wage earners was 4.5 points (out of 70) higher than those earning below the living wage.

Specialised healthcare services have been effective in supporting access to healthcare in Member States where universal healthcare is not available

In Germany, the Open.med Munich scheme is a charity run scheme that aims to improve access to healthcare, particularly for people on low incomes or those who are not covered by health insurance and struggle to meet the costs of healthcare. The programme has been functioning since 2006. Targeting a range of vulnerable people who experience barriers to healthcare due to low income, including the in-work poor, the scheme provides free medical and psychosocial consultation services (Aertxe der Welt, 2014). This would suggest that services of this nature are important in supporting those in-work poverty access healthcare services in Member States where universal healthcare is not provided.

Victims of domestic and intimate partner violence

Overview of policy context

The passage of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) in 2011 marked a major step forward in the level of international legal protection for victims of intimate partner violence and domestic violence in Europe. It outlines key measures to be enacted, based on "5Ps": comprehensive and holistic **p**olicies to tackle the issue; **p**revention of violence; **p**rotection of victims; **p**rovision of support services and **p**rosecution of perpetrators (Council of Europe, 2011). Within these, it lays down the key principles for service provision. Importantly, this instrument has been ratified by just over half of the Member States of the EU¹⁴.

There is no legal instrument designed by European Union institutions specifically to protect women from violence, although the EU has made several political commitments, which advocate for the protection of violence against women. This includes the following:

- The Stockholm Programme (2010-2014): stressed that women who experience domestic violence are a vulnerable group in need of protection, including legal protection. This strengthened the EU's commitment to tackle gender-based violence more effectively.
- Women's Charter: adopted by the European Commission in 2010, the Charter declares the development of a comprehensive action plan to tackle domestic violence against women.
- Strategy for Equality between women and men (2010-2015): the strategy led to a call to develop an EU strategy to tackle violence against women.

Scale of the problem

The Council of Europe describes **domestic violence** as "all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit, irrespective of biological or legal family ties, or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence as the victim" (Council of Europe, 2011).

Intimate partner violence is a form of domestic violence, describing "a pattern of assaultive and coercive behaviours, including physical, sexual and psychological acts, as well as economic coercion, which adults or adolescents may use against their intimate partners without their consent" (EIGE, n.d.).

Domestic and intimate partner violence is a widespread phenomenon in all Member States, primarily affecting women and children. It is a significant public health problem estimated to be experienced by one in three women the world over (WHO, 2013a). Domestic and intimate partner violence is a human rights violation and recognised as a form of gender-based discrimination, rooted in inequalities between men and women (EPRS, 2014).

Whilst women can be the perpetrators of violence, and men and boys can be victims of violence at the hands of both sexes, recent research conducted among the EU-28 shows that violence against women is predominantly committed by men (FRA, 2014).

¹⁴ As of 27 January 2017, those that have not ratified are: Bulgaria, Cyprus, Czech Republic, Estonia, Germany, Greece, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Slovakia and the UK. http://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/210/signatures?p_auth=U3E8xV8o

Reliable and comparable data on the prevalence of domestic violence in the EU and its Member States is lacking. This is partly down to difficulties in collecting reliable data, because there is particular fear, shame and stigma associated with domestic violence and often victims fail to report incidences of violence committed against them. But also because there are inconsistencies in how data is collected and reported, and until fairly recently (the 1990s), domestic violence was perceived as a private matter in which Member States had little interference (FRA, 2014).

Note that there are debates around the terminology that should be used to describe those who have experienced domestic and intimate partner violence: 'victims', 'survivors', 'victim-survivors' or others. Although this literature view uses 'victims', not everyone would subscribe to this term, and readers are encouraged to use the language that they find most appropriate.

Health needs/challenges for victims of intimate partner violence and domestic violence

This section examines the health challenges experienced by victims of domestic and intimate partner violence.

There are considerable health risks associated with domestic and intimate violence. Domestic violence can have serious immediate and long-term consequences for the victims, in terms of both physical health (including sexual and reproductive health) and mental health.

In the immediate term, domestic violence can lead to physical injury and trauma. The FRA (2014) survey on violence against women found that as many as 68% of women reported having been subject to physical or sexual violence in their lifetime, by either an intimate partner or another person. The most common injuries tend to be musculoskeletal injuries to the head, neck and face, although injuries to the genital area are also common. Systematic analysis of studies into domestic violence injury, based on data collected from 31 countries, found that 42% of women who had been injured as a result of intimate partner violence out of all women who had experienced domestic violence (WHO, 2013c). This shows the potentially large health burden for women because of injuries from domestic violence.

At its worst and most severe, domestic and intimate partner violence can result in death. The WHO (2013c) reports that across countries with available data, since 1982, the median prevalence of intimate partner homicide is estimated to be 13% - with as many as 38% of the total number of murdered women (on comparison to 6% of murdered men) being killed by an intimate partner. Globally, available data suggests that intimate partner violence leading to fatal injury in the European region is relatively lower than in other regions, such as South-East Asia, Africa and the Americas.

Literature also highlights a wide range of more long-term health issues associated with domestic violence and include some of the following:

- Literature on the health outcomes of victims of domestic violence has found that victims are increasingly vulnerable to sexually transmitted diseases (STDs), including HIV. Increased vulnerability to HIV and STDs is associated with direct infection from forced sexual intercourse and the potential for increased risk from the general effects of prolonged exposure to stress (Fernandez-Botran et al., 2010; Newton et al., 2011).

- Violent relationships are often characterised by fear and controlling behaviours. They are also associated with higher rates of adverse reproductive events as a result of coercion and sexual violence. As a result, women in abusive relationships are more likely to experience unintended pregnancies to which there are health risks to mothers whether the pregnancy is carried to term or aborted (Goodwin et al., 2000; Pallitto, Campbell and O'Campo, 2005; Silverman, 2007).
- Studies have found that increased stress levels of pregnant women can have a negative affect during pregnancy, and may increase the risk of low birth weight and premature births. Living in an abusive environment and experiencing domestic violence is marked by stress, which is an important risk factor for maternal health (Hill et al., 2016).
- Domestic violence can also have a negative effect on the mental health of victims. Experiences of domestic violence have been associated with greater risk of depression, post-traumatic stress disorder and suicide (Hyde et al., 2008; Devries et al., 2013).

Barriers to accessing healthcare

This section outlines the issues relating to access to health experienced by victims of domestic and intimate partner violence. Health care services have a key role to play in identifying and documenting incidences of domestic violence. Therefore, overcoming barriers to accessing health care is important in meeting the needs of this vulnerable group.

As reported above, it is widely thought that incidences of domestic and intimate partner violence go largely under-reported and is underestimated within health service data. This is mainly because many women, regardless of their country's health system, do not seek health care for their injuries or to escape their situation. For example, the FRA (2014) found that among the 42,000 women they surveyed from across the EU, only 33% of victims of intimate partner violence and 26% of victims of non-partner violence contacted the police or another organisation.

The literature suggests that several barriers prevent women from accessing appropriate health care services. These include:

- **Psychological barriers.** Fear, shame and emotional dependency can have a negative impact on women experiencing domestic violence in accessing health care services. Victims may be in a position where they are reluctant to seek help because they are fearful of the repercussions of telling someone else, or that they may feel ashamed for being a victim of domestic violence. Victims may suffer from a complete loss of self-esteem, which can lead to a sense of culpability in which they think they are responsible for the situation and are reluctant to seek health care support in order to protect the perpetrator (Bonewit and De Santis, 2016).
- **Failure of health care services to detect signs** of domestic violence (see below).

- **Economic dependency of women.** This is one of the main indicators of gender inequality that affects the ability of women to leave a violent relationship. Women are more likely to experience lower pay, unemployment and poverty compared to men (EIGE, 2016). Depending on the welfare system of individual Member States, women who face particular economic difficulties may struggle to afford the cost of accessing health care services to meet their health needs (Helweg-Larson, et al., 2003), adding a further barrier and challenge in improving their health. As a sign of the economic vulnerability associated with abuse, homeless women are often victims of abuse and family violence (both physical and psychological) and may pass through different and alternative stages before eventually becoming homeless or in a shelter¹⁵.

Health care services have a key role to play in identifying, responding to, and preventing incidents of domestic and intimate partner violence. Recent studies show that women who are victims of violence are more likely to consult or be in contact with health services compared to other services and agencies (Yeung et al, 2012; FRA, 2014). However, health care professionals often have little training or skills to identify and deal with victims of domestic violence.

One study examined the experiences and expectations of mental health service users who have experienced domestic violence in the UK to get a better understanding of how psychiatric services respond to service users who have experienced domestic violence, through the qualitative meta-synthesis of relevant literature. It found that mental health services often fail to identify and facilitate disclosure of violence, and develop appropriate responses that prioritise the safety of the victim. In addition, mental health services were reported to lack consideration for the role of domestic violence in precipitating or exacerbating mental illness. A preference for focusing on biomedical models of treatment and stigmatisation of mental illness were found to be particular issues, which inhibited appropriate and effective responses (Trevillion et al., 2014).

Health providers must support victims appropriately with immediate and long-term care, ideally through the primary services. The health system also has an important role to play in referring victims on to specialist forms of support in the domestic violence sector (García-Moreno et al., 2014).

Evidence of policies to address issues affecting this group

Providing tools to healthcare workers to identify and respond to cases of domestic and intimate partner violence more effectively

Women who have experienced intimate partner violence are more likely to seek out health care than women who have not (García-Moreno et al., 2014). Results from the FRA survey found that the majority of women in the EU (87%), think it would be acceptable for doctors to routinely ask women who have present certain injuries if they have been caused by violence. This suggests there is an opportunity for the health service to take a leading role in identifying signs of domestic violence and responding appropriately, rather than simply dealing with the specific health issues presented to them.

¹⁵ Identified in project interviews.

Systematically undertaking this form of clinical inquiry systematically requires health professionals to know how to do so safely. Research finds that women are more likely to disclose incidents of violence if health-care providers ask sensitively, empathetically and in private, under safe conditions (for example, without their partner present) (Black, 2001; WHO, 2013c; García-Moreno et al., 2014). Antenatal care, family planning and gynaecological services are potential avenues for screening, as well as emergency services (more likely to encounter women with injuries) (García-Moreno et al., 2014).

In the UK, the Identification and Referral to Improve Safety (IRIS) programme has been thoroughly evaluated and associated with positive results, (Health Foundation, 2011). The programme was piloted between 2007 and 2010 and commissioned by local health services. IRIS is a training and support programme for primary care clinicians and involves:

- Two training sessions run by an 'advocate-educator' and targeted at doctors and nurses in their practices¹⁶ about how to ask women appropriately about domestic violence, and how to respond if violence is disclosed;
- An electronic prompt for doctors reminding them to enquire about abuse¹⁷;
- A clear referral pathway for those who disclose violence to the advocate-educator;
- Advocacy and signposting for those who have been referred (Health Foundation, 2011).

A randomised control trial found that it was more common for doctors and nurses in practices that received the IRIS intervention to identify women experiencing domestic violence and to refer them to specialist domestic violence agencies (Feder et al, 2011). The programme is also associated with cost savings (Devine et al., 2012).

