European Commission

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

Scientific Report

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Document Control

Document Title	Pilot project related to the development of evidence based strategies to improve the health of isolated and vulnerable persons (SANTE/2014/C4/034)- Scientific Report
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Date	October 2017

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1 Introduction

1.1 Conceptualising, measuring and addressing vulnerability in relation to health

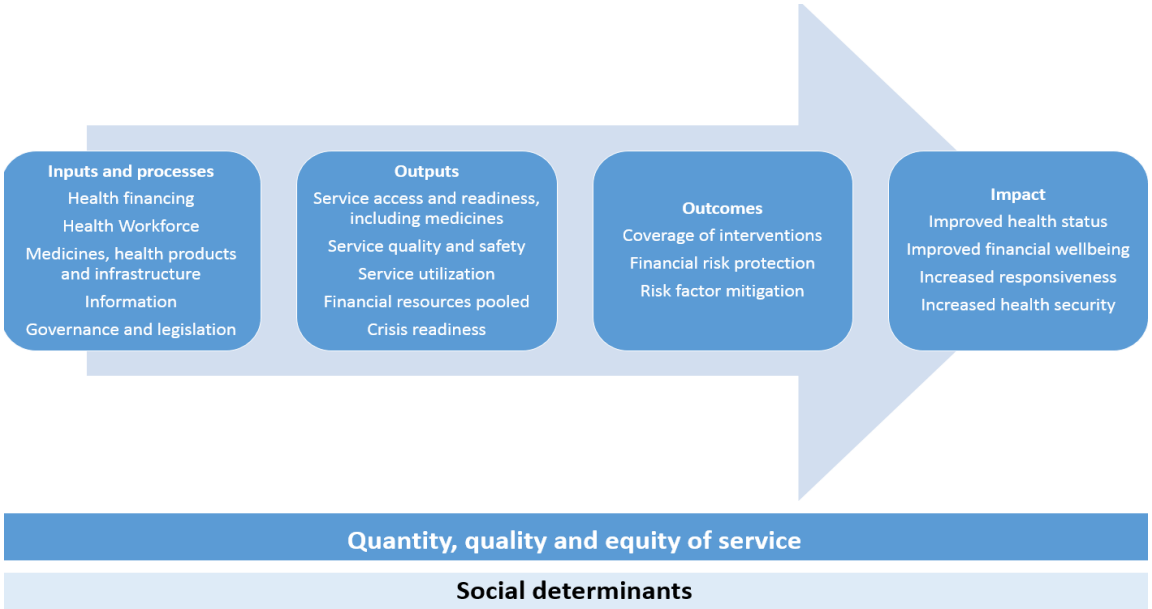
Due to specific individual and social characteristics, some groups or segments of a population are more likely to face poor health status and access to health care than the general population, contributing to the situation of health inequalities.

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 the 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.

1.2 Important definitions for the project

1.2.1 Defining health inequalities

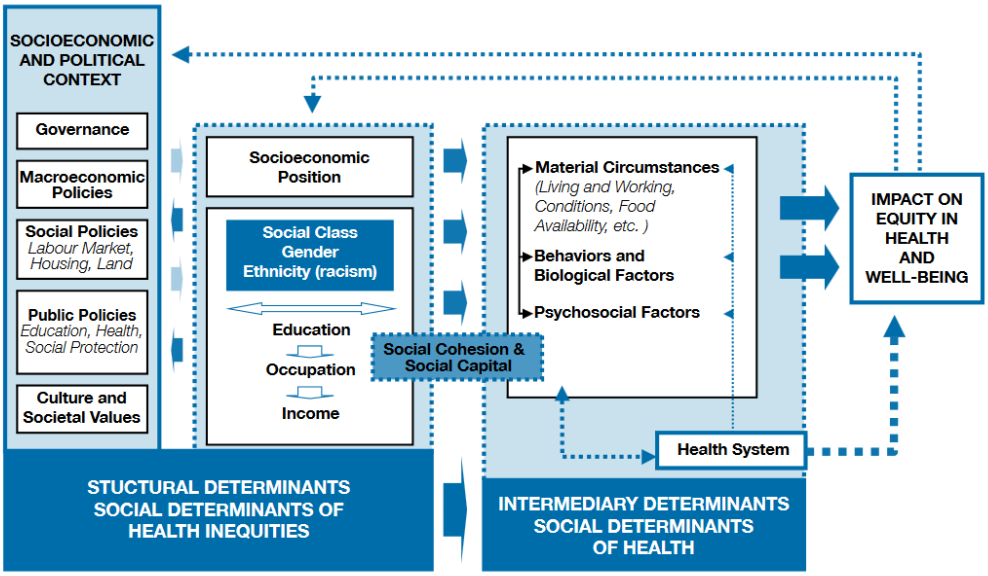
Health inequalities are broadly defined as 'differences in health status between individuals or groups, as measured by for example life expectancy, mortality or disease' that arise from 'avoidable differences in social, economic and environmental variables' (European Commission, 2009a). A key element of the concept of health inequalities is that they are 'unnecessary, avoidable, unfair and unjust'. Alongside focusing on heath 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, which shows how the result of social, economic and political mechanisms affect health determinants and access to healthcare.

Figure 2. CSDH conceptual framework



Source: *Solar and Irwin (2010)*

1.2.2 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 terms 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.

The concept of accumulative processes of exclusion that drives 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).

1.3 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.

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 that 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. It also identifies that 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 action plans across many Member States. 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, survivors of domestic violence, prisoners and homeless people are the groups least likely to be targeted by interventions.

2 The story in numbers

2.1 The scale of health inequalities in the EU

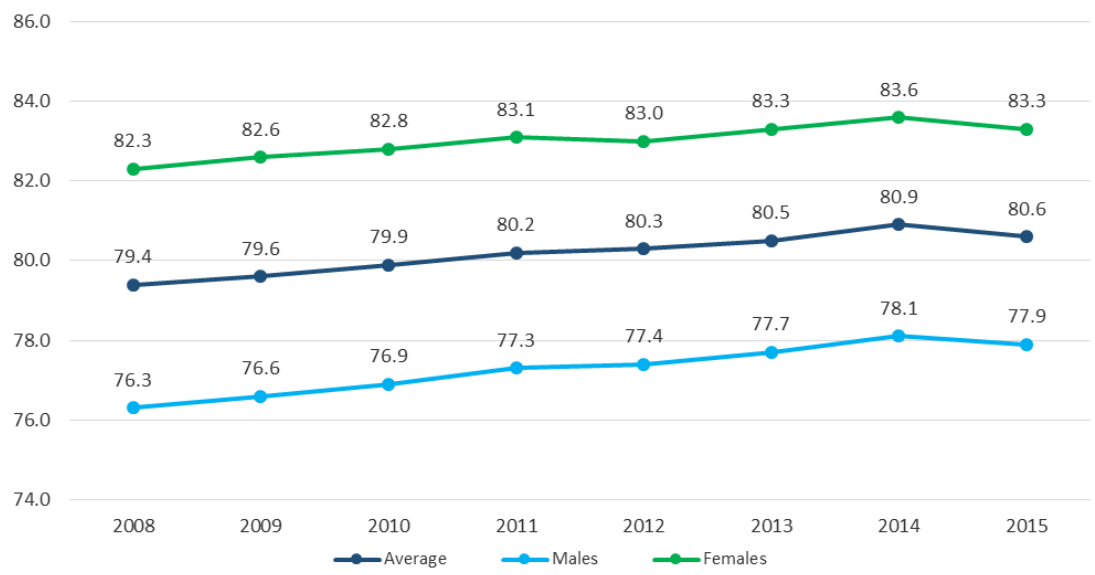
Over the last decade, population health indicators have improved across the European Union. However, these indicators suggest that an increase in health has not been experienced equally. There are still widespread inequalities in health and access to healthcare between and within Member States, reflecting 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 80.6 years in 2015: an increase in average life expectancy of 1.2 years compared to 2008. Average life expectancy for men was 77.9 years, compared to 83.3 years for women. However, the data also show that in 2015 life expectancy in the EU-28 fell (by an average of 0.3 years compared to 2014) for the first time. These data are illustrated in Figure 3 below.

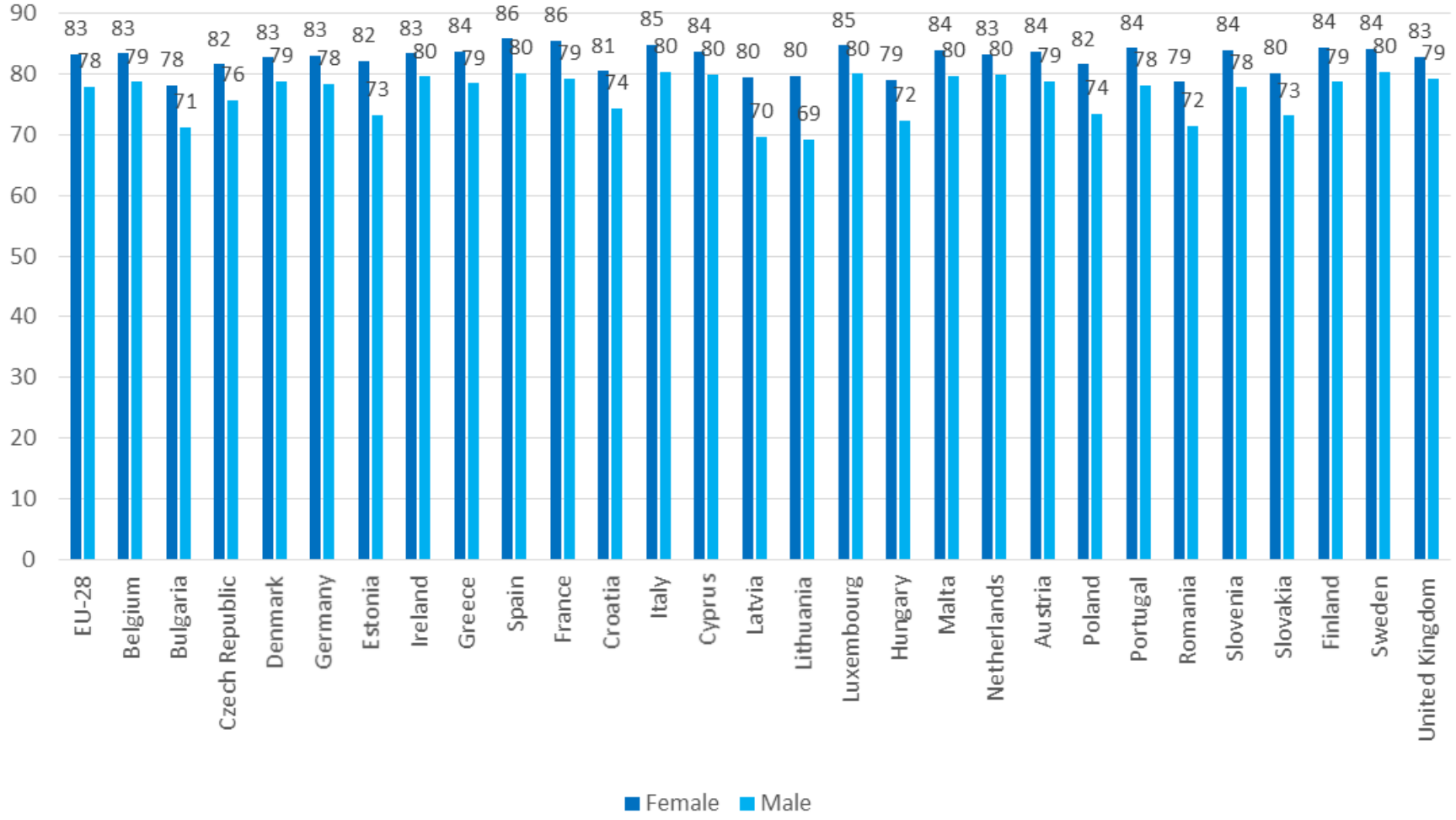
Figure 3. EU-28 average life expectancy at birth, 2008-2015



Source: *Eurostat (2017a)*

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 2015, but was consistently higher for women. Data for each Member State in 2015 are presented in Figure 4 below.

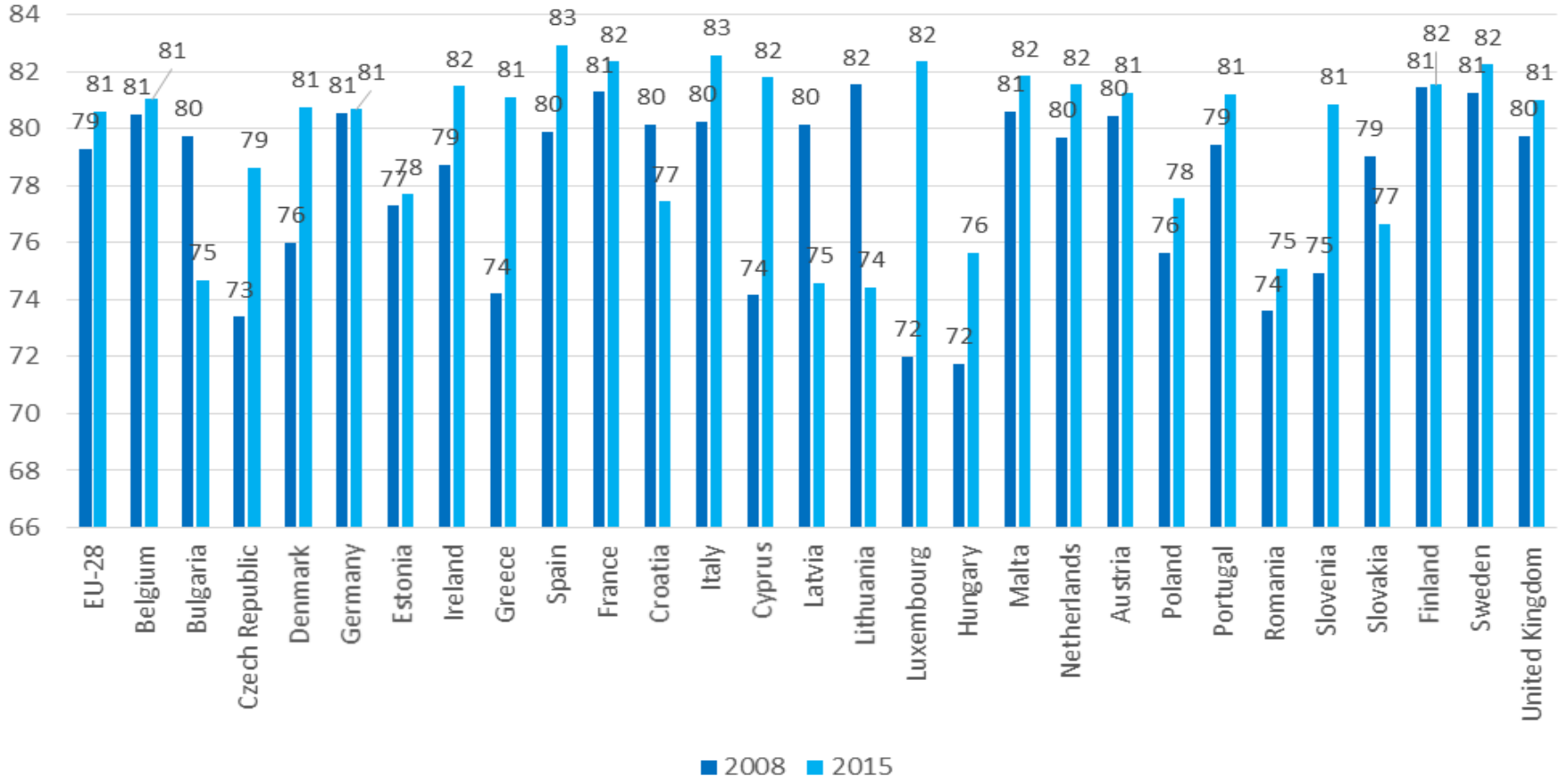
Figure 4. Life expectancy at birth by sex, 2015



Source: *Eurostat (2017a)*

The data also show persistent and significant differences in life expectancy between Member States. In 2008, the difference between life expectancy in the Member State where life expectancy was lowest (Lithuania) and the Member State where it was highest (Italy) was 10 years. This gap had decreased slightly by 2015 although was still significant, with a gap of 8.5 years between the Member States with lowest life expectancy (Lithuania) and the Member State with highest life expectancy (Spain).

Figure 5. Life expectancy at birth, by country, 2008 and 2017



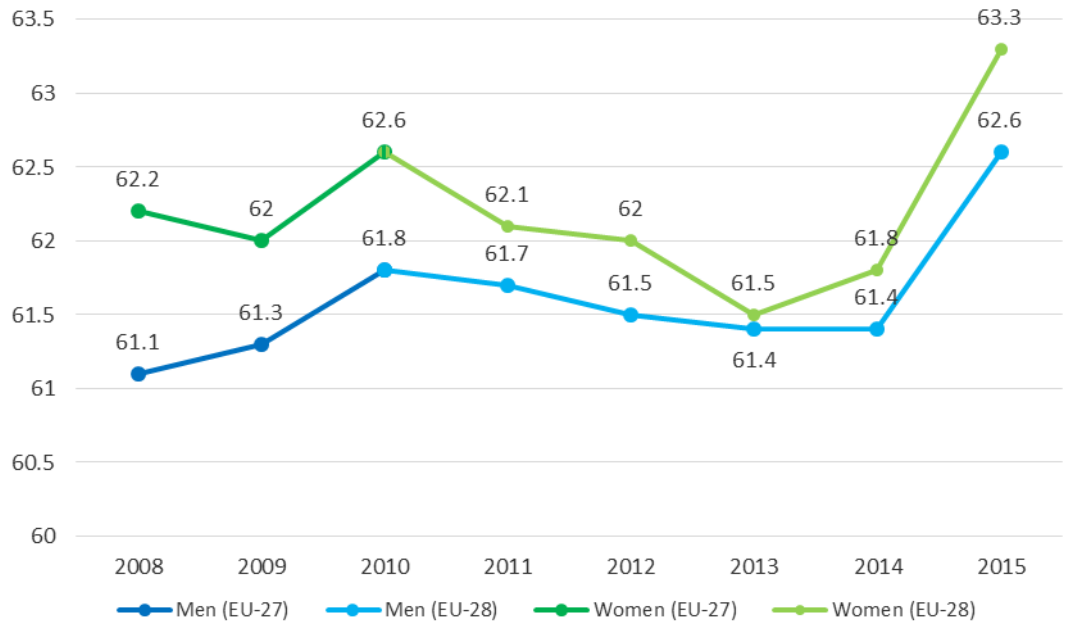
Source: *Eurostat (2017a)*

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, 2017b). For men (at age 25 in 2013), the lowest life expectancy in any country for those with tertiary education (ISCED 5-8) was 51.2 years (Romania), the lowest was 39.2 years for those with lower secondary level or below (ISCED 0-2) (Estonia) (Eurostat, 2017b).

In addition to life expectancy, measures of healthy life years (HLY) are also important. Unlike conventional life expectancy measures, which show the average age that individuals of a certain age can expect to live until, measures of HLY show only average age to which 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 6. For both sexes, HLY at birth showed a slight decline after 2010, before increasing dramatically between 2014 and 2015 marginally. Interestingly, in 2015, 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 6. Healthy life years at birth, by sex, EU-27 and EU-28

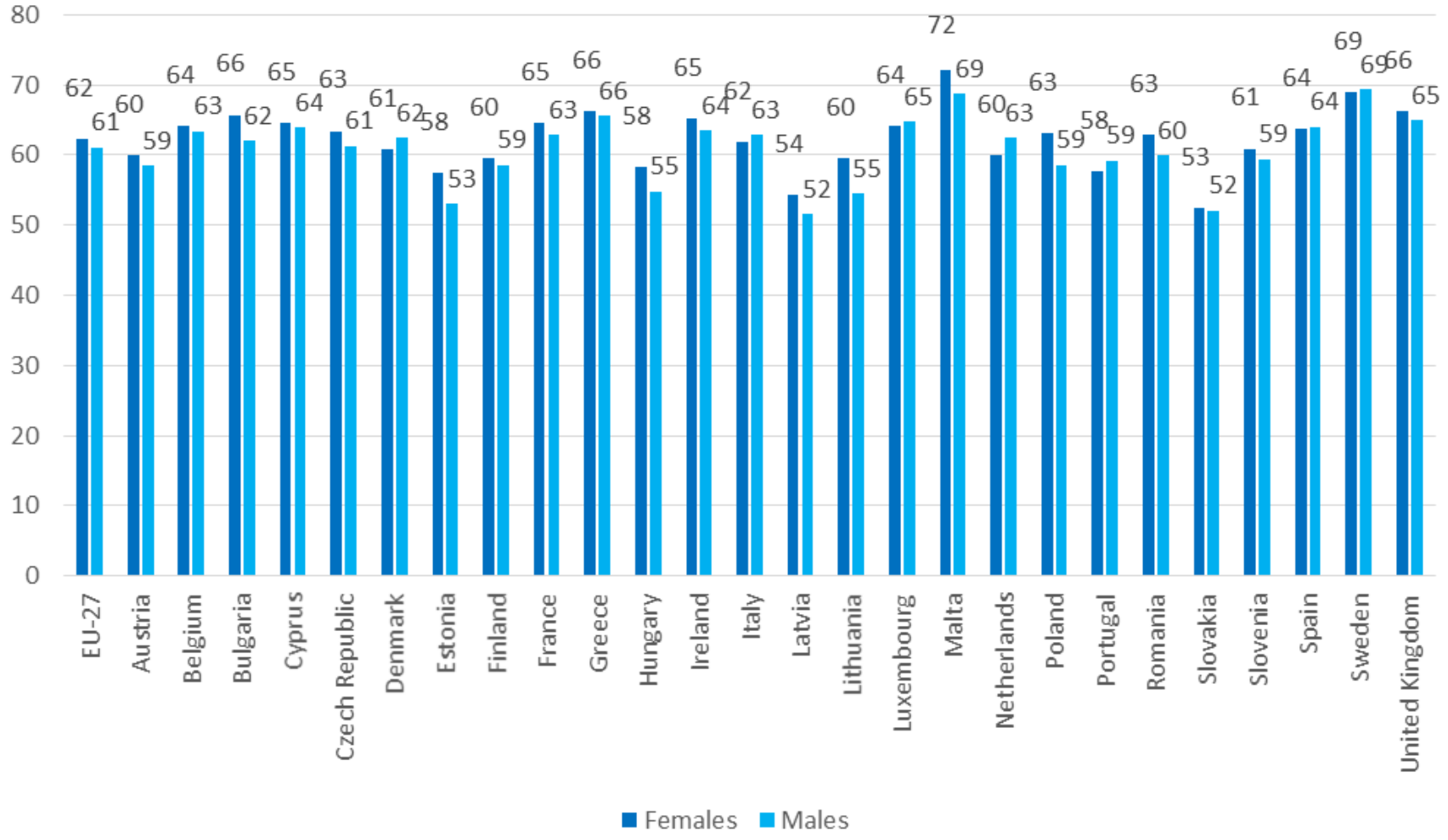


Source: *Eurostat (2017a).*

EU-27 data available for 2008-2010, EU-28 available for 2010-2014.

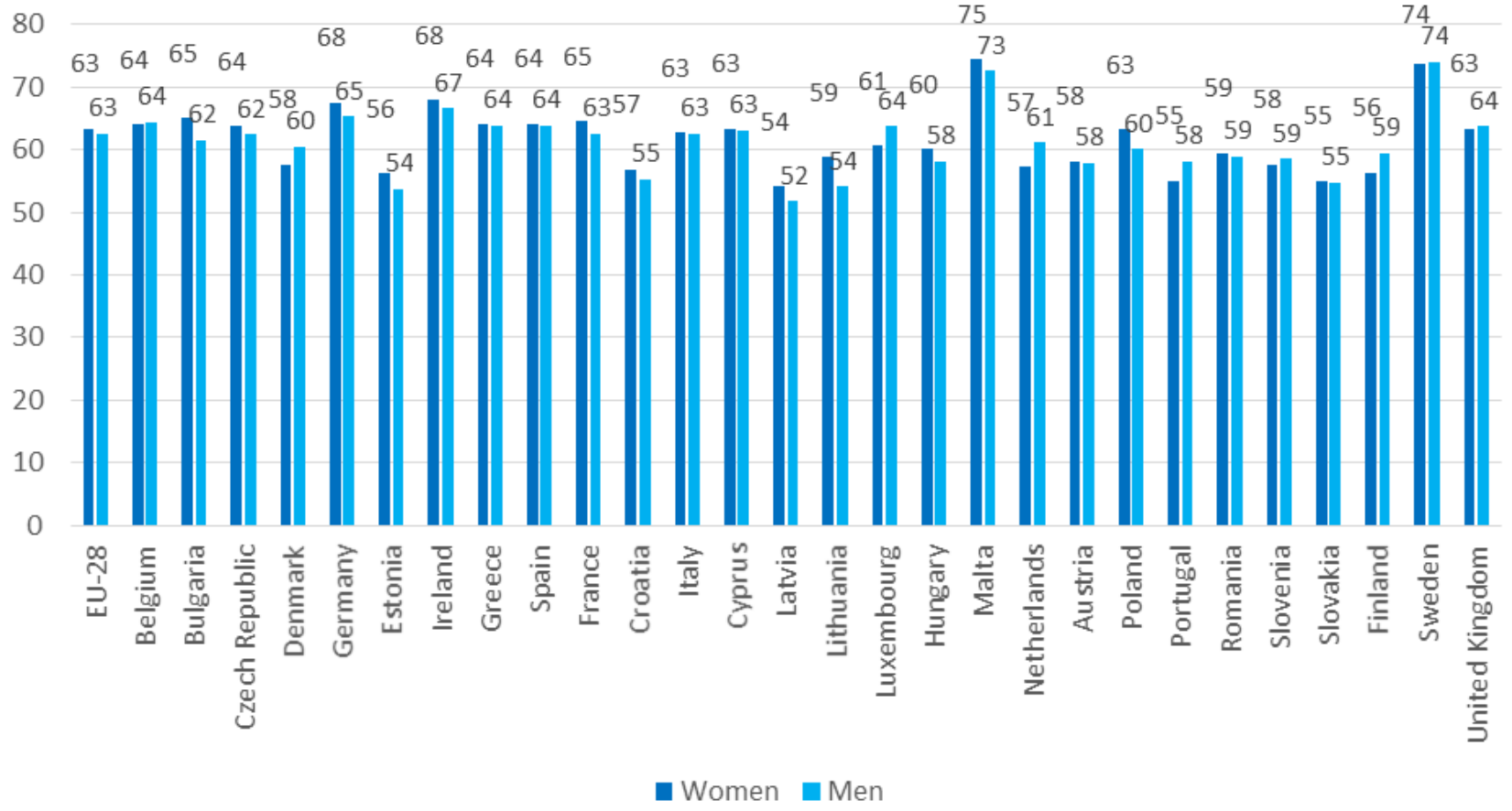
Figure 7 and Figure 8 provide a breakdown of HLY by Member State for 2008 and 2015. Within these data, some variation is evident at individual Member State level. For example, between 2008 and 2015, the average HLY at birth increased significantly for both men and women in Sweden (by 4.6 years for men and 4.8 years for women). Other countries, however, saw both HLY decrease for both men and women, in the United Kingdom, for example, HLY fell by 1.3 years for men and 3 years for women over the same period. No consistent trend can be observed across EU-28 Member States.

Figure 7. Healthy life years at birth by Member State, 2008



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

Figure 8. Healthy life years at birth by Member State, 2014

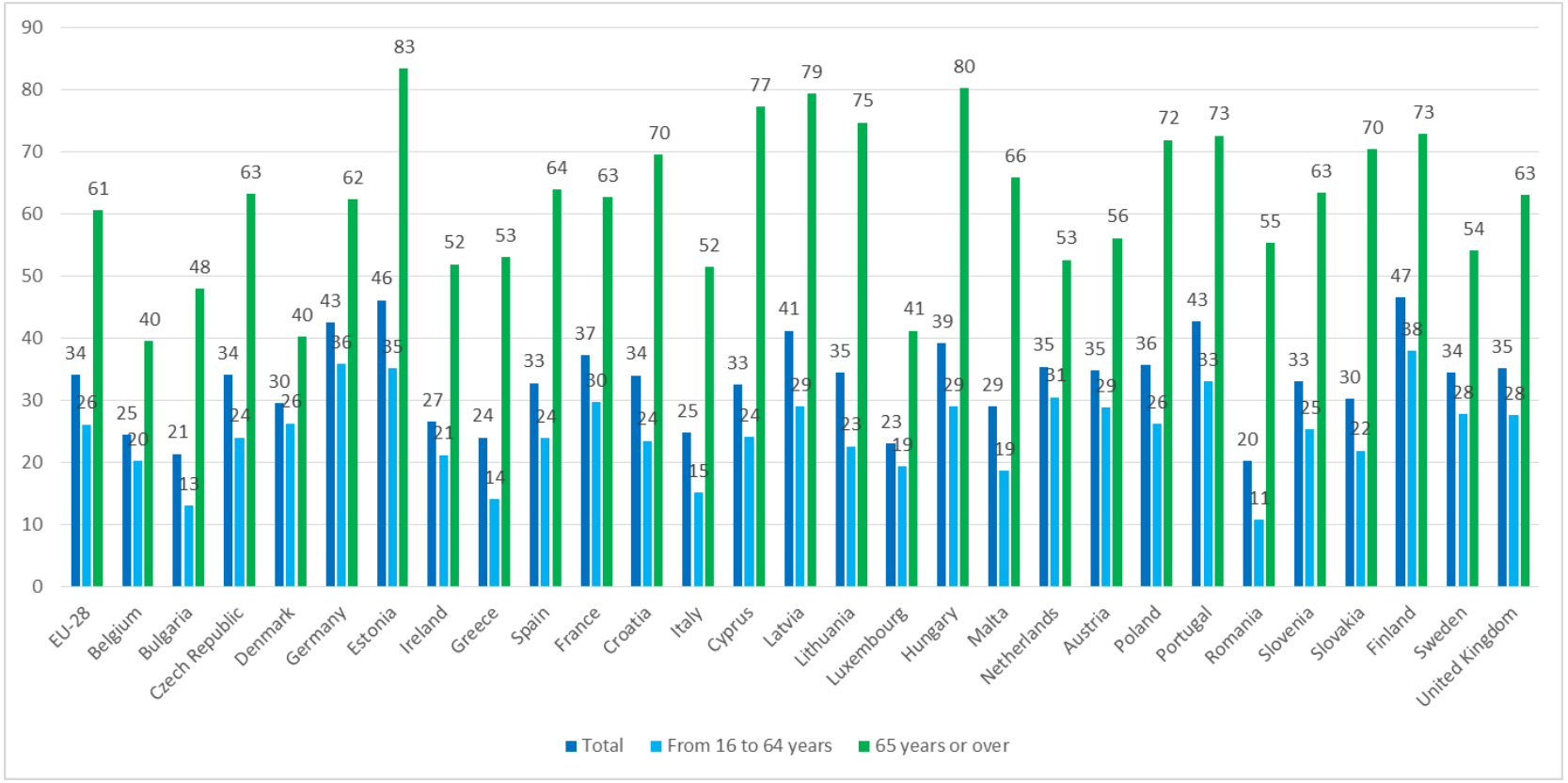


Source: *Eurostat (2017a).*

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 9 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 (Eurostat, 2017c).

Figure 9. Figure 1. Proportion of people with long-standing illness or health problem, by age

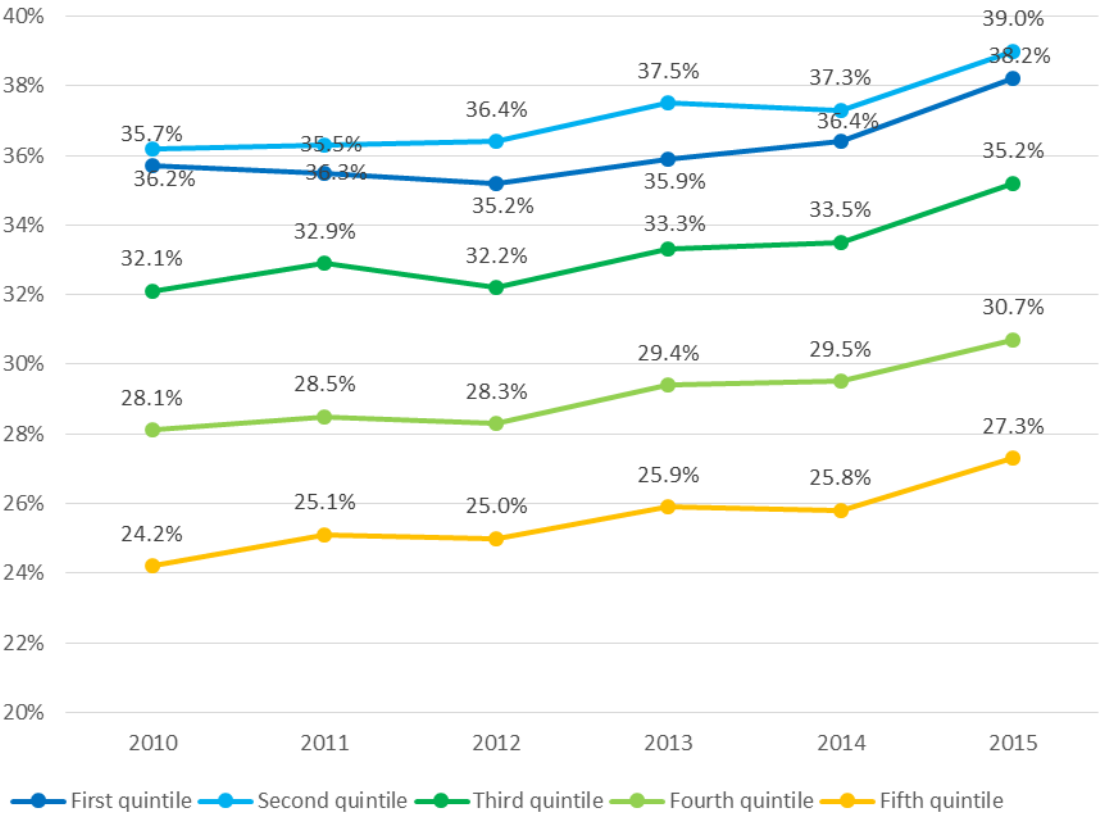


Source: *Eurostat (2017c)*

Another significant difference is between people with different levels of income. As shown in Figure 10 EU-28 residents with the highest incomes (fifth quintile) have a significantly lower rate of long-standing illness or health problems than those with the lowest incomes (first and second quintiles). In 2015, the difference between people in the first and fifth income quintiles was 10.9 percentage points.

It is potentially of interest that 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).

Figure 10. Proportion of people with long-standing illness or health problem, by income quintile



Source: *Eurostat (2017c).*

Inequalities in access to healthcare

The EU supports 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 (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 .

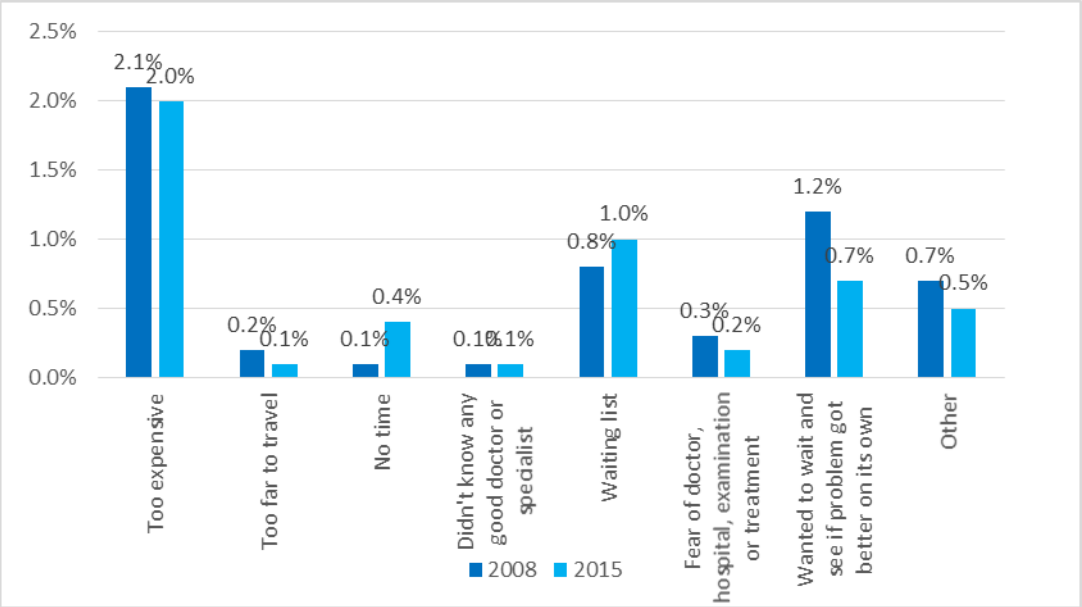
One method of measuring to what extent the objective of equity of healthcare access is achieved is through assessing reports of unmet needs for healthcare, which are collected by the EU Statistics on Income and Living Conditions survey (EU-SILC). Inequalities in access are influenced by several key issues, 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 2015, 5% 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 12.8% of the population in Poland (Eurostat, 2017d).

Figure 11 presents the reasons 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. Distance to travel to receive medical examination and lack of knowledge regarding good doctor or specialists were consistently the least frequently cited issues.

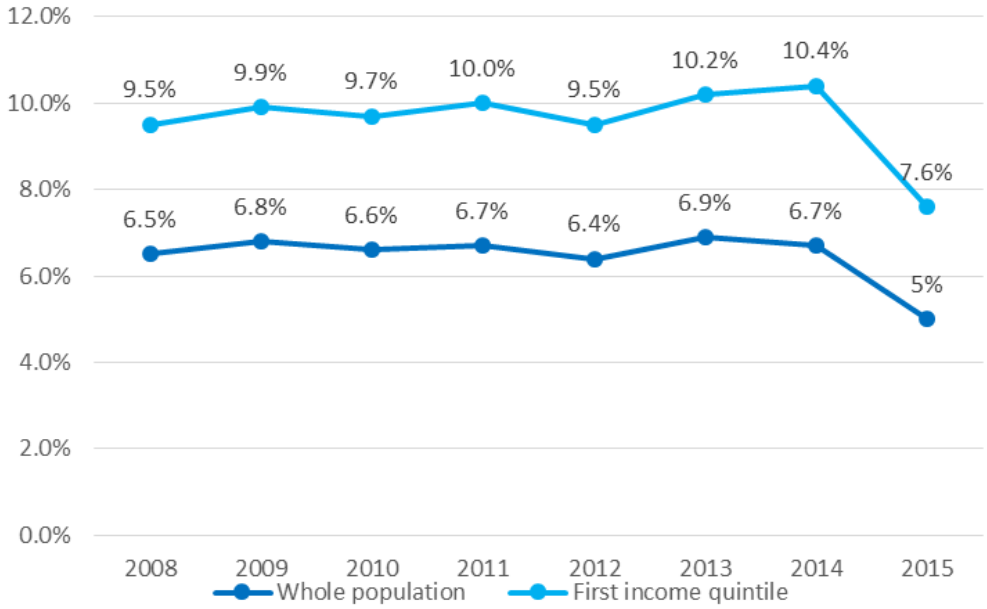
Figure 11. Self-reported unmet needs for medical examination, by reason given, 2008 and 2015



Source: *Eurostat (2017d). All data are for EU-27 (excludes Croatia).*

Considering this issue alongside income level, people with low incomes are most likely to report having unmet healthcare needs than the population as a whole, as shown in Figure 12. In particular, they are the most likely to report having unmet needs due to the cost of healthcare. Self-reported unmet healthcare needs which occur due to the cost of treatment are also 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).

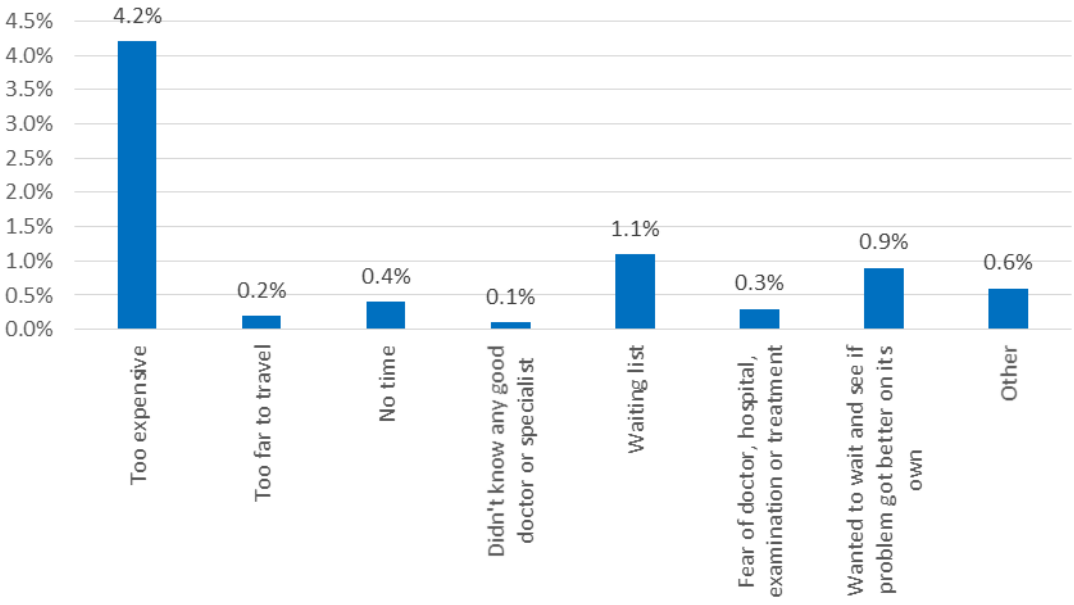
Figure 12. Self-reported unmet needs for medical examination, 2008-2015



Source: *Eurostat (2017d). All data are for EU-27 (excluding Croatia).*

Figure 13 illustrates data which show the prevalence of various unmet medical needs for the first income quintile. These data illustrate 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 13. Self-reported unmet needs for medical examination by reason: first income quintile (2015)



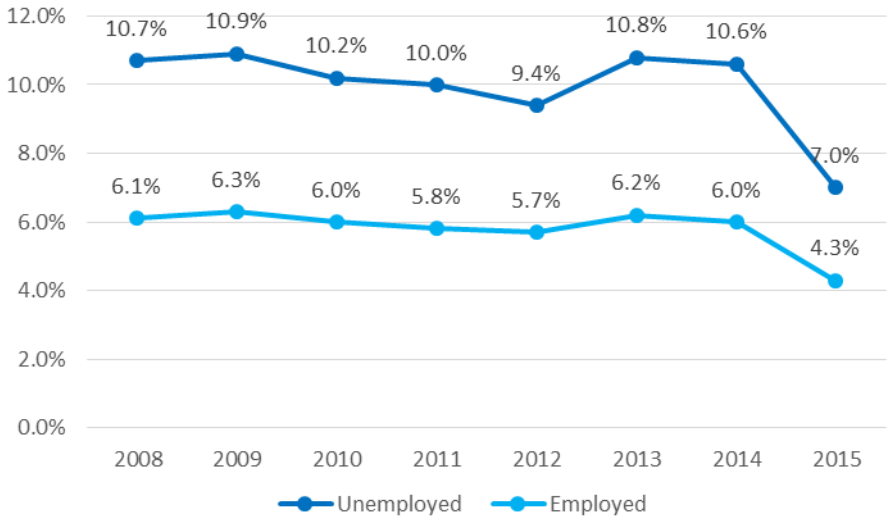
Source: *Eurostat (2017d). All data are for EU-27 (excluding Croatia).*

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 11.

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; however, 2015 data suggests the gap maybe narrowing slightly, with the prevalence of unmet needs among unemployed persons consistently between four and five percentage points higher.

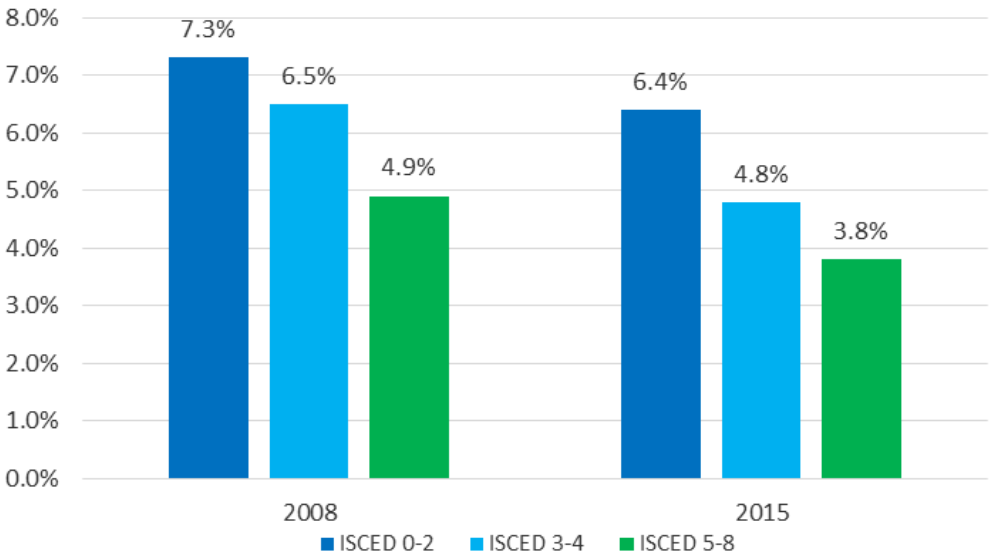
Figure 14. Self-reported unmet medical examination needs, by employment status



Source: *Eurostat (2017e). All data are for EU-27 (excluding Croatia).*

The level of educational attainment also correlates with access to healthcare. As shown below 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 2015, 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.

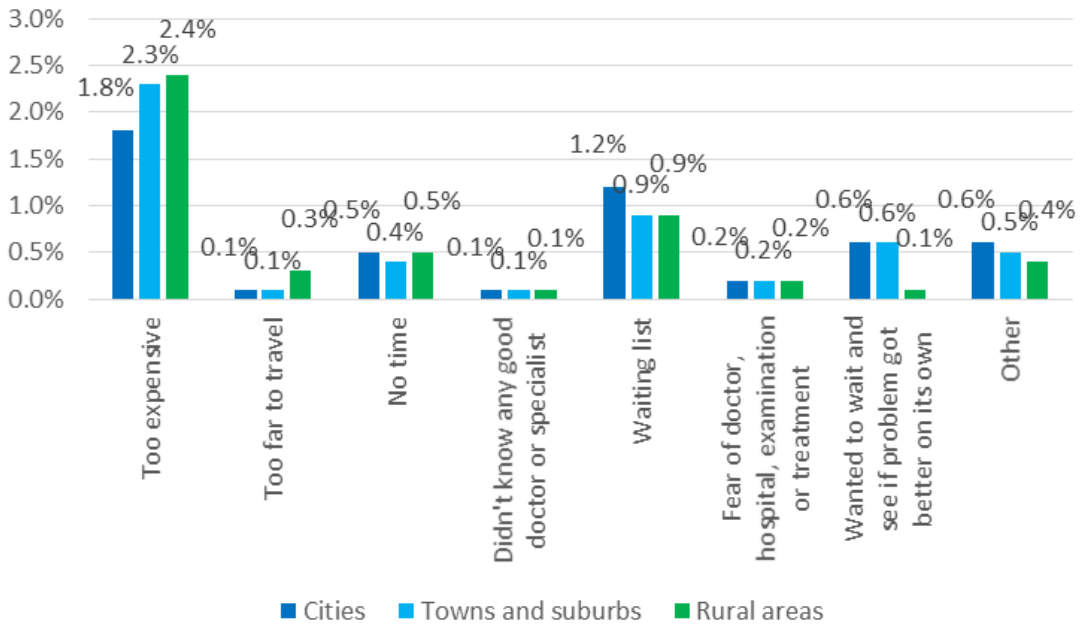
Figure 15. Self-reported unmet medical examination needs, by educational attainment



Source: *Eurostat (2017e). 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 (5.8%) was nearly one percentage point higher than the proportion of those who live in towns and suburbs (4.9%) or cities (4.9%). As Figure 16 below shows, there is no single 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 (2017f). All data are for EU-28.*

The quality of healthcare services provided constitutes a further factor contributing to 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 showed 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).

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 previous rates of spending increase in the sector reduced (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)

2.2 The situation amongst VulnerABLE survey respondents

2.2.1 Survey methodology

As part of the 'VulnerABLE' pilot project that aims to increase the knowledge and understanding of the health situation of vulnerable and isolated people in the EU, the findings of the pan-European survey provide insights into the particular health needs and risk factors faced by:

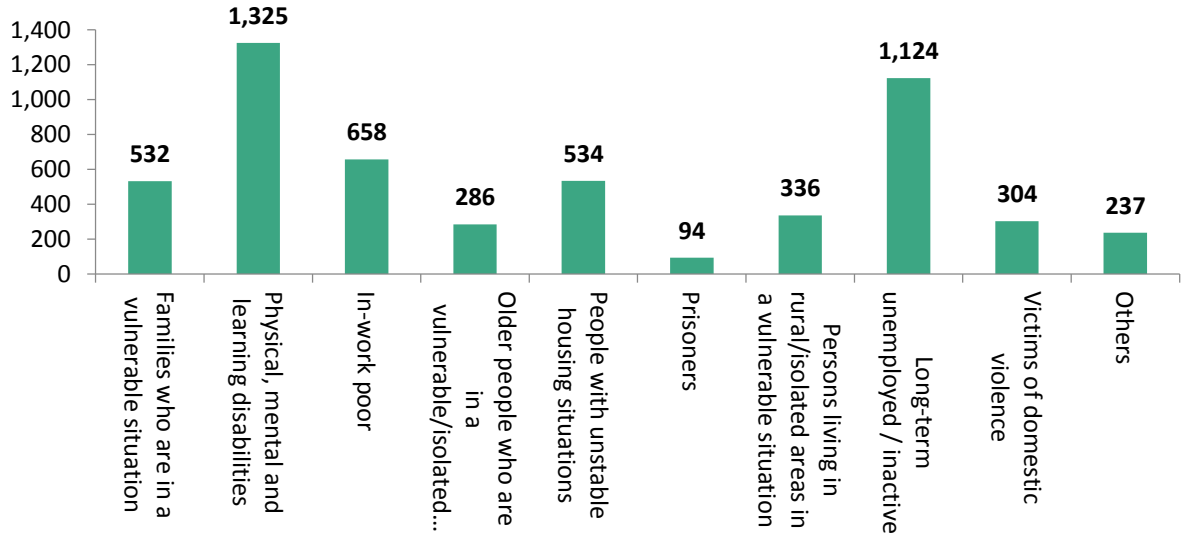
- Families who are in a vulnerable situation (e.g. lone parents with young children);
- Having physical, mental and learning disabilities or poor mental health;
- In-work poor;
- Older people who are in a vulnerable/isolated situation;
- People with unstable housing situations (e.g., homeless people);
- Prisoners (or ex-prisoners in vulnerable situation);
- Persons living in rural/isolated areas in a vulnerable situation;
- Long-term unemployed / inactive (not in education, training or employment); and
- Survivors of domestic violence.

The survey contributes to identifying the most effective strategies for improving the health of vulnerable and isolated people, who are, due to particular circumstances, at a higher risk of experiencing poor health and/or facing barriers in accessing healthcare services.

The survey was conducted by GfK in 12 Member States: France, Germany, Greece, Italy, Lithuania, Netherlands, Poland, Romania, Slovakia, Spain, Sweden and the UK. To reach members of all target groups, the current survey used a mix of offline Paper-Assisted Personal Interviews (PAPI) and online Computer-Assisted Web Interviewing (CAWI). For the PAPI approach, local stakeholders (i.e., social workers, charity workers and other NGO's) that are in regular contact with vulnerable and isolated people were recruited. Under the guidance of GfK, these organisations collected 1.938 surveys between 20 July and 30 November 2016 from respondents of all nine target groups. The CAWI approach helped to collect additional 2.249 questionnaires via the local GfK panels between 22 November and 9 December 2016. While both approaches were used for each target group, the PAPI approach was particularly successful in reaching people with physical, mental and learning disabilities, people with unstable housing and older people in vulnerable and isolated situations. The CAWI approach was most useful in reaching in-work poor and long-term unemployed people.

The survey was completed by 4.187 respondents. People with physical, mental and learning disabilities (n=1.325; 32%) and long-term unemployed and inactive persons (n=1.124; 27%) are represented most often. Figure 17 below offers an overview of the respondents in each target group.

Figure 17. Number of survey respondents per target group

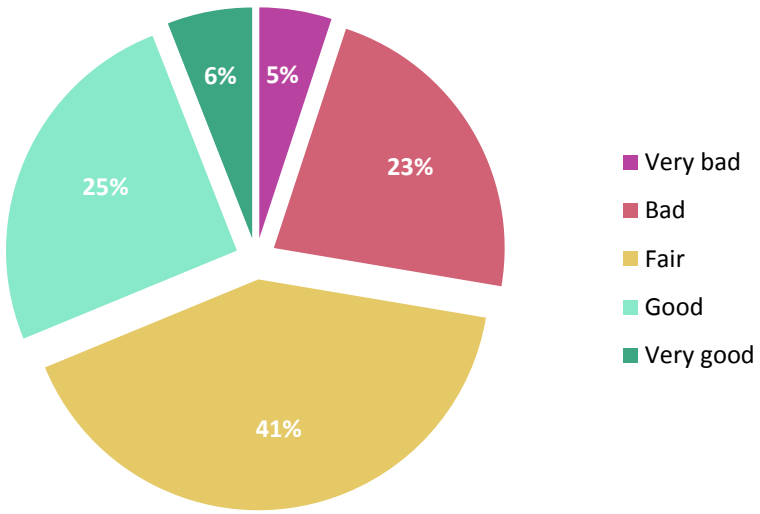


The following sub-sections present outline key findings from the survey.

2.2.2 The health situation of people in vulnerable and isolated situations

Firstly, the survey investigated the health situation of people living in vulnerable or isolated situations and provided insights into the specific health issues faced by this particular target group. The findings of the survey suggest that a considerable proportion of vulnerable and isolated people do not have a positive perception of their health: only 31% of respondents evaluated their health as (very) good, while 28% of the respondents evaluated their health as (very) bad (these data are illustrated below in Figure 18).

Figure 18. Self-reported health status



The results differ across the various surveyed target groups and some target groups reported relatively worse health than other groups (full results are presented in 6 0). These data illustrate that people with physical, mental and learning disabilities are more likely to report (very) bad health (39% compared to an average for all respondents of 28%) and are less likely to report a (very) good health (22% compared to the average

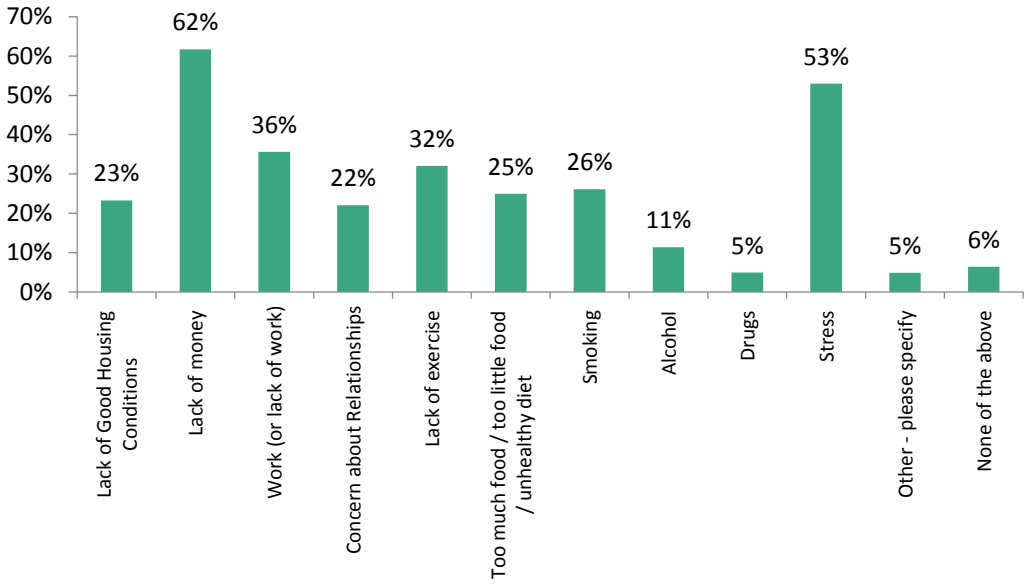
of 31%). The same is found for older people living in a vulnerable or isolated situation (respectively 38% reporting bad health compared to an average of 28% and 22% reporting good health compared to an average of 31%). Furthermore, long-term unemployed reported significantly more often that they have bad health (31% compared to the average of 28%) and less often that they have a good health (28% compared to the average of 31%) and survivors of domestic violence were most likely to report very bad health (10% compared to an average of 5%).

In contrast, the in-work poor respondents and people with unstable housing reported a better health. Concretely, in-work poor were significantly less likely to report a (very) bad health (17% vs. 28%), while they are more likely to report a fair health (47% vs. 41%) and good health (30% vs. 25%) than the average respondent. People with unstable housing were more likely to report a very good health compared to the average (10% vs. 6%).

The survey found that 61% of respondents reported having long-standing illnesses, disabilities or infirmity. Most of those long-standing health problems were related to respondents' mobility (42%), stamina, breathing or fatigue (37%) and mental health (31%). Moreover, feelings of psychological stress were assessed. Many individuals reported feeling particularly tense (29%) feeling lonely (27%) and feeling depressed or downhearted (28%) at least most of the time, or did not wake up fresh and rested (60%) more than some of the time.

Focusing on barriers for the respondents' health, Figure 19 illustrates the results of the survey which present various factors. This analysis show that, while the health of vulnerable and isolated people was affected by various factors, the lack of money (62%) and feelings of stress (53%) were the most common factors.

Figure 19. Factors affecting people's health



The importance of financial factors in determining access to healthcare was further confirmed by the fact that respondents in difficult financial situations self-reported health status was poorer compared to wealthier respondents, 36% of those in a difficult financial situation reported bad health status compared to 15% of those in an easy financial situation (see 6 00). The findings for the different target groups illustrate that the lack of money played a greater role for the in-work poor (72%), people living in an unstable housing situation (71%), members of vulnerable families (68%) and long-term unemployed or inactive people (66%). In contrast, the lack of money had a lower impact on the health of surveyed prisoners (41%) and people with physical, mental or learning disabilities (57%). For prisoners, the lack of money was 'only' the third most mentioned factor, after smoking (55%) and stress (54%). 'Feelings of stress' was the second most

prevalent factor for most respondents and this is the case across all target groups. However, survivors of domestic violence (62%), members of vulnerable families (59%) and people with an unstable housing situation (58%) were relatively more likely to report feelings of stress as being detrimental for their health. In contrast, the health of vulnerable and/or isolated older people was less affected by feelings of stress (40%).

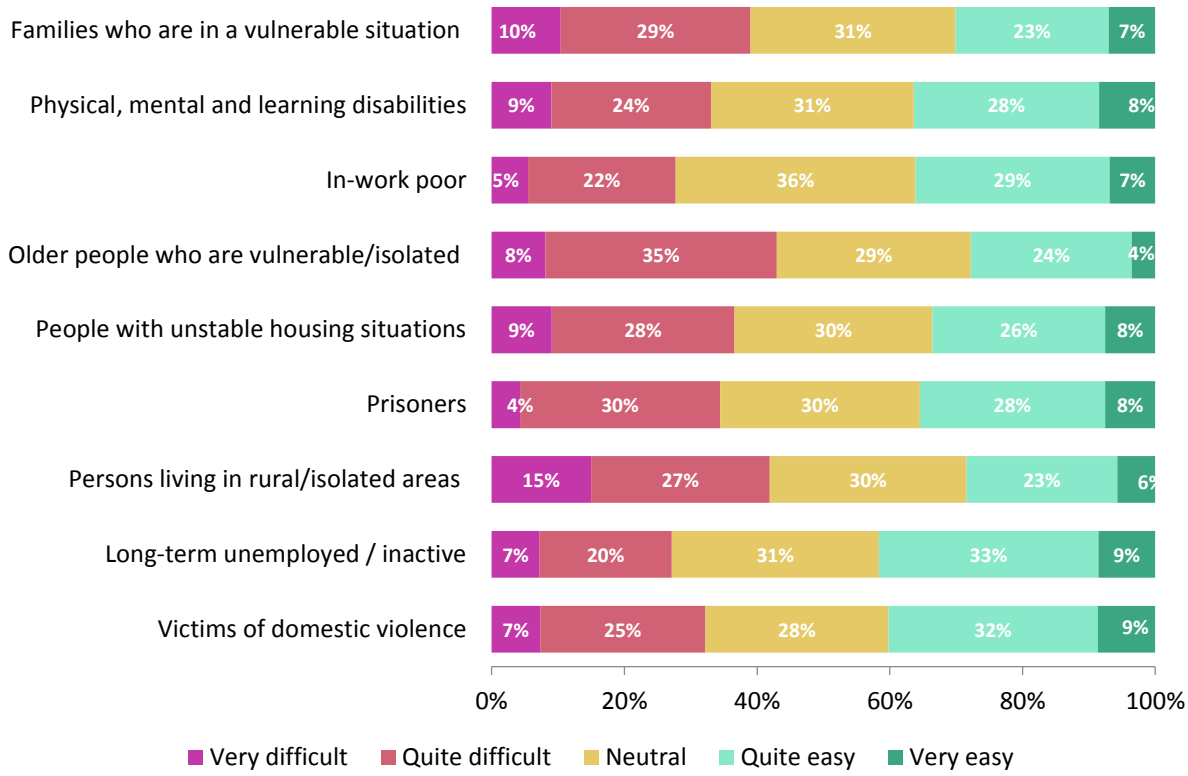
2.2.3 Access to healthcare services

Another aim of the survey was to assess problems that vulnerable or isolated people may have with accessing required healthcare services. The results suggest that vulnerable and isolated people have at least some problems with the access to health care. While 37% of respondents found it easy to access health care services when needed, 32% of respondents thought that it was difficult. It is important to note, that respondents with a bad or very bad health found accessing healthcare particularly difficult: 50% of the respondents that reported a bad or very bad health experienced difficulties with accessing healthcare services, while this was only 19% for respondents with a (very) good health.

The ease with which respondents could obtain healthcare differed slightly across the surveyed target groups (see Figure 20 below). For example, members of vulnerable families found it slightly more difficult to access healthcare: 39% (compared to an average of 32%) found it very or quite difficult, while 23% (compared to an average of 29%) found it quite easy. The same is true for people living in rural or isolated areas (15% compared to an average of 8% found it 'very difficult'; 23% compared to an average of 29% found it 'quite easy') and older respondents in vulnerable and/or isolated situations (35% compared to an average of 24% found it 'quite difficult' and 4% compared to an average of 8% found it 'very easy'.

In contrast, long-term unemployed or inactive respondents found accessing healthcare slightly easier: fewer respondents in this group had difficulties accessing healthcare (20% compared to an average of 24% found it 'quite difficult') and a greater share of these respondents found accessing healthcare ('quite') easy (33% compared to an average of 29%). Similarly, fewer in-work poor respondents found accessing healthcare ('very') difficult (5% compared to an average of 8%).

Figure 20. Ease of accessing healthcare by target group

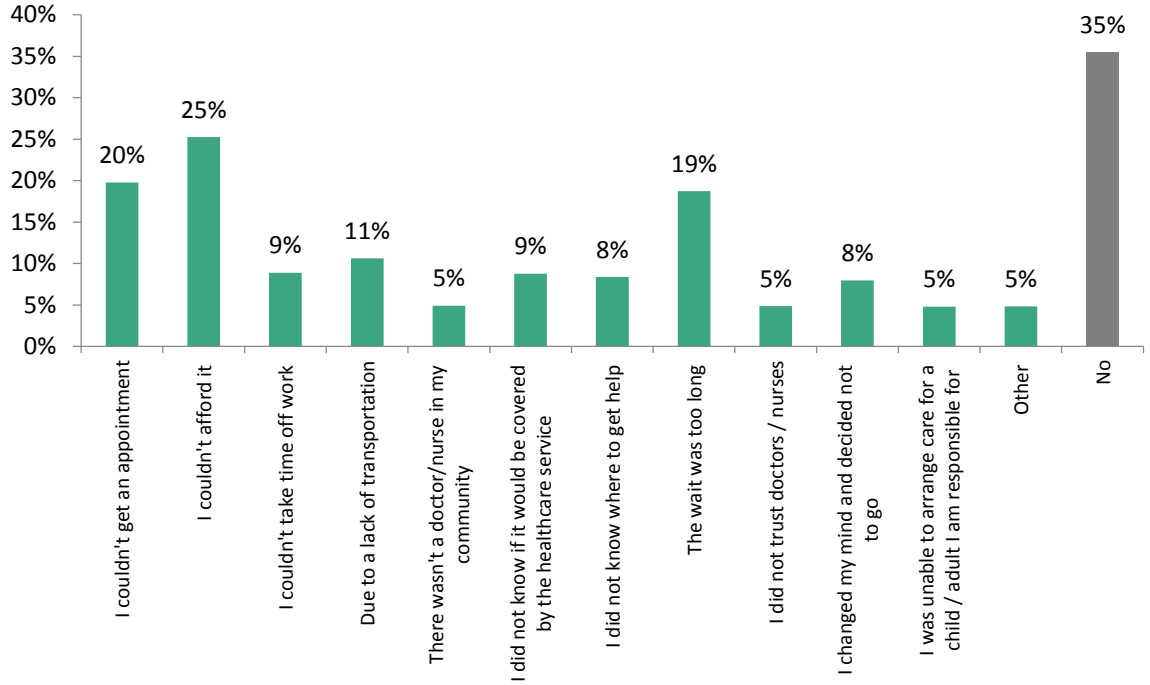


To understand the factors that hinder vulnerable and isolated people from accessing healthcare, the survey investigated factors that inhibited respondents from accessing (1) medical practitioners, (2) dental examinations or treatments and (3) medication. Moreover, respondents' ability to understand health information provided by doctors, nurses and other healthcare professionals was also explored as a potential barrier to healthcare access by the target group.