It is worth bearing that IRIS did not promote universal screening of all women accessing primary care services, and the effectiveness of this approach (as opposed to targeted clinical inquiry of the kind advocated by IRIS) has been debated (WHO, 2013e; Cole, 2000; Davidson et al., 2000). For instance, some, especially in the USA, argue that all women accessing certain health services should be asked about their experience of partner violence, whereas others believe a more selective approach is necessary, based on "clinical and diagnostic considerations" (WHO, 2013e, 17). The WHO does **not** propose universal 'screening', but instead proposes that health-care professionals be taught to recognise the health symptoms of intimate partner violence, and, where detected, ask about violence (WHO, 2013e; García-Moreno et al., 2014).

- The IRIS programme is highlighted as best practice in the UK government strategy, *Ending Violence against Women and Girls 2016 – 2020*.
- Key lessons from the initial rollout of IRIS have been investigated (Health Foundation, 2011). These include the following:
- The degree of patient interaction, understanding of patients' social history, topics covered in clinical interviews and the views of patients all affected the degree to which domestic violence was discussed.
- Key obstacles in the rollout of the programme included clinicians' insufficient time and/or knowledge of resources available.

¹⁶ Reception and administrative staff also receive a shorter training session.

¹⁷ However, focus group participants cautioned about the use of electronic prompts on all patients' records, as they can become easy for doctors to ignore if they appear too frequently. For more on this issue, see the report of the focus group.

- The length of the clinicians' relationship with the patient could affect disclosure negatively and positively.
- It is important take professionals' feedback of training and referral scheme into account (including through a 'feedback loop'), although this should not be at the expense of the 'core' curricula of the programme.
- Clinical champions bring more legitimacy to the endeavour. It is important to work with clinical champions who are personally committed to the programme.
- It is important to show the economic savings that such interventions can generate; demonstrating the cost per Quality-Assured Life Year (QALY) may not be enough on its own.
- Service users should be engaged in advisory/support positions.
- It is necessary to work with credible voluntary groups that can offer diplomatic advocate-educators.

Building upon the IRIS model, the EU previously funded the IMPLEMENT programme, which provided training and support on how to offer specialised support to victims of violence in health systems across six European countries¹⁸ (Austria, Bulgaria, Romania, Germany, Italy and France). The training was designed by Women against Violence Europe (WAVE) and the United Nations Population Fund (UNFPA). The full package is available online¹⁹ and specifically targets healthcare professionals in Eastern Europe and Central Asia. Successes and failures of the IMPLEMENT programme were discussed at length during the VulnerABLE focus group on 'Strategies to improve the health of victims of intimate partner violence and domestic violence' (23 Jan 2017)²⁰.

The VulnerABLE project undertook two case studies into approaches that aimed to increase the awareness of health professionals in identifying and supporting victims of domestic and intimate partner violence:

- In Austria, Vienna's hospitals introduced a Training Curriculum ('Violence against women and children – victim protection') to enhance the sensitivity of health professionals when dealing with victims of domestic violence, ensuring adequate support to victims and supporting effective responses among providers. This involved a multi-agency group of hospitals and local governmental women's support agencies developing a training curriculum for health professionals on how to support victims of domestic violence. Qualitative research conducted as part of the programme found that the main benefit of the training curriculum was meeting the needs of health professionals who felt they lacked appropriate education and training. One obstacle identified during the implementation of the training Curriculum in Vienna's hospital training was that the project found it difficult to incorporate the training agenda into the working hours of health professionals (EIGE, 2015).

¹⁸ <http://test.wave-network.org/content/implement-training-manual-now-available>

¹⁹ <http://eeca.unfpa.org/publications/strengthening-health-system-responses-gender-based-violence-eastern-europe-and-central>

²⁰ See the focus group report for more information.

- The Medical intervention against violence²¹ in Germany aimed to raise awareness of doctors and to develop unified standards for the treatment of women victims of violence. The pilot programme which ran between 2008 and 2011 was funded by the German Ministry of Family, Senior Citizens, Women and Youth (BMFSFJ). The programme evaluation found that doctors are a complex target group to work with, given the varying standards and procedures to which they adhere (EIGE, n.d, b). This meant that from the outset it was quite hard to shift perceptions and approaches with regard to treating female victims of violence in a certain way. In order to overcome this obstacle and successfully introduce new standards and procedures, the evaluation suggested that was important to make sure that doctors were involved with the intervention from the outset. Ensuring that medical associations were committed was an important tool in promoting the new intervention.

A meta-analysis of qualitative studies suggests that the appropriateness of responses of healthcare professionals to intimate partner violence is linked to the context of the consultation, a woman's readiness to confront the matter, and the type of relationship between the woman and clinician (Feder et al, 2006). Another study (Evans and Feder, 2016) has confirmed the importance of an individual who acts as an 'enabler' for women in helping them to access specialist domestic violence services, making them more likely to disclose violence to a professional. Initial contact with specialist domestic violence services also played an important role in legitimising help-seeking via other formal and informal channels (Ibid).

Offering appropriate clinical care

Beyond identification of domestic and intimate partner violence, health-care providers must offer appropriate clinical interventions to support victims, including post-rape care (for example, pregnancy/STI prevention, access to abortion, long-term mental health services) (García-Moreno et al., 2014). Both the WHO and the National Institute for Care Excellence have published detailed guidelines and quality standards for delivering care to those who have experienced domestic and intimate partner violence (WHO, 2013e; NICE, 2014; NICE, 2016).

The recommendations assessed as 'strong' by the World Health Organisation are given in Table 2 below²².

Table 2. Summary of WHO recommendations (2013) on responding to intimate partner violence and sexual violence against women: clinical and policy guidelines

Recommendation	Key points
Identification and care	
Women disclosing any form of violence require immediate support from health-care providers	Health-care providers must provide non-judgemental support and enquire about violence carefully, without applying pressure and in a private and confidential setting; Providers must support women to access key resources, such as legal and other services; Providers must help women and children to safety.

²¹ Model project Medizinische Intervention gegen Gewalt an Frauen – MIGG.

²² Where relevant, recommendations for survivors of sexual assault are given in the table, as this form of violence can also take place within the context of an intimate relationship. That said, some strong recommendations related to survivors of sexual assault are not included here, if they repeat the recommendations specifically for survivors of intimate partner violence.

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	If providers cannot directly offer support they must direct women to another healthcare professional who is immediately available to offer help.
Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis and subsequent care.	<p>When providers ask, it must always be in a safe, private and confidential setting and following training on how to ask, with a clear protocol in place on the minimum response and referral pathway.</p> <p>Clinical conditions linked to intimate partner violence include:</p> <ul style="list-style-type: none"> • Symptoms of depression, anxiety, PTSD , sleep disorders • Suicidality or self-harm • Alcohol and other substance use • Unexplained chronic gastrointestinal symptoms • Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction • Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes • Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other • Repeated vaginal bleeding and sexually transmitted infections • Chronic pain (unexplained) • Traumatic injury, particularly if repeated and with vague or implausible explanations • Problems with the central nervous system – headaches, cognitive problems, hearing loss • Repeated health consultations with no clear diagnosis • Intrusive partner or husband in consultations <p>Note: these examples of conditions were lifted directly from WHO, 2013e, but originally were adapted from Black, 2011, 428-439.</p>
Care for survivors of intimate partner violence	
Women with a pre-existing diagnosed or partner violence-related mental disorder (such as depression, or alcohol use disorder) who are experiencing intimate partner violence should receive mental health care for the disorder in accordance with the intervention guidelines of the WHO Mental Health Gap Action Programme (mhGAP) (WHO, 2010d).	<p>Interventions should be delivered by health-care professionals with a good understanding of violence against women.</p> <p>Cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR) is recommended for women who are no longer facing violence but who are experiencing PTSD.</p> <p>It is most appropriate that specialists provide psychotropic medications in women who are pregnant or breastfeeding.</p>
Clinical care for survivors of sexual assault: Recommendations	
<p>The WHO makes a series of detailed recommendations for survivors of sexual assault. Amongst others, healthcare providers should:</p> <ul style="list-style-type: none"> • Take a complete history, recording events to determine what interventions are appropriate, and conduct a complete physical examination (head-to-toe, including genitalia); • Offer emergency contraception to survivors of sexual assault presenting within 5 days of sexual assault, ideally as soon as possible after the exposure; • Offer safe abortion, in accordance with national law, if a woman presents after the time required for emergency contraception (5 days), emergency contraception fails, or the woman is pregnant because of rape; • Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 	

- hours of a sexual assault, on the basis of an assessment of the survivor's HIV risk;
- Offer prophylaxis/presumptive treatment for chlamydia, gonorrhoea, trichomonas and syphilis, in line with national guidance.

Days following assault:

- Offer written guidance on coping with severe stress;
- Avoid psychological debriefing.

In the 3 months after the assault:

- Take a 'watchful waiting' approach, unless the person is depressed, has alcohol or drug use problems, psychotic symptoms, is suicidal or self-harming or has difficulties functioning in day-to-day tasks;
- For those incapacitated by post-rape symptoms, organise for them to have cognitive behaviour therapy (CBT) or eye movement and desensitization and reprocessing (EMDR);
- Respond to other mental health issues (symptoms of depression, suicide, drug or alcohol use), in line with WHO mhGAP intervention guide (WHO, 2007).

More than 3 months after the assault:

- Assess for mental health problems (symptoms of acute stress/PTSD, depression, alcohol and drug use problems, suicidality or self-harm) and treat depression, alcohol use disorder and other mental health disorders using the mhGAP intervention guide (WHO, 2010), which covers WHO evidence-based clinical protocols for mental health problems;
- If the person has been assessed as experiencing post-traumatic stress disorder (PTSD), arrange for PTSD treatment with cognitive behaviour therapy or eye movement and desensitization reprocessing.

Healthcare policy and provision

As far as possible, integrate care for women who are experiencing intimate partner violence and sexual assault into existing health services.
Establish multiple models of care for survivors, but especially focus on the primary care system.
Health-care providers who have received training on gender-sensitive sexual assault care and examination should be available at all times.

The WHO recommendations also include detailed guidance on **training for healthcare providers** and the question of **mandatory reporting to the police**

Source: WHO, 2013c, pp.16-41. The *VulnerABLE* research team highly recommends that practitioners and researchers in this area refer directly to the original source for its detailed recommendations and evidence.

Adopting multi-sectoral responses

At the Member State level, UK multiagency services have been found to be effective in addressing some of the health challenges experienced by victims of domestic violence. Here, multi-agency risk assessment conferences (MARACS) are used to identify victims of intimate partner violence from across services. MARACs adopt a partnership approach, bringing statutory and voluntary agencies together around the same table to discuss the cases of individual high-risk victims, and formulate co-ordinated action plans for each of them. They operate as one element of wider infrastructure, which includes Specialist Domestic Violence Courts (SDVCs) and Independent Domestic Violence Advisers (IDVAs). The agencies that attend MARACs vary but include the police, probation service, IDVAs, children's, health and housing services as well as a range of other adult and child-focused services. Any agency may refer a case to a MARAC, based on its assessment of risk. This method has been evaluated and found to work well. One potential issue in its delivery is the significant administrative burden that the intervention places on those involved with MARAC meetings, in some cases potentially reducing the ability of police to provide services for victims themselves (Robinson, 2004). Some have also warned of the shortcomings of MARACs in that they may only focus on 'high-risk' victims (Stanley and Humphreys, 2014).