It was found that, respectively 65%, 52% and 45% of the respondents encountered at least one problem that prevented them from visiting a medical practitioner, from getting dental examination/treatment or from getting medication.

As illustrated in Figure 21 below, the three most commonly cited reasons why vulnerable and isolated people did not get the medical attention they needed, were that they could not afford it (25%), that they couldn't get an appointment (20%) and that the wait was too long (19%). The occurrence of these three reasons differs across the target groups. The affordability of medical attention was reported as the main reason for not getting medical treatment. While this factor was the most prevalent problem for all target groups, the extent of this problem varied across the target groups.

Figure 21. Problems when trying to get medical treatment



Across all three investigated healthcare services (medical practitioners, dental examinations or treatments and medication), high costs were perceived as the main reason preventing respondents from accessing required healthcare (cited by respectively 25%, 30% and 26% of all respondents). The cost factor was most often mentioned for dental treatments (30%) and least often for medical practitioners (25%). In addition, for medical treatment, the inability to get an appointment (20%) long waiting times (19%) were also seen as relevant factors.

The findings also revealed interesting differences between the surveyed target groups. Vulnerable and isolated older people (43%), persons living in rural or isolated areas (42%) and members of vulnerable families (39%) reported more difficulties with accessing healthcare services when they needed them. Almost all target groups reported the costs of healthcare services as the most important barrier to healthcare access. However, across all three healthcare services, the cost factor had an even greater impact for members of vulnerable families (39%-45%) persons living in rural and isolated areas (36%-40%), people living in unstable housing situations (33%-40%) and the in-work poor (31%-42%). The costs for medical practitioners and medication were also significantly more relevant for vulnerable older people (33% & 32%). It is also noticeable that the group of people with physical, mental and learning disabilities seems to be consistently less affected by the costs of all three healthcare services: medical practitioners (21%), dental treatments (27%) and medication (27%). Members of vulnerable families (28%), people with unstable housing (27%) and vulnerable and isolated older persons (27%) found it more difficult than average (21%) to understand the health information provided by doctors, nurses and other healthcare professionals.

Somewhat consistent with the findings discussed in the previous paragraphs, access to healthcare is also consistently affected by the socio-demographic factors education and finances. Firstly, access to healthcare is reported as more difficult for low-educated respondents (46%) and respondents in a difficult financial situation (39%) than the average respondents (32%). The unaffordability of the healthcare facilities as a barrier to healthcare access is also most often reported by these two groups of respondents. In addition, respondents with only a basic education and respondents in a difficult financial situation report more problems with the costs of medical practitioners (37% and 33%), dental treatments (35% and 39%) and medications (37% and 34%).

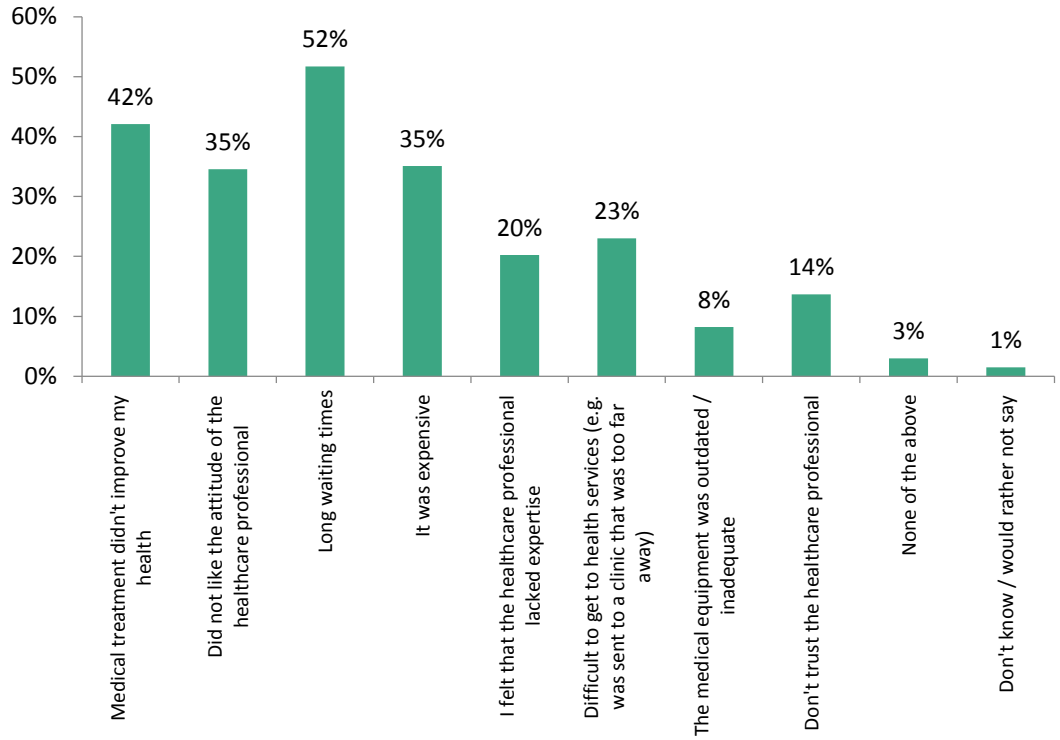
Finally, the ease of understanding health information was also affected by educational level and financial status of the respondents. Respondents with a basic education (33%) and respondents in a difficult financial situation (25%) found it significantly more difficult to understand information provided by healthcare providers than the average respondent of this survey (21%).

2.2.4 Satisfaction with healthcare services

The survey results also provide insight into how satisfied people living in vulnerable and isolated situations are with the healthcare services they receive. Almost half of all respondents were either quite or very satisfied (43%), while less than one quarter of the respondents were dissatisfied (22%) with the healthcare services they received in the past year. However, it is noticeable that respondents with a bad health, who probably are more frequent user of the healthcare system, were the least satisfied. 40% of respondents with a bad health were dissatisfied, compared to only 29% who were satisfied. Dissatisfaction with medical treatment was also higher for a number of specific health conditions. The results show that these health conditions, which include problems with vision, dexterity, memory, stamina, breathing or fatigue and social or behavioural issues, were not only limited to physical or mental issues.

In relation to the reasons for dissatisfaction with the healthcare services, respondents (that indicated that they were very or quite dissatisfied) were mostly dissatisfied because of long waiting times (52%), the belief that the medical treatment did not improve the respondents' health (42%), the costs of the treatment (35%), and a bad attitude of the healthcare professional (35%) (See Figure 22 below).

Figure 22. Reasons for dissatisfaction with medical treatment



The results for the target groups reveal some interesting differences. As such, the satisfaction with healthcare services is particularly low for (ex-) prisoners (34% were very or quite dissatisfied), vulnerable and isolated older people (31%) and persons living in rural isolated areas (31%).

The reasons for dissatisfaction with the results of their medical treatment also differ between the target groups. Long waiting times were most often a cause for dissatisfaction for persons living in isolated areas (65%), vulnerable older people (63%), the in-work poor (61%) and people with physical, mental or learning disabilities (57%)., People with disabilities did also believe most often that the medical treatment did not affect their health (53%) and had most concerns about the attitude of the healthcare professional (43%). Vulnerable older people (47%), the in-work poor (44%) and members of vulnerable families (43%) were also most dissatisfied because of the costs of the medical treatment.

Socio-demographic breakdowns also revealed some notable differences. The dissatisfaction with the results of medical treatments was higher for respondents with only a basic education (29% were very or quite dissatisfied) and for respondents in a difficult financial situation (28%).

The reasons for dissatisfaction with the healthcare services were only somewhat affected by socio-demographic differences. The impact of waiting times did not differ across the different groups of respondents. However, older respondents were somewhat more dissatisfied because they did not believe that the medical treatment affected their health (55+ years 48%). Respondents in a difficult financial situation were more dissatisfied because of the costs of the medical treatment (39%), while respondents in an easy financial situation were more dissatisfied because of the bad attitude of a healthcare professional (42%).

2.2.5 Summary of results by groups of vulnerable and isolated people

The survey results identified significant differences for the various target groups. Firstly, the self-reported health varied across the target groups included in the survey. The average share of all groups reporting bad health was 28%. However, among those with physical, mental and learning disabilities 39% of bad health. Other groups reporting above average levels of bad health were: older people in vulnerable and isolated circumstances (38%), survivors of domestic violence (33%) and long-term unemployed (31%). These target groups (except for long-term unemployed) were also more likely to report long-term illnesses, disabilities and infirmity (respectively 84%, 73% & 67% vs. 61% average).

Problems with mobility, with stamina, breathing and fatigue and with mental health were the most common health problem areas identified by all target groups. Looking at differences between the target groups shows that problems with mobility and stamina, breathing or fatigue were more often than average (respectively 42% and 37%) reported by vulnerable and isolated older people (respectively 56% and 48%) and physically or mentally disabled people (respectively 51% and 40%). Mental health problems were more often reported by physically or mentally disabled (44%), people with unstable housing (39%) and survivors of domestic violence (45%), compared to an average (31%) among all groups.

Survivors of domestic violence and people with unstable housing, along with members of vulnerable families were most likely to portray other signs of psychological stress. As such, members of these target groups felt more often particularly tense (respectively 41%, 39% and 38% felt so most or all of the time), lonely (39%, 40% and 32%) and depressed (44%, 39% and 35%). Additionally, people with disabilities felt significantly more depressed or downhearted (32%) than the average respondent. In-work poor respondents (17%) and persons living in rural or isolated areas (15%) were the least likely to wake up feeling fresh and rested.

The access to healthcare also differed across target groups. Members of vulnerable families (39% found it quite or very difficult), persons living in isolated or rural areas (42%) and vulnerable and isolated older people (43%) experienced more difficulties with accessing the healthcare services in the past year, compared to the average of all survey respondents (32%).

High costs were mentioned as the main reason for not visiting medical practitioners, accessing dental examination/treatment or getting medication. The unaffordability of all three healthcare services was reported most often by members of vulnerable families (respectively 41%, 45% and 39%) and persons living in isolated or rural areas (40%, 40% and 36%). Also, in-work poor (42%) reported more problems with the costs of dental care and people with unstable housing (40%) had more problems with both the costs of dental care and medication. It is also notable that people with physical, mental and learning disabilities were significantly less affected than other groups by the cost of all three healthcare services (21%, 27% and 21%).

Members of vulnerable families (28% found it quite or very difficult), people in unstable housing situations (27%) and older people in vulnerable and isolated situations (27%) also had more problems with understanding health information provided by doctors, nurses and other healthcare professionals.

The satisfaction with healthcare services was particularly low for people without stable housing (29% is very or quite dissatisfied compared to an average of 22% for all groups). The role of the four most prominent reasons for dissatisfaction with the healthcare also differed across the target groups:

- Long waiting times were cited most often by dissatisfied people living in rural or isolated areas (65%), vulnerable older people (63%), the in-work poor (61%) and people with physical, mental and learning disabilities (57%).
- The perceived ineffectiveness of the medical treatment was most often mentioned by dissatisfied people with physical, mental and learning disabilities (53%) and long-term unemployed (49%).
- The costs of the medical treatment were most often identified as barriers in accessing healthcare by dissatisfied vulnerable older people (47%), the in-work poor (44%) and members of vulnerable families (43%).
- Dissatisfaction with the attitude of the healthcare professional was most often mentioned by people with physical, mental and learning disabilities (43%).

2.2.6 Summary of results by socio-demographic profiles

Socio-demographic breakdowns of the survey results provided further insights into differences between different socio-demographic groups, with differences between respondents with different educational levels and financial situations as the most common factors.

Firstly, the self-reported health status was the worst for respondents with only a basic education (37% reported bad or very bad health), respondents in a difficult financial situation (36% reported bad or very bad health) and vulnerable older respondents (37% reported bad or very bad health). Similar results were found for long-standing illnesses, disabilities or infirmity (where respectively 74%, 69% and 64% reported bad or very bad health).

The type of health problem also differed across the socio-demographic profiles. As such, mobility issues were most common for older respondents (55%), while problems with stamina, breathing and fatigue were reported most often by older respondents (44%), women (41%) and respondents in a difficult financial situation (40%). Mental health issues were the most common among young respondents (18-34 years; 37%) and low-educated respondents (36%). Looking at signs of psychological stress, respondents with only a basic education and with a difficult financial background were also more likely to feel particularly tense (respectively 33% and 35%), lonely (34% and 32% vs. 27%) and depressed (both 33% vs. 28%). Middle-aged respondents (35-54 years old) also felt more tense (32% vs. 24%) and depressed (30% vs. 25%) than older respondents. Women (19%) and middle-aged respondents (19%) were also less likely than average to wake up fresh and rested.

It is not surprising that the financial position, as an influence on good health, was most often reported by respondents in difficult financial situations (78%). However, also respondents with only a basic education (67%) and middle-aged respondents (64%) identified financial status as a barrier to their health. Feelings of stress, another prominent reason for health problems, was also more commonly cited as a barrier by respondents in a difficult financial situation (57%), while respondents with only a basic education (44%) reported stress significantly less often than the average respondent. The results also show that respondents younger than 55 years (58%-60%) and women (57%) were more affected by stress.

A difficult financial situation and a low (basic) education were also related to problems with accessing healthcare. Respectively 39% of respondents with a difficult financial situation and 46% of low-educated respondents found it difficult to access healthcare. These difficulties with accessibility were generally caused by the high costs of the investigated healthcare services (i.e. medical practitioners, dental examination/treatment, and medication). It is noticeable that low-educated respondents and respondents in a difficult financial situation found it most difficult to pay for medical practitioners (37% and 33%), dental care (37% and 33%) and medication (35% and 39%). Women also experienced more difficulties with accessing healthcare (34%) and found it, compared to men, slightly more difficult to pay for dental care (32%) and for medication (28%). Finally, the satisfaction with healthcare services also differed across socio-demographic differences. Again, respondents in a difficult financial situation (28%) and respondents with only a basic education (29%) were most dissatisfied with the results of the medical treatment they have received in the last 12 months. The affordability of medical treatments, as a driver for dissatisfaction, was reported most often by respondents with a difficult financial background (39%). Low-educated respondents were most dissatisfied because of the long waiting times (48%).

2.3 Quantitative findings on health inequalities

Based on Eurostat data, 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. Findings from the survey do not provide any insight on trends across time.

Evidence from Eurostat data highlights persistent health inequalities between different population subgroups. For example, men's life expectancy and 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). The survey results suggest that slightly fewer females reported good or very good health than males, 30% compared to 33%. The finding could suggest that females living in isolated and vulnerable situations health status is worse than their male counterparts, contrarily to what happens in the general population.

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 in the prevalence of long-standing illness and poor health among individuals aged 65 and over between Member States. The survey results confirm the evidence from Eurostat. Vulnerable and isolated people often deal with health issues, which are often attributed to the lack of money or the feelings of stress. Vulnerable older respondents (55+) and individuals with lower education attainment are the groups with the lowest self-reported health status.

Evidence from Eurostat data 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 compared to the general population. A similar finding emerges from the survey: vulnerable and isolated people find it often difficult to obtain the healthcare they need, due to their ability to afford necessary healthcare services. This is especially the case for people stating that they have bad health. It also emerges that satisfaction with health services is dependent on people's health: satisfaction is often lower for people who need healthcare the most.

Eurostat data illustrates that the prevalence of unmet healthcare needs varies by group, with the specific reasons behind unmet needs also varying. Nevertheless, some trends can be observed in the data, the vast majority of people in the first income quartile (i.e. the least wealthy) stated that their unmet healthcare needs were due to the cost of healthcare, although this varied from country to country. Similarly, in the survey it emerges that the three most prominent reasons why vulnerable and isolated people did not receive the medical attention they needed, were that they could not afford it (25%), that they couldn't get an appointment (20%) and that the wait was too long (19%).

While the survey results differed for various socio-demographic variables, there was a consistent role of the respondents' education and their financial situation in relation to their health situation, access to healthcare and satisfaction with healthcare services. Both respondents in a difficult financial situation and respondents with only a basic education frequently cited the lack of financial resource as detrimental for their health (67% and 78% stated this). Feelings of stress were also mentioned particularly often by respondents in a difficult financial situation (stated by 57% of such respondents), but less often than average by respondents with only a basic education (44%).

All of the inequalities found during this evidence review remained broadly stable during the period covered (using the Eurostat data), although the proportion of people who cited the cost of healthcare as the primary reason for not seeking treatment did rise.

3 In-depth analysis of the issues facing each target group

This chapter provides an overview of the findings from the literature review and the focus groups for each sub-group. These findings are presented alongside some of the key quantitative data outlined in the previous chapter.

3.1 Older people

Summary of quantitative findings

Chapter 2 shows that the prevalence of illness or health problems is much higher among people aged 65 and over than people aged under 65 (Eurostat, 2017c). 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 those under 65. Whilst the higher rates of long-standing illness or health problems among older people is not surprising, the data also shows considerable differences between Member States. Rates of long-standing illness or health problems among those aged 65 and over in individual Member States vary significantly, from 39.5% (Belgium) to 83.4% (Estonia).

Among respondents to the VulnerABLE survey, older people who were in vulnerable or isolated circumstances had the second highest rates of bad health (38%) and long-term illness, disability or infirmity (73%), well above the average rates for all survey respondents (28% and 61% respectively). Older respondents also had the highest rates of problems with: mobility (56%); and stamina, breathing or fatigue (48%).

Older people in vulnerable or isolated situations also reported having greater difficulty accessing healthcare services than average, 43% reported finding healthcare services difficult to access, compared to 32% of all survey respondents. This was primarily due to the cost of healthcare, although difficulty understanding health information provided by doctors, nurses and other healthcare professionals was another barrier older people often faced (this was stated by 27% of such respondents).

3.1.1 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 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).

3.1.2 Scale of the problem

Europe is the world's oldest continent by population 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, 2017g), 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, Member States such as Italy (22%), Greece (21%) and Germany (21%) have relatively high shares, whilst countries like Poland (16%), Luxembourg (14%), Cyprus (15%) and Slovakia (14%) have low proportions of older people, with Ireland reporting the lowest proportion of older people in the EU (13%) (Eurostat, 2017g). Therefore, it is likely that challenges will differ across Member States and so will the level of vulnerability experienced by some older people.

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.

3.1.3 Health challenges

3.1.3.1 Trends in the literature

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 factors 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 Drozdzak 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 (linked

with older age) as a predictor of poor health, 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; Siegrest, 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).

3.1.3.2 Focus group findings

In addition to frailty and biological ageing, the focus group identified two main factors affecting the health of older people. The first is the living built environment (environmental determinants), which includes elements such as transport, availability of supermarkets and pharmacies, safe public spaces, and adequate housing. The second factor is the specific needs of each person, at micro, meso and macro levels. Very often one initial need or challenge may lead to greater challenges later on (e.g. loss of vision can impact on mobility which in turns can affect social exclusion). This second finding supports the findings from the literature review that greater levels of health problems among older people can in part be explained as the knock-on impacts of situations experienced by individuals in their earlier life.

Some specific enablers of independence and inclusion, which could serve to buffer vulnerability and support good life-styles, were also identified during the focus group, such as having benches in public spaces, public toilets, safe public environments, access to services including transport, availability of pharmacies, supermarkets, and other relevant retailers. Besides the direct impact on health of access to medicines and healthy food, all these enablers can prevent social exclusion and increase mobility.

The needs and challenges faced by vulnerable older people are numerous. These can range from the need to feel one's life is worth living ("to have a reason to get up in the morning") and the need of overcoming (emotional) loneliness, to needs related to stopping abuse or mistreatment, which older people may become more at risk of as they become more dependent on others. Mental health care represents another dominant need for this group. Often mental health is endangered by isolation, mistreatment, or misdiagnosis of disorders (e.g. dementia is often misdiagnosed as depression, and vice-versa) which leads to inappropriate medical treatment. Continuous access to mental health services even in old age is imperative to preserve the well-being of older people.

Besides personal needs, structural needs were also identified. These include the need for more specialised doctors (properly trained geriatricians) and for better monitoring of older people's needs. Concerning the latter, there are clear issues in accessing older people for monitoring, which include their living in isolation, their lack of mobility, and their limited ability to participate in surveys. There's a need for multi-disciplinary teams at local level to do this monitoring and subsequently feed information to regional or national level in a bottom-up process.

3.1.4 Access to healthcare

3.1.4.1 Trends in the literature

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, 2015a).

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).

3.1.4.2 Focus group findings

Feedback from the focus group supported several of the challenges and barriers identified by the literature review. Participants in the focus group also highlighted structural ageism, lower levels of health literacy, and low incomes as key barriers to healthcare experienced by older people.

The differential treatment that older people often receive from health professionals compared to young people was mentioned as one barrier to health. Issues with communication between health providers and older patients can be part of the problem. This may lead to a perception that older people are unable to make decisions or fully understand matters related to their health.

Another important barrier emphasised during the focus group was the low health literacy of the most vulnerable old people, who lack knowledge on what to do or where to go to deal with health issues. This barrier can be exaggerated by the complexity of the structure of health and other relevant services (e.g. social services).

Finally, costs of healthcare represent a growing issue. While the financial burden of healthcare for the individual might not be perceived as overly heavy when entering old age, increases in healthcare needs and a decrease in independency can cause older people’s financial security to quickly deteriorate, reducing their ability to cope with

growing costs. This can escalate social exclusion and poverty, with further associated impacts on the health of older people.

3.1.5 Evidence of policies being used to support this group

3.1.5.1 Trends in the literature

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 healthy 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.

Active Ageing Index results for 2010, 2012 and 2014 highlight 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 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.

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; 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, including incentives for employers to hire older workers and increased flexibility of work (through part time and temporary employment) (EuroFound, 2013).

3.1.5.2 Focus group findings

The solutions discussed revolved around four themes: age-friendly environments, inter-sectoral collaboration, social interventions, and personalised services. Focus group discussions centred on examples of best practice at Member State level, rather than the European-level policies discussed in the previous section.

Age-friendly environments

In order to maintain older people's independency and mobility, "age friendly environments" should be ensured. A specific example is represented by "dementia friendly municipalities", which follow the same principles of disability friendly municipalities: There is overall awareness of the issue across different services, including supermarkets and other retailers, transport, etc. The physical structure of the environment is also adjusted to simplify navigability, and police officers have special training to, for instance, find lost people. As an example, local shops in Bruges (Belgium) have been trained to recognise signs of dementia and treat customers with dementia with respect and understanding. By raising awareness and educating citizens, the quality of life of people with dementia is improved and they feel comfortable maintaining their daily habits.

Age-friendly environments need a whole of community approach and should aim to keep older people active within the community. In order for age-friendly environments to be successful, an assessment of what "age-friendly" means in (the contexts of) different communities should be performed. Age-friendly environments also need to be created in collaboration with older people for them to be effective.

An example of change towards creating an age-friendly environment is seen in Udine, Italy. The city has carried out a mapping exercise comparing neighbourhoods, distribution of older people across the territory, and availability of services. This has allowed them to make changes in urban planning and ensure that essential services, such as a pharmacy, a doctor, a supermarket and a bus stop are provided within 500 metres of older people's living locations.

Inter-sectoral collaboration

Inter-sectoral collaboration is vital to improve health and access to healthcare and other services for older people, especially at local level. Various types of services available within municipalities should collaborate, going beyond social care: a true Health in All

Policies (HiAP) approach is recommended, including also the private sector and other players in the field.

HiAP can be difficult to achieve because of conflicting priorities across sectors, working culture, separated budgets, and lack of capacity. However, HiAP initiatives initiated at local level, where it is sometimes more feasible, can then be scaled up and influence decision making at national level too.

Advocacy for HiAP and face-to-face exchanges of good practices could foster this approach. The Commission was seen as an actor that can play a key role in organising such face-to-face interactions.

Holistic approaches to health and well-being

The health of older people goes beyond focusing on medical issues, and should be addressed from a holistic point of view that considers the older person in a wider social context. There are various solutions to increase or maintain the well-being of older people, including, for instance, creating mixed communal houses or designing activities that enable older people to maintain a feeling that they are valued, to achieve their self-worth potential (based on individual needs).

Neighbourhood centres could be part of the solution: meeting points against isolation and easily reachable by services (health, social, etc.) to develop interventions. Another interesting approach is that of "social neighbourhood teams". In the Netherlands, 87% of municipalities have so called "Sociale wijkteams" (social neighbourhood teams). They are involved in helping older people to live independently for a longer time. Every municipality is responsible for shaping these social teams (the social teams have a contract with the municipality), so there are some differences in their approach. However, important topics are in general: prevention, connecting formal and informal care, better referral to adequate care and decreasing the use of secondary care, and addressing loneliness in older people.

It was found that a legislative framework for social inclusion solutions is missing at EU level and in some Member States, especially concerning age discrimination. At EU level, however, there is work undergoing on a Convention on the Rights of Older People, which is a promising step towards better societies facing the current demographic changes. This could potentially help address the 'ageist healthcare systems' barrier identified.

Awareness raising of older people's needs and challenges and of their impact on society should be enhanced, also among older people themselves. This could further be developed into effective empowerment of older people to allow them to fully participate in their communities.

Training and education should be provided to both older people and professionals. Medical and social professionals should recognise the full person, including their social history, if they want to make an impact on their well-being. Training should also be implemented, either by inclusion in school curricula or via community level organised sessions, on the detection of abuse: family, cleaning services, GPs, community nurses, emergency services, and pharmacists should be the target of such training.

Person-centred services

Person-centred care and services are becoming more and more valued in order to ensure the well-being of older people. A specific example of person-centred care is to have specialised nurses or practitioners with time to look into the specific issues faced by the person they are providing care to, and get specialised services on board. In Germany these are organised by insurance companies, while in other countries it can be in the hands of charities or other not-for-profit organisations. Insurance companies should also actively inform people on their rights to benefits. In Belgium, for instance, this is compulsory. The language used to inform older people of their rights to benefits should however be improved, in order to make information more understandable and

accessible. Furthermore, it is noted that home visits are better than letters when it comes to informing older people.

3.1.5.3 Relevant case studies

As part of the VulnerABLE project, an inventory of practices was produced, collecting good practices from across the European Union that promote health and access to healthcare for people living in vulnerable and isolated situations.

Three practices in the inventory seek to improve the health of older people. One (Healthy Ageing Supported by Internet and Community) seeks to tackle the lifestyle factors that contribute to poorer health among the elderly. The other two practices focus on healthcare services themselves; one of these (Health promotion and prevention of risk) aims to reform service delivery by enabling health professionals to care effectively for older people; the other involves preventative home care visits for older people who do not have support from social services.

Table 1. Relevant case studies for this target group

Title	Organisation & country	Main objectives	Web link
Healthy Ageing Supported by Internet and Community	Turtu University of Applied Sciences (FI) Transnational	This project aims to empower older people in Europe to take care of their own health. Besides helping older people on a person-to-person basis, this project also aims to make services more cost effective and increase their quality through cooperation between regional service providers, and policy recommendations regarding communal elderly services.	http://www.hasicproject.eu/en/node/31
Health promotion and prevention of risk – action for seniors (Pro-Health 65+)	Jagiellonian University Medical College Poland	Aims to prepare a manual for health workers, to advise them on the most effective health promotion strategies for older people. Research aims to be disseminated among healthcare professionals to help them tailor and improve the care of older people.	http://www.pro-health65plus.eu/?About_project___Expected_outcomes
Our life as elderly (OLE II)	City of Luleå – Administration of Social Services (SE) Transnational	This project works to increase the quality and responsiveness of care and services available to older people within four themes: competence development and staff recruitment; health and social services; housing and services; networks.	www.ourfuture.eu

3.2 Children and families from disadvantaged backgrounds

3.2.1 Overview of policy context

Summary of quantitative findings

The survey results in chapter 2 show that individuals from families in vulnerable situations (at risk) reported in 25% of cases being in a bad (22%) or very bad (3%) health situation.

From the same group, 58% of respondents declared having long-standing illnesses, disabilities or infirmity. 26% of respondents declared having experienced mental health issues. The areas that were most affected by individuals within this target group experiencing long-standing illnesses, disabilities or infirmity were: mobility; stamina breathing of fatigue and mental health.

With regard to the factors affecting access to healthcare, individuals from this target group reported that lack of money was a determining factor in access to healthcare in 68% of respondents.

Concerning the feelings of psychological stress, members of vulnerable families were reported to be more likely to feel particularly tense (38%), lonely (32%) and depressed (35%) than the average.

The United Nations Convention on the Rights of the Child (UNCRC), adopted by the United Nations in 1989, 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, in the same year the Charter of Fundamental Human Rights of the EU, proclaimed in 2000, became legally binding. This ensures 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).

3.2.2 Scale of the problem

According to the literature, 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 2015, the proportion of children aged 0-17) living in households at risk of poverty or social exclusion in the EU-28 was 26.9, ranging from 15.3% in Denmark to 46.0% in Romania. 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; 24.7% for 18-64 year olds and 17.4% for people aged 65 and above (Eurostat, 2016b).

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 62.2% of households with dependent children with low and very low work intensity were at risk of poverty in 2014 (Eurostat, 2016b).

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 managing 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 half (46%) lone-parent households in the EU were at risk of poverty or social exclusion, compared with 20% of households comprising couples with children (EIGE, 2016). Lone mothers were particularly at risk of poverty and social exclusion (ibid)[1].

During the Focus Group meeting, issues related to the definition of this target group and the terminology were discussed. The target-group was considered to be very broad, encompassing people in different situations and with different needs. Notwithstanding this suggestions were made to add more groups to the list: family carers (as they emerge as a group with specific health needs); families with migrant background; undocumented migrant families; Roma families; and transnational families.

Participants agreed that there was a need to be more specific when defining the types of families composing the target-group: for instance, concerns were raised with regards to the typology of 'families in difficult financial situation', as it was considered that several issues might be subsumed under 'financial situation'. Likewise, participants

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

highlighted that the existence of different legal rights to access healthcare services makes it difficult to include some categories of population in the target group.

3.2.3 Health challenges

3.2.3.1 Trends in the literature

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 significant 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 (Sengoegle et al., 2013). In addition, poverty is also a risk factor for adverse childhood experiences, 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. Studies have found that lone parents often experience poorer physical and mental health compared to their two-parent counterparts (Rousou et al., 2013). 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.

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% compared to 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, and have lower self-esteem, poorer family finances and poorer self-reported health

3.2.3.2 Focus group findings

Similar results emerged from the Focus Group. The participants agreed that families from disadvantaged background face the same health problems than other families but that they are more likely to be impacted by specific issues such as lack of access, lack of services, etc.

Participants discussed specific health problems faced by some of the groups composing the target-group. Family carers (mainly mothers who care for dependent family members, such as their children and the elderly) experience mental (burn out because of isolation) and physical (exhaustion) health issues. Participants noted that prevalence of health issues among carers at home are increasing due to the general longer life expectancy of the population, and the higher proportion of age-related or long term diseases such as dementia or Alzheimer. Participants also mentioned the rise of the 'Sandwich generation' (when adults have to care for both their children and their parents at the same time) and the potential health issues faced by those carers. Participants also identified some specific health issues faced by children from families with disadvantaged backgrounds, this included school harassment; bullying and cyber bullying; and unhealthy food habits (reinforced by advertising and food marketing). Problems of parental addiction (to drugs, alcohol, and tobacco) were also mentioned as affecting children in negative ways. Participants also noted that mental health diseases are often difficult to detect but that they represent a significant problem (a participant noted that in Portugal, between 2008 and 2015, the rate of mental health diseases increased from 19.8 % to 31.2 %).

During the discussion, a holistic approach of health was adopted and participants agreed that several socio-economic factors influence health. Consistent with the data presented above, the focus group highlighted that poverty is understood as one of the main factors contributing to poor health.

According to some participants, specific forms of child custody may also affect the health of children. They mentioned that children from rebuilt families might experience more mental health problems. However, other participants recommended to avoid over-generalising on recomposed families. They highlighted that single parent families are not necessarily more likely to experience poor health per se, but they are more likely to experience economic and financial issues, which might make them more vulnerable. This is a potentially interesting aspect which is not part of the data analysis presented above.

3.2.4 Access to healthcare

3.2.4.1 Trends in the literature

There is limited literature examining the barriers in access to healthcare for at-risk-children and families across the EU; 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 both physical and practical barriers are significant 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 to access required services. The research also suggests that social barriers, such as poverty, disability, ethnicity and being a father can pose a barrier to access services. In addition, the research suggests that time required and the pressures of managing a household and childcare can affect single parents accessing services.

3.2.4.2 Focus group findings

More articulated results came from the Focus Group discussion. Specific barriers faced by the target-group to access health were discussed.

The cost of treatment, and especially long-term treatment was considered as one of the main barriers to access healthcare. Indeed, children and families from disadvantaged background face important problems when they have a disability and/or a long term disease, due to the cost of the treatment involved. It was noted that most governments do not support these costs or only partially (e.g. through support such as transport to the doctor surgery) and that important investments are needed in the long term.

Isolation at home, and especially in the cases of people providing care to their family is both a cause of poor health and a barrier to access health care. Participants noted that isolated people are typically less likely to be provided information on existing services and often find themselves without resources when they face health issues. Isolation was considered to most common among those with a relatively difficult economic situation.

Participants mentioned the stigma (actual and perceived) as important factors hindering access to health care. The phenomenon of 'shy poverty' (when people are living in poverty but do not want other people to know that this is their state) would impede people to ask for certain types of services (such as free meals).