Another evaluation of specialist frontline services for victims of domestic violence in the UK investigated three agencies offering specialist support as part of a multiagency response (including MARACs and the SDVCs). This found that the services achieved positive safety outcomes for victims, with a total cessation of abuse for 59% of service users and a reduction in risk for 74%. Alongside a reduction in violence and abuse, the evaluation identified positive health and wellbeing outcomes among service users, with 72% reporting an improvement in their quality of life and 82% expressing confidence about accessing support in the future (Co-ordinated Action Against Domestic Abuse, 2012). The study highlights UK Government’s call to End Violence Against Women and Girls (VAWG) Action Plan (2014) as a key driver behind the service delivery. This sets out the UK’s vision on reducing violence against women, which focus on early intervention, supporting effective local approaches, driving cultural change, improving data collection and linking the issue of domestic violence into other national policy areas.

One study (Stanley and Humphreys, 2014) explores multi-agency collaboration specifically in relation to protection of child affected by domestic violence. This is important given that children are some of the main victims of domestic violence in Europe. Amongst others, it highlights the use of Multi-Agency Safeguarding Hubs (MASH) in England (UK) as a multi-agency screening mechanism centred on child protection and assessing/filtering referrals from a range of agencies. This process is facilitated by a 'sealed intelligence hub', in which multiple agencies can securely share information and generate a picture for risk assessment. Early evidence suggests that MASH hubs can lead to more sensitive risk assessment (Home Office, 2013; Stanley and Humphreys, 2014).

People living in unstable housing conditions (including the homeless)

This section focuses on issues relating to the vulnerability of people living in unstable housing conditions, including the homeless. The experience of living in unstable housing conditions is often referred to as homelessness. The term covers a broad spectrum of living conditions that are comprehensively summarised under the European Typology on Homelessness and Housing Exclusion (ETHOS) (European Commission, 2014b) and can be grouped into four main concepts, detailed in Table 3.

Table 3 European Typology on Homelessness and Housing Exclusion (ETHOS)

Concept	Description
Roofless	Regarded as the most extreme condition of homelessness, people who are roofless include people who sleep rough or people who stay in night shelters.
Houseless	People who are houseless include those in accommodation specifically for the homeless; women’s shelters; people in accommodation specifically for housing immigrants; and, people due to be released from institutions (such as prison or mental health hospital).
Insecure	Insecure refers to people who are living in insecure accommodation (such as ‘Sofa-surfing’, living with family and friends); living under threat of eviction and living under the threat of violence (such as victims of domestic violence).
Inadequate	Inadequate refers to people who are in temporary or non-standard accommodation; living in unfit housing; and, living in extreme overcrowding.

People who experience unstable housing conditions often move between these different categorisations as their circumstances fluctuate and change.

Overview of policy context

The right to social housing and assistance is included in the EU charter of fundamental right in Paragraph 3 of Article 34 which focuses on social security and social assistance "so as to ensure a decent existence for all those who lack sufficient resources" (European Commission, 2009d).

Individual member states are responsible for policy on homelessness prevention and some (such as Croatia, Cyprus, Finland, Poland, Portugal Romania and Spain) have developed specific policies aimed at improving the accessibility of housing for vulnerable groups (e.g. the homeless, older people) (EuroFound, 2016). However, there is currently no EU level strategy on homelessness. Recently, the European parliament has called for the adoption of such a strategy in a written declaration in July 2016 a reiteration of similar calls from 2011 and 2014 (European parliament, 2016).

The commission offers support to member states in combatting homelessness via the Social Investment Package (European Commission, 2013). Here it makes recommendations to member states for prevention, service delivery, re-housing and reintegration of homeless people.

At the 2010 'European consensus Conference on Homelessness' in 2010 the consensus conference jury called for a move towards 'housing led' approaches to homelessness. The jury recommended " a shift from using shelters and transitional accommodation as the predominant solution to homelessness towards increasing access to permanent housing and increasing the capacity for both prevention and the provision of adequate floating support to people in housing on the basis of need" (European Consensus Conference, 2010).

Scale of the problem

In the aftermath of the 2008 global economic crisis, housing costs as a share of disposable household income have increased and are the greatest expenditure item for most households across Member States. Issues relating to affordable housing, housing exclusion and homelessness have increased in saliency and are likely to feature high on the political agenda in years to come (EuroFound, 2016).

However, there is no systematic data available on homelessness populations at the EU level and there is a large variability in the quality and availability of data on homelessness in each Member State, in terms of general information on homelessness and in relation to the four concepts used in the ETHOS. The lack of a harmonised indicator is a major challenge in identifying and understanding the scale of the problem in relation to this target group. Therefore, establishing robust and comprehensive statistics on the prevalence of people living in instable conditions is very difficult.

Analysis conducted by the European Observatory of Homelessness (2014) of available data found that some Member States, such as Denmark and Finland, report very small homeless populations of around 0.1% of the population (despite using a very broad definition). Whilst Member States such as the Czech Republic (0.3%), France (0.24%) and Germany (0.11%), as well as Italy (0.2%) and the Netherlands (0.16%) also reported a low prevalence of homelessness using a narrower definition. Spain (0.05%) and Ireland (0.05%) reported the lowest levels of homelessness, but again, this was using a narrower definition than the ETHOS categories.

Data is available on overcrowding²³ across the EU-28 Member States, captured by the EU-SILC. The most recent data indicates that the average rate of overcrowding across the EU was 17%, whilst the highest rates of overcrowding were in Member States such as Romania (51.6%), Hungary (47.2%) and Poland (46.3%), and the lowest rates in Cyprus (2.8%), the Netherlands (2.5%) and Belgium (1.6%) (Eurostat, 2014b).

Whilst some people may experience homelessness once, it is more common for people to experience it repeatedly throughout their lifetime. Homelessness is strongly linked to poverty, social exclusion and destitution, which drive vulnerability. The drivers of homelessness and vulnerability are complex, and are associated with a wide range of factors including relationship breakdown, physical or sexual abuse, lack of qualifications, unemployment, drug and alcohol abuse, physical and mental health issues, criminality, debt, lack of social support networks, background of being institutionalised as a child, and death of a parent during childhood (Wright and Tompkins, 2006).

Health challenges

This section outlines the health challenges experienced by people living in insecure living conditions. There is a lack of literature on the health needs of the homeless population across the EU. However, available literature on the health needs of homeless populations indicates that this group is characterised by multiple physical and mental health needs (Roche, 2004). For example, research conducted in the UK into the health needs of 2,500 homeless people found that 73% of homeless people reported having physical health needs (with 41% reporting long-term health issues; 80% reported some form of mental health issues (with 45% having received an official diagnosis); and, 39% reported having a drug problem at some point in their life (Homeless Link, 2014).

Roofless living conditions are often associated with the most severe risks to both physical and mental health. Literature on the health needs of this sub-group indicate that they are at increased risk of contracting communicable diseases (compared to the general population), including Tuberculosis and Hepatitis. They are also at greater risk of developing multiple morbidities, including respiratory and circulatory conditions; injury (particularly through violence), poor oral health, feet problems, skin diseases and infection; serious mental health issues, including schizophrenia, as well as depression and personality disorders; and drug and alcohol dependence, including use of hard drugs such as crack cocaine and heroin (Griffiths, 2002).

Literature on the health needs of people in unstable living conditions, such as those living in insecure and inadequate living conditions or people who are houseless, indicate that these sub-groups are associated with mental health issues (including depression), respiratory problems, skin diseases, and digestive problems (Shelter, 2004). There is also evidence that dependents of those living in unstable situations are likely to experience mental health issues, including social, emotional and developmental problems (Sleed et al., 2011; Kyle et al., 2010). A study of homeless populations in two Irish cities conducted in 2015 found that a third of the study population had self-harmed, three fifths had suicidal thoughts and more than a third had attempted suicide (O'Reilly et al, 2015).

²³ Overcrowding is defined by the number of available rooms in a household, the household's size, as well as its members' ages and family situation.

There are many factors linked to worse health outcomes for people in this group. One risk factor is that homeless individuals are also more likely to use tobacco products (McNeil, 2012; O'Reilly et al, 2015) exposing them to harm. Another risk factor concerns poor nutrition in the group. A recent evidence review was conducted of studies that explored nutrition among homeless people. The review identified multiple studies that showed diets containing high levels of saturated fat, low fruit and vegetable intake and found numerous micronutrient deficiencies among homeless individuals that suggest the presence of malnutrition. The review further highlighted that as nutrition played a key role in immune function and in the managing of some long-term conditions (Seale et al. 2016).

Access to healthcare

This section describe the issues in relation to access to healthcare for people living in insecure living conditions. People experiencing homelessness and living in unstable conditions are likely to experience significant barriers in accessing mainstream healthcare. Research has found that, in addition to barriers relating to poverty (such as being unable to afford the cost of healthcare which have discussed in previous sections of this paper), homeless people have particular issues accessing health care due to accessing primary care services and tend to be over reliant on secondary and acute health services (Homeless Link, 2014). For the most vulnerable of homeless people (those deemed roofless), they are likely to live particularly chaotic lives, leading to unplanned health service use which usually occurs at a point of crisis and out of hours of mainstream primary care services (North West London NHS, 2013).

There are also bureaucratic barriers that affect this group, as mainstream primary care services often require a person to provide a fixed address in order to access the service; something which the majority of homeless people lack (European Commission, 2014b). For example, in Luxembourg access to health and social care is directly linked to an address and those without a permanent address are therefore unable to access health care (Médecins du monde, 2015a). In countries that operate a co-payment system the cost of healthcare may be a barrier or bureaucratic barriers may exist so that individuals do not receive the exemption they are entitled to. In 2015, Médecins du monde highlighted that new regulation in Portugal related to the declaration of income meant that some homeless people were unable to prove their exemption from medical co-payment (Médecins du monde, 2015b).

The literature also suggests that other factors, such as stigma and lack of trust, may affect the utilisation of health services among this group, particularly amongst the most vulnerable. Evidence from the UK shows that alongside practical barriers such as difficulty registering with primary care or difficulty travelling to services, homeless people also had perceived barriers such as negative attitudes towards them from practitioners or previous bad experience of health services (Rae and Rees, 2015). Homelessness is often experienced alongside other issues, such as poor mental health or substance abuse, and people may feel uncomfortable in seeking help with their problems (Stephens, 2002).

Poor links between mainstream health services, housing and social care providers have also identified as areas where homeless people have encountered difficulties in accessing health services (Lester, 2003).

Mirroring demographic changes seen within many societies as a whole, there is evidence that the homeless population is ageing in some European countries (such as the UK), and in non-European countries (such as Canada and Japan). There are high levels of illness and morbidity among homeless older people yet this group is currently comparatively underserved by current policy (Crane and Joly, 2014).

Evidence of policies to address the health needs of people in insecure living conditions

This section examines approaches used to address health challenges of people living in insecure living conditions. There is limited research into the impact of strategies to address the health needs of homeless people at the EU or Member State level. At the national level, policy responses have sought to address the health needs of homeless populations through integrated solutions across housing, health and other social policy areas, using a universal approach.

Overall policy responses to homelessness

In Norway, the Government introduced a homelessness strategy focusing on preventing homelessness by reducing the number of evictions and people moving into temporary accommodation (including length of time spent living in temporary accommodation), alongside emphasising the responsibility of a range of welfare services to meet the health needs of homeless people through universal health services (KRD, 2006). However, it has been suggested that this approach was limited in providing public care for health needs around drug abuse and the existing system failed to reach all people in need of care (Anderson and Yerhus, 2012).

Recently, in homelessness policy there has been much discussion and research into the homelessness prevention model, Housing First. In this model, homeless people are provided with a non-conditional offer of permanent housing. This is in contrast to traditional 'staircase' models from which the individual graduates into permanent housing through a shelter system. The Housing First model is promoted by European Federation of National Organisations Working with the Homeless (FEANTSA) who have produced a toolkit for policy makers on implementing a housing first model (Pleace, 2016). This supports the policy's continued growth throughout Europe and the opportunity for learning from others' experience. The implementation of the model in Europe was based on the success of the original New York service and services developed across the USA. In Europe, it was pioneered in Finland in 2008 as part of the national strategy on homelessness and in Denmark. Since then it has spread to several countries across Europe where individual organisations or local governments have piloted the model.

Several evaluations show that Housing First is highly effective at keeping people housed and therefore ameliorating the health issues caused or exacerbated by rooflessness (Pleace, 2008). A 2013 review of evidence also exists which looked at how effective Housing First policies were in promoting health. It found that Housing First was at least as good as "staircase" services in improving mental health, substance abuse and physical health with the added feature of being better at keeping people in housing (Pleace & Quilgars, 2013). Positive evaluation from Europe on health outcomes can be seen in evaluations of individual projects. For example, the evaluation of English Housing First project reported that of the 60 service users who provided outcomes data most stated that their general health was better than it had been a year before they started working with Housing First. Additionally, 63% service users reported better health since using Housing First (38 of the 60 service users) (Bretherton and Pleace, 2015). In the French Un Chez-Soi d'abord Housing First programme, interim results showed a reduction of nights spent in hospital of 18.3 nights in the six months prior to joining Housing First compared to 8.8 nights in the previous six months after they had been on the programme for 12 months. Generally, contact with hospital and frequency of stays had reduced considerably (Tingland & Psarra, 2015).

The positive results of Housing First should be considered in light of the high level of investment required for them to operate. Sustainability depends on the political will and funding opportunities available. These projects will be more challenging in situations for housing stock is already under pressure. Housing First is a long-term investment, as the considerable difficulties of individuals are expected to be ongoing, therefore long-term investment is required to achieve positive outcomes.

Targeting the specific health needs of those in insecure housing conditions

In contrast to the overall approach to reducing homelessness seen in national strategies and Housing First models, much of the literature on addressing the health needs of homeless people has focused on targeted and specialist service interventions to address the health needs of homeless people at a local level. Targeted interventions tend to focus on a specific type of homelessness, such as people who sleep rough on the streets or homeless families (Wright and Tompkins, 2007). Evidence indicates that this type of approach can be effective in addressing specific needs of homeless populations. For example, a UK study by Slead et al. (2011) evaluated a pilot implementing a baby clinic into a hostel for homeless families in order to address attachment and developmental issues prevalent among this group. The service was based on a collaboration between parent-infant psychotherapy services and health visitors, and engaged with 30 families to take part in the intervention (with 29 making up the control group). The study found that indices of mental and motor development of infants improved due to the pilot.

The provision of specialist services tends to focus on specific health needs or issues that relate to homelessness, such as drug and alcohol abuse or communicable diseases.

Approaches to combatting communicable diseases

A UK study by Craig et al. (2008) assessed the impact of an outreach model of care (using a tuberculosis link worker) to address tuberculosis among vulnerable groups (including the homeless). Homelessness is associated with poor treatment outcomes for people with tuberculosis. The study found that the role of a tuberculosis link worker helped address the needs of vulnerable people with tuberculosis. The link workers are able to by mitigate against risk factors that complicate the treatment of tuberculosis such as alcohol and substance misuse by providing enhanced social support. This facilitated patients successfully completing treatment.

A further example of a programme targeting communicable diseases among this group effectively is Find & Treat, an active TB screening service based in London. The Find & Treat service is based in a mobile health unit that travels to various parts of London to screen homeless individuals. The service has been running since 2007 and is commissioned through the National Health Service (NHS). A 2011 economic analysis by the National Institute for Health and Clinical Excellence (NICE) (2011) found that active TB screening is cost-effective in situations where the population has a higher incidence of TB (such as homeless populations) compared to standard approaches.

Specialised services for homeless people can be particularly effective where they combine specialist knowledge and understanding with enhanced access. One form of improving access to healthcare is to bypass standard referral routes that require the patient to present at primary healthcare services and bring healthcare services directly to affected individuals. As well as screening around 10,000 high risk individuals a year for TB and supports the TB treatment of 300 socially vulnerable and complex cases of TB. Service data from between January 2008 and June 2013 showed that Find & Treat conducted 45,385 X-rays that led to 385 referrals, resulting in a total of 84 diagnoses of pulmonary Tuberculosis. Of these cases, 84% went on to fully complete treatment within 12 months (UCL, 2014). This success can in part be attributed to the specialist knowledge of the target group available in the service and the multidisciplinary approach of the service. Find & Treat recognises that TB is a socially complex disease; the service therefore works with individuals to understand and combat the aspects of their life which lead to general ill health and TB specifically, such as homelessness and alcohol and drug dependency (Health in Hackney scrutiny commission, 2016).

Managing the care pathway for those with unstable housing situations

Another area of the care pathway that can become complicated for individuals experiencing unstable housing relates to the ways in which a patient's exit from secondary care is handled. If an individual is discharged into an inadequate or unstable housing, this affects their ability to recover totally and increases the likelihood of readmission (Hwang and Burns, 2014). A systematic review of American medical respite programmes, which are transactional facilities to manage this change, demonstrates that these programmes do reduce the likelihood of readmission as well as the total number of days spent in hospital (Doran et al, 2013).

Tackling health inequalities in access to healthy lifestyles

Other approaches to improving overall health is to tackle the inequalities in access to healthy lifestyle behaviours such as exercise. Many organisations that provide the opportunity for homeless individuals exist across Europe. One of the more established models of this sort of interaction is street football. This practice is seen across Europe; the Danish Ombold charity presents a particularly developed example of this. The charity has been operating since 2003. Evaluation evidence from 2014 suggests that the weekly football training model was effective at improving the health of homeless individuals. As part of the evaluation, survey was conducted among players at the weekly Ombold training. A total of 102 individuals participated in the survey. Of the respondents three out of four said they felt physically better since beginning the weekly training. Around two-thirds (65%) believed the training improved their mental wellbeing and half of the respondents reported that they smoke and drink less since joining Ombold. The social experience of Ombold encourages individuals to attend trainings regularly and the Danish Homeless World Cup team provides inspiration to those taking part. Ombold is open to anyone regardless of their standard of playing and people are encouraged to attend even if they feel they cannot play that day. Ombold players share common life experiences and being part of this peer group "as you are here and now" is a major draw of participating in Ombold (Ombold, 2016).

Harm reduction approaches to healthcare among those with unstable housing situations

Homeless individuals are disproportionately affected by substance misuse issues. One approach to supporting the health of an individual is a harm reduction methodology. These programmes take the approach of reducing the secondary harm, such as blood borne diseases. There are increasing number of programmes across Europe, which offer a harm reduction approach for individuals with drug dependencies. The Housing First model follows a harm reduction approach entitled 'recovery orientation'. In this, the Housing First scheme provides the individuals with support and enables them to seek help from services without requiring them to do so. In the Housing First model, service users can exercise a high degree of choice and control. In the evaluation of the English Housing First practices, service users reported that this, along with a sense of security and flexible support they were offered were the key strengths of the Housing First model (Bretherton & Pleace, 2015).

Another practice that embodies the harm reduction methodology is that of Drug Consumption Rooms (DCRs), which offer a safe space for homeless drug users and can support transitions into rehabilitation and detox programmes. These are currently at use in many EU Member States and there is an increasingly strong evidence base showing that DCRs are a cost-effective way to reduce overdose deaths, ambulance call-outs to overdose events, needle-sharing and public injecting (Kappel et al. 2016).

There are multiple strategies across Europe being used to combat health inequalities among homeless populations. Strategies may combat more directly either ill health related to homelessness or homelessness more generally but in both cases a holistic view is often taken that recognises the social determinants of poor health and that improving housing situations will ultimately tend to improve health outcomes.

Prisoners

This section focuses on the issues relating to the vulnerability experienced by prisoners.

Overview of policy context

Safeguarding of prisoner health remains the responsibility of individual Member States, and at the European level is primarily addressed by the (non-binding) European Prison Rules. Originally based on the *United Nations Standard Minimum Rules for the Treatment of Prisoners*, the newest version of the European Prison Rules was adopted by the Council of Europe in 2006 and sets out standards and principles for the treatment of prisoners, including specific considerations for health problems of particular importance to the prisoner population (such as drug addiction, infectious diseases and mental health) as well as more general prison functions such as accommodation, hygiene, food and medical services. While the European Prison Rules are used as a frame of reference for European Court of Human Rights judgements, and as a benchmark for evaluating prison conditions in individual Member States, no other formal policies relating specifically to prisoner health exist (Maculan et al., 2013).

In terms of initiatives addressing prisoner health, the WHO have run the Health in Prisons Programme since 1995²⁴, which gives technical advice to Member States on linking prison health systems with public health systems, and tackling prisoner health problems (such as communicable diseases, drug use and mental health). Beyond this, initiatives are implemented at the individual Member State level and as such are inconsistent in both scale and remit. For example, in France, the United Kingdom and Italy, the responsibility to deliver prison healthcare is managed by the Member State health ministries. In contrast, in Portugal and Poland healthcare services are the responsibility of prison administration institutions (Maculan et al., 2013).

Scale of the problem

There is a distinct lack of literature and data on the EU's prison population as a whole, with the majority of previous research having been conducted at the Member State level. The use of quality standards and prison health indicators differs widely across countries. This Member State-level research is also inconsistent and patchy, but nonetheless gives us some insight into the health needs experienced by prisoners across Europe, as well as some of the Member State-level measures being taken to address these needs.

An overview of the EU's prison population indicates that there is a considerable number of people imprisoned across Member States, and prisoner numbers are high relative to prison capacity. Most recent data comprising both adult and juvenile prisoners suggests that there were around 643,000 prisoners in the EU-28 (excluding Scotland) in 2012, rising 7% from 2007 (Eurostat, 2016m). Other data sources indicate that prisons in the EU were close to their capacity (holding 94 inmate per 100 places) and a considerable number (43%) of prisons were experiencing overcrowding in 2013 (Aebi and Delgrande, 2015).

Health challenges

Vulnerable groups – also referred to as 'underserved' groups – can be overrepresented amongst groups that enter prison. According to a report by Penal Reform International (2015), in most countries, prisoners are drawn from the poorest sections of society, and the link between poverty and ill health is well established. Many people who end up in prison can also have a low level of educational attainment and have experienced high levels of unemployment (WHO, 2014).

Prisoners are also relatively likely to have a history of problem drug use, relative to the general population (European Monitoring Centre for Drugs and Addiction, 2012). This affects their health situation and in particular their risk of having a communicable disease. One study (Larney et al., 2013) found that detainees with a history of injection drug use (IDU) were nearly 12 times more likely than general detainees to have Hepatitis C.