It was noted that the lack of information on health and on available healthcare services, as well as unfamiliarity with peoples' own rights are important obstacles preventing access to healthcare. A lack of take-up of rights was considered to be a contributing factor explaining poor health of certain families. Participants also highlighted existing administrative burdens to access certain health services. For specific groups, this issue perhaps compounded by a lack of legal access to the health care system (for example, for undocumented migrants).

The lack of quality care (and the way children and families from disadvantaged background are treated when they go to the doctors) is also a cause of poor health and of limited access to healthcare. Indeed, participants mentioned issues with regards to confidentiality or with regards to the attitude of service providers towards users. This was considered to be a particular issue for young people who access the same services than their parents.

3.2.5 Evidence of policies being used to support this group

3.2.5.1 Trends in the literature

The literature review showed examples of policy options aiming at initiatives aiming at: addressing the health needs of these families; reducing poverty and improve the economic circumstances of this group; supporting families in the care of children.

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) (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 year's 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).

Initiatives to reduce poverty and improve the economic circumstances of the family are also important. Access to childcare for families at risk of poverty has been linked with better wellbeing outcomes and life chances (Eurostat, 2016), 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 (Cantillion, 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, 2016g). 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).

There is also significant research relating to supporting disadvantaged families to give children the best start in life. In this respect, 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 State 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).

Specific initiatives to directly address the needs of disadvantaged families are also important. For example, 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. The programme also encourages 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).

3.2.5.2 Focus group findings

The experts from the Focus Group identified a few policies and initiatives at national and local level that had a positive impact on the health of children and families from disadvantaged background.

The promotion of work life balance policies - including improved childcare services, parental leave, long-term care services for an aging population and, people with Alzheimer or disabilities - were mentioned as one of the most important policy solutions.

Participants also discussed the importance of developing community-based care and to implement solutions moving towards the deinstutionalisation of care, such as the development of more home-based 24h services, potentially using EU funding. Deinstitutionalisation of care was seen as an empowering solution, enabling people to have a say on the type of care they want.

The importance for carers to have time for themselves was also highlighted by the experts. A good practice example (i.e. *Maisons vertes*) developing a space for carers to meet and talk about their issues, was also provided.

Creating an environment that supports prevention was considered as a necessary step. One participant mentioned the example of a group of parents volunteering to confidentially listen to children at school. The long term care agenda was mentioned as an important issue, and the need to develop the right type of community based services.

With regards to the impact of poverty on children's health, a participant mentioned an initiative taken by a municipality in Portugal. The municipality realised that children from disadvantaged background who benefited from free meals during the school term were not able to have a proper lunch during summer time. The municipality decided to open one school during the summer holidays where lunch was provided to children. To avoid the stigma linked to poverty, the focus was made on the activities that were offered during the day, rather than on the provision of free meals. Although the initiative was found interesting, some participants insisted on the fact that to be effective in tackling health issues related to poverty, the measures should address the structural issues that lead to poverty. The link between poverty and social exclusion was highlighted, so as the need to address the different sides of poverty (and not only the material side).

Creating a cabinet to support families in school, with health technicians including nurses, doctors, and psychologists (such initiative was implemented in Portugal) was noted as potentially having a positive impact on the health of children from disadvantaged background. Participants also mentioned the need to recognise the invisible work done by carers (usually women) who, although they have worked all their life and provide important health services, are not visible on the labour market, and do not receive a pension at the end of their working life. Participants encouraged policy solutions that would recognise the valuable role of carers and give them access to pension rights.

With regards to improving health literacy, programmes such as active citizenship (in particular providing informal health literacy to parents and families) were found to have a positive impact. Through such initiatives young people can be trained to be autonomous and to make their own decisions with regards to their health from a very young age. Children with disabilities should have the same opportunities to have relationships as other children. A participant mentioned some initiative aiming to provide parents caring for children with disabilities with specific support to give their children more autonomy.

Participants mentioned the importance of work-life balance policies to improve the health of people from a disadvantaged background (and welcomed the European Parliament Resolution on work-life balance). The development of family friendly work places should be encouraged. Initiative such as a small network of Italian SME coming together to meet the need of their employees at local level are considered as good practices.

To improve health services and their accessibility, participants emphasised the need to take into account the knowledge of the community or groups of people targeted by the services. For instance, training people to help and provide health advice to other members of their community can be a decisive factor to make a programme successful.

Participants pointed out the problems that some groups of people face to access health care when health insurance is linked to employment. They also noted a tendency to adopt a neoliberal approach on health services, and to borrow policy solutions from countries where there is no healthcare system and where health problems are important. They recommended to avoid those types of solutions as they tend to see people as economic actors only.

3.2.5.3 Relevant case studies

As part of the VulnerABLE project, an inventory of practices was produced, collecting good practices from across the European Union that promote health and access to healthcare for people living in vulnerable and isolated situations. Four case studies on approaches targeting at-risk children and families were included. Three of these focus on increasing access to a range of services for children and families from disadvantaged backgrounds, who tend to be defined as those from lower socio-economic groups. The services provided are healthcare and often social welfare, educational and recreational activities. The fourth practice (DIATROFI, Greece) seeks to tackle inequalities in health status by providing free school meals in deprived areas of Greece.

Table 2. Relevant case studies for this target group

Title	Organisation & country	Main objectives	Web link
Sure Start (Biztos Kezdet)	Ministry of Human Capacities Hungary	The Sure Start programme is provided to families with children aged 0-5. Sure Start premises provide mothers - or other caregivers - and their children with capacity building activities delivered by trained staff (e.g. activities to encourage and promote children's physical development, communication and emotional stimulation).	http://gyermekneveles.tok.elte.hu/6_szam/pub/koscsone.pdf
Family centres	Regions, local authorities (municipalities) and health care providers Sweden	In 'family centres', universal access to healthcare is provided, as well as information and support (e.g. information for pregnant women, parenting counselling, training for unemployed parents and welfare guidance).	http://www.vgregion.se/upload/Folkh%C3%A4lsa/rapporter/Family%20centre.pdf
Schutzengel	Guardian Angel GmbH Germany	This project aims to improve access to services and quality of services to children from families in difficult social situations. It offers support and services to families, e.g. local midwifery and paediatric services, peers support meetings. Support is provided through family midwifes, social workers and volunteers.	https://www.gesundheitliche-chancengleichheit.de/good-practice/schutzengel/
Food aid and healthy nutrition programme: DIATROFI	Institute of Preventive Medicine Environmental and Occupational Health (PROLEPSIS) Greece	A programme delivering free school meals for children in deprived areas of Greece.	http://diatrofi.prolepsis.gr/en/what-we-do/scientific-documentation.html

Source: ICF Case study inventory

3.3 People living in rural/isolated areas

Summary of quantitative findings Chapter 2 shows that people living in rural areas are slightly more likely to report unmet healthcare needs than those living in towns or cities[2] (Eurostat, 2017f). The most important reason cited by rural residents was cost. Although only a low proportion of rural residents (0.3%) stated that long distance was the reason for their unmet needs, they were still three times as likely as those in cities/towns to state this (Eurostat, 2017f).

VulnerABLE survey findings largely confirm the access difficulties experienced by those living in rural/isolated areas and in particular the impact of cost. In the last year, 42% of participants living in these areas experienced difficulties in accessing healthcare services (higher than most other target groups in the study). High cost was the main reason why they did not visit medical practitioners, receive dental examination/treatment or get medication. 40% of those in rural/isolated areas cited (in) affordability as a barrier to getting medical treatment. After cost, the most important reasons why people living in rural/isolated areas did not receive medication were: not knowing if their healthcare insurance covered it (18%); a lack of transport (17%); and there not being a pharmacy/other source of medication in their community (17%).

In all, 31% of people in rural/isolated areas were very or quite dissatisfied with their healthcare services, according to the VulnerABLE survey. These individuals were most likely to put this down to the long waiting times that they face before accessing services (reported by 65% of dissatisfied people in rural/isolated areas)[3]. More than a quarter (26%) have not received medical treatment due to not being able to get an appointment.

Most people (59%) living in rural/isolated areas reported having a long-standing illness, disability or infirmity[4]; this condition was particular likely to affect these individuals' mobility (46%) and stamina, breathing or level of fatigue (42%).

3.3.1 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 areas[5]. 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 areas[6].

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

[2] Reported by 6.8% of rural residents, 5.8% of those in towns and 5.7% of those in cities.

[3] Long waiting times will prevent some of these individuals from getting treatment altogether.

[4] Long-standing' is broadly defined: it includes any illness that troubled the respondents in the past 6 months and is likely to affect them in the next 6 months.

[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

of health workers in individual regions (European Commission, 2015b). This type of action is discussed in more depth under the "evidence" section below.

3.3.2 Scale of the problem

In 2016, around 27.5% of the EU-28 population lived in rural areas compared to 72.5% of the population who lived in urban and suburban areas (Eurostat, 2017h). 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, in 2015, a higher proportion of people living in rural areas of the EU were at risk of poverty and social exclusion (25.5%) compared to those living in cities (24%) (Eurostat, 2017v). 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 urban residents to report satisfaction with their accommodation 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[7] (as well as Portugal) were more likely to have higher quality of life compared to those people living in rural areas. In contrast, 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, 2015b). 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

[7] Member States that joined after 2004.

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). For this reason, this analysis focuses mainly on the inequities between rural and urban areas.

3.3.3 Health challenges and barriers to service access

3.3.3.1 Trends in the literature

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 in 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 factors[8]. 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 2014[9].

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. These 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).
- 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

[8] 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.

[9] 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.

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 nursey 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.

3.3.3.2 Focus group findings

- ***Working in rural practice***

Much of the focus group discussion was devoted to the unique aspects of rural practice, as well as the challenges that doctors can face in delivering care in rural settings.

The focus group was especially useful in demonstrating differences in the types of workload of rural and urban doctors. Participants agreed that one of unique features of rural general practice – relative to urban care – is the **emphasis on relationships**. Indeed, family doctors are often called upon to act as not only care providers, but also as local economists and counsellors. According to some participants, the role that doctors play in the community can be seen as a key benefit of operating a rural general practice, but it can also pose a big challenge when it comes to recruiting individuals with the right 'skills mix'. New doctors need to be able to 'speak the language' of patients

and empathise with their needs/concerns (with a shared value system). This illustrates one of the core issues in recruiting suitable clinicians in rural areas.

Rural doctors can experience **social and professional isolation** in delivering care, perhaps indicating a need for greater attention to occupational health within rural practice. Relatedly, participants from many countries highlighted the **high workload/caseload of rural GPs** in the face of growing demand. 'Burn out' was considered especially problematic in Greece, Italy, Germany, Latvia and the UK, with participants calling for **greater training** on stress management and external emotional support. According to one participant, "*In one word, exhaustion [is] the key issue in many European countries".* In Ireland and Latvia, limited out-of-hours and **locum cover** is also a big challenge, restricting the level of capacity when GPs go on leave and forcing other doctors to take up their work. Some participants also emphasised **difficulties in making their medical practices financially viable**, due in some cases to a particular capitation scheme in place and challenges in physically taking more patients. These issues may explain to some extent the difficulties in *retaining* healthcare professionals in rural areas (identified as an issue within the literature).

Much of the discussion centred on the challenges in **recruiting the next generatio**n **of clinicians** in rural areas. Potential reasons include a stereotypical view of rural general practice; a **lack of incentives** for individuals to choose rural areas and the **limited mobility** associated with rural practice. One participant cautioned that when young doctors are sent to rural areas without being asked in advance (as happens on some occasions), this can put them off rural practice and result in them leaving as soon as they are able.

Developing the skills of other healthcare workers in GP surgeries (not just doctors) was seen as one potential way to alleviate this issue.

As well as issues in getting right number/quality of clinicians, participants in some areas pointed to **other shortages in the system**, such as a **lack of medical equipment and poor facilities**.

The session did not focus in much detail on vulnerable sub-groups within rural communities, although some participants identified travellers as one such group (e.g. in Ireland). Cultural and psychological barriers can be especially important in stopping these individuals from seeking the care they need.

- ***Organisation of rural health systems***

Confirming the impression from the literature, participants warned of the **challenge of organising emergency and/or out-of-hours services within rural settings**, which can lead GPs to have to take on an 'A&E' role within their surgeries, such as in some rural parts of Slovenia. One participant referred to this as the "*most challenging area in medical care".* It can be very hard for GPs to cover emergency services, as it may mean they need to *"drop"* a patient in their practice to go and tend to someone else experiencing a medical emergency. Another participant described these practical challenges in more detail; in some countries, it can be typical for there to be one emergency team covering a whole county, who may then need to call GPs out to support them. GPs are in a difficult position not only due to needing to leave the patients in their surgery, but also because they can face a long delay (sometimes more than an hour) in waiting for the ambulance, which delays the delivery of care and can endanger patients with serious conditions. The **limited role for preventive care** in some rural areas can fuel additional demand for services at the point of crisis – a point less emphasised within the literature.

Another new point that came out of the focus group was the impact of the crisis on rural healthcare provision. Participants from Greece and Italy warned that in southern European countries, there are currently **contradictory trends**, whereby demand for healthcare in rural areas is increasing, but there is a wider policy focused on reducing healthcare expenditure. In Italy, this was seen as a particular risk to well-functioning

out-of-hours systems in rural areas. In this context, one participant warned, *"We are not going in the right direction to help vulnerable people. It probably will become worse…"*

Some other issues discussed in relation to service provision in rural areas include the following:

- Rural GPs may have infrequent **access to particular forms of specialist care** in urban areas (e.g. once a week) and – even after referrals are organised – some residents in rural communities may not feel comfortable/able to travel to see specialists if it will cost them money and require travel to another city.
- It can be **difficult for rural GPs, district nurses and/or other clinicians to deliver home care, due to the time required and long waiting lists**. For example, some warned that home care in the UK is typically underfunded, due to a failure of government to recognise the time it takes.
- In some areas, there can also be **gaps in social care and outpatient care**. For example, one participant from Poland warned that it is often hard to attract individuals to social care, due to low pay within the sector and a lack of incentives.

Some participants noted moves towards digital service delivery in rural areas. For example, in Poland, there are electronic prescriptions, as well as a broader appetite for mobile technology in service delivery. However, other participants warned of the challenges that older people may face in using these services, and pointed out how significantly the share of older people with computers varies across areas.

One participant highlighted the importance of keeping in mind the various components of the 'chronic care' model[10], as a way of structuring analysis.

- ***Other factors affecting the health needs of rural communities***

Supporting the literature findings, participants considered that **wider social issues,** including **demographic change**, are important in affecting the health needs of rural communities. In many areas, the growing share of elderly people in the population and the outward migration of the young is having a knock-on impact on the patients that rural doctors see, as well as types of care that they require (particularly, appropriate responses to multi-morbidities and co-morbidities). In some areas, rural doctors are primarily serving the elderly population.

Some participants also discussed the impacts of **changing family structures** (e.g. in Poland), with moves away from the extended family in some places and thus fewer people to care for dependents. This places greater pressure on rural GPs.

The **socio-economic situation** and level of **rural development** can also affect the health needs of rural communities. For example, a lack of services in an area can fuel the outward migration of young. Similarly, a lack of public transport can make some patients (especially the elderly) more reliant on others to support/maintain their health. This situation can represent a vicious cycle, whereby gaps in key services (e.g. mental health services) can make some people leave the area and reinforces socio-economic deprivation there. In these cases, providing healthcare then becomes more expensive and time-consuming, as residents are more likely to have more issues.

3.3.4 Evidence of policies being used to support this group

3.3.4.1 Trends in the literature

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

[10]This defines six aspects of a health care system that promotes high-quality chronic disease care. These are: the community, the health system, self-management support, delivery system design, decision support and clinical information systems. See http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18

poverty was highlighted in by the WHO's Commission on Social Determinants of Health in is 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 was in place from 2005 to 2008 and largely funded by the Ministry of Health and Social Affairs. It was 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).

Other methods of improving the delivery of other services – such as mammographic and other screening services – were explored in the focus group and are discussed below.

- ***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).

3.3.4.2 Focus group findings

Focus group participants were in broad agreement with the typography of responses identified in the literature and highlighted in the box below.

Solutions presented at the focus group (based on earlier strands of research)

Reforms to service delivery

- eHealth / technological solutions
- Improved distribution of primary healthcare services (more GPs and family doctors)
- Reforms to emergency services
- Better/integrated transport networks
- Mobile health services

Measures to improve human resource in rural healthcare services

- Policies to recruit, retain and professionally develop staff (e.g. financial incentives)
- Flexible and responsive continued professional development
- Flexible employment opportunities
- Development of practitioners with specialist skills (generic specialist)
- Greater professional support to staff
- Better coverage of rural health in the curricula of medical students (e.g. rural general placements)

Targeted measures to improve access for specific sub-groups

- Sharing costs across population, etc.
- Outreach services for particular groups (e.g. home visits for the elderly and people who are less mobile)

The session confirmed that rural doctors across Europe are adopting creative strategies to cope with the challenges they face and to ensure that they are reaching out effectively to all of the local community. This includes more traditional methods of outreach (such as home visits for the elderly), as well as newer forms of service delivery, such as e-prescriptions and mobile health units for particular groups, such as traveller groups and seasonal workers. More is being done to encourage young doctors to pursue a career in rural general practice, including incentives and rural placements during university medical courses. Some rural doctors' surgeries have also tested screening services run

by outside professionals (such as cervical smears) – as a way of expanding the role of preventive care and making patients feel more comfortable coming forward.

Examples

The need to respond to challenges associated with clinician shortages in rural areas was discussed at length. One participant explained one method that works well in Sweden, whereby a company recruits doctors who are willing to go on rural placements for two to three weeks (locum cover). This, however, requires negotiation with health authorities, as they are the ones who must pay for the service.

Another participant described the situation in Germany, where there is a shortage of young people in rural practice, as well as the challenge of too many specialists delivering primary care. In response, this participant noted two successful projects that focus on providing rural placements for students. Local communities coordinate these, including paying for students' transport fees. The participant argued that this appears to be having some effect and is likely to spread more widely. The only challenge for rural doctors is that it can be hard work to offer the students sufficient time and support (due to other pressures). One participant cited the importance of doctors having professional support, such as that offered by national doctors' associations or the European umbrella body, U-EMO. Building upon this initiative, some argued that the best chance of sustainable change comes from locally driven solutions that can be shown to be successful and rolled out (rather than centrally driven initiatives). To some extent, this can avoid the politicisation of health issues by central authorities.

To improve disease prevention, the health ministry organised cancer-screening tests in rural areas in Latvia in 2009. Due to a low response rate, rural doctors in Latvia responded by introducing cancer screening themselves directly where they live, which led to greater uptake and meant that family doctors' practices were the 'owners'. This arrangement is organised based on an agreement with government (which sets out how doctors should work). One rural practitioner believed that this system generally works well, although the restrictions/rules change often. Some obstacles to its effectiveness are the level of doctors' time taken in getting test results from labs in urban areas and the high cost of prescriptions. As there are no plans for e-prescription or electronic x-ray results, this situation can be very problematic for rural doctors in Latvia, demonstrating the impact that inadequate internet services can have on health care delivery in rural areas. It is worth noting that in some Member States, the practice of mobile cancer screening services is more established, such as in the UK, where mobile breast cancer screening services have in place for some years.

To reduce barriers to accessing certain screening services, a rural practitioner in Latvia now allows external midwives or experienced doctor's assistants to do cervical screening in the surgery twice a year, in order to reduce any stigma/embarrassment on the part of service users (who know the doctor directly). There have also been moves towards integrated care services in some rural parts of Romania.

To support particular groups, some participants discussed the delivery of mobile health services. For example, in Norway and Northern Germany, there are mobile health services dealing for travellers (including seasonal workers and tourists), offering services that otherwise could be difficult for them to access. Likewise, in some rural areas of Latvia, there are plans to introduce mobile mammography services, due to the low level of uptake of ordinary cancer screening programmes (travel, logistical barriers, etc.). However, such services can be dependent on the time and initiative of rural doctors to proceed.

Participants also considered the role of digital services in rural healthcare delivery, such as online guidance and e-prescription. This can be especially helpful for doctors in saving them time. However, this approach needs to be carefully considered, given the limited technical literacy of some of the target group and data sensitivity.

Reflecting on their understanding of quality healthcare in rural settings, participants proposed that doctors need a wide spectrum of knowledge (which arises through experience) and that services must be accessible, with opportunities for disease prevention and screening. To achieve true equity of provision, there needs to be minimal difference in patients' experiences, regardless of whether they are in urban or rural areas. More generally, participants agreed with the idea that health spending should be seen as a long-term societal investment.

3.3.4.3 Relevant case studies

As part of the VulnerABLE project, an inventory of practices was produced, collecting good practices from across the European Union that promote health and access to healthcare for people living in vulnerable and isolated situations.

Four practices seek to improve the health of people living in rural and isolated areas. Two of these (Mallu does the rounds; Mobile healthcare fund) involved mobile health services, which travelled to remote areas to provide access to a range of preventive and curative treatments. As part of the other two practices, health promotion and community engagement activities were carried out, to improve the health status of rural residents.

Table 3. Relevant case studies for this target group

Title	Organisation & country	Main objectives	Web link
«Let's Live Healthily» Part of Project Mura	Murska Sobota Institute of Public Health Slovenia	Project piloted in Slovenia's Pomurje region which is deprived compared to the rest of Slovenia and has a lower life expectancy. The aim is to promote healthy lifestyles among adults in rural communities through health promotion workshops.	http://www.eu2008.si/fr/News_and_Documents/Fact/March/0310_publikacija.pdf
Mallu does the rounds	South Karelia Social and Health Care District (Eksote) Finland	The Mallu bus was designed by the South Karelia Social and Health Care District (Eksote) to be an easy-to-use medical service for people in rural areas; health monitoring services, pharmacy tasks are provided and small operations are carried out. These services are delivered through an integrated mobile facility, a converted mobile caravan.	https://enrd.ec.europa.eu/sites/enrd/files/fi-mallu-does-the-rounds-gp_web.pdf
Mobile healthcare fund	Fundatia de Sprijin Comunitar (Community Support Foundation) Romania	Mobile health programme travels to remote places and provides family planning, social support, health education essential drug supply for emergencies and the very poor, transport for vaccination programmes, and training for health care professionals.	http://www.reliefundforromania.co.uk/trustees_report.html
Building Healthy Communities Programme	Combat Poverty Agency Ireland	This programme brings together several community run projects aiming at tackling health inequalities. Various activities are organised, such as: training modules for community health representatives, creation of peer support networks, and training on community development approaches to health.	http://www.combatpoverty.ie/publications/EvaluationOfTheBuildingHealthyCommunitiesProgramme_2009.pdf

3.4 People with unstable housing situations (the homeless)

Summary of quantitative findings

The findings of the VulnerABLE survey indicate that for people with unstable housing situation; the satisfaction with health services was particularly low for people without stable housing (29% stated they were very or quite dissatisfied).

The relationship between unstable housing and mental health seen in the literature was reflected in the survey. Mental health problems were reported by 39% of those with unstable housing, with 58% reporting feelings of stress as being detrimental for their health. Living in unstable housing and/or being homeless are generally associated with low income and material welfare. As shown in Chapter 2, EU-27 residents with the lowest incomes (fifth quintile) have a significantly higher rate of long-standing illness or health problem than those with the highest incomes (first and second quintiles) (Eurostat, 2017c). They are also more likely to have unmet health needs and the most likely to report having unmet needs due to the cost of healthcare (2016e).

The findings of the VulnerABLE survey show that low income played a greater role for people living in an unstable housing situation (71%). Similarly, high costs were often mentioned among this group as the main reason for not visiting medical practitioners, getting dental examination/treatment or getting medication people with unstable housing (40%).

Furthermore, more respondents living in unstable housing situations found health information difficult to understand than in other groups in the survey, with 27% finding it 'quite' or 'very' difficult.

3.4.1 Overview of policy context

The right to social housing and assistance is included in the EU charter of fundamental rights in Paragraph 3 of Article 34. This article 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 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 European 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).

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 4.

Table 4. 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 change.

3.4.2 Scale of the problem

In the aftermath of the 2008 global economic crisis, housing costs as a share of disposable household income increased and are the greatest expenditure item for most households across Member States. Issues relating to affordable housing, housing exclusion and homelessness 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 overcrowding 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 in 2015 was 16.7%, whilst the highest rates of overcrowding were in Member

States such as Romania (49.7%) and Poland (43.4%), and the lowest rates in the Netherlands (3.3%), Belgium (1.6%) and Cyprus (1.4%) (Eurostat, 2017).

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).

3.4.3 Health challenges

3.4.3.1 Trends in the literature

This section outlines the health challenges experienced by people living in insecure living conditions. There have been few studies assessing the health needs of the homeless population across the EU. 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). 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).

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, skins 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).

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 among this 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 highlighted this as a major concern given the fact that nutrition played a key role in immune function and in the managing of some long-term conditions (Seale et al., 2016).

3.4.3.2 Focus group findings

Participants discussed issues related to definitions and refining the target group. The target-group was considered to be very broad, encompassing people in different situations, having different health needs and facing diverse challenges in healthcare. Participants therefore emphasised the need to adopt a more specific terminology; the term 'homelessness' was considered as more appropriate and suggestions were made that the study uses "homeless people" instead of "people in insecure housing situation". The participants considered that concentrating on 'homeless people' would allow a more focused approach for the discussion.

Participants confirmed the literature review findings on poor physical health. They added that many common health issues related to homelessness are a result of a lack of access to hygiene noting that homeless people have difficulties in accessing basic and urgent facilities such as toilets, and are thus unable to maintain regular hygiene, which in turn can cause additional health issues.

Participants mentioned skin problems; dental problems; and other issues that are often related to lack of access to hygiene and to homeless people's lifestyle. Some findings from a study carried out in France on this group were mentioned. The study identified mental health issues; infectious diseases (including HIV; tuberculosis; malaria); substance abuse; and respiratory diseases as the most frequent forms of health problems. Participants also confirmed the literature findings of addiction and drug use as major issues among the homeless population. According to participants, physical, mental health and addiction typically accompany each other.

With regards to the survey findings, participants noted that asking vulnerable people for a subjective assessment of their health situation can be an issue in itself and they recommended that efforts be made to gather more objective data on the health situation of those groups. Participants went on discussing specific responses rates to some of the survey questions. According to the participants, there is a lot of literature on health issues of homeless people that could be useful to understand why such high proportion of homeless people (33%), when asked about their health issues, responded to the "Other" category. During the discussion, it was noted that the poor health situation of homeless people is often determined by a combination of issues rather than by a single health problem.

Participants showed interest in knowing more about the survey methodology, and especially about how the interviews were conducted. They highlighted that asking about health can touch upon sensitive issues, and that interviews need to be carefully conducted. Overall, participants considered that assessing the health needs of homeless people through a survey was problematic, as the survey questionnaire does not enable a complete picture of those needs to be gathered. For instance, one participant mentioned existing research that would have shown the over representation of people with brain trauma among homeless people. However, this fact is not likely to emerge from the questionnaire.

Moreover, participants also considered that results from the survey would be influenced by the different health literacy levels among homeless people. It was noted during the discussion that sometimes, homeless people have health problems they are not even aware of. For instance, in general, detection of cancer among homeless population happens at a later stage than for the general population. As a result, homeless people are much more likely to die of cancer than the general population.

One participant suggested to look at an 'objective' indicator to measure good health: the indicator on life expectancy. Participants noted that it is sometimes difficult to get this information but overall, it is estimated that homeless people's life expectancy is below 50 and is even lower for homeless women, partly due to constant exposure to violence. Those data were considered as potential indicators to assess health needs of homeless people, as well as revealing the failure of the healthcare system.

Other important health issues among homeless people were mentioned during the discussion, including suicide or rapid aging. Symptoms that go with aging often go undetected. Participants also noted that maintaining social networks is important for the health of these individuals, and shelters do not facilitate social relations. Couples have specific issues too. They often face difficulty in finding shelters (which are often reserved either to single persons or families) and do not have privacy to have intimate relations. During the discussion, participants also emphasised the specific health issues faced by homeless women which should be taken into account.

3.4.4 Access to healthcare

3.4.4.1 Trends in the literature

This section describes 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 been 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).

3.4.4.2 Focus group findings

The focus group confirmed the issues raised in the literature review in terms of access to healthcare for this group such as bureaucratic difficulties, inability to pay for treatment and stigma. Participants also raised some further issues such as lack of follow up to treatment, and, accesses to end of life care.

Participants noted that when in need of treatment, people belonging to the large group of 'homeless people' (roofless/instable housing situation) experience difficulties to follow the whole treatment programme of until the end of their illness (for instance in case of tuberculosis). Often, homeless people start medications and then have to stop because they are back on the street. There is a need to put people in stable situation so that they can follow a full course of treatment (for instance by providing them with secure accommodation).

Homeless people often experience specific issues in accessing end of life care/palliative care provided in mainstream services. Shelters are often not equipped to provide those types of care and their staff are not trained to respond to the specific needs that homeless people present. Participants noted that when homeless people die in a shelter, this also has consequences for the mental health of the other homeless persons surrounding them, which are often overlooked.

The administrative system surrounding shelters is often poorly adapted to the needs of homeless people. For instance, a participant mentioned the issue of homeless people with drug addiction problems in Greece. Those people cannot access detox centres because they do not have an address, and they do not have a place in shelter because they are have drug addiction problems.

When speaking about homeless people, participants recommend distinguishing between different subgroups of people: those who are entitled to access healthcare services, and those who are not (e.g. irregular migrants). For instance, migrants who are homeless have only access to two shelters in Brussels. One participant mentioned FARES, the Brussels-based association working on respiratory health issues such as tuberculosis. 95% of people who are supported by the association are migrants. The association provides funding to homeless shelters so that migrants with respiratory issues can stay in a stable location for the duration of their treatment. Some homeless people need a solution that is sometimes incompatible with their legal situation. With migrants often there are also issues with languages.

With regards to issues related to prevention of diseases and poor health, upfront payment for primary healthcare was identified as an important barrier for homeless people, therefore making sure that homeless people have access to public health insurance was noted as an important. When sick or in need of treatment, homeless people often go to the emergency services because services are free of charge. However, focus group participants noted that to access those services, people are now increasingly asked to show their insurance card first. So even when healthcare is free, there are procedures that can act to hinder homeless people's access.

Confirming the findings of the literature review participants noted that this may be partly due to the fact that in some cases doctors are reluctant to provide care to homeless people. Participants explained that attitudes toward homeless people can impact their access to healthcare. They noted that the stigma often becomes a self-stigma, explaining why homeless people do not try to access to healthcare. Moreover, in some Member States, homelessness is criminalised, which does not foster homeless people's access to healthcare.

With regards to the survey results showing difficulty to get access to doctors, a participant mentioned the findings from previous research that had asked doctors who cared for homeless people about what would be required to more effectively treat such patients. Responses from the doctors included having access to training on homeless people's issues and needs; and developing stronger connections between social and medical services. The lack of connection between social and medical services was found to be a particularly issue when some participants mentioned that there were 600,000 beds in homeless shelter throughout Europe, and that it was known that most of the people sleeping in those shelters were sick. However, as there is no link with medical services, these people do not receive adequate treatment.

Participants insisted on the fact that the causes of homelessness should not be individualised but they should be attributed to the failed structures in the Member States, including lack of quality jobs; lack of affordable housings; increasing prices of housing; exclusion from social housing because too many people are on the waiting list. A participant reminded us that in Brussels, 30,000 people are waiting for a social housing. People spend on average 10 years on the waiting list. Thus, according to some participants, it would be important to look at the broader causes, to understand how social policies might have an impact on homelessness in different countries and how the economic system contributes to putting people in homeless situations.

It was also considered important to realise that there are other 'competing priorities' for homeless people, and health is often the last priority in their life.

3.4.5 Evidence of policies being used to support this group

3.4.5.1 Trends in the literature

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.

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).

Housing First

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 looked at how effective Housing First policies were in promoting health. It found that Housing Frist 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 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 Sleed et al. (2011) evaluated a pilot project 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.

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 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 Find & Treat 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 or 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 may involve tackling 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. 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 training 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 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.

3.4.5.2 Focus group findings

The participants made several suggestions to improve the health and access to healthcare of people in unsecure situation, including:

- Improve understanding of homelessness and of the causes of homelessness:
- People in contact with homeless people should be better trained to understand their needs;
- The causes of homelessness should be better addressed by public policies;
- Address barriers to access healthcare:
- Improve access to healthcare services and recovery services for this target group;
- Better integration of mental health in the programmes implemented to provide healthcare to homeless people;
- Provide integrated services and improve the coordination between social and healthcare services to homeless people.

In general, participants were cautious in not singling out a specific practice as a good one, as the effectiveness might be strongly linked to the context it was implemented in. Thus, they recommended not to single out random measures that can be working in one setting and not in another. For instance, they mentioned the Danish experiment 'Freak housing for freak people' that had shown positive results in Denmark for a small group of people. When the same experiment was implemented in Romania, it was not successful. Similarly, the importance of sport programmes involving people in unsecure housing location should not be over-emphasised. Participants did not consider it as a valuable practice that should be replicated, as the impact of such measure is hardly evaluable. Likewise, harm reduction as an approach was considered as something bringing positive results, but participants did not have specific examples to present. The practice aiming towards 'harm reduction' was considered as having a positive impact, but its implementation had to be adapted to the context.