Once individuals reach prison, the environment is often characterised by high population density and confined spaces, which brings with it particular health risks for prisoners (WHO, 2007; Maculan et al., 2013). One study from 2013 suggests 43% of prisons in Europe experienced overcrowding (Aebi and Delgrande, 2013). Overcrowding in particular can increase stress (Rouillon et al., 2007).

Health risks in prison can include:

²⁴ <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/who-health-in-prisons-programme-hipp>

- Greater risk of infectious diseases;
- Greater risk of physical trauma;
- Greater risk of substance abusive behaviour;
- Greater risk of chronic disease²⁵; and,
- Severe mental health problems (Fazel et al., 2002), reflected in high rates of self-harm and self-inflicted death in prisons (WHO, 2007).

The precarious state of health in prisons when compared to the general population is reflected in prisoners' lower life expectancy and acute/long-term physical and mental illness (Barry, 2010).

There is also the likelihood that existing health issues may be aggravated by the prison environment (WHO, 2013d). For instance, those with mental health needs can be overrepresented in the prison population, and research suggests these needs can then remain unmet or become worse once individuals are in prison (due to a lack of adequate psychiatric treatments) (Maculan et al., 2013).

In Europe, it is relatively rare for prison health to come under the responsibility of the Ministry of Health, affecting the degree to which it is seen as a public health concern (Maculan et al, 2013). When prison health is not under the remit of the Ministry of Health, this can result in a 'two-tier' system when it comes to the quality of care delivered in prisons versus the quality of care delivered to general public (as confirmed in interviews and the focus group conducted for the VulnerABLE project). Project interviews also suggest that not having prison health under the remit of the Minister of Health can result in additional cost/insurance issues when trying to deliver specialized treatments.

Whilst it should be stressed that the large majority of prisoners are likely to face higher rates of health needs and challenges accessing health care compared to the general public, the literature explored in this review pointed to specific groups of people within the prison population who are particularly vulnerable to poor health. Some groups face particular health needs and barriers to health, placing them at a greater risk of vulnerability. They include the following:

- Prisoners with mental health needs
- Young prisoners
- Female prisoners
- Older prisoners

As discussed in the Focus Group on prisoners' health, ethnic minority prisoners can also be especially at risk of poor health²⁶.

Prisoners with mental health needs

People with mental health problems often end up in prison as other institutions fail to identify their needs earlier. Many people with existing mental health problems end up in prison as other services and the criminal justice system fail to identify and meet their needs. Whilst literature does cover the mental health needs of prisoners, there is little available data on the scale of mental health needs across the EU-28.

²⁵ As emphasised in the Focus Group, chronic disease is a leading cause of death amongst people in prison and often receives insufficient attention in the discussion of prisoners' health needs.

²⁶ See the report of the Focus Group for more information.

Research from the UK and Ireland shows that rates of depression and suicide are significantly higher among the prison population than the general population (Kennedy et al, 2004; Prison Reform Trust, 2016). Data on the number of suicides in adult prisons provides an indicative figure of the scale of mental health issues among prisoners in the EU. They reveal that there is a considerable health issue across Europe. For example, across Europe in 2012:

- France recorded 123 deaths by suicide,
- Italy recorded 56 deaths by suicide;
- England and Wales recorded 58 deaths by suicide;
- Poland reported 143 suicide attempts and 18 deaths by self-harm; and
- Latvia recorded 7 by suicide.

While only intended to be used for indicative purposes (and unlikely to reveal the true extent of prison suicides), these figures highlight the considerable mental health needs with Member State prison systems (Maculan et al., 2013).

Young prisoners

Young prisoners face considerable risks of mental and physical health. There is insufficient literature on the population of young people in prison across the EU. This may be due in part to the variance in age at which an individual can become criminally responsible across Member States, as well as differences in how and where young people are detained. Nevertheless, there are some Member State level studies that have captured the health needs young people in prison.

For example, a study in Switzerland into the health needs of adolescent prisoners found that prisoners reported a range of health needs, including somatic disorders, mental health disorders, trauma and addiction. The majority of prisoners reported at least one health problem (87%), the most common of which were substance abuse, mood and sleep disorders, physical abuse and skin diseases. Depression was also reported among prisoners; however, the study team believed that depressive symptoms often pre-existed the individual's detention but were exacerbated by their imprisonment. Additionally, the study also found that the majority of prisoners were born outside of Switzerland (94%) and originated from countries where armed conflict had occurred in recent years (69%). This might also have an impact on their vulnerability (Haller and Meynard, 2004).

Two studies conducted in the UK found that young prisoners had high levels of health need. A systematic review into the health needs of prisoners aged 10-17 in England and Wales found young prisoners experience higher rates of complex health problems compared to young people in the general population, including physical and mental health, as well as learning difficulties (Lennox, 2014). Similarly, a different systematic review also found young people to be at greater risk of physical and mental health problems including substance abuse, self-harm and depression (Harris, 2006).

A longitudinal study in the UK of 97 male prisoners aged 12-17 found that the level of psychiatric morbidity among this group is high. The most prevalent psychiatric disorders included conduct disorder (91%), substance abuse (69%), major depression (22%) and anxiety (17%). Whilst the study found that overtime, the rates in conduct disorder decreased – potentially as a result of the rehabilitative programmes going on in the prison – some of the prisoners who did not show signs of depression at the start of the study later developed signs (Kroll et al., 2002). This suggests that the prison environment may be detrimental to the mental health of young people, and follows similar findings from the Haller and Meynard study.

Women prisoners

Prison systems are often designed for men and neglect the health needs of women. Due to their position as a minority group in prisons, their health needs may be neglected by health providers/systems in prisons.

There can be worryingly high rates of mental health issues amongst women in prison. One study (Owen, 2004) found that 90% of women prisoners in England and Wales had diagnosable mental disorder, substance misuse or both. Other research suggests that women are more likely to experience certain mental illnesses, addiction to hard drugs and a tendency to engage in self-harm, compared to male prisoners (WHO, 2007). An analysis of a psychiatric morbidity survey in the UK found evidence that suggest more female prisoners are prescribed psychotropic drugs in prison (O'Brien et al., 2001). In addition, women have found to make up almost half of all self-harm reported incidents (Prison Reform Trust, 2005).

Women may also engage in other risky behaviours, such as smoking, drinking, and unsafe sex (Harris et al., 2006; WHO, 2007). For example, a study in the UK of a prison found that women are more like than male prisoners to be heavy smokers (82% to 77%) and are significantly more likely to smoke than women in the general population (27%) (Marshall, et al., 2000). Other research found that female prisoners were at a greater risk of cervical cancer than women in the general population. The researches attributed this to women in prison being less likely to have had a regular smear test whilst inside or outside of prison (Plugge and Fitzpatrick, 2004).

Prison systems may also cater poorly for women who act as the primary caregivers. In most Member States, there are fewer prisons for women, which can result in women being imprisoned far away from their families, which can have a string of implications for visitors and dependent children (Wetton and Sprackett, 2007).

Older prisoners

Older prisoners (50-60 years and older) are another group who are particularly vulnerable in prison. They tend to have a complex profile of physical and mental health problems. A study in the UK into the health needs of older male prisoners found very high rates of physical and mental health disorder among prisoners aged 50 years and older. Around 90% of prisoners had a physical health need. Physical health conditions included a range of long-term conditions, such as osteoarthritis, asthma, high blood pressure, diabetes, high cholesterol, hearing loss, heart disease, prostate problems and Chronic obstructive pulmonary disease. Mental health was also found to be an issue, particularly for prisoners age 50 to 59, with a total of 61% of older prisoners reporting a mental health disorder. Mental health problems included major depression, substance misuse and personality disorders, as well as psychotic disorders (Hayes et al., 2012).

Other literature has also highlighted the health needs of older prisoners as a particular issue. A systematic review of literature on prisoner health needs in England and Wales found that among 203 older male prisoners, 83% reported a longstanding illness or disability, which is significantly higher than the figures for their younger counterparts and older men in the general population (65%). For older men in this group, the most commonly report physical problems included musculoskeletal problems, cardiovascular and respiratory problems (Harris et al., 2006; Fazel et al., 2001a).

In addition, psychiatric needs of older male prisoners within this cohort was 32%. The most common of these needs was depression, which they found to be higher than among the general population and was associated with risk factors such as poor physical health and previous psychiatric disorder (Fazel et al. 2001b).

The literature found also suggests that older prisoners present different health needs to the majority of the prison population who tend to experience more problems with drug use and psychosis. Therefore, there is concern that older prisoners may not get access to the healthcare they require as the prison health care system focuses on chronic illness rather than acute illness (Hayes et al., 2012).

Barriers to healthcare

This section examines issues relating to access to healthcare for prisoners. Despite legislation regarding the standards of health care provision at both the EU and Member State level, health care in EU prisons is often insufficient to meet the needs of the prisoner population, with prisons lacking the facilities to offer appropriate access to healthcare for prisoners. For example, in Greece, there are reportedly a high number of prisons with no permanent member of staff on site who is qualified to provide medical services to prisoners. Similarly, in 2010, 17% of prisons in Latvia did not have a single medical practitioner onsite, and, where there are medically trained staff onsite, there is often insufficient staff compared to the number of prisoners (Maculan et al., 2013).

Analysis of European instruments of human rights (WHO, 2013d), indicates that there is a high frequency of poor practice in relation to prisoner health care across Europe. This includes:

- Prisoners' right to health being frequently disregarded.
- Failure to meet special care of duty for prisoners – covering safety, basic needs and human rights, including health.
- Health care staff often do not act independently of prison authorities but are involved in the process of discipline and punishment.

For women prisoners, prison systems tend to be developed to accommodate male prisoners and often fail to address the specific needs of female prisoners, such as childcare (including pregnancy) (Wetton and Sprackett, 2007). Women are often imprisoned for non-violent crimes and tend to serve shorter sentences, leading to a quick turnover of prisoners. This can mean that there is little time to address the health care needs of female prisoners (Harris et al., 2006).

Evidence of policies to address the health needs of people in prison

As stated by the WHO (2014), 'The state has a special duty of care for those in places of detention which should cover safety, basic needs and recognition of human rights, including the right to health'.

The health of people in prison is important; as discussed, they are drawn from some of the most vulnerable groups in society and may experience serious health issues before they arrive. For most prisoners, they will eventually return to the community and take with them any diseases or health issues that go untreated whilst in prison. Therefore, there is an incentive for Member States to ensure that this vulnerable group receive appropriate health protection and treatment for the benefit of all of society (WHO, 2014).

A good prison health care system is an opportunity to address ill health and reduce some of the health inequalities experienced by the vulnerable population. Recommendations from the Council of Europe on prison health (WHO, 2013d) propose a range of policy changes to improve prison health care provision. These include:

- A holistic approach to prison health care, involving the whole-of-government in coordinating and managing all relevant agencies and resources to deliver good health and wellbeing to prisoners.

- Accountability and provision for prison health and prison health care sitting with health ministries.
- Health ministries' actively advocating for healthy prison conditions.

By taking this approach, the WHO believe that, in the long term, this will lead to better health outcomes for prisoners, better public health for society and help reduce inequalities in health.

According to interviewees for the VulnerABLE project, key benefits of moving prison health into the public health agenda include: better training of prison healthcare staff; more consistent health guidelines on the same diseases; better monitoring of prison health indicators; and greater availability of specialised treatments in prisons, such as transplants and dialysis.

Policies specifically addressing prisoner health inequalities are not consistently evident across all Member States, but some do have policy measures aimed specifically at improving prisoners' health. In England, for example, a 2013 agreement between the government agencies for prisoner management²⁷ and healthcare service delivery²⁸ makes commissioning and delivery of healthcare services within English prisons the joint responsibility of all three agencies, rather than the responsibility of just the prisoner management service. The rationale for this agreement is to ensure that healthcare services commissioned within prisons are equivalent to those available to the general population, thereby helping alleviate health inequalities experienced by prisoners. There is also some limited evidence of national-level NGO initiatives in this area: for example, a programme called Community-based Health and First Aid in Action (Irish Red Cross) has trained prisoners to act as peer mentors, raising awareness about hygiene issues among their fellow inmates to help reduce unsanitary behaviours.

Some Member States also have policies designed to tackle specific prisoner health inequalities, with a view to making conditions within prison as similar as possible to the outside environment. In Denmark, for example, all prisoners are made responsible for preparing their own meals, and in support of this are given cookery classes and the ability to purchase raw ingredients for meal preparation. One aim of this policy is to improve the nutritional content of prisoners' food, thereby helping reduce rates of communicable diseases and mental health problems among prisoners.

Indicative findings from evaluations of Denmark's model of prisoner self-cooking suggest that this model has improved knowledge of health eating among prisoners, with a potential knock-on impact on improved prisoner nutritional intake and overall health as a result. These findings also found that incidents of disruptive/poor behaviour were reduced inside prisons after the implementation of these policies, suggesting a positive impact of the policy on prisoner mental health. Preliminary evaluation results from the Irish Red Cross programme which began in 2009 and has run in all prisons in Ireland since 2014 also indicated that the programme has been successful in raising prisoner self-esteem and reducing unhealthy behaviours (such as smoking) among prisoners in a number of prisons.

Emerging results from other strands of the VulnerABLE project also suggested that the following could improve prisoner health:

- Better screening of prisoners for health issues when they arrive to prison and throughout their time there;

²⁷ National Offender Management Services (NOMS)

²⁸ NHS England, Public Health England

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- Harm reduction measures to support the safe use of drugs and tackle addiction and substance abuse in the long term;
- Improving trust and communication between healthcare professionals and prisoners;
- Empowering prisoners to improve their own health, for example giving them greater agency over their food or holding a 'weapons amnesty';
- More systematic monitoring of prison health indicators (e.g. treatment completion, drug treatment outcomes, screening levels, mortality rate from infectious diseases, serious mental illness).

Chapter 3: Conclusions from the literature review

Conclusions

This section draws on the findings from the literature review and presents conclusions.

Conceptualising vulnerability in health

- The European Commission understands health inequalities as 'differences in health status between individuals or groups, as measured by for example life expectancy, mortality or disease' that arise from 'avoidable differences in social, economic and environmental variables'.
- Crucial to the concept of health inequalities is the idea that they are unnecessary, avoidable, unfair and unjust.
- Vulnerability is a social phenomenon, affected by multiple processes of exclusion that can lead to or result from health problems.
- The concept of vulnerability is not static. Individuals can be more or less at risk of being in a vulnerable situation, depending on the interaction of personal (inborn or acquired) and societal and environmental factors. Those factors provide or deprive individuals from certain types of resources. The more personal resources (good mental and physical health, good coping skills, etc.) and the more environmental support a person has, the less likely that person is to be at risk of vulnerability (Rogers, 1997).

Measuring health inequalities

- Over the last decade, population health indicators have improved across the European Union. However, these indicators suggest that an increase in health has not been experienced equally. There are still widespread inequalities in health and access to healthcare between and within EU Member States.
- Life expectancy, the prevalence of ill health and the level of unmet need varies across different population subgroups, according to the latest data. For example:
 - Old age increases the likelihood that someone will have a long-standing illness or health problem.
 - The wealthiest residents of Europe are significantly less likely to have a long-standing illness or health problem than those with the lowest income.
 - Cost is the most common reason why Europeans' need for healthcare is unmet.
 - Those living in rural areas are more likely than urban residents not to access healthcare they need because of cost or distance.
 - Those with lower levels of education are also more likely to have a lower life expectancy.

Overall responses to the issue

- The EU Fundamental Rights Charter and the International Covenant on Economic, Social and Cultural Rights advocate for the right of access to healthcare for all people within the EU, particularly vulnerable and marginalised groups. Whilst Member States are primarily responsible, the EU has a mandate for supporting national strategies to improve public health and healthcare provision.
- The EU endorses equality of access to healthcare for all people as an important policy objective. However, there are differences in access to healthcare across Europe. In some Member States access to social insurance (including public health care) is linked to employment or dependency status (i.e. Germany), whilst in other Member States it is available irrespective of employment status (i.e. UK).
- Through a consistent and integrated policy framework, the EU has responded to health challenges facing Europe combining legislation, cooperation and financing in its EU Health Strategy 'Together for Health' and subsequent Communications 'On effective, accessible and resilient health systems (European Commission, 2007; European Commission, 2014c). Amongst other things, this aims to promote health and reduce health inequalities.
- In most cases, Member States have strategies or programmes in place that address the health inequalities of multiple disadvantaged groups within one single plan. Where such plans identify specific vulnerable groups, they most commonly identify children and young people, older people and those in rural/isolated regions (and not necessarily all the target groups of the VulnerABLE project).

The situation of vulnerable sub-groups

Older people

- Europe is the world's oldest continent by demography and its ageing population (19.2% of people in the EU are estimated to be aged 65 and over in 2016) poses particular challenges for policymakers. However, the proportion of older people differs considerably from one Member State to another (as high as 22.0% in Italy, compared to as low as 13.2% in Ireland in 2016) (Eurostat, 2017b).
- There have been important legislative changes to outlaw discrimination on the grounds of age. Article 25 of the Charter of Fundamental Rights (binding from 2009) set out a wide range of rights relating to older people, including the rights to non-discrimination, social security, healthcare and education.
- Older people are often confronted with the long-term health impacts of vulnerable situations experienced over their life-course (Zaidi, 2014).
- Older people, as a group, are more likely to experience a wide range of health needs (including higher rates of morbidity and mortality) than the rest of the population (Drozdak and Turek, 2016).
- Socioeconomic factors are identified as a key determinant of health and vulnerability in later life, with those experiencing greater disadvantage experiencing poorer health and wellbeing (Knesebeck et al., 2007; Siegrist, 2009).

- Structural ageism can be a problem within health systems (AGE Platform Europe, 2016).

Policy responses:

- Research into active and healthy ageing suggests that lifelong learning, working longer and retiring later, as well as volunteering in old age, is associated with improving or prolonging good quality of life in old age, providing work is of good quality and does not negatively impact on health (Knesebeck et al., 2007; Siegrest, 2009). The EU's employment strategy has focused on encouraging Member States to implement active ageing policies to increase the participation of people aged 50 and over in the labour market (Eurofound, 2013).
- The diversity of national approaches to supporting older people is reflected in countries' varying scores in the 'Active Ageing Index'. The index provides an indication of the level of action in Member States to progress towards active and healthy ageing across four domains – employment, social participation, independent living and capacity for active ageing (Walker and Zaidi, 2016).
- To meet the health and social care demands of people with complex health needs, research and policy in some Member States highlights the importance of person-centred care and personal budgets in providing adequate care for older people (Gridley, Brooks and Glendinning, 2014). However, to meet the growing demand on health and social care services of an ageing population, this will require the expansion of the health workforce (UKCES, 2015).
- The European Innovation Partnership in Active and Healthy Ageing has implemented and sustained an action plan 'Replicating and Scaling Up Integrated Care', co-funded by the Commission, which specifically aims to develop more integrated care systems to support older people with long term conditions. Similarly, while there is little evidence on the outcomes of the project, the Our Life as Elderly (OLE II) project²⁹, in place in various European countries, aims to develop specific services to meet the need of older people through improving the quality and responsiveness of health and social care services available to older people.

At-risk children and families

- In 2014, 27.8% of children lived in households at risk of poverty or social exclusion in the EU, ranging from as high as 51% in Bulgaria to as low as 15% in Denmark. In most Member States, unlike other groups, proportion of children in this position measured by the AROPE Indicator, increased between 2010 and 2014 (Eurostat, 2016h).
- Lone-parent families constituted by 85% of lone mothers, are particularly at risk of poverty or social exclusion – true of nearly half of such households in 2014, as opposed to 20% made up of couples with children. Family structure is associated with negative impact on total household disposable income, with nearly one in two (46%) lone-parent households being at risk of poverty in the EU compared to 20% of two parent households (EIGE, 2016)

²⁹ <http://www.ourfuture.eu/>

- A body of literature explores the links between vulnerable families, poverty and poor health whilst there is little evidence on health needs as well as limited literature examining barriers to access to health care for at risk children and families.
- Research conducted across 26 European countries found significant and positive correlations between income inequality and a country level childhood injury mortality rates (Sengoegle et al., 2013).
- Poverty is a risk factor for adverse childhood experiences³⁰, which can lead to a range of health needs including respiratory, circulatory and oncological diseases; mental health problems; drug abuse; and risky health behaviours (UCL IHE, 2015).
- Studies have found that lone parents, particularly mothers, often experience poorer physical and mental health compared to their two-parent counterparts (Rousou et al., 2013). They may also be less likely to access healthcare services.

Policy responses:

- There are a range of strategies and initiatives at the EU level that seek to directly or indirectly address the needs of at-risk children and families.
- Access to childcare for families at risk of poverty has been linked with better wellbeing outcomes and life chances (Eurostat, 2016h).
- Good quality childcare is also associated with better child development and breaking the cycle of disadvantage (European Commission, 2013b).
- Welfare payments to vulnerable families, including lone-parent families, are important in reducing poverty risk, as they increase household incomes. Universal approaches are considered particularly effective, in comparison with more selective approaches (Cantillion, Collado and Van Mechelen, 2015).
- Parental leave policies are linked to greater ties between parents and the labour market after the arrival of dependent children, offering job protection and financial support (Boeckmann et al., 2014).
- Good practice examples from EU Members States focus on increasing access to a range of services for at-risk children and families, such as in the Sure Start programme implemented in Hungary and the UK. These often combines healthcare, social welfare, education and recreational services.

People living in rural/isolated areas

- Recent figures indicate that there were fewer people living in rural areas (27.6% of EU-28 population) compared to urban areas (72.4%) in 2013 (Eurostat, 2016i).
- Physical location is a major determinant of vulnerability. Rural areas tend to have relatively limited access to healthcare and other services compared to urban areas, due to a range of demand/supply factors (Mechanic and Tanner, 2007). Rurality is

³⁰ Situations which lead to an elevated risk of children and young people experiencing damaging impacts to health and social outcomes throughout the life-course.

often a neglected factor that influences health status and health service provision (WHO, 2010a).

- According to the literature, key barriers to healthcare in rural areas can include travel times and limited access to transport, distance, expense (both in terms of the costs of delivering services and the costs of accessing them), and/or a lack of health facilities and professionals. Office hours, rural culture, a lack of anonymity and stigma can also be obstacles (Deaville, 2001).
- Literature about the specific health needs of rural/isolated populations in the EU is limited.
- There is evidence from some Member States (such as Bulgaria and Romania) that pharmacies, essential medicines and specialised services are more difficult to access in rural areas (Georgieva et al., 2007; Vladescu et al., 2008).
- There are signs that the level of unmet need in rural areas is increasing in the EU (Eurostat, 2016g).