In response to mobile operations discussed in the literature, initiatives that have developed mobile hospitals to reach out people in unsecure housing situations were found interesting, but participants wanted to highlight that those are just the first step and that outreach should not stop there. Mobile hospitals are useful to make detections, but after that, there is a need to put people into the existing social network and healthcare system. What is needed in this respect is to educate mainstream services to understand the needs of homeless people and to understand the social mechanisms of homelessness. It was recommended not to advocate for a parallel healthcare system, but to promote measures aiming to make the mainstream healthcare system more available to respond to homeless people's needs and issues.

Participants discussed the potential impact of 'Housing First' programmes on homeless people, as was reflected in the literature, this is an approach with a high profile currently. They agreed that although having a stable house is an instrument of integration, the health impact should not be overestimated. 'Housing first' does not always objectively improve health issues ('housing first' programmes have been implemented only recently and it is also too early to make any statement). However, such programmes seem to have an impact on increasing people's feeling of security, and thus on people's subjective health. Nevertheless, participants stressed that access to housing cannot replace health interventions.

Some participants also mentioned issues with regards to the implementation of 'housing first' programmes, such as the increase cost of medical services (especially for homeless women) linked to stable housing, as people then enter into the mainstream healthcare system; or the fact that in some programmes, housing was allocated on a 'good attitude' basis. Participants noted that in general, stable housing increases the cost of life in general, so some homeless people prefer to stay in shelters.

One-stop shops were mentioned. Participants considered that those are needed to connect health services with social and housing services, but their implementation is complex. Important characteristics when developing healthcare services for homeless people should be multidisciplinary and low access. This echoes the findings of the literature which point to low threshold multidisciplinary interventions such as Find & Treat as effective interventions for this target group.

Social services in hospital can establish contact with social services outside, but it is important that medical information be distributed. This is problematic when it is confidential and can only be shared between doctors.

The importance of education and training was highlighted several times, including understanding the key transitions, periods, risks, issues, needs, etc. and the importance to understand the role of the healthcare professionals. Developing health knowledge centre was also considered as helpful. Participants recommended making access lower and training professionals to be able to treat and care for homeless people. Indeed, people working with homeless people should receive proper training to respond to their specific issues and needs. Additionally is was recommended to develop and provide integrated services: for example, health workers could work with housing associations, to build a strategy to find solutions to provide homeless people with housing solutions when they leave the hospital.

Some participants discussed the development of intermediate places for accommodation where homeless people can stay to recover when they leave the hospital and are too sick to go back to the shelter. Such places have been developed in France. Homeless people can stay in those settings after leaving the hospital and receive care. Some national housing federations have also built care centres associated to hospitals which provide mental health services.

Following on from this point, some participants also suggested that one of the recommendations should focus on making it impossible for hospital to discharge people if they do not have an address (as it would already be the case in the UK). Other participants noted that such a measure could have an adverse effect, and that hospitals might decline treating homeless people even more. There was a disagreement about the potential of such measure, some seeing it as a risk, others as a potential to change practices.

Participants emphasised the need to enforce the right to housing in all EU Member States (for now, most Member States have signed but not enforced this right). One of the arguments in favour of 'Housing first' could be that it is cheaper than having people in the street (and specific public services including health, police, justice, etc. have to be provided). Savings can be made on the health sector and could be reinvested in the housing system.

Participants noted that homelessness often falls out of the policy agenda on health. DG SANTE has the potential to take some important policies on improving homeless people's health. Promoting investment in measures to prevent homelessness was highly recommended. Preventive measures were considered as key, as emergency services do not solve the issues of homelessness. Preventive measures could include providing counselling services, controlling the rent prices, controlling of the territorial distribution of housing (e.g. which parts will be given to housing, with which consequences on the prices, speculation, etc.).

Food is an important issue, and there should be some work to increase the quality of food distributed in shelters. However, participants agreed that food is not enough to have a good health. Participants also considered it as an issue when food banks might become part of the social care system.

Participants also discussed the facilities and emergency accommodations such as shelters and agreed that often, those are badly designed and poorly maintained. Shelters should be made safer, with individual rooms that can be locked for instance. Several participants noted that homeless people (especially women) are often afraid to go to such places. Women should not be at risk of sexual harassment. The physical space should be made more welcoming. Some initiatives have also been taken to enable homeless people to meet their basic hygiene needs, such as in Paris, where some restaurants now allow homeless people to use their toilets to clean themselves, or in Budapest where the initiative 'City for everybody' was recently implemented. The initiative aimed at building more public toilets and to encourage homeless people to use those facilities. Homeless people are afraid to go to the public toilet because they cannot take their things with them, and criminalised when they do their necessity in the street. So such initiatives are considered as interesting practices.

Psychological and emotional environments are important and should be taken into account when developing solutions. Participants considered valuable some initiatives aiming at strengthening social networks around people (using peers; social services; medical services; etc.). One participant mentioned that when homeless people have pets, they do not wish to be separated from them. This is an issue when they need to receive treatment at the hospital, or sleep into a shelter that does not admit pets. To respect homeless people's decision to keep their pets with them, some cities have developed different initiatives. There are now some shelters where pets are accepted, or some vets volunteering to take care of the pets when a person in an unsecure housing situation has to go to the hospital.

Some participants suggested to increase evidence-based research on the issue of homelessness and to share this knowledge between experts. There is already a lot of evidence on homelessness available, which should be collated and systematically disseminated. Furthermore, there should be more evaluation of the programmes that have been implemented. Policy solutions should focus on how to prevent people from getting into the street and on how we can develop programmes to help homeless people to stay out of the street. It was noted that in some countries, regional and local health authorities are obliged to develop a homelessness strategy. According to some of the participants, this could be a good practice to replicate. In Scotland for instance, public health authorities have developed a programme for homeless people and it was considered as being very effective.

Promoting coordination between patients, medical services and social services was considered as highly effective. Involving the patient in the strategy, so that people can understand what is happening, what are the solutions, etc. was a practice promoted by all participants. This coordination should also involve sharing of information on the patients between services.

3.4.5.3 Relevant case studies

As part of the VulnerABLE project, an inventory of practices was produced, collecting good practices from across the European Union that promote health and access to healthcare for people living in vulnerable and isolated situations.

There are four case studies that showcase methods of improving the health of people with unstable housing conditions (the homeless). Two practices (Find and Treat; DCRs) deliver healthcare services to the homeless, although the latter (DCRs) offers a less conventional form of treatment, as it gives the homeless a safe space in which to take drugs and supports them to enter rehabilitation programmes. The other two practices (Ombolt; Housing first) aim to tackle the causes of poor health among the homeless.

One (Housing first) provides the homeless with unconditional access to permanent housing, which is seen as a prerequisite for improving their health. The other practice (Ombolt) enables the homeless to participate in a football league and be part of a supportive community – with many positive impacts for their health.

Table 5. Relevant case studies for this target group

Title	Organisation & country	Main objectives	Web link
Drug consumption rooms (DCRs)	Municipalities Denmark	Drug consumption rooms (DCRs) are dedicated centres where homeless people can take drugs, under the supervision of a nurse. The aim is to reduce the high number of drug-related deaths and incidents created by unsafe and public intake, and to improve access to healthcare and treatment for vulnerable users	www.emcdda.europa.eu/themes/harm-reduction/consumption-rooms
Find & Treat, London	University College London Hospital (UCLH) UK	In London a mobile health unit has been funded which travels across the London boroughs and screens homeless people for TB.	https://www.uclh.nhs.uk/ourservices/servicea-z/htd/pages/mxu.aspx
Housing First	Local NGOs, European Federation of National Organisations working with the Homeless (FEANTSA) Transnational	Housing First is a practice model to support homeless people in particularly difficult situations (people with mental illnesses, with problematic drug and alcohol abuse, with high support needs; people experiencing long term or repeated homelessness). The project provides access to permanent housing without any preconditions.	http://feantsaresearch.org/IMG/pdf/improving_health_and_social_integration_through_housing_first_a_review.pdf
Ombolt Homeless Football League	Ombold Denmark	A football league for homeless youth, to encourage physical activity, sports and integration.	http://ombold.dk/wp-content/uploads/2015/12/OMBOLDs-%C3%A5rsrapport-2015-Web.pdf

3.5 The long-term unemployed and the inactive

Summary of quantitative findings

Chapter 2 shows that unmet health needs of unemployed people are consistently higher than unmet needs of employed people. Eurostat data show that between 2008 and 2014 the prevalence of unmet needs for unemployed people has been 4-5% points higher than for employed individuals (Eurostat (2017e).

VulnerABLE survey findings show that unemployed people were more likely to report bad health than the average respondent (31% vs. 28%) and 66% of respondents within this group reported that lack of money had an impact on their health.

With regard to access to healthcare access, 27% of survey respondents from this group reported having difficulties in accessing healthcare, 31% were neutral, 33% found quite easy to access to healthcare and 9% very easy.

3.5.1 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.

3.5.2 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. 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 4.0% of the labour force was classed as long-term unemployed in 2016. Levels of long-term unemployment were fairly equal between men and women at 4.0% and 3.9% respectively (Eurostat, 2017j).

Similarly, people who are classed as inactive[11] on 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 27.1% across the EU-28 in 2016. (Eurostat, 207k).

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, 2017k). 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

[11] 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.

health), as well as distance from the labour market caused by, for example, familial responsibilities (Lotters et al., 2012).

3.5.3 Health challenges

3.5.3.1 Trends in the literature

The results of the literature show that 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 various groups in 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).

3.5.3.2 Focus group findings

A Focus Group was organised on long-term unemployed, inactive and in-work poor and focused on the example of Greece. The results of the meeting confirmed the substantive issues identified in the literature review.

The Focus Group experts stated that poverty and poor health are inextricably linked. The causes of poor health are rooted in political, social and economic injustices/inequalities and poverty can be understood as both a cause and a consequence of poor health. Poverty increases the chances of poor health and poor health in turn traps people in poverty.

The majority of the participants noted that dramatic changes were made to the Greek healthcare system in accordance with austerity measures. Austerity measures also resulted in citizens being forced to contribute more towards the cost of their medications. Furthermore, during the Greek economic crisis, public hospitals had to slash budgets up to 50% and, as a result, basic supplies had long been in low supply, and the numbers of doctors and nurses were critically low. Especially at the beginning of the economic crisis, rising poverty and unemployment left a large percentage of the population without public healthcare coverage.

The effect of the recession and further job cuts has impacted significantly on the health of those remaining in employment by creating more stressful and insecure work environments, linked to bad health conditions, especially for those into low-paid and insecure jobs. The health experts claimed that the bad economic status of Greece, as well as the relevant changes that occurred during the last decade, are clearly reflected in health indicators. Moreover, they stated that during this period there was an outbreak of diseases associated with poor living conditions (e.g. diabetes).

However, participants emphasized the progress that has been made since the implementation of the introduction of the Law 4368/2016. In particular, they stated that this law, voted by the Greek Parliament in February 2016, offered the right to healthcare services access for 2.5 million Greeks, not covered by any social security scheme. The new Law foresees health coverage for vulnerable social groups, including refugees and undocumented immigrants, ensuring that all will be equally treated. Moreover, the Law introduces incentives for medical personnel and doctors to seek recruitment in areas that are under-populated and distant from urban centres, facilitating the process with the creation of Recruitment Councils that bypass bureaucracy. All participants agreed that the new Law is a progressive and necessary legal tool that supports crucial social needs, but they underlined that this extension of healthcare access to all, came without any budget increase.

The participants also noted that long-term unemployment, economic inactivity and in-work poverty have been linked with worse mental health, increased morbidity and mortality and that the link between risk factors is unclear, as they are interrelated and may in turn also influence these situations. For example, the effect of unemployment etc. may be mediated or increased by a range of individual and societal factors, such as age, sex, socio-economic status, ethnicity, minority status, duration of unemployment, the level of social cohesion in Greek society, social protection and the Greek welfare system and limited labour market opportunities.

3.5.4 Access to healthcare

3.5.4.1 Trends in the literature

The literature review results show that people experiencing long-term unemployment and economic inactivity are likely to experience barriers in accessing healthcare in relation to cost, particularly within Member States where access 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).

3.5.4.2 Focus group findings

Concerning the barriers to healthcare, the health experts from the Focus Group mentioned that for instance, although the new Law 4368/2016 in Greece offers free access to healthcare services for all people, poverty still remains a major cause of ill health and a barrier to accessing health care when needed. Firstly, the huge number of vulnerable people in need of public health services impacts on the quality of healthcare. Secondly, persons that belong to socially vulnerable groups cannot afford to purchase goods or services needed for good health, including sufficient quantities of quality food and health care. Thirdly, the percentage of the cost that patients have to pay in purchasing pharmaceuticals is another problem itself, as poor people cannot afford it. In Greece, this problem is enhanced by the unwillingness of health professionals (e.g. doctors and pharmacists) to accept and provide generic drugs, and to communicate to patients that generics are equal to the branded drugs, which in some cases are very expensive. As a participant mentioned, this is the main reason why Greece has one the highest per capita consumption of pharmaceuticals in Europe, counted in monetary value.

Another barrier linked to poor health, identified by the focus group, is the reduction of screening for diseases such as breast and prostate cancers, as well as the limited use of primary health care that force patients to present for treatment at late stages when serious conditions have already taken hold. Moreover, especially for people that live in isolated areas (rural areas and islands) the high transportation costs in order to receive health services or reach a health centre, because of the lack of relevant health structures, constitutes an added problem.

Last but not least, the participants mentioned that there is a significant lack of information concerning the advantages of the new Law and the provision of free health care access for persons not covered by any social security scheme. Barriers that poor people face relate to factors such as the lack of information on appropriate health-promoting practices or the lack of voice needed to make social services work for them.

Participants also pointed out specific needs or health issues for the project's target-groups that are strongly connected to the above barriers and the life conditions they experience. Marginalized groups and vulnerable individuals lack the information, money or access to health services that would help them prevent and treat disease. For example, the need of unemployed, inactive and poor people for psychological support and counselling services for stress management, as well as for healthy lifestyle and habits (e.g. diet, exercise, reduced alcohol consumption, etc.). According to the Focus Group participants, the health needs of these people vary: they may have mental health problems, and/or they may need dental care, eye care, etc. Many health problems are undetected until they become severe. For example, mental health problems such as anxiety, stress and depression frequently go undiagnosed, because health professionals focus primarily on other diseases.

3.5.5 Evidence of policies being used to support this group

3.5.5.1 Trends in the literature

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 state systems 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 the programme has led to an increase in fresh food consumption (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 an improvement in 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.

3.5.5.2 Focus group findings

The findings from the Focus Group focus on the Greek system example and the key actions and proposals to be put in place. The results on the reorganisation of the health systems and improved access to health services are in line with the survey findings.

The Focus Group participants agreed that the main key organisations that need to be involved in policy solutions are: a) the Ministry of Health, b) the Ministry of Employment, Social Security and Social Solidarity, c) the Municipalities - as governmental bodies closest to citizens and their everyday life requirements- and d) NGOs. The role of these organisations is important, in order to design and implement a variety of programmes for the reduction of inequalities in health outcomes and the enhancement of financial/social protection of the target-groups.

Moreover, Universities and other academic/research bodies can contribute significantly by offering scientific data to policy makers, as well as by sensitizing the population on primary health prevention and health issues in general. The participants stressed out that effective policy-making should involve mechanisms that help these target-groups to overcome geographic, social and psychological barriers to accessing health care and reducing cost of treatment. More specifically, the participants referred the following key actions and proposals to be carried out by the Greek authorities and key actors:

- Measures and actions to combat unemployment;

- The economic and political structures that sustain poverty and discrimination need to be transformed in order for poverty and poor health to be tackled. Tackling the structural causes of poverty and poor health, for example calling for measures to tackle inequality and injustices such as tax evasion, are central to what is needed from the Greek state. In the same context, detailed Protocols should be developed in order to engage all involved professionals to follow the most effective ways for support social vulnerable groups (e.g. prescription of low-cost medication/generics);

- Emphasis must be placed on tackling stereotypical attitudes regarding the use of health services, as the majority of the Greek population tend to seek services and support from higher-level health structures and do not "trust"/utilize primary health care services. In the same context, it is important to develop policies in order to reduce total consumption of health care, e.g. by limiting "irrational drug prescribing", strengthening the referral system, or improving the quality of providers (especially at the lower level);

- Implementation of measures to prevent, detect and manage health problems among the target-groups, by primary health care/ awareness-raising of general practitioners in order to manage and support the health needs of these people;

- Reducing inequalities in determinants of health status or health care utilization, such as reducing distance (through providing services closer to the poor), subsidizing travel costs, targeted health promotion etc;

- Development of nation-wide campaign in order to inform all Greek citizens about their health rights and the provisions of the new legislation (free access to health care for all). The campaign has to take into consideration the difficulties of social vulnerable groups in accessing information (development of mobile health units etc.);

- Promotion and implementation of education and programs on health issues;

- Finally, some participants from municipal organizations noted the important and positive role of the Municipal Clinics as they provide free of charge services to a large amount of social vulnerable population. Moreover, they presented initiatives that Ministries have designed and that are soon to be implemented by the Greek Municipalities (in 2017), such as:

  a) The creation of Municipal Community Centres that will approach holistically the health and social needs of residents, and

  b) Creation of Local Health Units that will provide decentralized services of primary health care (small clinics in neighbourhoods), staffed by general doctors and paediatricians that will work as family doctors, as well as nurses and other health professionals.

Finally, the participants recognized the role of NGOs' Social Clinics and Pharmacies that have contributed to the support of social vulnerable groups' heath needs. They also noted the need for networking and collaboration between all health service providers – governmental, non-governmental and private.

3.5.5.3 Relevant case studies

As part of the VulnerABLE project, an inventory of practices was produced, collecting good practices from across the European Union that promote health and access to healthcare for people living in vulnerable and isolated situations.

Two case studies highlight approaches that target the long-term unemployed and/or inactive. Both practices focus on addressing inequalities in health status, rather than offering direct access to healthcare services. The first practice (Sortir de soi sortir de chez soi) relates to both health and employment, aiming primarily to train and support unemployed women to re-enter the workforce. Part of the training programme includes a health module, meaning that there is a specific health aspect, as well as a focus on improving the participants' self-esteem and employment outcomes.

The second practice (Action nutritionnelle) subsidises fruit and vegetables in particular shops, to make it more affordable for those on low incomes to lead a healthy lifestyle. Unemployed people are also able to do short work placements in the shops. Whilst the practice is not targeted solely at the unemployed or inactive, these groups can benefit from its activities and, in so doing, improve their health.

Table 6. Relevant case studies for this target group

Title	Organisation & country	Main objectives	Web link
Action nutritionnelle dans une épicerie solidaire	A.N.D.E.S. Association Nationale de Développement des Epiceries Solidaires France	Project aimed at setting up shops for vulnerable groups to access fresh fruit and vegetables to improve eating habits. At the same time, such groups were employed by the project, which aimed at integrating them into the job market.	http://www.epiceries-solidaires.org/retour_des_rencontres_nationales_2009.shtml
Sortir de soi sortir de chez soi	Office for Equal Opportunities (Cellule Egalité des Chances) of the Brabant Wallon Province Belgium	This project implemented a 3-month programme for unemployed women to prepare them to re-enter the workforce. For instance, sessions were organised to inform the participants about the local labour market, and training and employment opportunities; or sessions providing an overview of the services offered by relevant public actors in the area of integration and employment.	http://www.clps-bw.be/sante-et-bien-etre-des-familles/decrire-une-experience?experiencePk=131

3.6 The 'in-work poor'

Summary of quantitative findings

The survey results show that the health situation of this group was good or very good in 36% of cases, fair in 47%, bad in 15% and very bad in 2% of cases. 47% of respondents within this group reported long standing illnesses, disabilities of infirmity.

With regard to the areas affected by long-standing illnesses, disabilities or infirmity the respondents most common answers were: stamina, breathing or fatigue (37%), mobility (31%) and vision (25%). Regarding the factors affecting the health of the in-work poor, the response was lack of money in 72%, followed by stress (56%), work/lack of work (37%) and lack of exercise (34%).

The results of the survey also show that access to healthcare was considered by the respondents within this this group as: quite or very difficult (27%), quite or very easy (36%), neutral (36%). The main issues encountered when trying to access healthcare were: lack of affordability (32%), too long waiting times (24%), inability to take time off work (21%), inability to get an appointment (20%).

3.6.1 Overview of policy context

From a policy perspective, the EU has sought to take action on the issue of in-work poverty by including as one of its goals for the European Employment Strategy, the aim to reduce the number of working poor and adding developing an indictor 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 detailed consideration on the links between in-work poverty and health (Frazer and Marlier, 2010).

3.6.2 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 2015 (Eurostat, 2017l). A breakdown of this data shows that:

- People in part-time employment 15.3%are at a higher risk of poverty compared to people in full-time employment 7.75 (Eurostat, 2017m);
- People in temporary employment (including zero hour contracts) (15.6%) are at higher risk of poverty compared to people in permanent employment (5.7%) (Eurostat, 2017n); 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) identified three main drivers of in-work poverty. These are outlined in Table 7 below.

Table 7. Drivers of in-work poverty

Drivers of in-work poverty	Scale of problem across EU
Low-pay	Most recent data on low-paid[12] employees across the EU-28 shows that 117.2% of people in employment were in low-paid jobs in 2014. The highest proportion of employees in low-paid work were in some Eastern European Member States – around every one in four employee (i.e. Lithuania, Latvia and Poland), whilst Member States such as Sweden, Belgium and Finland, had the lowest proportions of employees in low-paid work (Eurostat, 2017r).
Households relying on a single earner	Most recent data shows that among households without dependent children, 13.2% of people living alone were likely to be at risk of poverty, compared to 8% of households with two or more adults. Similarly, 19.9% of single person households with dependent children were at risk of (monetary) poverty compared to two parent households (11.2% with on dependent child) (Eurostat, 2017o).
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 38.2% of the population aged 0-59 in the EU-28 lived in households with very low work intensity in 2015. Member States such as Slovenia (65.4%) and Lithuania (63.8%) had the highest proportion of households with low work intensity, compared to Member States such as Denmark (14.2%) and Finland (17.8%) (Eurostat, 2017p).

3.6.3 Health challenges

3.6.3.1 Trends in the literature

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).

Literature on employment circumstances linked to the in-work poor indicate that this group is likely to have specific health needs. Low-paid jobs are often associated with stress, due to high psychological demands (Karlasson, 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

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

[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.

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).

3.6.3.2 Focus group findings

A common Focus Group was held for the long-term unemployed, the inactive and the in-work poor. Please refer back to section 3.5.3.2 for the findings on the health challenges faces by the in-work poor.

3.6.4 Access to healthcare

3.6.4.1 Trends in the literature

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).

3.6.4.2 Focus group findings

A common Focus Group was held for the long-term unemployed, the inactive and the in-work poor. Please refer back to section 3.5.4.2 for the findings regarding access to healthcare.

3.6.5 Evidence of policies being used to support this group

3.6.5.1 Trends in the literature

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 14.2% to 15.6% (of all those in employment) in 2015 (Eurostat, 2017n). Likewise, there has been an increase in involuntary temporary employment (7.2%in 2008 to 7.8% in 2016) and part time work (17.5% in 2008 to 19.5% in 2016) (Eurostat, 2017s; Eurostat, 2017t).

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.

3.6.5.2 Focus group findings

A common Focus Group was held for the long-term unemployed, the inactive and the in-work poor. Please refer back to section 3.5.5.2 for the findings on policy evidence.

3.6.5.3 Relevant case studies

As part of the VulnerABLE project, an inventory of practices was produced, collecting good practices from across the European Union that promote health and access to healthcare for people living in vulnerable and isolated situations.

There are two practices in the inventory that target the in-work poor. The first of these (Open.med Munich) aims to increase direct access to healthcare services for the in-work poor, by offering medical treatment to those without medical insurance. The second (Empregosaudavel) is different in that it takes a research-based approach to promoting

good mental health among temporary and unemployed workers, by developing indicators and good practices.

Table 8. Relevant case studies for this target group

Title	Organisation & country	Main objectives	Web link
Open.med Munich	Ärzte der Welt (Doctors of the World) Germany	Offers medical treatment to people without medical insurance, with the aim of improving the health of all individuals residing in Germany, including those without legal residence status.	http://www.aerztederwelt.org/projekte/projekt-details/article/bestnoten-fuer-openmed.html
Empregosaudavel	Faculty of Medicine of the University of Lisbon (FMUL) Portugal	This initiative set up a mental health network to promote good mental health among unemployed and temporary workers, by: organising capacity building activities for healthcare and social care professionals; carrying out interventions aiming at reducing health social and economic inequalities; fostering and facilitating cooperation initiatives between the different interest groups.	http://empregosaudavel.org/en/goals/

3.7 Prisoners

Summary of quantitative findings

Prisoners and ex-prisoners were the group of VulnerABLE survey respondents most likely to say that their health was affected by smoking (55%), and more likely than average to state that alcohol (28%) and drugs (16%) affected their health (overall averages for smoking, alcohol and drugs: 26%, 11%, 5%). However, prisoners/ex-prisoners were the group who reported the highest levels of good health. 42% rated their health as 'good' or 'very good', compared to 31% of the overall survey respondents.

Prisoners/ex-prisoners were the group most likely to state they had not accessed healthcare services within the past year. 13% had not done so, compared to a survey average of 7%. Prisoners/ex-prisoners were also the group most dissatisfied with the healthcare services they received. Of prisoners who had accessed healthcare in the past 12 months 39% were dissatisfied with its quality, compared to 24% of all respondents. This was most frequently due to the length of waiting times.

3.7.1 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 1995 , 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, delivery of prison healthcare is the responsibility of the Member State health ministries. In contrast, in Portugal and Poland healthcare services are the responsibility of prison administration institutions (Maculan et al., 2013).

3.7.2 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 585,000 prisoners in the EU-28 in 2015, falling 6% from 2008 (Eurostat, 2017q). 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).

3.7.3 Health challenges

3.7.3.1 Trends in the literature

Vulnerable groups – also referred to as 'underserved' groups – are overrepresented amongst those 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. People who end up in prison also generally have a lower level of educational attainment and have experienced higher levels of unemployment than the overall population (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 Addition, 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:

- Greater risk of infectious diseases;
- Greater risk of physical trauma;
- Greater risk of substance abusive behaviour;
- Greater risk of chronic disease; 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; and
- Older prisoners.

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

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.

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 Wale 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 significant distance 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 disorders 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).

3.7.3.2 Focus group findings

The prison health continuum

An individual's life before, during and after prison combine to affect their overall health and wellbeing. Their health is affected by each of these transitions and experiences. Participants stressed repeatedly that those who go to prison generally come from a lower socioeconomic background where they are already subject to health inequalities. For example, the proportion of migrants or those who have experienced homelessness is higher in the prison population than in the general population. Furthermore, people who are in prison are much more likely to be coping with an addiction to drugs or alcohol and mental health issues.

For the vast majority of people in prison, their time there is finite and they will then return to society. Participants explained that, for this reason, an individual's time in prison actually represents an opportunity for health services to engage with people who have had limited access to health interventions previously, potentially delivering the best standard of care that they have ever received.

The move to and from prison were flagged by participants as key touchpoints where health care outcomes can be affected. If an individual's health and care in prison is not joined up with their health and care in the community, their health is likely to suffer due to a lack of continuity and the opportunities afforded by potentially greater access to healthcare whilst in prison can be lost. Participants commented that the period of time that individuals spend in prison systems is often too short to treat fully some health problems and that many health problems are chronic, requiring consistent care once the individual has left the prison system. In some cases, the prison environment can also exacerbate or create health conditions, therefore leaving individuals in worse health than when they arrived, creating further issues for them as they leave the prison system and enter the community.

Before prison

To participants, one of the most important ways to improve people's healthcare was to keep them out of the prison system entirely – described by one participant as a "*legitimate public health outcome*". This involves wider justice policy considerations, such as the growth of open prisons, shorter sentencing and community sentencing.

Participants called for increased use of community sentencing for those for whom a health problem such as poor mental health or substance addiction was at the root cause of their criminal behaviour. In these cases participants stressed that the appropriate outcome would be drug rehabilitation or mental health support but that, in many cases, the community care available is not sufficient and judges may decide to sentence the individual to time in prison because this will be the place where they may receive the best care. Similarly, participants noted that the prison population often contains induvial who should be in secure psychiatric care but that there is often not enough provision for this to meet demand. Finding routes to rehabilitation that avoid prison and ensuring that prison is only used in appropriate circumstances are then the first step in improving the healthcare of people in prison.

Entering prison

Participants agreed that within the prison system all health issues are overrepresented. Participants attributed a large part of overall poorer health in prisons to the wider social determinants of health that people experience outside prison such an unemployment, indebtedness, and insecure housing. Furthermore, participants observed that often the care system outside of prison and within prison are not connected, meaning that patient's records are not transferred between the two settings. This situation makes it vital that systematic health screening is in place for individuals arriving to prison (as explored in the 'Solutions' section below).

Within prison

Participants acknowledged that those in prison can be more susceptible than the general public to virtually all forms of health issues. Those in prison have lower life expectancy and worse health outcomes than the general population. Participants highlighted well-documented prison health concerns such as higher prevalence of communicable diseases, mental health issues, and suicide, as well the likelihood of poor dental health and the increasing prevalence of chronic non-communicable disease. This fits with the findings of the literature review, which also highlighted higher prevalence of communicable disease, mental health issues and suicide among prisoners.

During the discussion, were able to go further and identify ways the prison environment itself contributes to these health problems. Challenges identified include:

- General overcrowding;
- Poor hygiene;
- A lack of personal space;
- A lack of exercise;
- Poor nutrition;
- People in prison being more likely to smoke; and
- The prevalence of drugs within prison (including new psychoactive substances, especially amongst younger people) – many of which can increase risk of communicable diseases.

The prison environment means that the individuals often experience a lack of control over daily life, such as the type of food they consume and their ability to take exercise. This combined with social effects of prison (boredom, isolation) tend lead to negative health behaviours, such as smoking. These conditions also make it difficult to manage and delay chronic diseases such as heart disease. A participant noted that cardiovascular disease was the leading cause of death within prisons in England. The prevalence of chronic disease is again exacerbated by the changing demographic of the prison population. As the average age of those in prison increases, in line with what is seen in the general population, the likelihood of chronic disease increases.

A further issue in the organisation of prison health is the variant quality found from location to location within a single country. Participants working directly with people in prison commented on what they felt to be a fragmented landscape of commissioning for services. A participant working in UK prisons related their experience of working with those with multiple complex needs and feeling unable to 'slot them in' to what can be a silo-style model on working on health issues.

3.7.4 Access to healthcare

3.7.4.1 Trends in the literature

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; and
- 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).

3.7.4.2 Focus group findings

The focus group identified a number of similar challenges to the literature review, in particular a shortage of resources. Health professionals delivering care within the secure prison setting face particular struggles in ensuring appropriate care. The participants stressed that, as the health needs of the population were higher than average, the resource needs of prison healthcare systems were also much higher, in terms of physical resources, human resources and time required with each patient. One participant urged a focus on "equivalence of outcomes, not equivalence of inputs" when resourcing prison health systems.

Some specific issues in providing healthcare within prisons were discussed. Participants highlighted:

- A built environment which may not be fit for purpose, for example inappropriate examining rooms and a lack of privacy for appointments;
- Secure IT systems that prevent effective working across prisons: participants noted that IT systems were often not up to date which made sharing information difficult. They also noted that privacy and data security measures meant that health professionals did not always have access to the information they need about patients;
- Insufficient links to community care, which is necessary to understand patients' records fully;
- A high turnover of health staff (given the challenging environment in some countries), which leads to difficulties in resourcing appropriately and in building relationships ;
- Difficulty in applying human rights principles when delivering care in a secure environment, for example ensuring prisoners' right to privacy, person-centred care and adequate patient choice over their treatment; and
- A lack of preventative care programmes that are appropriate for the prison environment (for example, taking into account prisoners' potentially limited capacity to exercise).

Participants also shared their frustrations over situations where an individual is removed from prison for specialist treatment (such as mental health or drug dependency programmes) and then returned to prison after their short treatment whilst still vulnerable. The professionals involved felt that this greatly complicated the continuing improvement of the individual's health and led to an increased rate of relapse.

Participants noted the role that non-health prison staff play in the health of people in prisons. The attitudes of prison guards and other staff can have major effects on the quality of health care within prisons.

One specific issue explored by participants was the role of prison staff as a 'filter' between those in prison and available healthcare. In other words, prison staff facilitate and control the patient's access to health care. This can manifest as an issue in several ways. Firstly, where prison resources are stretched there may not be human resources available for guards to accompany people in prison with health needs to medical appointments, which may contribute to the high number of do-not-attends (DNAs) seen in the prison system, as well as late diagnosis and poor health management. Furthermore, the role of prison staff as gatekeepers to care poses issues for confidentiality, in many cases people in inmates must be willing to share the details of their medical requirement with prison staff in order to access care. Prison staff also may not have the knowledge to recognise symptoms of illness (especially in the case of mental health or substance misuse) and be unable to make appropriate referrals to health professionals.