The ageing of rural populations, poses challenges to the delivery of healthcare services, particularly primary care, in rural areas across Europe. The limited use of preventative services can also be problematic³¹. *Policy responses:*

- The EU supports rural areas through its rural development policy (2014-2020), which (amongst other things) funds social inclusion projects in rural areas.
- The WHO has called for policies to improve access to health care and better meet the needs of rural populations. This includes the following actions: improve the level of human resource within rural populations; improve the regulation and monitoring of rural areas; improve the service delivery in rural areas; and improve access to healthcare through financial measures (CSDH, 2008).
- Recruiting and retaining healthcare professionals is a particular difficulty in rural areas across Europe. A range of strategies has been tested to alleviate this, particularly incentive schemes for clinicians and early exposure to rural practice within the medical curricula of students (Straume and Shaw, 2010).
- For example, the Pacte Territoire Santé in France, an agreement between the Ministry of Health and other organisations that aims to attract more clinicians (mostly GPs) to rural parts of the country. As well as giving some financial incentives, this agreement also aims to establish some of the same conditions in rural practice as those that GPs find appealing in urban areas: in particular, greater team work and telemedicine (European Commission, 2015b). Likewise, the AGnES community medicine programme in Germany provided support to GPs in rural areas aimed at reducing travel time for GPs by upskilling community nurses to conduct routine treatment for patients with long terms conditions through e-health equipment (OECD, 2010).
- Recent research conducted by the European Commission (2015b) highlighted that "combinations of measures" may be most effective in attracting health professionals to areas where there is a shortage, i.e. not only financial incentives but also

³¹ As indicated in the Focus Group on 'Strategies to improve the health of those living in rural and isolated areas'. See full report for more information.

educational opportunities and chances for career growth. Whilst the former may lead to faster results, the latter is seen as more successful in bringing lasting change to an area.

- The concept of 'rural-proofing' can be helpful in adapting health policies to meet the needs of rural populations more successfully and deliver public services on an equitable basis with those living in cities (Rural Health Advocacy Project, 2015).
- Member States (such as Germany, France and the United Kingdom) have implemented a wide range of strategies to guarantee health service provision in rural areas and address geographical inequities in access to healthcare, as confirmed by the World Health Organisation and in other research (Davies et al., 2008). These include improved distribution of primary healthcare services; increased ambulance services (and lower response times); increased hospital capacity; modernised health infrastructure; greater use of technology; mobile/outreach services; and an integrated transport system.

Strengthening prepayment processes supports risk-sharing amongst the rural population and can significantly reduce the financial barriers associated with rural access to healthcare (World Health Assembly, 2005; WHO 2010a; CSDH, 2008).

People living with physical and learning disabilities and poor mental health

- Levels of physical and learning disabilities, as well as poor mental health, across the EU are difficult and complex to measure as data on the prevalence is either not collected or reported inconsistently. Recent data shows that approximately 73 million people aged 15 and over people in the EU-27 Member States experienced some kind of disability according to the International Classification of Functioning, Disability and Health definition in 2012 (Eurostat, 2012).
- An estimate of those experiencing mental health problems from 2010 suggests that 38.2% of EU citizens experience mental health issues – circa 164.8 million people (Wittchen et al, 2011). The most frequently reported issues include anxiety (14%), severe depression (6.9%), somatoform (6.3%), ADHD in youth (5%), issues caused by substance abuse (>4%), and dementia (1-30% depending on age group) (Wittchen et al, 2011).
- This group can experience a shorter life expectancy and increased risk of early death compared to the general population, as well as being exposed to major health problems, such as obesity, circulatory and respiratory diseases (Hollins et al., 1998; Disability Rights Commission, 2007).
- The quality and appropriateness of healthcare services for individuals living with physical and intellectual disabilities or poor mental health represents a serious problem. For example, general healthcare professionals often lack appropriate skills to deal with mental health patients, and patients are expected to use the same services as the general population (European Commission 2008c; Wahlbeck and Huber, 2008).
- People experiencing physical disability are may face physical barriers in accessing good quality healthcare as a result of building design and town planning (WHO, 2011).
- The needs of this group and underlying reasons behind health inequalities are diverse.

- Research suggests there are many causes of the health inequalities between this group and the general population, including greater risk of poverty, poor housing, unemployment, social disconnectedness, discrimination, exposure to abuse, and greater risk of negative health behaviours (DRC, 2007).

Policy responses:

- Literature on the specific policy responses to address the health needs of this group largely focus on improving the provision of health care services through training to increase the knowledge and skills (as well as change attitudes) of healthcare professionals in treating this vulnerable group (Devine and Taggart, 2008; Hardy et al., 2011).
- For example, a Chronic Heart Disease (CHD) education resource was piloted among a residential community support organisation working with adults with complex learning disabilities. As a result of the training, staff showed an increase in knowledge in CHD topics, leading to greater understanding of the health of those they support and thereby improve health outcomes (Holly, 2014)
- Whilst health care practitioners may be aware of the needs of this group on a general level, this understanding may not always be put into practice. Research emphasised the need for health professionals to take time to consider patients' individual needs and any necessary adaptations to their care (Brown et al., 2013).
- Some policies aim to encourage greater uptake of sport and health literacy. These challenge the disadvantaged position of those with learning disabilities in society, with positive impacts on health status. For example, the Special Olympics Youth Unified programme – in Serbia, Poland, Ukraine, Germany and Hungary – aimed to get more people with learning disabilities into sport; it involved both those with and without learning disabilities as 'athletes' and 'partners' respectively. This culture of inclusion was noted as a success factor by an evaluation (Dowling et al, 2010).

People experiencing long-term unemployment and economic inactivity

- Around 5.1% of the labour force was long-term unemployed in 2014, with more than half having been unemployed for more than two years. Levels of long-term unemployment were fairly equal between men and women at 10.8% and 10.9% respectively (Eurostat, 2016i).
- The most recent data on the EU's economically inactive population indicates that the share of the economically inactive population within the working age population was around 27.7% across the EU-28 in 2014. There was higher rate of inactivity among women (33.5%) than men (21.9%) in 2014 (Eurostat, 2015f).
- Long-term unemployment and inactivity significantly affects individuals and society as a whole. In particular, it is associated with poverty and social exclusion (Eurostat, 2015b).
- The causes of long-term unemployment and inactivity are complex and often associated with a lack of qualifications, employment opportunities and poor health (including mental health), as well as distance from the labour market due to, for example, familial responsibilities (Lotters et al., 2012).
- Participation in the labour market or exclusion from it has a significant impact on life chances, risks of material deprivation and well-being that may influence or determine people's health throughout the life-course (Donkin et al., 2014).

- Literature indicates that long-term unemployment and inactivity is associated with a range of poor health outcomes, including premature ageing, poor mental health, negative health behaviours and worse self-reported health (Ala-Mursula et al., 2013; Bosque-Prous et al., 2015).
- This group are likely to experience barriers in accessing healthcare in relation to cost, particularly within Member States where access to healthcare is reliant on in-work benefits or insurance coverage, or where there is a direct financial cost involved in accessing care. For example, in the Netherlands, there is a gatekeeping system, whereby people are required to access healthcare through their general practitioner and pay medical expenses of up to 350 euros per year (Dubois and Anderson, 2013).

Policy responses:

- Across the EU, welfare states have focused efforts on trying to get those claiming unemployment benefits, many of whom have long-term health conditions, back into work.
- Research suggests that providing subsidies and support for people on low incomes can improve the health and wellbeing, including an association between higher disposable income and better health outcomes, and proximity to stores offering fresh food linked to reduce rates of overweight and obesity and better health outcomes (Aron, et al., 2015; Bell et al., 2013).
- For example, the Action nutritionnelle dans une épicerie solidaire (A.N.D.E.S) (Nutritional action in a solidarity store) programme in France aimed to improve access to healthy foods for people on low incomes or at risk of poverty and also support the long-term unemployed back into employment by providing job opportunities and work placements. An evaluation showed positive employment outcomes and greater consumption of fresh food (A.N.D.E.S., 2017).
- Other research shows the positive health impacts of a low-threshold health promotion programme for older, long-term unemployed workers, composed of knowledge transfer and a professionally instructed strength and endurance training (Kreuzfeld et al., 2013).
- Another study (Limm et al., 2015) concluded that a health promotion programme, based on a train-the-trainer approach, showed positive effects on health-related quality of life and mental health, especially anxiety, of long-term unemployed persons.

In-work poor

- There is a lack of research on this group, and it is difficult to measure the number of people in this position. More research is needed to fully understand the scale and issues experienced by the in-work poor. However, Eurostat data indicates that people in employment are at risk of poverty across the EU. The most recent data shows that 9.5% of the employed population in the EU-28 Member States were at risk of poverty in 2014 (Eurostat, 2016k).
- Key drivers of in-work poverty include low pay, households relying on a single earner, and individuals not working enough hours to make ends meet (Eurofound, 2010).

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- Literature on the employment circumstances associated with in-work poverty indicate that this group are likely to have specific health needs (Harkins and Egan, 2013).
- Research has demonstrated that job stress is associated with lower-paid and lower status employment (Karlsson, et al., 2010).
- Evidence also suggests a social gradient between job security and mental health. A study by Vives et al. (2013) found that the more insecure a person's employment status, the more likely they were to report poor mental health.
- Some evidence suggests that the use of healthcare services varies according to labour market status (Virtanen et al., 2006).
- This group may also be less likely to access health services, for a range of reasons. Low-paid and temporary employment is less likely to be accompanied by employment-related benefits, such as health insurance. Some Member States may require the costs of healthcare to be paid upfront. The in-work poor may be unable to afford to access health services due to a lack of disposable income (Virtanen et al., 2006).

Policy responses:

- Welfare transfers can effectively reduce the risk of poverty by boosting the income of the household above the relative poverty threshold, as reflected in EU statistics on income and living conditions (EU-SILC, 2007).
- One study (Lundberg et al., 2013) – analysing the effect of social protection and income maintenance policies on health and health inequalities – found that the totality of social protection, rather than individual policies, is important in reducing health inequalities.
- National research has identified the benefits of the living wage on psychological wellbeing (Flint, Cummins and Wills, 2014).
- In Germany, the Open.med Munich scheme aims to improve access to healthcare, particularly for people on low incomes or those who are not covered by health insurance and struggle to meet the costs of healthcare. The scheme provides free medical and psychosocial consultation services (Aertxe der Welt, 2014).
- It is worthwhile to note that this group may overlap with other target groups of the VulnerABLE project, especially lone-parent families. Some of the interventions that prove effective in improving health may thus apply across groups.

Victims of domestic and intimate partner violence

- Whilst women can be the perpetrators of violence, and men and boys can be victims of violence at the hands of both sexes, violence against women in the EU is predominantly committed by men (FRA, 2014). Domestic and intimate partner violence is a widespread phenomenon in all Member States. Exact figures on the prevalence of domestic violence are difficult to come by and more research is needed to understand the scale of this issue. However, it is recognised by the WHO as a significant public health issue affecting one in three women the world over (WHO, 2013a).