Professional standards of prison staff

As noted in the discussion, across Europe there are different standards for recruitment and training of prison staff. For example, in Scandinavian countries the role of prison officer is a graduate role with a focus on rehabilitation, whereas in other countries, such as the UK, the role is considered less specialist and the entry requirements are less high.

Furthermore, prison staff may be reluctant to change. One participant relayed that, from their experience, in Germany prison staff are state officers who are often resistant to change.

Participants also noted that it can be difficult to maintain positive relationships with prison authorities. In working for an NGO, one participant noted that difficulties can arise when flagging issues or seeking resources if the governors perceive that they are being criticised.

Providing care after prison

The focus group also explored the challenges of providing healthcare for prisoners post-release. Participants noted that the turnover of the prison populations is high. For example, it was stated that more than 100,000 people come in and out of prison every year in Italy. As these people return to difficult social situations, complicated further by a stay in prison, continuity of care is important even for those not demonstrating ill health at the time of their release.

As highlighted during the literature review, in most Member States prisoner healthcare is the responsibility of the prison service rather than the national Ministries of Health. This means providing care for released prisoners can be complicated by a lack of communication between the prison health service and the health service in the wider community. Resulting problems identified during the focus group included an individual's unique identifiers not being joined up between services, leading to records for patients not being forwarded to their new doctors even if the individual enrols with a new primary care service.

The prison environment can act as an incubator for communicable illnesses, and those leaving prison may therefore bring communicable diseases back into the community. Prisons also represent a clear way of containing the illness. If individuals can remain in contact with the health system, this represents a good opportunity to catch outbreaks of communicable diseases before they spread further in the community. For example,

the duration of individuals' stay in prison is often a good opportunity to inoculate against certain communicable diseases (with consent). Furthermore, healthy behaviours learnt in prison could act as a model to others within the community. For example, if an individual is able to cease smoking whilst in prison they may be able to model this behaviour on their return to the community; this is more likely if they continue to receive support.

3.7.5 Evidence of policies being used to support this group

3.7.5.1 Trends in the literature

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 earlier, they are disproportionately drawn from some of the most vulnerable groups in society and are therefore more likely to 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 prisoners 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 prisoners. 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; and
- 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 management and healthcare service delivery 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.

3.7.5.2 Focus group findings

Bringing prison health onto the public health agenda

A specific issue for the delivery of healthcare in prisons is the political consideration of public attitudes towards prison health. To participants, in line with prisoners' human right to health[14], the standard of healthcare provided in prison should be equal to that afforded to the rest of society. As one participant stated "*the deprivation of liberty is the punishment; it should not be more than that*". However, in many contexts, the attitudes of politicians and prison governors to the role of prison will influence the standard of care that those in prison receive. The resources required to provide quality and appropriate healthcare are greater in prison (for reasons explained above); however, it is worth noting here the generally lower socioeconomic status of those in prison, which reflects itself in higher health needs. The level of resources, attitudes of staff, and access to interventions can be reflective of the attitudes of those running the prison. Several participants observed that the attitude of the prison governor to health as an aspect of rehabilitation and the wider role of prison as a place for rehabilitation or punishment will make itself felt throughout the prison environment.

Focus group participants were all in agreement that prison health was better provided under the auspices of the general public health system rather than as presided over by the ministry of justice, supporting the WHO recommendations identified by the literature review.

Participants noted that health services already have the expertise and experience to provide healthcare to the general population. This health expertise and experience means that they are therefore also best placed to provide healthcare in a prison environment that is equal to those who are not in prison. Prison health services that are separated from a national health service will struggle with a lack of institutional expertise as well as the additional challenges of prison healthcare. One participant stated that separate commissioning by the justice department had, in their experience, always led to sub-standard prison hospitals.

Another inequality between health care provided in prison and in the general population observed by the participants was the application of health guidelines. For example, the international guidelines that are used in the general population, such as guideline of the reduction of salt intake, are not utilised in prison environments, and the prison

[14] Everyone has the right to "the enjoyment of the highest attainable standard of physical and mental health", in line with Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (adopted 16 Dec 1966, entered into force 3 January 1976).

population are not included within international targets. This further separates the experience of healthcare in prison from that received in the community.

Any change in prison health systems are likely to require a change in attitude or additional resources. Participants discussed the difficulties in making the case to the relevant authorities for increased investment in healthcare. They discussed the value of demonstrating the ways in which interventions are cost-effective. According to participants, the cost-saving benefits of healthy prisoners represent a 'community dividend', as members of a healthy prison population requires less secondary care and are in a healthier state when they re-join the community; they are therefore less likely to reoffend and to spread communicable diseases.

Supporting equivalence of care in prisons

Sexual health and Blood-borne Viruses (BBV) screening and management in the West Midlands, UK

Health challenge

- Previously, sexual health services and services for blood-borne viruses (such as HIV and Hepatitis B) in the West Midlands were provided by an in-reach consultant who visited the prison monthly, covering geographically dispersed prisons. This situation did not represent equivalence of care, as those in prison had to wait for the service to arrive monthly to address their symptoms.

Intervention

- In order to address this, a nurse-led service was established within each prison whereby a nurse could identify symptoms and manage the treatment of those with a sexual health problem, with support from local specialists. Appropriate nurses were identified through a training needs assessment and are being trained to provide sexual health and BBV services (building upon an existing national training programmes).

Challenges in implementation

- Especially difficult in establishing this service in the female estate
- Sexual health typically considered 'low priority' issue in prisons
- Challenges in encouraging individuals to disclose health issues they are facing, due to a lack of basic privacy (for example, having to collect prescriptions in front of peers)
- Difficult to find clinical placements for the nurses in training
- Fragmentation in commissioning, for example the laboratory testing is commissioned separately.
- The funding cost of £1500 per nurse (plus the cost of filling nurse placements whilst they are training) is high. This makes the initiative less sustainable if nurses leave the prison after completing the training, due to the extra opportunities afforded.

Results

- Those in prison were able to have similar access to sexual health and BBV services as the non-prison population.

Peer-led initiatives

The participants were united in underlining the effectiveness of peer-led approaches, and pointed to a range of examples from Ireland, the UK and Luxembourg. These are approaches where inmates are empowered through training and responsibility to make healthy decisions for themselves and act as health promotion agents for others.

Focus group participants also highlighted the Red Cross initiative in Ireland, stating this gives inmates decision-making capabilities for issues that affect their daily lives,

highlighting outcomes such as an inmate-led weapons amnesties, a colour coded system of mopping in order to contain communicable disease, a health mentor programme and an HIV testing programme. One participant reporting that early results from Ireland suggested that taking part in the Red Cross initiative is associated with a cut in reoffending by 70%.

Another peer-support initiative discussed during the focus group is the health champions system in UK prisons. These champions are peer supporters for those with substance misuse issues. The peer supporters offer encouragement for individuals to attend appointments, which has led to a reduction in rate of those that did not attends (DNAs). In Staffordshire, health champions previously also played a role in supporting smoking cessation. Another participant discussed the important role that ex-prisoners have played within the Advisory Group of the Royal College of Psychiatrists' Quality Network for Prison Mental Health Services in the UK and Ireland.

In 2017, a Food Matters inside & out Prison project will begin operations in Wandsworth Reform Prison (London, UK). This trains prisoners to work as peer mentors ('food champions') who promote healthy food choices amongst their peers. The project also advises staff and caterers on improving the variety of food on offer.

One participant shared an interesting initiative from Luxembourg that focuses on offenders at a later stage in the care pathway. Specifically, mobile home-care services have been trialled for former prisoners, in order to support those with Tuberculosis (TB). This involves other former prisoners acting as trained focal persons and administering treatment. The big advantage of this initiative is that ex-prisoners are more likely to trust somebody who has had similar experiences to them. This was a collaboration between the Ministry of Health and Ministry of Justice, although NGOs also played an important role in the delivery of the programme.

Participants emphasised the importance of offering sufficient incentives to prisoners who take on these roles, including payment, in order to give recognition to the positive role they are playing. However, there can be tensions over how to make these types of approaches financially sustainable. For example, one participant described the REHAB programme tested in some of Italy and Spain's prisons. This has had successes in addressing the issue of mistrust and poor communication between prison staff and people in prison, by undertaking capacity building with the prison administration and peer educators. Due to increases in the level of trust that prisoners have of doctors, this has led, for example, to improvements in the testing rate of HIV. This initiative was run by the Italian Society for Prison Health, with the support of the Ministry of Justice and a private sponsor. However, as highlighted by one participant, these types of activities often face funding pressure, especially when peer educators are paid. Further in-depth research is available on these types of approaches[15].

Normalising prison life

During the focus group, participants also emphasised the effectiveness of approaches that seek to 'normalise' prison conditions, making them as similar as possible to life outside of prison and supporting individuals' long-term reintegration into the community.

Focus group participants discussed the example of Danish prisons. The self-catering aspect of this was explored during the literature review, although focus group participants also noted that those in prison are also responsible for cleaning their cells and washing their own clothes. Key benefits of this approach are that prisoners have a day that is comparable to life outside prison, as well as receiving training and their own

[15] For example, see Anne-Marie Bagnall, Jane South, Claire Hulme, James Woodall, Karen Vinall-Collier, Gary Raine, Karina Kinsella, Rachael Dixey, Linda Harris, Nat MJ Wright (2015), 'A systematic review of the effectiveness and cost-effectiveness of peer education and peer support in prisons' *BMC Public Health*. 2015; 15: 290. Published online 2015 Mar 25. doi: 10.1186/s12889-015-1584-x

money (which helps them when they leave prison and can reduce re-offending). It was noted that in Italy prisoners can similarly buy food and prepare it themselves.

Normality in Norwegian prisons[16]
The principle of 'normality' runs through the Norwegian correctional system. This is based upon the understanding that, other than the deprivation of liberty, none of prisoners' rights should be affected when they enter prison. If their rights are undermined, it is the responsibility of the authorities to justify why. The ultimate aim of the system is to reintegrate prisoners back into society, meaning that the level of security in place will be gradually reduced as an inmate progresses through his/her sentence.

For more information on the Norwegian model, see:
http://www.kriminalomsorgen.no/information-in-english.265199.no.html

Screening prisoners on arrival

Effective screening systems can ameliorate the prevalence of late-stage diagnosis and untreated medical problems within the prison population. Given both the greatly increased likelihood of existing health needs within the population entering prison and the systematic issues surrounding the transfer of health records, the importance of systematic health screening for individuals on arrival to prison is paramount. A full screening programme can identify mental health symptoms and chronic health conditions and establish a path for the management of these health problems.

Whole prison approach

Participants stressed that a healthy prison population requires a 'whole-prison approach'. This embodies not only an effective prison health care system, but also a commitment to health in all aspects of prison life that affect health, emphasis on the health of all people in prison (not only inmates but also staff, visitors and families), and finally considering the whole prisoner pathway.

As an aspect of this approach, prison staff can benefit from capacity building that increases their role within the health of the prison population. For example, staff can receive specialist training which enables them to be proactive in supporting prisoner's mental health.

Monitoring, evaluation and quality standards

A significant amount of the discussion was devoted to the issue of measuring quality and impact within prison health systems. There are a range of internationally accepted standards on prison health, in particular those developed as part of the WHO Health in Prisons Programme[17], the European Committee for the Prevention of Torture[18], and the European Prison Rules[19].

There are also guidelines available at the national level, especially within the UK and Ireland. Participants identified quality guidelines such as the Standards for Prison Mental Health Services, developed by the Royal College of Psychiatrists (updated edition

[16] This example was not identified by focus group participants; instead it arose through the additional desk research of the VulnerABLE team. It has been added to this report as it exemplifies the focus group discussion around normalising prison life.

[17] WHO Europe (2014), Prisons and Health, edited by Stefan Enggist, Lars Møller, Gauden Galea, Caroline Udesen. Available online: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf?ua=1

[18] See the 'health care services' section of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2006), *The CPT standards: "Substantive" sections of the CPT's General Reports,* CPT/Inf/E (2002) 1 - Rev. 2006 English. Available online: www.cpt.coe.int/en/documents/eng-standards-scr.pdf

[19] Council of Europe (2006), *European Prison Rules.* Available online: www.coe.int/t/DGHL/STANDARDSETTING/PRISONS/PCCP%20documents%202015/EUROPEAN%20PRISON%20RULES.pdf

published in 2016). The standards are currently being applied in 42 prisons across the UK and Ireland, who engage in an annual review process using these standards as a framework[20]. These standards can drive up the quality of mental healthcare in prisons, by identifying where improvements could be made, whilst also identifying areas of good practice for others to learn from. National engagement of prison mental health services in the process would minimise the variation in quality seen between prison services that is currently being observed.

To ensure compliance, such standards are closely linked to the monitoring of prison health outcomes. Participants recognised the challenge of measuring progress towards these and understanding the situation 'on the ground' in prisons in different countries. Participants discussed the importance of appropriate Health Needs Assessments and an ongoing cycle of monitoring and improvement within the prison health system (including audits). This was identified as missing in the majority of prison contexts within the participants' experiences, and represents a *"big infrastructure project [in relation to] bringing health informatics into prisons".*

Health Needs Assessments in the UK

In the UK, Prison Health Needs Assessments[21] are produced more regularly than in other European countries. These cover, for example:

- demographic and other features of the prison population (such as length and type of sentence, and movements in and out of prison);
- health services on offer (including outpatient/inpatient areas, screening services and primary care clinics);
- the prevalence and management of physical disease, communicable disease, sexual health issues, physical disability, social care needs, mental health issues, learning disabilities and substance misuse;
- health promotion activities;
- planned and unplanned secondary care
- Recommendations[22].

England (UK) also makes use of prison health indicators to support monitoring, as given in the box below. These can offer important benchmarking data for prison health systems.

[20] www.rcpsych.ac.uk/pdf/2nd%20Edition%20Standards%20for%20Prison%20Mental%20Health%20Services%20Publication1.pdf

[21] https://www.gov.uk/government/publications/health-needs-assessment-prison-examples

[22] Based upon NHS England Health & Justice Staffordshire & Shropshire Local Area Team (2015). *West Midlands Prisons Health Needs Assessment 2014-2015: Report Number 4 of 11. HMP Dovegate: Final Version April 2015*, produced by OHNA Ltd. https://www.gov.uk/government/publications/health-needs-assessment-prison-examples

Public Health England Health and Justice Indicators of Performance

In 2014, Public Health England revised their previous prison health performance quality indicators and produced the health and justice indicators of performance (HJIPs). These indicators serve as a comparison of the performance of different prisons and a method by which to indicate those that are poorly performing and those that are examples of good practice.

Participants emphasised the need to ensure that data-collection tools are designed in such a way that does not over-burden clinical staff, and that considers clinicians' requirements. They also require fit-for-purpose IT systems. One participant recommended potentially the use of a unique identifier for an individual, which can be used to identify their interactions with the health and justice systems, and potentially enable longitudinal cohort studies.

The development of a WHO database on prison health with 150 indicators has been developed and data collection is currently taken place in all Member States of the WHO European Region. The database offers further lessons in this regard.

When data is collected, there is also a need to ensure that statistics are published regularly, in order to demonstrate systematic inequality and, at its most extreme, violation of the human rights of people in prison. This data should include information on the treatment that inmates are receiving. For example, in Berlin (Germany), a statistic has been tested on ICD coding of diagnosis. There has also been some work on the development of substance misuse statistics.

Generating data on the use of TB, HIV and Hepatitis B treatment, Germany

One participant discussed an initiative in Berlin, Germany, to use secondary pharmaceutical data on the use of TB, HIV and Hep B treatment in prisons. Infectologists analysed this, and discovered a very poor use of vaccination.

3.7.5.3 Relevant case studies

As part of the VulnerABLE project, an inventory of practices was produced, collecting good practices from across the European Union that promote health and access to healthcare for people living in vulnerable and isolated situations.

Four practices in the inventory target prisoners. Two of them (Danish model; Community-based Health and First Aid in Action) aim to promote health awareness and healthy behaviours among prisoners, by empowering them to take control of aspects of life such as their nutrition and prison hygiene. The other two practices focus more on changing health services for prisoners, by increasing screening for mental health issues (PICLS) and by supporting harm reduction approaches to drug use.

Table 9. Relevant case studies for this target group

Title	Organisation & country	Main objectives	Web link
Danish model on food systems in correctional facilities	Danish Prison and Probation Service, Ministry of Justice Denmark	A programme allowing prisoners in all centres to be responsible for the preparation and management of food served in prisons.	http://www.kriminalforsorgen.dk/Files/Filer/Publikationer/Brochurer/kort_og_godt_uk_2011.pdf
Community-based Health and First Aid in Action	Irish Red Cross Ireland	Groups of selected prisoners are trained as peer educators and do hands-on health promotion among fellow inmates to raise their awareness about community health, personal hygiene, first aid and well-being.	http://www.irishexaminer.com/ireland/call-to-track-the-spread-of-diseases-in-prison-406655.html
Prison In reach and Court Liaison Service (PICLS)	Irish Prison Service, Department of Justice and equality Ireland	This project focuses on identifying prisoners with serious mental illness and referring them to appropriate mental health services as soon as possible.	http://www.jsijournal.ie/html/Volume_8_No._2/[2008]2_McInerney_O_Neill_Prison_Psychiatry.pdf
Health education for social prosperity	Initiative for Health Bulgaria	The initiative aims to reduce harm from drug use among prisoners in three prisons across Bulgaria, by increasing the capacity of prison staff to deal with drug issues. The main activities are: training modules for prison staff on treatment and prevention of drug use, brief interventions in case of drug use; harm reduction in case of drug use. Health training session are also organised with inmates	http://www.healthyprisons.info/en/

3.8 Survivors of domestic violence and intimate partner violence

Summary of quantitative findings EU-wide data on health inequalities is not well suited to judging the situation of survivors of intimate partner violence and domestic violence, as it does not identify this group directly. However, VulnerABLE survey results give a richer picture of the health situation and barriers to healthcare access experienced by this group.

The VulnerABLE survey suggests that a greater proportion of this group (33%) have a poor overall health than the average amongst the target groups (28%). Of all the groups, survivors of intimate partner/domestic violence were most likely to experience mental health problems (45%) and to show signs of psychological stress, such as feeling particularly tense most or all of the time (reported by 41%) or being depressed (44%). Most (67%) report having long-standing health issues (where mental health issues are most likely to feature). Relative to other target groups, it is also most common for this group to report very bad health. Most survivors find that the following factors affect their health: lack of money (66%) and feelings of stress (62%). Perhaps unsurprisingly, 'concern about relationships' is much more likely to be a factor affecting the health of survivors (37%) compared to the group average (22%).

According to the VulnerABLE survey, the main reasons why survivors cannot access medical treatment are being unable to afford it (26%), being unable to get an appointment (24%), having an excessive wait (21%) and lacking transport (18%). Cost is also the main barrier to this group accessing medication.

Just over a quarter (26%) of survivors are dissatisfied with health services. In order of importance, the main causes are long waiting times (43%), not liking the attitude of the healthcare professional (40%), medical treatment not improving the individual's health (36%) and cost/lack of trust (both 28%).

3.8.1 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 survivors 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 survivors; **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 EU[23].

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.

[23] 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

- 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.

3.8.2 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 survivor" (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 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 survivors 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).

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 survivors are unable to report incidents of violence committed against them. However, there are also 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 should not interfere (FRA, 2014). Supporting the literature, focus group participants recognised that there are a range of methodological issues when it comes to identifying – and understanding the situation of – those affected by domestic and intimate partner violence, partly due to the prevailing social discourse. Another issue mentioned was that controlling and coercive behaviours in particular form a pattern/lifestyle, rather than being events-based, which serves as a barrier to their measurement. Prevalence surveys were considered as providing only partial information, as participants noted that it is often difficult for women to report the violence due to the perpetrator's presence.

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 report uses 'survivors', not everyone would subscribe to this term, and readers are encouraged to use the language that they find most appropriate.

During the focus group, much discussion was devoted to the need to involve survivors themselves in research of this kind, and to establish methods of systematically representing user interests. At the same time, participants recognised the challenges of involving survivors in a project of this scope and scale (i.e. EU-wide, focusing on multiple groups in vulnerable situations). They recommended that, in future, user interests and representation be an even more central consideration within the research.

3.8.3 Health challenges

3.8.3.1 Trends in the literature

There are considerable health risks associated with domestic and intimate violence. Domestic violence can have serious immediate and long-term consequences for the survivors, 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 survivors of domestic violence has found that survivors 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. As indicated by the VulnerABLE survey, research suggests that 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 survivors. 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). This confirms the picture from the VulnerABLE survey results that poor mental health is particularly likely to be the cause of long-standing illness amongst survivors.

3.8.3.2 Focus group findings

Health consequences of domestic and intimate partner violence

Focus group participants highlighted the significant research that has been carried out on health risks and problems experienced by survivors of domestic abuse and IPV, including group measurements and systematic reviews. Research has shown that women survivors of domestic violence are more likely to experience specific health issues, including gynaecologic issues and non-specific pelvic pain, and participants found that IPV has a direct and negative impact on women's sexual health[24]. In particular, on mental health, a number of systematic reviews have been published by UK researchers in recent years, looking at the risks of developing problems in particular around depression, PTSD and suicidality.

Participants agreed that there are always several short-term and long-term consequences of IPV. They highlighted that, in the case of IPV, physiological health issues go in hand with mental health issues and can be difficult to separate. Sexual health and mental health issues often add themselves to the physical trauma and the injuries. According to a recent survey, 76% of women experiencing domestic violence and abuse were above the clinical threshold for a mental health diagnosis, including depression, anxiety and post-traumatic stress disorder (Ferrari et al, 2016). However, some participants noted that the actual percentage should be 100%. To many, women experiencing IPV never feel safe, they have to live with constant level of anxiety, and often, after leaving a situation of violence, they experience post-traumatic stress disorder due to the high level of stress they lived in for many years. Participants noted that undiagnosed mental health problems are an important issue among survivors of IPV. Indeed, one participant that "*[mental health issues] often dwarf all of the others",* describing how the use of Domestic Homicide Reviews in the UK has demonstrated that many of the female survivors are the ones who have experienced controlling/coercive behaviours for many years; the first physical incident will be what results in their death.

Adverse sleep experience is also an important (health) consequence for women, as well as the adverse consequences for parenting. Domestic violence impinges on parenting/mothering in many complex ways, for example, mother's mental health, disruption to the attachment and bonding, and situations in which children are manipulated by the offending parent to turn away from the [mother][25].

3.8.4 Access to healthcare

3.8.4.1 Trends in the literature

This section outlines the issues relating to access to health experienced by survivors 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

[24]Over email, one academic commented that the limitations of study designs mitigate against being able to establish a clear causal Comments over email from an academic: "what we know about consequences is still not demonstrative of causal relationships given the limitations of study designs (i.e. a lack of longitudinal research to establish causality); however the evidence for risk factors and associations is strong".

[25] Sources provided over email following the event: Humphreys, C., Lowe, P., & Williams, S. (2009). Sleep and domestic violence: Exploring the interconnections between mothers and children. *Child and Family Social Work, 14*(1), 6-14. Lapierre, S. (2009). More responsibilities, less control: Understanding the challenges and difficulties involved in mothering in the context of domestic violence. *British Journal of Social Work, 40*(5), 1434-1451. doi:10.1093/bjsw/bcp080

33% of survivors of intimate partner violence and 26% of survivors 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. Survivors 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 survivor of domestic violence. Survivors 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 survivors of abuse and family violence (both physical and psychological) and may pass through different and alternative stages before eventually becoming homeless or in a shelter[26].

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 survivors 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 survivors of domestic violence. This situation may explain to some extent the result from the VulnerABLE survey that, of those who are dissatisfied with healthcare services, 40% put this down to not liking the attitude of the healthcare professional.

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

[26] Identified in project interviews.

3.8.4.2 Focus group findings

Survivors can face a range of barriers to accessing healthcare, including psychological barriers, financial barriers and fears for their own safety and that of others. However, these will differ across European countries depending on the health and social care system in place, as well as the level of support offered to this group.

To participants, ongoing stigma and a lack of adequate programmes can act as specific barriers to mental health interventions. Most often, mental health programmes deal with the symptoms rather than the causes, meaning, for example, that women may be offered antidepressants only. This perhaps partially explains the finding from the VulnerABLE survey that, of survivors dissatisfied with healthcare services, over one in three (36%) stated it was because the medical treatment had not improved their health.

Survivors' responses to mental health programmes can differ depending on their life situation. To be receptive to the programmes, women need to have had time to think about their future; participants mentioned the concept of 'readiness'. Women need to be ready to build their self-esteem again. Perpetrators, however, will have an impact on women's readiness when they are in an abusive relationship and/or after they leave it. 'Readiness' as a concept thus cannot be understood in isolation.

Participants discussed specific issues linked to the UK health and social care system, such as limited access to shelters. In the UK, shelter places are generally funded by the benefits system; however, the eligibility criteria for these benefits can be narrow, and women who do not qualify have to pay to access these places using their own funds. In reality, this situation can make shelters inaccessible for many individuals, including better-paid professionals, due to the high expense. Participants also noted that women survivors of IPV are more likely to need access to abortion services, so the lack of provision of these services in some Member States (such as Ireland) was considered as an important issue. Reproductive coercion is a particular aspect of IPV; the socio-cultural context and structural factors can exacerbate or challenge this, based on the choices that are made available to women.

In addition, it was mentioned that during a violent relationship, survivors show resilience and that PTSD-related issues often appear two years after the woman has left a violent relationship. Those issues need to be picked up later on.

Participants noted the lack of continuity of care for women survivors of domestic abuse and IPV, and highlighted the need to increase their access to trained health practitioners. This is discussed in more depth below.

Groups facing additional barriers to accessing care

Participants mentioned particular groups of women that may face additional issues in accessing healthcare, which includes the following:

- Migrant women (including those who are undocumented), due, for example, to limited recourse to public funds (to fund their entry into a shelter). Women in the UK who are on short-term spousal visas can also face particular issues in accessing services.
- Older adults, many of whom may not expect them to experience violence after years within a relationship;
- 'Traveller' women in Ireland and elsewhere, due to difficulties in obtaining a divorce, a higher level of early marriage and cultural differences when it comes to the acceptability of domestic violence;
- Women with disabilities, especially when they experience violence from their carer(s).

Women in rural areas and women in extended families were also mentioned as facing issues in accessing services. Due to prejudice and stigma, all these groups of women can face barriers to accessing healthcare; some might even face a higher level of

isolation. Social norms in general can play a role in dissuading women from disclosing violence; these norms can be particularly restrictive in certain communities. Young people can also have more difficulty to access healthcare, due to less overall contact with medical services, as well as a lack of life experience to identify patterns of violence. They often face peer pressure and normalisation of jealousy in relationships.

Participants pointed to the new challenges presented by new media and technologies. Partner abuse takes different forms, including sexting, abusive technology, control through social media, etc. and participants noted that the impact of new technologies is still unknown. The landscape of abusive tactics is constantly changing. Cyber space can allow coercive control to operate in a way it has not previously (for example, revenge pornography and other forms of digital abuse).

Pressures on clinicians and gaps in infrastructure

Participants mentioned some issues faced by practitioners that could affect women's access to healthcare. Clinicians have to manage competitive priorities and have limited time to deal with potential cases of IPV; they may be scared or even think that this is a 'woman's issue'. Moreover, participants noted that GPs are often not free from stereotypes on gender roles and IPV, and that these affect the treatment that women receive.

Moreover, participants noted that the premises where women survivors are supposed to look for support are often not adequately designed to respond to the specific needs of women survivors of violence.

The impact of austerity measures on survivors' access to healthcare was also mentioned by some participants as an important issue. They all agreed that specialist support services are substantial, and yet those are the first to suffer from the cuts. For instance, in the UK, specialist trained officers (STOs) within police forces used to be sent on all cases of domestic violence but, due to cuts, this is no longer the case.

Gaps in the evaluation of support programmes was mentioned as a barrier to identifying effective interventions. Participants lamented that cost effectiveness is often used as the main criterion for judging success.

Barriers to disclosure

When those experiencing violence are unable to disclose this, it can undermine the appropriateness of the care that they receive, as well as the follow-up support. Put another way, participants considered that an important enabling factor for women to access adequate healthcare was the disclosure of the abuse to their clinicians (or reporting it to an agency). However, participants noted that sometimes women who have experienced domestic abuse and/or IPV do not recognise those behaviours as such. This is sometimes the case with people experiencing coercive and controlling behaviours. Participants highlighted that usually women do recognise their situation, but sometimes the agencies from whom they seek help do not believe them, do now know how to respond or do not know how to access support for them; survivor blaming is still considered an important factor hindering survivors' access to healthcare[27]. In particular, participants emphasised that women may justifiably fear for their – and others' – safety, affecting their willingness to report violence and/or take action following reporting. Relatedly, abusive partners can obstruct actively survivors' access to health and ability to report their experiences, for instance insisting on attending GP visits with them. The severity of this issue differs depending on the country, for example in the UK, IRIS-trained GPs are encouraged to see patients alone. Several participants

[27] One participant recommended an article for understanding how "the processes of gendering […] are situating women as culpable victims" (Abstract). See Marianne Hester, 'The Three Planet Model: Towards an Understanding of Contradictions in Approaches to Women and Children's Safety in Contexts of Domestic Violence'. *Br J Soc Work* 2011; 41 (5): 837-853. doi: 10.1093/bjsw/bcr095

also mentioned that women often feel unable to report to agencies for fear that their children would be taken away from them if they report.

There may also be cultural constraints that impede certain groups of women from seeking help. It may also be difficult for survivors to talk with friends about cumulative and escalating incidents.

As shown in other strands of research for the VulnerABLE report, these challenges to disclosure are significant, as there are recognised quality standards[28] for providing appropriate clinical care to survivors (unlikely to be met if clinicians are not aware of the violence). Clinicians can also play a vital role in referring patients on to specialist domestic violence services, given that women who are experiencing violence are more likely to consult or be in contact with health services compared to other services and agencies[29].

As a key issue, participants noted the lack of coordination and information sharing between the different agencies in contact with survivors. According to participants, relevant parallel services may have an inadequate role in the treatment of survivors of violence, due to a lack of integration.

Identification and Referral to Improve Safety (IRIS) Programme, UK

What is it?

IRIS (Identification and Referral to Improve Safety) is a domestic violence and abuse (DVA) training support and referral programme in the UK.

What does IRIS do?

Based in General Practices, IRIS aims to build the capacity of professionals to best identify and support women who are experiencing DVA from a current partner, ex-partner or adult family member. Information and signposting for male survivors and perpetrators is also given. Core services provided are:

- Ongoing training and support to practice teams;
- Electronic prompts on patient records as a reminder to healthcare professionals to ask about DVA and record data safely;
- Creating local clinical champions to co-deliver training and peer support other colleagues;
- Health education resources for practices and patients;
- Advocacy for patients through the support of an advocate educator;
- Named contact for patient referrals through enhanced care and referral pathways.

How does IRIS work? IRIS is a collaboration between primary care and third sector organisations specialising in violence against women and girls (VAWG). An advocate educator is linked to general practices and based in a local specialist service. The advocate educator works in partnership with a local clinical lead to co-deliver the training to practices.

Has IRIS been successful?

[28] World Health Organization (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva: WHO; UK National Institute for Health and Care Excellence (NICE) (2016). *Domestic violence and abuse*, Quality standard [QS116); UK National Institute for Health and Care Excellence (NICE) (2014). *Domestic violence and abuse: multi-agency working,* Public health guideline: PH5.

[29] See Yeung, H., Chowdury, N., Malpass, A. and Feder, G. (2012), 'Responding to domestic violence in general practice: A qualitative study on perceptions and experiences'. *International Journal of Family Medicine,* vol. 2012; European Union Agency for Fundamental Human Rights (FRA) (2014), *Violence against women: an EU-wide survey. Main results.* Luxembourg: Publications Office of the European Union.

Yes- IRIS has proven to be a cost-effective intervention. IRIS was the first European randomised controlled trial of an intervention to improve the healthcare response to DVA. 24 control practices and 24 intervention practices, on two sites[30] (Bristol and Hackney), were evaluated during 2007-2010. Results showed that, **in interventions practices**:

- Women were **22 times more likely to have a discussion with a clinician about referrals**;
- Women were **6 times more likely to be referred to an advocate**;
- Women were **3 times more likely to have DVA identified on their medical record**s.

Outcomes were based on the number of referrals to domestic violence agencies providing advocacy, and the level of disclosure of domestic violence in patient's medical records. There is also a range of other evidence available on IRIS' positive outcomes.

What next for IRIS?

The IRIS model has been **up scaled nationally across the UK** and is commissioned in 34 parts of the country. The national IRIS team provides support and guidance to areas who wish to implement the model. Commissioning guidance is available and a training for trainers programme is delivered locally.

3.8.5 Evidence of policies being used to support this group

3.8.5.1 Trends in the literature

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

As mentioned, 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.

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) (see box above). The programme was piloted between 2007 and 2010 and commissioned by local health services. IRIS involves:

- Two training sessions run by an 'advocate-educator' and targeted at doctors and nurses in their practices[31] about how to ask women appropriately about domestic violence, and how to respond if violence is disclosed;

[30] In other words, 48 practices in total: 24 practices in Bristol (12 control; 12 intervention) and 24 practices in Hackney (12 control; 12 intervention).

[31] Reception and administrative staff also receive a shorter training session.