- The passage of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) in 2011 marked a major step forward in the level of international legal protection for victims of intimate partner violence and domestic violence in Europe.
- Intimate partner violence and domestic violence can have serious immediate and long-term consequences for the victims, in terms of both physical health (including sexual and reproductive health) and mental health (FRA, 2014).
- Specific impacts include physical injury and trauma, exposure to sexually transmitted infections (STIs), unwanted pregnancies (and the negative health effects associated with these), severe mental health issues (depression, PTSD, suicide), and even death (Fernandez-Botran et al., 2010; Newton et al., 2011).
- Many women, regardless of their country's health system, do not seek health care for their injuries or escape their situation, due to psychological barriers, economic dependency, and fears for their safety and that of others (FRA, 2014).

Policy responses:

- Health care services have a key role to play in identifying, responding to, and preventing incidents of domestic and intimate partner violence. Recent studies show that women who are victims of violence are more likely to consult or be in contact with health services compared to other services and agencies. However, health care professionals often have little training or skills to fulfil this role (Yeung et al, 2012; FRA, 2014).
- Undertaking this form of clinical inquiry systematically requires health professionals to know how to do so safely. Research finds that women are more likely to disclose incidents of violence if health-care providers ask sensitively, empathetically and in private, under safe conditions. Antenatal care, family planning and gynaecological services are potential avenues for screening, as well as emergency services (more likely to encounter women with injuries) (Black, 2001; WHO, 2013c; García-Moreno et al., 2014).
- In the UK, the Identification and Referral to Improve Safety (IRIS) programme has been thoroughly evaluated and associated with positive results. A randomised control trial found that it was more common for doctors and nurses in practices that received the IRIS intervention to identify women experiencing domestic violence and to refer them to specialist domestic violence agencies (Feder et al, 2011). The programme is also associated with cost savings (Devine et al., 2012).
- The effectiveness of 'universal screening' in GP surgeries is debated in the literature. Some argue that all women accessing certain health services should be asked about their experience of partner violence, whereas others believe a more selective approach is necessary, based on clinical factors. The WHO does **not** propose universal 'screening', but instead proposes that health-care professionals be taught to recognise the health symptoms of intimate partner violence, and, where detected, ask about violence (WHO, 2013e).
- Beyond identification of domestic and intimate partner violence, health-care providers must offer appropriate clinical interventions to support victims, including post-rape care (for example, pregnancy/STI prevention, access to abortion, long-term mental health services). The WHO has published detailed guidelines and

quality standards for delivering care to those who have experienced domestic and intimate partner violence (WHO, 2013e).

- Multiagency services can also be effective in addressing some of the health challenges experienced by victims of domestic violence, such as the multi-agency risk assessment conferences (MARACS) used in the UK.

People living in unstable housing conditions (including the homeless)

- The experience of living in unstable housing conditions is often referred to as homelessness. This covers a broad spectrum of living conditions, as reflected in the European Typology on Homelessness and Housing Exclusion (ETHOS). This distinguishes between those who are: i) roofless (sleeping rough or staying night shelters); ii) houseless (in accommodation specifically for the homeless; women's shelters; people in accommodation specifically for housing immigrants; and, people due to be released from institutions); iii) in insecure accommodation (under threat of eviction or violence); or iv) in inadequate accommodation (which is temporary, non-standard, unfit or overcrowded).
- However, there is no systematic data available on homelessness populations at the EU level and there is a large variability in the quality and availability of data on homelessness in each Member State, in terms of general information on homelessness and in relation to the four concepts used in the ETHOS. The lack of a harmonised indicator is a major challenge in identifying and understanding the scale of the problem in relation to this target group and more research is required to understand the scale of the problem across the EU.
- Based on available data, estimates suggest that some Member States (such as Denmark and Finland) report very small homeless populations of around 0.1% of the population. Similarly, other Member States such as the Czech Republic (0.3%), France (0.24%) and Germany (0.11%), as well as Italy (0.2%) and the Netherlands (0.16%) also reported a low prevalence of homelessness using a narrower definition (European Observatory of Homelessness, 2014).
- Data on overcrowding³² across the EU-28 Member States indicates that the average rate of overcrowding across the EU was 17%, whilst the highest rates of overcrowding were in Member States such as Romania (51.6%), Hungary (47.2%) and Poland (46.3%), and the lowest rates in Cyprus (2.8%), the Netherlands (2.5%) and Belgium (1.6%) (Eurostat, 2014b).
- Whilst some people may experience homelessness once, it is more common for people to experience it repeatedly throughout their lifetime. Homelessness is strongly linked to poverty, social exclusion and destitution (Wright and Tompkins, 2006).
- The drivers of homelessness and vulnerability are complex. They include relationship breakdown, physical or sexual abuse, lack of qualifications, unemployment, drug and alcohol abuse, physical and mental health issues, criminality, debt, lack of social support networks, background of being institutionalised as a child, and death of a parent during childhood (Wright and Tompkins, 2006).

³² Overcrowding is defined by the number of available rooms in a household, the household's size, as well as its members' ages and family situation.

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- In the last decade, housing costs as a share of disposable household income have increased and are the greatest expenditure item for most households across Member States. This has pushed issues relating to affordable housing, housing exclusion and homelessness high up on the political agendas of Member States (EuroFound, 2016).
- Available literature on the health needs of homeless populations indicates that this group has multiple physical and mental health needs (Roche, 2004).
- Roofless living conditions are often associated with the most severe risks to both physical and mental health. Literature indicates that they are at increased risk of contracting communicable diseases (compared to the general population), including Tuberculosis and Hepatitis. They are also at greater risk of developing multiple morbidities, including respiratory and circulatory conditions; injury (particularly through violence), poor oral health, feet problems, skin diseases and infection; serious mental health issues, including schizophrenia, as well as depression and personality disorders; and drug and alcohol dependence, including use of hard drugs such as crack cocaine and heroin (Griffiths. 2002).
- There are many factors linked to worse health outcomes for people in this group, including negative health behaviours.
- In addition to barriers relating to poverty, homeless people tend to be over reliant on secondary and acute health services (Homeless Link, 2014). The roofless are likely to live particularly chaotic lives, leading to unplanned health service use, which usually occurs at a point of crisis and out of hours of mainstream primary care services (North West London NHS, 2013).
- Bureaucratic barriers also affect this group, as mainstream primary care services often require a person to provide a fixed address in order to access the services (Médecins du monde, 2015a).
- Other factors, such as stigma and lack of trust, may affect the utilisation of health services among this group (Rae and Rees, 2015).
- Poor links between mainstream health services, housing and social care providers can also be a barrier to access (Lester, 2003).

Policy responses:

- Several evaluations show that Housing First, the homelessness prevention model, is highly effective at keeping people housed and therefore ameliorating the health issues caused or exacerbated by rooflessness. In this model, homeless people are provided with a non-conditional offer of permanent housing. This is in contrast to traditional 'staircase' models from which the individual graduates into permanent housing through a shelter system (Pleace, 2016).
- The Housing First model is promoted by European Federation of National Organisations Working with the Homeless (FEANTSA); it has spread to several countries across Europe.
- A 2013 review of evidence also exists which looked at how effective Housing First policies were in promoting health. It found that Housing First was at least as good as "staircase" services in improving mental health, substance abuse and physical health with the added feature of being better at keeping people in housing (Pleace &

Quilgars , 2013). Positive evaluation from Europe on health outcomes can be seen in evaluations of individual projects.

- The positive results of Housing First should be considered in light of the high level of investment required for them to operate (Pleace, 2016).
- In contrast to reducing homelessness in national strategies and Housing First models, much literature has focused on targeted and specialist service interventions to address the health needs of homeless people at a local level, targeting a particular sub-group of the homeless, such as the roofless (Pleace, 2016).
- Outreach models have been linked to positive health results. UK research (Craig et al., 2008) assessed the impact of an outreach model of care (using a tuberculosis link worker) to address tuberculosis among vulnerable groups (including the homeless), and found that this enabled integrated health and social care supported patients successfully completing treatment (78%).
- One form of improving access to healthcare is to bypass standard referral routes that require the patient to present at primary healthcare services and bring healthcare services directly to affected individuals (UCL, 2014).
- Another approach to improving overall health is to tackle the inequalities in access to healthy lifestyle behaviours such as exercise, as seen in homeless football leagues being tested in many countries (Ombold, 2016).
- Homeless individuals are disproportionately affected by substance misuse issues. One approach to this issue (linked to positive health outcomes) is the harm reduction methodology. These programmes take the approach of reducing the secondary harm, such as blood borne diseases (Bretherton & Pleace, 2015).

Prisoners

- The most recent data suggests that there were around 643,000 prisoners (adult and juveniles) in the EU-28 (excluding Scotland) in 2012.
- Many of these individuals come with pre-existing vulnerabilities – also referred to 'underserved' groups. For example, research indicates that prisoners are more likely to be drawn from poorer sections of society, to have a history of problem drug use (linked to greater risk of communicable diseases) and existing mental health needs (Penal Reform International, 2015).
- The environment within prison, particularly if characterised by overcrowding and poor hygiene, can exacerbate pre-existing health issues³³.
- Health risks in prison can include: greater risk of infectious diseases; greater risk of physical trauma; greater risk of substance abusive behaviour and greater risk of chronic disease than those in the general populations (WHO, 2007).
- People in prison can also experience severe mental health problems, reflected in high rates of self-harm and self-inflicted death in prisons (WHO, 2007).

³³ However, as emphasised by participants in the VulnerABLE focus group, prison can also represent a moment in which to tackle the health inequalities amongst those who arrive, delivering a higher standard of care than they would have previously received.

- The precarious state of health in prisons when compared to the general population is reflected in prisoners' lower life expectancy and acute/long-term physical and mental illness (Barry, 2010).
- Some groups can be especially vulnerable within the prison environment, especially older people, those with existing mental health needs, women, younger people and those from ethnic minorities.

Policy responses:

- In Europe, it is relatively rare for prison health to come under the responsibility of the Ministry of Health, affecting the degree to which it is seen as a public health concern. Greater accountability for the ministry of health, as recommended by the World Health Organisation, is linked to important benefits, including better training of prison healthcare staff; more consistent health guidelines on the same diseases; better monitoring of prison health indicators; and greater availability of specialised treatments in prisons, such as transplants and dialysis³⁴.
- Member States (such as Denmark and Ireland) also have policies designed to tackle specific prisoner health inequalities, with a view to making conditions within prison as similar as possible to the outside environment. In Denmark, for example, all prisoners are made responsible for preparing their own meals, and in support of this are given cookery classes and the ability to purchase raw ingredients for meal preparation. Indicative findings from evaluations of Denmark's model of prisoner self-cooking suggest that this model has improved knowledge of health eating among prisoners, with a potential knock-on impact on improved prisoner nutritional intake and overall health as a result (WHO, 2013d).
- Prisoner empowerment can be especially important for improving health. In Ireland, the Community-based Health and First Aid in Action programme (led by the Irish Red Cross) has trained prisoners to act as peer mentors, raising awareness about hygiene among their fellow inmates and reducing unsanitary behaviours (WHO, 2013d).
- Other effective policy responses emerging from other strands of research for the VulnerABLE project include: better screening of prisoners for their health needs on arrival, harm reduction measures and more systematic monitoring of prison health indicators.

³⁴ Identified in project interviews.

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