- An electronic prompt for doctors reminding them to enquire about abuse[32];
- 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.
- 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 survivors of violence in health systems across six European countries[33] (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

[32] 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.

[33] http://test.wave-network.org/content/implement-training-manual-now-available

available online[34] and specifically targets healthcare professionals in Eastern Europe and Central Asia. Successes and failures of the IMPLEMENT programme were discussed at length during the focus group and are outlined further down in the box below.

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

- In Austria, Vienna's hospitals introduced a Training Curriculum ('Violence against women and children – survivor protection') to enhance the sensitivity of health professionals when dealing with survivors of domestic violence, ensuring adequate support to survivors 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 survivors 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).
- The Medical intervention against violence[35] in Germany aimed to raise awareness of doctors and to develop unified standards for the treatment of women survivors 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. This meant that from the outset it was quite hard to shift perceptions and approaches with regard to treating female survivors 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 survivors, 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).

[34] http://eeca.unfpa.org/publications/strengthening-health-system-responses-gender-based-violence-eastern-europe-and-central

[35] Model project Medizinische Intervention gegen Gewalt an Frauen – MIGG.

The recommendations assessed as 'strong' by the World Health Organisation are given in Table 10 below[36].

Table 10. 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. 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 /identification and subsequent care.	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. Clinical conditions linked to intimate partner violence include: • 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

[36] 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.

	• Intrusive partner or husband in consultations Note: these examples of conditions were lifted directly from WHO, 2013e, but originally were adapted from Black, 2011, 428-439.
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).	Interventions should be delivered by health-care professionals with a good understanding of violence against women. 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. It is most appropriate that specialists provide psychotropic medications in women who are pregnant or breastfeeding.
Clinical care for survivors of sexual assault: Recommendations	
The WHO makes a series of detailed recommendations for survivors of sexual assault. Amongst others, healthcare providers should: • 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 (EMD R);	

- 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 survivors of domestic violence. Here, multi-agency risk assessment conferences (MARACS) are used to identify survivors 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 survivors, 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 survivors themselves (Robinson, 2004). Some have also warned of the shortcomings of MARACs in that they may only focus on 'high-risk' survivors (Stanley and Humphreys, 2014). The focus group participants also highlighted some shortcomings of this model (see focus group section below).

Another evaluation of specialist frontline services for survivors 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 survivors, 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 survivors 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).

3.8.5.2 Focus group findings

Providing tools to practitioners

As discussed at length, clinicians can play a crucial role in identifying and responding to individuals who have experienced domestic and intimate partner violence. Focus group participants were in full agreement with this. The example of the IRIS programme was mentioned several times as good practice (see box above). This includes on-going support and training by a named consultant ('advocate educator', 'AE'), who acts as a named contact point for the entire practice time. An IRIS Advocate Educator is able to work with approximately 25 General Practices. The AE also acts as a named contact for patient referrals providing advocacy to those experiencing domestic violence. However, it was noted that if support from the AE stops, the referral rates from clinicians drop; GPs' personal relationships and specialist/target support seem to be more likely to encourage them to undertake clinical inquiry than access to a generic directory of services. Based on the programme findings, having a *named person* in the practice offering on-going support and to whom GPs can refer patients is vital.

Participants with knowledge of other GP training programmes noted that the effectiveness of training partly depends on the motivation of the doctors. IRIS has shown that it is important to have a targeted and dedicated programme for general practice and to ensure that the ancillary staff team are included and supported by the programme too. According to participants, enquiring about experiences of domestic violence requires many communication skills, which GPs sometimes lack. Participants agreed on the substantial role of the 'enabler': someone who can recognise the signs and is able to conduct direct, safe and supportive enquiry with survivors. In the framework of IRIS programme, the full clinical team (including doctors, nurses and healthcare assistants) receive specific clinical enquiry training on how to talk to potential survivors, as well as time to practise/rehearse. The admin/reception team receive training too, but for safety/confidentiality reasons they are trained to respond to disclosure, rather than to clinically enquire. Another participant mentioned her experience of working in Canadian rape survivor centre, where rape survivors often disclose the incident to the receptionist. It was seen as particularly important that all health staff receive training, not just clinical teams

The success factors of IRIS were discussed by participants. It was noted that in order to continue mainstreaming IRIS at a national level, proper funding was necessary. Whilst strategically the programme is recognised as best practice (e.g. UK Home Office Violence Against Women Strategies, Domestic Homicide Reviews, research by Public Health England), this is not supported with secure funding. This is contributing to a

level of demand that is challenging for the National IRIS team to meet. It is important for sites who commission IRIS to adhere to the model. It is evidence based (from a RCT) and its successful implementation depends on staying true, in the most part, to all facets of the model.

Other projects that aim to improve practitioners' understanding of IPV were mentioned. These include the IMPLEMENT programme, co-ordinated by Women Against Violence Europe (WAVE) and outlined in the box below.

IMPLEMENT Project

What is it?

Capacity-building programme targeted at health professionals, gender-based violence (GBV) advocates and women survivors of violence. It took place in six countries (Austria, Bulgaria, Romania, France, Italy and Germany). It was based upon IRIS and the Survivor Protection Groups in Austria. It was co-ordinated by the Austrian Women's Shelter Network with a range of partners: networks, women's shelters and counselling centres, advisory board and researchers, UNFPA.

Issues it was trying to address: under-reporting and weak identification of domestic and intimate partner violence in health settings; gaps between women's support services and the health sector; gaps in regular data collection; lack of referral pathways and multi-agency cooperation; limited capacity and sensitivity of health professionals to effectively respond to domestic violence and refer survivors to appropriate support services.

How did it work?

A project aimed to provide training to health practitioners so that they can in turn train their own colleagues on how to identify domestic/intimate partner violence. First, a training manual was developed and based on the WAVE/UNFPA Manual "Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia". This manual was translated from English into the national partner languages: German, Italian, French, Romanian and Bulgarian. In the meantime, in each national setting, a clinical lead (health professional) was paired with a GBV advocate (typically someone from a women's specialist support service, or in rare cases, a social worker in a hospital). This Manual was then used during a Train the Trainer Seminar, which brought together all clinical leads and GBV advocates from the six partner countries, over a two-day period. Upon this training, the clinical lead and GBV advocate pairs performed capacity-building seminars with health professionals in their respective health settings. The team of health professionals that participated in each setting varied, including the size of the teams and the departments. For the most part, these capacity-building seminars drew together a variety of health professionals from emergency departments, and there was an average of 10-hour training in each health setting. In some cases, the training was mandatory, in other cases, participants volunteered to participate. While these capacity-building seminars took place, the clinical lead and GBV advocate in each national setting held meetings with management and presented at national or European-level conferences, to raise awareness, establish sustainable structural improvements in the health settings, and disseminate project results. Routine data collection also took place in each health setting, shared with the GBV advocate, to record service user statistics.

The level of governmental and legal support varied by countries. In Austria, there is a legal requirement for hospitals to have a group of practitioners trained on IPV; likewise, in France, at least one clinician in each emergency service should act as GBV advocate, by law.

Successes:

The presence of on-site GBV advocates;

Regular data collection by practitioners, shared with the GBV advocate;

Regular case discussion management;

Safer rooms set up for disclosure (e.g. in Romania);

Greater visibility for the issue (posters).

Challenges:

Lack of management support for the initiative in some countries (undermining success);

The programme was introduced in an emergency department in France, but many staff here were over-worked, which reduced the rate of referrals;

Lack of motivation on the part of doctors in some countries;

Difference between voluntary and mandatory training;

Lack of interactive trainings in some countries.

Lessons:

Reinforcement of learning for practitioners is important – active follow-up and continued trainings, particularly for new staff

When determining the teams to train in the health setting, It is worth screening participants first (for instance, through a pre-questionnaire) to determine knowledge, experience and attitudes first, and separate the participants depending on the stage they are at. This way, the trainings can be more tailored to the participants' needs

Useful to have more roleplays, so that participants can understand how identification and referral happens to in reality (helps to practise communication)

There should be two clinical leads instead of one, to ease the burden/share responsibility, particularly in settings in which management support is weak

Cross-country initiatives of this kind should focus on similar health setting *sizes* to facilitate the identification of patterns and barriers

Need for sufficient resources for translation/interpreters, particularly in settings which receive a high-level of patients in which the national language is not their first language

Important to meet regularly with health professionals for roundtable/expert input, case studies

Management support is necessary to make the initiative successful and ensure sustainability

Infrastructure and social/political affect the likelihood of success

More information available here: http://test.wave-network.org/content/implement-training-manual-now-available

In terms of improving identification of survivors, participants identified healthcare settings where there are more likely to be survivors of domestic and partner violence, such as abortion clinics. In such settings, clinicians in the UK are highly trained to provide survivors with information on available services and have more time to do so. Sexual assault survivors' centres were also described as a place where need assessments can be carried out. More generally, participants agreed on the need to develop 'one-stop-shops' for survivors.

To facilitate survivor identification, **participants discussed the utility of reminders/prompts** for doctors that identify potential survivors based upon the frequency of their visits; main clinical presentations; etc. There was discussion of the

utility of automatic, blanket electronic prompts, with some participants dubious about their value, given the range of medical software that GPs must navigate between and the tendency to ignore automatic pop-ups. Another participant, however, explained that 'HARK' electronic prompts – used within IRIS. This acts as a prompt, electronic pop up, for clinicians to enquire about experiences of domestic violence and abuse. Linked to a range of conditions attributed to experiences of domestic abuse, HARK reminds clinicians of the dimensions of abuse, to enquire about abuse and to record abuse.

One participant pointed to the positive use of prompts within **abortion clinics** in the UK. Specifically, prompts in paper medical history forms are used in abortion care in the UK to identify women experiencing domestic abuse and refer them to help. All women are asked verbally about domestic abuse in abortion services. The rationale here is the potentially high prevalence of domestic/intimate partner violence amongst those who attend abortion services. Generally, the clinicians also have good listening skills, excellent training and more time within individual patients. Finally, counsellors are normally available who can provide support either immediately or within days. Thus, it was seen as a key arena in which to support the disclosure of violence. Another potential arena suitable for inquiry/case-finding may be **antenatal clinics**, as mentioned by one individual[37] and indicated in the literature review. Relevant factors here may be increased contact between women and health providers over the antenatal period, potentially higher trained staff, etc[38].

One participant saw the prompts in abortion clinics as more successful than those tested in UK sexual health clinics on medical record software. The latter was seen as less effective as clinicians were prompted to ask a great list of questions, which often diluted the reason behind the questions and were sometimes too vague (for example, "are you happy at home?")[39]. **It was suggested that computer systems use selective alerts**, for example targeted at GP patients who attend frequently with telling conditions (pelvic pain, etc).

There was **general agreement amongst participants that universal screening and prompts are not effective**; this needs to occur on a more selective basis. Consequently, they also preferred the language of 'clinical inquiry' or 'case-finding', as opposed to screening.

Human factors are crucial: trust, empathy and confidentiality are essential to the success of any intervention. Safety must also be central to interventions, given the presence of the perpetrator and the risk of homicide/severe incidents when women try to leave or after they have left.

Further evidence available here: O'Doherty L., Hegarty, K., Ramsay, J., Davidson, L.L., Feder, G., and Taft, A. (2015) 'Screening women for intimate partner violence in healthcare settings'. *Cochrane Database of Systematic Reviews* (7), CD007007

[38] Studies in antenatal populations also show considerable variation in rates of IPV during pregnancy – see Jahanfar S1, Janssen PA, Howard LM, Dowswell T., 'Interventions for preventing or reducing domestic violence against pregnant women' Cochrane Database Syst Rev. 2013 Feb 28;(2):CD009414. doi: 10.1002/14651858.CD009414.pub2. See also Devries KM, Kishor S, Johnson H, Stöckl H, Bacchus LJ, Garcia-Moreno C, Watts C. 'Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries', *Reprod Health Matters*. 2010 Nov;18(36):158-70. doi: 10.1016/S0968-8080(10)36533-5 and Van Parys, A., Verhamme, A., Temmerman, M., and Verstraelen, H. 'Intimate Partner Violence and Pregnancy: A Systematic Review of Interventions' *PLOS*, January 17, 2014 http://dx.doi.org/10.1371/journal.pone.0085084

[39] However, this question was judged to be effective and worth asking on a routine basis: "Are you afraid of your partner or anyone else at home"

Mental health interventions

Participants then discussed the **effectiveness of programmes that aim to provide women survivors with mental health support** (which, as indicated by the VulnerABLE survey and the literature review, is a significant health issue amongst this group)**.** All agreed that mental health support should be highly targeted and offered to women who already understand the patterns of domestic violence, otherwise they do not understand the reasons behind this support. These issues are explored in the example given in the box below.

Psychological Advocacy Toward Healing (PATH) study[40]

What is it?

The PATH study was a randomised control trial in the UK that focused the psychological and mental health issues faced by women experiencing domestic violence and abuse (DVA), comparing the effectiveness of i) standard agency advocacy assistance and ii) standard agency advocacy assistance and ten sessions of 'Specialist Psychological advocacy (SPA)support. It included a nested qualitative study to explore women's experiences of the intervention. This trial included the development of a manualised training package for DV advocates who delivered the course of SPA sessions. The trial targeted women of all ages who approached one of two DV agencies (Bristol and Cardiff) for help. It was part of a five-year programme grant award by the National Institute for Health Research. Key partners for the work included NextLink (Bristol), Cardiff Women's Aid (CWA) and Domestic Violence Training Ltd.

Issue(s) it was trying to address: women approaching specialist DV agencies have a need for support for mental health and psychological interventions, as well as practical support for housing, finances and legal issues. The PATH study aimed to add in a counselling component, delivered by specially trained DV advocates working in DV agencies. It offered tailored counselling to women survivors of IPV, aiming to provide them with psychological support and practical tools to rebuild their lives after a violent relationship.

Successes:

The psychological intervention was found to have a small but positive impact on mental health and psychological functioning (as measured by the PHQ-9 and the CORE-OM).

The qualitative study revealed that the intervention filled a gap in the availability of psychological-emotional support, highlighted as a significant lack in the usual advocacy group. Women who took part in the trial and received psychological support reported a reduced self-blame and increased self-esteem. **Challenges:**

The dropout rate was high. This was partly attributed to insufficient continuity of care: there was a high staff turnover, meaning women often lost the contact person with whom they had established trust. It was also found that the counselling should be more tailored to individual needs: some women did not want deep psychological work and other did not want the practical tools.

Many impacts are not easy to measure. The lack of resources to train DV advocates was also a problem.

Lessons:

[40] The trial protocol is publicly available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3718639/

- It is important to engage women who are 'ready' – some women are too caught up resolving practical issues to engage with psychological work. For example, it is important not always to offer this support at the first appointment.
- Advocacy alone has positive effects, but advocacy with mental health support has even greater effects.
- Women valued counselling and the specific focus on domestic violence over generic support
- The manualised part of the intervention was especially sustainable.

Multi-agency initiatives

Initiatives identified as good practices by the research team, in particularly the Multi-Agency Risk Assessment Conferences (MARACs), used in the UK to identify high-risk cases of domestic violence and already considered within the literature review. Whilst participants recognised positive evaluation results of MARACs (see above), they also pointed out **the limits of MARACs,** including: the issue of agencies that are unable to complete the DASH risk assessments adequately; the limitations of agency representation at MARACs; and insufficient understanding of survivors' safety when offering support/actions. Sometimes, individuals are assessed at a level of risk that is not representative of their situation, meaning they receive little or no support even when in need of it. In particular, some participants pointed out that controlling behaviours are sometimes missed by agencies. Furthermore, health practitioners are frequently unable to attend these sessions due to timetabling issues, resulting in a loss of this crucial perspective.

Tailoring services to survivors' needs

Participants noted that **survivors' voices** are often missing from health interventions that seek to support them. As a rule, participants agreed that users should be involved in the development of services and that survivors' perspectives should be better promoted within service design, particularly when it comes to the services on offer (as occurred with the IRIS intervention). For example, one participant planned to test 'information cafes' within migrant centres as a way of reaching out to this group.

One participant mentioned the development of a website called 'I Decide', aiming at helping women make their own choices and design their own safety planning, based on the range of behaviours they are experiencing. One of its successes was the strong evidence base for it, especially the feasibility work carried out in the USA and Australia[41]. However, this participant warned it is very hard for users to realise that abuse is not 'normal'.

With regards to the difficulties that women survivors may face in disclosing violence to their clinicians, participants mentioned some initiatives, such as the setting up of a separate room for survivors in Romania (where only the survivor can enter) or ensuring access to translators (who do not have links to the family/community) in Germany.

[41] For relevant research, see Tarzia L, Murray E, Humphreys C, Glass N, Taft A, Valpied J, Hegarty K. 'I-DECIDE: An Online Intervention Drawing on the Psychosocial Readiness Model for Women Experiencing Domestic Violence', *NCBI* 2016 26(2) 208-16; also ongoing research by K Hegarty on 'I-DECIDE: Trial of an online healthy relationship tool and safety decision aid for women experiencing domestic violence', available here: http://medicine.unimelb.edu.au/research-groups/general-practice-research/abuse-and-violence/development-and-evaluation-of-an-online-healthy-relationship-tool-and-safety-decision-aid-for-women-experiencing-domestic-violence-i-decide

Health Needs Assessment of Sexual Assault Referral Centres (SARCs), UK

SARCs provide medical care (as well as a range of other support) to survivors of sexual violence (which can include those who have experienced intimate partner/domestic violence). One participant shared her experience of working on a Health Needs Assessment of SARCs within a region of the UK, which served as a benchmark against national quality standards. It also involved a multi-agency steering group, which included representatives from the voluntary, health and social care sectors, as well as the police. The participant highlighted that involving diverse groups was important for capturing a range of perspectives.

Some recommendations were accepted and are still in place five years after the assessment; for example, there is now a crisis worker in every centre. However, there are still some challenges, such as facilities that are not fit-for-purpose.

Such assessments can be an important for ensuring that support for survivors of intimate partner/domestic violence is appropriate and meeting minimum standards[42].

Changing attitudes

Participants discussed potential solutions to the issues above. They considered it crucially important to foster **attitudinal changes**, and some participants mentioned the need to **work more closely with perpetrators**. They identified the need for research on the types of perpetrators programmes that work and the methods of developing these. However, some participants pointed out funding difficulties, as such programmes can compete for funding with women's organisations and women's shelters.

The **role of education** was highlighted by several participants as a key area for prevention work. According to participants, it is necessary to identify the values that support violent behaviour, and to tackle the issue from an early age. For example, one participant mentioned a survey[43] on IPV among young people in Bristol, which was useful for understanding the patterns of violence amongst them. There is also a need to educate police officers and other people in contact with survivors. Participants noted that often, a range of professionals do not understand the mechanisms of coercive control, and that social norms can even encourage violent behaviours. This can be especially worrying given that domestic abuse puts women at risk of serious harm and homicide. It is especially important to recognise coercive and controlling behaviours in relation to risk, as they can be frequently missed by agencies/professionals.

A participant noted that there is a need to **challenge conceptions about who can get help and how.** Sometimes, women who get help are seen as weak. Professionally/agencies need to treat survivors with the status they deserve. There is a need to work on the representation of survivors and their identity. Professionals working with survivors of domestic abuse and IPV should have as their prime concern women's safety, and that of any children.

Participants highlighted the need to challenge the **norms associated with negative masculinities**. As a positive example, they referred the international campaign targeting men, White Ribbon, which encourages men to stand together in opposition to violence against women. Participants also noted that social media campaigns or public health campaigns should be better evaluated.

[42] Many of such assessments are available online. For example, see: www.northumberland.gov.uk/WAMDocuments/259D5658-FA97-4A77-BAB4-87A9D2802DB2_1_0.doc?nccredirect=1

[43] Run by the National Society for the Prevention of Cruelty to Children (NSPCC).

3.8.5.3 Relevant case studies

As part of the VulnerABLE project, an inventory of practices was produced, collecting good practices from across the European Union that promote health and access to healthcare for people living in vulnerable and isolated situations. There are four practices that aim to improve the health of survivors of domestic violence, including intimate partner violence. The two practices from Austria and Germany aim to sensitise healthcare professionals to identify and support victims of domestic/intimate partner violence more effectively. A related practice (MARACs) aims to take a more holistic approach to supporting victims, by bringing together professionals from healthcare, social care and the third sector to identify and risk assess cases of domestic abuse. The final practice from Spain supports two target groups – victims of domestic/intimate partner violence primarily, but also at-risk children and families. Specifically, the lead organisation, the Health and Family Association, offers care and guidance to victims of intimate partner violence, as well as helping to detect intimate partner violence among women attending its centres for other programmes, such as the Maternity Risk programme.

Table 11. Relevant case studies for this target group

Title	Organisation & country	Main objectives	Web link
Multi-agency risk assessment conferences (MARACs), United Kingdom 2003–14	Home Office UK	This project organises meetings which bring together professionals from healthcare, social care and the third sector concerned with domestic abuse, in order to identify and risk assess cases of domestic abuse.	http://www.safelives.org.uk/sites/default/files/resources/Saving_lives_saving_money_FINAL_REFERENCED_VERSION.pdf
Medical intervention against violence (Model project Medizinische Intervention gegen Gewalt an Frauen - MIGG), Germany 2008–11	GESINE (government funded organisation) Germany	The programme aims at developing unified standards for the treatment of women victims of domestic violence and improving the ambulatory health treatment of women suffering violence. This was done by carrying out intense exchange with universities and healthcare units; offering doctors support in documenting injuries for use in a court of law; giving specialist advice and information to patients.	http://eige.europa.eu/gender-based-violence/good-practices/germany/setting-standards-medical-care-victims-gender-violence
Care for Maternity At Risk Programme	Saludyfamilia (Health and Family Association) Spain	The programme aims to promote good maternal and reproductive health among vulnerable women and young people, by offering care and guidance for victims of intimate partner violence. It also helps to detect intimate partner violence among women attending the centres other programmes.	www.saludyfamilia.es/sites/default/files/Programa%20Atenci%C3%B3%20a%20la%20Maternitat%20a%20Risc.2014.pdf
Training Curriculum: 'Violence against	Vienna women's health programme; Vienna Municipal Department	The programme aims at enhancing the sensitivity of health professionals in dealing	http://eige.europa.eu/sites/default/files/documents/MH01

women and children' - Victim protection in Vienna's hospitals Austria, 2001–14	of Women's Affairs; Youth and Family Offices of Vienna; Vienna Hospital Association; Vienna Municipal Hospitals Austria	with victims of domestic violence, by ensuring adequate support to victims and creating awareness and effective responses among providers in the main hospitals in Vienna.	14678ENN_WEB.PDF

3.9 People with physical, mental and learning disabilities or poor mental health

Summary of quantitative findings

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 (Eurostat, 2015b). The results VulnerABLE survey indicate that a high proportion of people with physical, mental and learning disabilities report a bad health (39%) and are less likely to report a good health (22%).

Reflecting the findings of the literature review and focus group the survey showed that those in this target group are likely to be experiencing additional difficulties to their disability. Among survey respondents with physical, mental and learning disabilities 51% reported difficulties with mobility and 40% reported difficulties with stamina, breathing or fatigue. Similarly, a high proportion (44%) of those who took the survey who are have a physical, mental or learning disability reported experiencing mental health problems. Also, people with disabilities also felt significantly more depressed or downhearted (32%) than the average respondent.

Around a quarter (24%) of this target group reported being dissatisfied with health services they received. The issues contributing to the dissatisfaction of this group with medical care were the perceived ineffectiveness of the medical treatment (mentioned by 53% of dissatisfied people in this target group) and long waiting times (57%). Of all groups those with physical, mental and learning disabilities were most likely to cite dissatisfaction with the attitude of the healthcare professional (43%). A further barrier experienced by some members of this group is the ability to understand health care information with 23% of survey respondents in this target group reporting that they found this difficult or very difficult.

The proportion of people with physical, mental, or learning disabilities reporting high cost as the main reason for not visiting medical practitioners, not receiving a dental examination/treatment or not getting medication was 21%, 27% & 21% respectively which is lower than for other groups.

3.9.1 Overview of policy context

There are at least two definitions which can be applied to the broad and diverse category of people living with physical, mental, and learning disabilities. The International Classification of Functioning, Disability and Health (ICF) applied by the WHO and the definition used for the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

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 Convention's definition adopts the so called social model of disability, recognising that disability is an

evolving concept and that barriers of attitude and environment often prevent people living with disabilities from exercising all their human rights and fundamental freedoms.

During the focus group on this topic participants were asked to give their opinion about the scope of the target group. With regard to the definitions used in describing the scope of the target group, the consensus was that the definition for disability used in the United Nations Convention on the Rights of Persons with Disabilities is more suitable than the International Classification of Functioning, Disability and Health definition used by the World Health Organization. One reason for this is that the definition was developed in association with people living with disabilities, increasing its accuracy. In terms of mental health participants agreed that the World Health Organization's definition for mental health is appropriate.

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.

Overall, this category are subject to clear legislation which recognises vulnerability and mandates equal treatment for those with disabilities as well as strategy of promotion of better mental health overall at a European Level.

3.9.2 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 EU-27 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, 2015b). The proportion of people living with disabilities is substantially higher in the 45-64 age group compared to people aged 15-44 (Eurostat, 2017u).

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).

3.9.3 Health challenges

3.9.3.1 Trends in the literature

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:

- Communication barriers can affect how people in this group 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). 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.
- 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 that non-disabled people (Plan, 2013) and therefore disproportionately likely to experience the negative health effects resulting from sexual abuse, exposing them to health inequalities.
- 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). This is reflected in the higher rates of mental difficulties seen among people in this target group in the VulnerABLE survey.
- In addition, 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).

These factors together can lead to increasing health challenges for those within these group which can be tackled in order to combat the decreased life expectancy of those with physical, mental and learning disabilities.

3.9.3.2 Focus group findings

The focus group of professionals echoed many of the issues uncovered during the literature review as well considering extra points and adding detail.

Violence

The participants noted that a serious healthcare concern for those with physical, mental and learning disabilities is violence at the hands of others. People living with learning and physical disabilities or poor mental health are more at risk of violence, including sexual violence, both in domestic and in health care settings. This echoes the literature review findings that disabled people are significantly more likely to be victims of abuse that non-disabled people (Plan, 2013).

Person-centred care

The findings from the literature review reflect that there may be communication barriers between healthcare professionals and members of the target group. In addition to communication issues stemming from the patients disability, participants noted how services for the target group often do not sufficiently involve patients in planning, developing and monitoring care to make sure it meets their needs. Sometimes health professionals may believe they are applying a person centred care approach, while the experience of the patient may be very different. Additionally, in the mental health setting, culture, lack of training and stigma towards patients often leads to forced treatment or institutionalization. Also patients are often insufficiently involved in the management of medication and its side effects.

The participants felt that there is still a need for a more person-centred approach to health and social care in the target group. Participants expressed the hope for a paradigm-shift towards person-centred health care; however, they acknowledged that innovation and adaptation in often ritualistic health care systems have proved to be very slow.

Informal carers

An additional consideration raised in the focus group was that people living with physical and learning disabilities or poor mental health are often reliant on self-management or the care provided by informal carers (e.g. a relative or spouse). Participants pointed out the negative consequences this situation may have for both the informal carer and the one being cared for. For example, informal carers may not always be practically available to help the person living with a disability or mental health problem, because they miss the right tools and equipment, or because their work or family life leave no time for informal care activities. They may lack adequate information, e.g. contact information of relevant institutions, or miss support in accessing IT tools.

The work of the informal carer is frequently undervalued, insufficiently recognized, or simply misunderstood. Informal carers may even experience stigma in the work place: employers or co-workers may consider someone less reliable because of their role as informal carer. This can lead to a situation where people providing informal care for vulnerable people become vulnerable themselves, which may in turn lead to unmet care needs for the person living with physical and learning disabilities or poor mental health.

Monitoring and Access

Overall, participants expressed their concern about several aspects of assessment and monitoring of physical and learning disabilities and mental health. First of all, disability assessments currently in use may not assess disability in the right way. For example, people may be asked whether or not they are able to wash, dress, eat, use the toilet or communicate their needs, without being asked how much effort is needed for these activities, i.e. assessing actual functionality. In addition, the ability to wash, dress, etc. may also be influenced by changes in the severity of the condition over time, meaning

people may at times need assistance where they did not need it before. Participants also indicated that sometimes, the time between a first and second disability assessment can be as long as 10 years. In the mental health setting, monitoring and assessment may be equally problematic, even though the causes may differ. In terms of assessment, for instance, it is difficult to decide what 'normal' adolescent behaviour is, and what behaviour is an indication of poor mental health. Issues of privacy and data protection were also mentioned in relation to monitoring people with poor mental health. There is a need to revisit the ways physical and learning disabilities and mental health are monitored and assessed, with an emphasis on improving adequacy and continuity.

3.9.4 Access to healthcare

3.9.4.1 Trends in the literature

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 are 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). Participants within the focus group reflected that the specialisation of healthcare meant

that those who treat physical health conditions may have little understanding of mental health conditions and therefore patients may be required to see a large number of specialists and lead to a situation where the connection between the patients physical and mental health is overlooked.

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.

3.9.4.2 Focus group findings

Complex systems

The participants agreed that the complexity of health and social care systems is frequently a barrier to achieving the highest attainable standard of health and well-being for people living with physical and learning disabilities or poor mental health. The way in which complexity affects the ability of individuals in this target group to manage their own healthcare as discussed by participants reflects the findings from the literature review which highlight how communication can be a barrier to healthcare for members of this group (Emerson and Baines, 2010).

The participants detailed how expanding medical knowledge and the increasing complexity of healthcare delivery have led to high levels of specialization in the healthcare workforce, often with little coordination or communication between specialists. People with complex conditions often need to see a vast range of specialists to have their healthcare needs met. In many services, specialization also leads to situations where the relationship between mental health and physical health is overlooked or not sufficiently taken into account.

The participants pointed out that due to its complexity, people living with physical and learning disabilities or poor mental health as well as their (informal) carers/families, often struggle navigating the system of health and social services. For instance, people may experience difficulties with formally being recognized as disabled, which may lead to missing out on certain (financial) benefits. Forms and official documents currently in use are often difficult to understand and use, especially for people with low education or IQ.

Health coverage

The literature reflects that those with physical, mental and learning disabilities are more likely to experience poverty or lack of material wealth (Nocon, 2006). The participants noted that this situation exacerbates the access to healthcare in that for some conditions, not all treatments and/or equipment necessary for improving patients' health and well-being are (fully) reimbursed. For instance, in some countries incontinence supplies and products for spinal bifida patients are not at all or only partly reimbursed by their health insurance. Similarly, people with poor mental health generally have easy

access to medication, but not to other types of psychosocial interventions, among other things because the costs for these interventions are not completely covered by their insurance. Appropriate coverage of health related costs is especially important because unemployment and lower incomes are common in the target group.

Age-appropriateness of care

An additional consideration arising from the focus groups was that people with mental health problems have difficulties accessing services appropriate to their age. For example, in many settings there are services in place aimed at children and services targeting adults, but no targeted tools for adolescents, which result in them risking ending up caught between two stools. This is a cause of concern, considering that often mental health problems arise around the age of fourteen, i.e. in early adolescence.

In the case of physical disabilities such as spina bifida, services for patients such as multidisciplinary care may even be completely discontinued at the age of 18 in some countries, with limited expertise, resources or will to create clinics featuring integrated multidisciplinary teams to coordinate healthcare for adult spina bifida patients.

3.9.5 Evidence of policies being used to support this group

3.9.5.1 Trends in the literature

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:

1. Reduce health inequalities among this group and improve access to primary care and equitable treatment;
2. (For health commissioners) Identify and develop outreach services and new models of delivery to meet the needs of this group; and
3. 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).

3.9.5.2 Focus group findings

The participants came up with a range of 'best practices' and solutions aimed at improving health and well-being and access to health and social services for the target group. Several of these reflected the importance of treating the individual as a whole person considering the difficulties in receiving joined up care reflected in the health challenges. Other solutions were related to the increasing use of technology in improvising healthcare outcomes for this group. The focus group participants also echoed the role of increasing education and understanding in combatting stigma. In this case the participants discussed interventions targeted at other professionals such as teachers and the general public to decrease stigma and improve understanding of the conditions faced by those within this target group.

Social prescribing

In Newcastle, Ways to Wellness provides social prescribing for people with long-term health conditions who attend general practitioner practices in the West of Newcastle (UK). A dedicated 'Link Worker' works together with the patient to access support, services and local activities, with the aim of improving quality of life of the patient. It goes without saying that the 'people skills' of the Link Worker are of crucial importance for the success of the initiative. The innovative funding mechanism was mentioned as one of the key success factors of the project. A Clinical Commission Group, a community funder using money raised by National Lottery players, and the Cabinet Office provided outcome-based funding, enabling Ways to Wellness to build its capacity before the benefits in terms of patients' well-being and cost-savings for the health system could be determined.

Engaging communities

"Trialogue" is a term used to describe an open dialogue and participatory process often used in so called 'Psychoseseminare'. These psychosis seminars bring together people with mental health problems, their family member and mental health professionals with the aim of improving (health care) services for those living with poor mental health. Trialogue is more and more often also used to engage communities in talking about mental health, thereby improving understanding and reducing stigma and social isolation. Psychosis seminars and the 'trialogue' principle were developed in Germany in the late eighties and are still highly popular in German speaking countries. More recently, it spread to other countries, for example Ireland.

In Denmark, an NGO and three municipalities developed a support system for people suffering from rare diseases to promote health literacy in the most vulnerable patients based on voluntarism. Eighteen volunteers called 'navigators', support 20-25 patients by acknowledging their personal situation, creating an overview of options and encouraging health literacy and support compliance . The navigators are either people suffering from a rare disease or a relative of a person with a rare disease; this implies that the support system is at times unavailable, but also means that the navigators can apply their experience-based knowledge to help the patients help themselves.

Technology

One of the participants pointed out the potential of bringing in technology to improve the health and access to care for the target group. For example, apps can be developed to be used by people with mental health problems to monitor emotions, contact health professionals, and find information on how to act in crisis situations. There are also

online courses for e.g. health professionals and informal carers that provide people with the opportunity to connect and share experiences. Good examples are the free online courses offered by the Institute of Psychiatry, Psychology & Neuroscience at King's College London, London (UK) , and the ACTION service in Sweden, that provides carers of older people (who can be suffering from physical or mental health disabilities) with a range of web-based educational caring programmes, videophone facilities for peer support with other users and access to a call centre run by professionals in the municipality, and an in-depth computer training course . Also mentioned as promising in the context of the employment of technology was the European Union's Horizon2020 Research and Innovation Project 'ICT4life', that aims to provide new services for integrated care through user-friendly ICT tools to improve the quality of life of people living with Parkinson's, Alzheimer's or dementia and their care givers .

Private sector and informal carers

From the perspective of the informal carer, providing care and support for people living with physical and learning disabilities or poor mental health, the private sector may have an important role to play by providing flexible working hours and other sorts of support. At national level, public organizations, NGOs, but also big private enterprises, are starting to realize that in order to retain or acquire workers the issue of informal care has to be taken into consideration. After a certain age, having to care for a spouse or a relative is an important cause for employee to opt for part-time work, early retirement, or even a complete change of job. A very limited amount of big enterprises in France is therefore offering their employees a subscription to a platform where they can receive personal 24/7 advice from a cardiologist, and an administrative worker who can provide information on e.g. subsidies. In the UK, the carers organization Carers UK created a 'label' for carer-friendly enterprises, awarded to enterprises that fulfil certain conditions in terms of support and protection of informal carers, for example, a flexible workplace, or activities to create awareness about the care issue among staff (e.g. a lunch meeting) . A challenge of the initiative is that it is mainly enterprises with high skilled employees offering this sort of support, in contrast to other industries with more temporary or low-skilled workers. The risk is therefore to leave those that are worst off further behind, increasing the socio-economic gap in health.

Campaigns and Media

Campaigns and the media were frequently mentioned by participants as effective tools to raise awareness and change broader societal perceptions around people living with physical and learning disabilities or poor mental health. Participants expressed their appreciation for attempts of companies and broadcasters to improve social inclusion by featuring people with physical disabilities in TV series or advertisements.

On the topic of targeted campaigns, the participants told that even though campaigns have proven to be effective in terms of addressing stigma and misconceptions, this solution is not without its challenges. First of all, there are large between-country differences in pre-existing levels of awareness and social inclusion that should be taken into account when transferring or developing awareness raising campaigns. In the mental health setting, the biomedical approach often used in awareness raising campaigns in the past was found not to decrease, but increase stigma towards people living with poor mental health. However, even the social approach to mental health problems used in the development of awareness campaigns of today has its weaknesses. There are examples of campaigns that managed to increase societies' knowledge and understanding on more common mental health problems such as depression, but failed to address misconceptions about more serious mental health issues such as schizophrenia.

The participants agreed that Social Media Campaigns can be a double edged sword; for example, an anti-bullying campaign can be effective in starting a conversation about an important topic among the target audience, but at the same time be used by that very same audience as a platform for online bullying. Also for Social Media Campaigns,

possibilities to determine overall impact on levels of awareness, as well as the extent to which the campaign reached its audience, may be limited. Algorithms employed by Social Media to create the content a user will see are based on 'Likes', connections, etc., creating a 'filter bubble', which may prevent awareness campaigns and the like from reaching their target audience.

The same accounts for the use of 'ambassadors' or 'champions', e.g. sports celebrities or movie stars, for awareness campaigns. A (national) celebrity speaking openly about his depression may be a highly effective tool for influencing public opinion and breaking social isolation for people living with poor mental health. However, personal experiences by definition cannot reflect the infinite versatility in experiences connected to a certain condition, and health professionals may feel uncomfortable with the promotion of certain types of medications or treatments by the ambassador (e.g. medical vs psychosocial approach to treatment of mental health problems).

Education

Schools and working environments were frequently mentioned as places to identify and reach out to vulnerable people, including people living with learning and physical disabilities or poor mental health. In Finland, researchers developed a training program for teachers to help them deal with challenging behaviour of children in the classroom, making sure to speak the language of the teachers and providing them with tools to address these behaviours. Next to a drop in absenteeism among teachers, there was a 30% reduction in the referral rate of students to youth mental care, identifying the training as a useful early prevention tool. However, even in countries where perceptions of mental health are quite advanced, teachers often do not receive formal training in dealing with challenging behaviour and mental health issues among children. Both at schools and at the workplace, people seem reluctant to receive training on mental health or disability, unless there are people in their organization who are directly affected. Besides, teachers may not be willing to interfere, because they believe the issues are to be solved in the private sphere, depending on cultural backgrounds and training. Sensitization and awareness may solve some of these barriers. Inclusion of compulsory training on these issues in education curricula for teachers could represent a solution.

In a Swiss Canton, a pilot scheme supports persons living with a recent diagnosis of a rare disease by providing information and training for caring specialists, coaching the patient, and coordinating different experts' interventions.

3.9.5.3 Relevant case studies

As part of the VulnerABLE project, an inventory of practices was produced, collecting good practices from across the European Union that promote health and access to healthcare for people living in vulnerable and isolated situations.

Three case studies showcase approaches that target people with disabilities or poor mental health. Broadly speaking, these practices aim to address key issues that can cause poor health status among people with disabilities and mental health issues. The precise focus of these practices differs widely, reflecting to some extent the diversity of this target group.

One (SLaM) seeks to change the *delivery* of healthcare to mental health patients, by improving the relationships between staff and service users in psychiatric units. The Special Olympics programme aims to improve the health status of children and young people with intellectual and physical disabilities, by helping them to participate in sport. The last practice seeks to improve health awareness among women with mental disabilities in the Czech Republic, by producing easily understandable information about sex and the female body.

Table 12. Relevant case studies for this target group

Title	Organisation & country	Main objectives	Web link
SLaM (South London and Maudsley NHS Foundation Trust) 'Tree of Life' approach	Tree of Life UK	This project aims to promote the recovery approach in hospital wards and to better prepare patients for hospital discharge through developing more positive relationships between staff and service users. This is done through peer support training to staff and service users within psychiatric units, using the 'Tree of Life' model.	http://www.supportslam.org.uk/why/supporting-service-users/the-tree-of-life
Special Olympics Youth Unified Sports programme	Special Olympics Europe Eurasia Foundation Transnational	This programme provides health services for children and adults with intellectual and physical disabilities. It helps them to participate in sport and live active lifestyles contributing to health and well-being, mainly through trainings combining young people with and without disabilities. Parents and families are also involved in the creation of an environment of social inclusion and integration.	http://www.specialolympics.org/uploadedFiles/LandingPage/WhatWeDo/Final%20Report%20Unified%20Sports10%20Sept%202010.pdf
I See! About Soul and Body for Women with Intellectual Disabilities[44]	Society to Support People with Intellectual Disabilities Czech Republic	This project produces easy to understand information for women with intellectual disabilities about sex and the female body to support them to make informed choices about sex, relationships, and their health.	http://eeagrants.org/project-portal/project/CZ03-0166

[44] Czech: Už vím! Srozumitelně o duši a těle pro ženy s mentálním postižením

4 Conclusions

This chapter brings together the findings from all stages of the research and presents the main conclusions for each target group.

4.1 Findings per group

4.1.1 Older people

Health needs and challenges

The prevalence of illness or health problems is significantly 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%). Whilst the higher rates of long-standing illness or health problems among older people is not surprising, the data also shows considerable differences between Member States. Rates of long-standing illness or health problems among those aged 65 and over in individual Member States vary significantly, from 39.5% (Belgium) to 83.4% (Estonia).

This is reflected in VulnerABLE survey findings. Among survey respondents, older people who were in vulnerable or isolated circumstances had the second highest rates of bad health (38%) and long-term illness, disability or infirmity (73%), well above the average rates for all survey respondents (28% and 61% respectively). Older respondents also had the highest rates of problems with: mobility (56%); and stamina, breathing or fatigue (48%).

Older people in vulnerable or isolated situations also report having greater difficulty accessing healthcare services than average, with 43% reported finding healthcare services difficult to access, compared to 32% of all survey respondents. This was primarily due to the cost of healthcare, although difficulty understanding health information provided by doctors, nurses and other healthcare professionals was another barrier older people often faced (27%).

Greater healthcare needs among the older population are caused by several key factors. Older people are much less likely to be in employment than younger population groups, due to factors such as retirement, early retirement and labour market discrimination. This leads to a reduction in older people's income, making access healthcare more difficult. This point is of particular importance given the general higher levels of healthcare needs experienced by older people due to the effects of biological ageing.

Also relevant is the fact that, in general, older people tend to have lower levels of education and therefore lower levels of health literacy than younger population groups, which can cause them to have greater difficulty understanding the information given to them by healthcare professionals. They are also more likely to struggle more with navigating the healthcare system.

Finally, older people are less likely than average to possess private transport and are therefore more reliant on public transport. 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.

Policy responses

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.

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. The maximum score on the Index is 56.4, indicating that a country has taken substantial steps across these four domains.

Active Ageing Index results for 2010, 2012 and 2014 highlight 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.

The European Innovation Partnership for Active Ageing was 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.

Age-friendly environments need a whole of community approach and should aim to keep older people active within the community. In order for age-friendly environments to be successful, an assessment of what "age-friendly" means in (the contexts of) different communities is needed. Age-friendly environments also need to be created in collaboration with older people for them to be effective. Neighbourhood centres could also be part of the solution: meeting points against isolation and easily reachable by services (health, social, etc.) to develop interventions.

A legislative framework for social inclusion solutions is missing at EU level and in some Member States, especially concerning age discrimination. At EU level, however, there is work undergoing on a Convention on the Rights of Older People, which is a promising step towards better societies facing the current demographic changes. This could potentially help address the 'ageist healthcare systems' barrier identified.

4.1.2 Children and families from disadvantaged backgrounds

Health needs challenges

The literature review and focus group results demonstrated the following:

- There are 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 experiences**, which can lead to a range of health issues including respiratory, circulatory and oncological diseases, mental health problems, drug abuse and risky health behaviours (UCL IHE, 2015).
- Families from disadvantaged background are **more likely to be impacted by specific health issues** such as lack of access, lack of services, etc. Cost of treatment, and especially long-term treatment, is indeed considered as one of the main barriers to access healthcare.
- **Children from deprived backgrounds** have considerably **worse health and wellbeing** compared to children from non-deprived backgrounds. A clear link was also found between children growing up in low income households and the poor health management and the prevalence of special or additional education needs, likely to affect children in adult life.
- **Lone parents** often experience **poorer physical and mental health** compared to their two-parent counterparts (Rousou et al., 2013). The observed health inequalities in the Rousou et al. (2013) study were associated with socioeconomic disadvantage due to either unemployment or insufficient welfare support. They are indeed more likely to experience economic and financial issues, which might make them more vulnerable.
- The **effect of growing up in a lone-parent household** has also been **linked with poor outcomes in adult life** (Suavola et al., 2000). Family background may impact on physical illness in early adulthood. Women from lone-parent families are more likely to be treated for any physical condition in hospital wards compared to women from two-parent families (61% versus 57%). Similarly participants from lone-parent families were more likely to develop higher rates of depression, and have lower self-esteem, poorer family finances and poorer self-reported health (Miller and Plant, 2003).
- With regards to **access to healthcare**, there is limited literature examining the barriers in access for at risk children and families across the EU; more research is necessary to understand the specific barriers this group may face. Research findings show that in general parents experience physical and practical barriers in accessing health care services (Katz, La Placa and Hunter, 2007). **Social barriers, such as poverty, disability, ethnicity and being a single parent can pose a barrier to accessing services**. In addition, the research suggests that time pressure of managing a household and childcare can affect single parents in accessing health services.
- The **stigma** and the self-stigma are important factors **hindering access to health care**. The phenomenon of 'shy poverty' (when people are living in poverty but do not want other people to know) acts as an impediment to people to ask for certain types of services (such as free meals).
- **Isolation at home**, and especially in the cases of people providing care to their family, is **both a cause of poor health and a barrier to access health care**. Participants noted that isolated people are not provided information on existing services and often find themselves without resources when they face health issues. Isolation was considered to be linked to difficult economic situation, and to the organisation of healthcare and social care.
- The **lack of information on health and on available healthcare services** as well as unfamiliarity with own rights are important obstacles to access healthcare. Existing **administrative burdens to access** to certain health services were also

highlighted. For specific groups, this issue is also added to the **lack of legal access to health care system** (e.g. undocumented migrants).

- The **lack of quality care** is also a cause of poor health and of limited access to healthcare. Indeed, participants mentioned issues with regards to confidentiality or with regards to the attitude of service providers towards users.

Policy responses

The literature review results showed examples of policy options aiming at: addressing the health needs of these families; reducing poverty and improve the economic circumstances of this group; supporting families in the care of children.

With regard to the **approaches to address the needs of at risk children and families**, initiatives were found at the EU and Member State level. 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). To support the implementation of the Social Investment Package and Recommendation for Investing in Children, the European Platform for Investing in Children (EPIC) 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).

With regard **to initiatives to reduce poverty and improve the economic circumstances of the family**, policy recommendations at the EU level state that Member States should encourage the participation of disadvantaged families by breaking down the barriers to childcare access, such as through subsidised childcare (European Commission, 2013b).

Welfare payments to vulnerable families, including single-parent families, are also important in reducing risks of poverty as they increase household incomes. **Universal approaches to healthcare** are considered particularly effective, in comparison to more selective approaches; the former tend to be associated with higher rates of family spending (Cantillion, 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, 2016g). Well-paid parental leave, subsidised childcare and cultural support for employment soon after childbirth are associated with a reduced gender employment gap and narrower 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 (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** (Mantouvalou, 2015).

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.

Concerning initiatives addressing the direct needs of disadvantaged families the example of the DIATROFI programme in Greece was provided. 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, and to encourage healthy eating among children and families. The programme **tackles food insecurity and hunger**, which are proven to have a negative impact on children health and 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).

The experts from the Focus Group identified policies and measures that are understood to have a positive impact on the health of children and families from disadvantaged backgrounds:

- **Provide information on health and healthcare services**: improving children's food choices and nutrition, by providing better targeted information, using different types of media. The importance of the Internet in children's access to information and to food marketing should be taken into account. Empowering people to make their own choice regarding their health is linked to improving their health literacy. Improving health literacy in both formal and informal education was presented as a recommendation for policy makers.
- **Address barriers to access healthcare**: any measure taken to address health issues faced by people in vulnerable situation should be cognisant of the potential stigma related to the issues (e.g. poverty). Addressing discrimination that impedes access to health care and health services.
- **Encourage participation**: beneficiaries should be involved in evaluating the quality of the services provided to respond to the issues they face. Associations should be involved in the development, implementation and evaluation of policies. Participants also highlighted the need to build synergies between different organisations.
- **Adopt a holistic approach to health**: health is impacted by what happens in other areas. To improve health, it is necessary to also address related policy themes. As such, policy recommendations should be developed in the health field, education field, employment field, recognising that these three areas are interlinked. Policies should focus on the service delivery, provision, prevention and on developing an enabling environment. The quality of services is important and should be added to the list of factors to be taken into account.

4.1.3 People living in rural/isolated areas

Health needs and challenges

In 2016, there were fewer people living in rural areas (27.5% of EU-28 population) compared to urban areas (72.5%) (Eurostat, 2017h). 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 UK), **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. The ageing of rural populations poses challenges to the delivery of healthcare services, particularly primary care. The focus group confirmed that in some rural areas doctors are now mainly serving the elderly population, with impacts on the type of care they deliver.

Physical location is a major determinant of vulnerability. Compared to urban areas, rural areas tend to have relatively limited access to healthcare and other services, due to a range of demand/supply factors (Mechanic and Tanner, 2007). Rurality is often a neglected factor that influences health status and health service provision (WHO, 2010a). Focus group participants highlighted how the level of rural development affects the health needs of rural communities. For example, a lack of services in a particular area may fuel outward migration of young people. Similarly, a lack of public transport may make some patients (especially the elderly) more reliant on others to support/maintain their health. This situation can represent a vicious cycle, whereby gaps in key services (e.g. mental health services) can make some people leave the area and reinforce socio-economic deprivation there.

EU-wide data demonstrates that **people living in rural areas are slightly more likely to report unmet healthcare needs than those living in towns or cities**[45] (Eurostat, 2017v). The most important barrier cited by rural residents is expense. VulnerABLE survey findings confirm that those living in rural/living areas face challenges in accessing quality services, particularly due to cost. For example, 40% of those in rural/isolated areas cited affordability as a barrier to getting medical treatment. In all, 31% of people in rural/isolated areas were very or quite dissatisfied with their healthcare services, according to the VulnerABLE survey. More than a quarter (26%) have not received medical treatment due to no appointments being available.

According to the literature, key barriers to accessing healthcare in rural areas 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).

Health services in rural areas commonly **struggle to recruit and retain qualified health care workers** to provide healthcare for the local populations (WHO, 2010a). The focus group identified key reasons for this, including a lack of incentives and stereotypical views of rural practice amongst potential new recruits. Challenges to retention include the social/professional isolation of rural doctors; high workload and burnout in some Member States (especially Greece, Italy, Germany, Latvia and the UK); and difficulties making rural practices financially viable (due in some cases to a particular capitation scheme in place and challenges in physically taking more patients).

There can also be key **differences in the type of workload of general practitioners in rural and urban areas.** For example, research in Bulgaria found that there is often a single general practitioner providing services to local rural populations. This limits each patient's ability to exercise their right to choose their doctor, as well as presenting difficulties in obtaining a second opinion (Georgieva et al., 2007). Focus group

[45] Reported by 6.8% of rural residents, 5.8% of those in towns and 5.7% of those in cities.

participants agreed that a unique feature of rural general practice – relative to urban care – is the emphasis on relationships. Indeed, family doctors are often called upon to act not only as care providers, but also to provide financial advice and counselling. According to some, the role that doctors play in the community can be seen as a key benefit of operating a rural general practice, but it can also pose a big challenge when it comes to recruiting individuals with the right 'skills mix'.

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 large proportion of the population in rural areas (Vladescu et al., 2008). Other research suggests that some rural residents may have lower levels of access to breast screening, treatment for acute myocardial infarction, asthma and cancer (Deaville, 2001). In some cases, greater distance to specialist services can reduce survival rates from some cancers and asthma (Davies et al., 2008). In addition, the focus group suggested that rural GPs may also have limited, infrequent access to specialist care in urban areas (i.e. once a week) and that, even after referrals are organised, some rural residents may feel uncomfortable visiting specialists if it is costly and requires travel to another city.

Relatedly, focus group participants warned of the **challenge of organising emergency and/or out-of-hours services within rural settings.** This may lead GPs taking on an 'A&E' role within their surgeries, such as in some rural parts of Slovenia. This can put them in a difficult position when it comes to prioritising patients. The **limited role for preventive care** in some rural areas can fuel additional demand for services at the point of crisis. 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 found that children were more likely to be seen by a family doctor than by a paediatrician, in rural areas. Although the full consequences of this are unclear, this many impact on the quality of specialist care available to young children in rural populations. The focus group warned of **gaps in social care and outpatient care**.

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). On the flipside, as highlighted in the focus group, it can be **difficult for rural GPs, district nurses and/or other clinicians to deliver home care**, due to the time required and long waiting lists. For example, some warned that home care in the UK is typically underfunded, due to a failure of government to recognise the time it takes.

EU-wide data indicates that the level of unmet need in rural areas may be increasing (Eurostat, 2017f). This impression was confirmed by some focus group participants, who warned of the impact of the crisis on rural healthcare provision in some countries, particularly southern European countries (Greece and Italy).

Policy responses

The EU supports rural areas through its rural development policy (2014-2020), which funds social inclusion projects in rural areas. The WHO has called for policies to improve access to healthcare and better meet the needs of rural populations. This includes the following actions: **improving the level of human resource within rural populations; improving the regulation and monitoring of rural areas; improve the service delivery in rural areas; and improving access to healthcare through financial measures** (CSDH, 2008).

Various strategies have been tested to alleviate the shortage of clinicians in some rural areas, particularly incentive schemes for clinicians and early exposure to rural practice within the medical curricula of students (Straume and Shaw, 2010). Typically, strategies focus on recruitment/retention incentives (such as subsidies), flexible and responsive continued professional development; flexible employment opportunities; development of practitioners with specialist skills (generic specialists); greater professional support for staff; and rural general placements for students. 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 educational opportunities and chances for career growth. .

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**.

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). In addition, the focus group confirmed that rural doctors across Europe are adopting creative strategies to ensure that they are reaching out effectively to all of the local community. This includes more traditional methods of outreach (such as home visits for the elderly), as well as newer forms of service delivery, such as e-prescriptions and mobile health units for particular groups. Focus group participants considered that digital services can play an important role in saving doctors time, but that they need to be carefully considered, given the limited technical literacy of some of the target group and data sensitivity.

To improve disease prevention in rural areas, some Member States (such as Latvia) have recently begun testing **mobile screening services,** as indicated in the focus group**.** It can undermine their effectiveness, however, if doctors need to spend significant time awaiting test results from labs in urban areas, due to the unavailability of electronic results. It is worth noting that in some Member States, the practice of mobile cancer screening services is more established, such as in the UK, where mobile breast cancer screening services have been in place for some years.

4.1.4 People with unstable housing situations (the homeless)

The problem of insecure housing has been increasing across Europe since the 2008 financial crisis. However, there is currently a lack of systematic data collection across the EU28 on those who are vulnerably housed. 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 summarises under the European Typology on Homelessness and Housing Exclusion (ETHOS) (European Commission, 2014b). These categories are roofless, houseless, insecure and inadequate.

Available literature on the health needs of homeless populations indicates that this group is characterised by multiple physical and mental health needs (Roche, 2004)

Health Challenges

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** (Homeless Link, 2014). Focus group participants explained common health issues faced by homeless people to be skin problems; dental problems; and other issues that are often related to lack of access to hygiene and to homeless people's life style. Homeless people (particularly roofless) are also at much greater risk of contracting communicable diseases (compared to the general population), including Tuberculosis and Hepatitis (Griffiths, 2002).

There is a link between experiencing homelessness and drug use. Research in the UK showed that **39% of homeless people reported having a drug problem at some point in their life** (Homeless Link, 2014). Homeless people are also more likely to experience mental health problems and this is confirmed in the VulnerABLE survey findings which showed that mental health problems were reported by 39% of people with unstable housing and 58% report feelings of stress as being detrimental for their health. Focus group participants noted that problems physical and mental health and addiction usually go together.

Further risk factors which exacerbate health issues for those that are homeless include tobacco use (McNeil, 2012; O'Reilly et al, 2015), poor nutrition (Seale et al. 2016) and violence (Griffiths, 2002). The focus group findings emphasise the **specific health issues faced by homeless women including constant exposure to violence**. Participants in the focus groups also noted that the **homeless population tend to have less knowledge of their own health situation**, for example, detection of cancer among homeless population happens at a later stage than for the general population.

In general, **roofless living conditions are often associated with the most severe risks to both physical and mental health** (Griffiths, 2002).However, 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, skins diseases, and digestive problems (Shelter, 2004).

Access to Healthcare

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), **homeless people have particular issues accessing primary care** services and tend to be over reliant on secondary and acute health services (Homeless Link, 2014). The most vulnerable of homeless people (those deemed

roofless), are likely to live particularly chaotic lives, leading to unplanned health service use which usually occur at a point of crisis.

The research also found that homeless people experience **difficulties in following the whole course of treatment until the end of their illness** (for instance in case of tuberculosis). This is due to the unstable nature of housing, with those mid treatment perhaps forced to stop due to other factors in their life, such as being roofless. The research also found that homeless people often experience specific issues to access end of life care/palliative care provided in mainstream services.

Members of this target group face **bureaucratic barriers to accessing healthcare**. One such issue is that 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). The literature also suggests that factors such as stigma and lack of trust, may affect the utilisation of health services among this group, particularly amongst the most vulnerable (Stephens, 2002). This was corroborated in the focus group where explained that attitudes toward homeless people can impact on their access to healthcare. They also noted that the stigma often becomes a self-stigma, explaining why homeless people do not try to access to healthcare. Moreover, in some Member States, homelessness is criminalised making homeless people wary of engaging with services.

The lack of connection between social and medical services was highlighted as particular issue, with weak or no link with medical services meaning that homeless people often do not receive adequate treatment.

Additionally, a significant element of homeless populations are irregular migrants who are not entitled to free accesses to t healthcare services. This status compounds the issues faced by the homeless population in general.

Policy Responses

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. The research found that important characteristics when developing healthcare services for homeless people should be multidisciplinary and low access. The findings also emphasise the role of policy at a national and European level at preventing homelessness in the first place through inclusive economic and social policies.

Training for healthcare providers

The importance of education and training was highlighted during the research, including understanding the key transitions, periods, risks, issues, needs, etc. and the importance to understand the role of the healthcare professionals. Focus group participants recommended making access lower and training professionals to be able to treat and care for homeless people.

Housing First

Recently, in homelessness policy there has been significant 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. 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).

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). However, focus group participants pointed out that although having a stable house is an instrument of integration, the health impact should not be overestimated and that these programmes have been implemented only recently and it

is also too early to make a judgement on healthcare Participants stressed that access to housing cannot replace the health intervention. The positive results of Housing First should be considered in light of the high level of investment required for them to operate.

Targeting specific health needs

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. 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**.

An 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. However, participants in the focus group noted that initiatives that such as mobile hospitals to reach out people in insecure housing situation were interesting but wanted to highlight that those are just the first step and that outreach should not stop there. Participants noted that mobile hospitals are useful to make detections, but after that, there is a need to put people into the existing social network and healthcare system. It was recommended by participants not to advocate for a parallel healthcare system, but to promote measures aiming to make the mainstream healthcare system more available to respond to homeless people's needs and issues.

Combining health and social care

Specialised services for homeless people can be particularly effective where they combine specialist knowledge and understanding with enhanced access. For example, the Find & Treat service also supports the TB treatment of socially vulnerable and complex cases using both medical and social work professionals. The service has an 84% success rate of treatment completion which has been attributed in part specialist knowledge of the target group available in the service and the multidisciplinary approach of the service (UCL, 2014).

Similarly, the research found models which support homeless individuals to exit from secondary care via a medical respite programme) can be effective. Focus group participants discussed the **potential usefulness of intermediate places for accommodation where homeless people can stay to recover when they leave the hospital and are too sick to go back to the shelte**r. Such places have been developed in France. Evidence from the USA suggests that such medical respite programmes have been shown to reduce readmission and days spent in hospital among homeless populations (Doran et al., 2013).

Tackling health inequalities in access to healthy lifestyles

Other approaches to improving overall health involve tackling inequalities in access to healthy lifestyle behaviours, such as exercise. Many organisations that provide such opportunities for homeless individuals exist across Europe. One of the more established models of this sort of interaction is street football. As well as regular exercise these groups provide homeless individuals with valuable social capital. However, focus group participants noted that the value of these activities in isolation should not be overestimated.

Some initiatives have also been taken to enable homeless people to meet their basic hygiene needs, such as in Paris, where some restaurants now allow homeless people to use their toilets to clean themselves, or in Budapest where the initiative 'City for everybody' was recently implemented. The initiative aimed at building more public toilets and to encourage homeless people to use those facilities. Similarly, Psychological

and emotional environments are important and should be taken into account when developing solutions. Participants considered valuable some initiatives aiming at strengthening social networks around people (using peers; social services; medical services; etc.).

Harm reduction approaches to healthcare

Homeless individuals are disproportionately affected by substance misuse issues. One approach to supporting the health of an individual are harm reduction initiatives. 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.

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.

4.1.5 The long-term unemployed and the inactive

Health needs and challenges

Long-term unemployment and inactivity are among the main concerns for policymakers in the EU as they negatively affects individuals as well as hindering economic growth. **Analysis of EU long-term unemployment data indicates that around 4% of the labour force were long-term unemployed in 2016.** The most recent data on inactive people indicate that in 2014 the share of the economically inactive population within the working age population (15-64 years old) was around 27.1% across the EU-28. 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, 2017k).

The results of the literature review confirms that 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. Long-term unemployment and inactivity are associated with a range of poor health outcomes, including: premature ageing, poor mental health, negative health behaviours (e.g. hazardous drinking), low levels of self-reported health, increased risk of mortality.

With regard to access to healthcare, the literature review results show that **people experiencing long-term unemployment and economic inactivity are likely to experience barriers in accessing healthcare in relation to cost**, particularly within Member States where access is reliant on in-work benefits or insurance coverage, or where there is a direct financial cost involved in accessing care.

The health experts from the Focus Group mentioned that for instance, although the new Law 4368/2016 in Greece offers free access to healthcare services for all people, poverty still remains a major cause of ill health and a barrier to accessing health care when needed. The huge number of vulnerable people in need of public health services impacts on the quality of healthcare. Also, individuals from socially vulnerable groups cannot afford to purchase quality food or pay for health care services.

Another barrier linked to poor health, identified by the focus group, is the reduction of screening for diseases such as breast and prostate cancers, as well as the limited use of primary health care that force patients to arrive for treatment at late stages when serious conditions have already taken hold. Moreover, especially for people that live in isolated areas the high transportation costs to receive health services or reach a health centre consists an added problem. The Focus Group participants also mentioned that there is a significant lack of information concerning the advantages of the new Law and the provision of free health care access for persons not covered by any social security scheme. Furthermore, the participants pointed out specific needs or health issues for the project's target-groups that are strongly connected to the above barriers and the life conditions they experience.

Policy responses

EU level policy has focused on creating sustainable job opportunities for the unemployed. 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. The European Council has 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 to encourage them to register with employment services, and provide specially tailored and personalised support to this group (European Union, 2016).

However, there is little evidence indicating how these policies address the health issues associated with long-term unemployment. According to the literature, across the EU welfare states have focused efforts on trying to get long term unemployed, many of whom have long-term health conditions, back into work.

For instance in the Belgian Brabant Wallon Province, 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).

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 bring 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 literature review provided examples of actions can support long term unemployed to improve their health and also move them closer to the labour market:
- 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 an improvement in both objective and subjective health.
- 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 (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 indicate that the programme showed positive effects on health-related quality of life and mental health, particularly anxiety, of long-term unemployed persons.

The findings from the Focus Group focusing on the Greek system indicate that the solutions for improving the health of long term unemployed are complex. The key organisations to be involved in policy solutions are multiple: the Ministry of Health, the Ministry of Employment, Social Security and Social Solidarity, the Municipalities and the NGOs. These actors should engage in the design and implementation of a variety of programmes for the reduction of inequalities in health outcomes and the enhancement of financial/social protection of the target-groups. Universities and other academic/research bodies can contribute significantly by offering scientific data to policy makers.

Effective policy-making should involve mechanisms that help long term unemployed to overcome geographic, social and psychological barriers to accessing health care and reducing cost of treatment.

Examples of key actions to be carried out in Greece were provided by the experts:

- Measures and actions to combat unemployment; measures tackling the structural causes of poverty and poor health;
- Measures addressing stereotypical attitudes regarding the use of health services, as increasing trust towards primary health care services;

- Measures to prevent, detect and manage health problems among the target-groups, by primary health care/ awareness-raising of general practitioners to manage and support the health needs of these people;
- Reducing inequalities in determinants of health status or health care utilization, such providing services closer to the poor, subsidizing travel costs, targeted health promotion etc.;
- Development of nation-wide campaign in order to inform all Greek citizens about their health rights and the provisions of the new legislation
- Promotion and implementation of education and programmes on health issues; and
- Promoting networking and collaboration between all health service providers – governmental, non-governmental and private.

4.1.6 The 'in-work poor'

Health needs and challenges

While the literature review highlighted 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. 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 (Karlasson, et al., 2010).

Literature also suggests a social gradient between job security and mental health. Vives et al. (2013) found that people in insecure employment were more likely to report poor mental health. 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.

Evidence of policies being used to support this group

The results of the literature show that a variety of initiatives were taken at EU level, to address the issues relating to in-work poor. However 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.

Conversely, trends show that, since 2012, the number of people in temporary employment increased from 14.22.8% to 15.613.3% (of all those in employment) in 2015 (Eurostat, 2017n). Likewise, there has been an increase in involuntary temporary employment (8.4% 7.2%in 2008 to 78.8% in 2016) and part time work (17.54.4% in 2008 to 19.57.7% in 2016) (Eurostat, 2017s; Eurostat, 2017t).

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 consist in: transfer payments and social benefits (such as in-work benefits and tax credits paid to those earning below a certain threshold) given to households as a means of increasing their income; labour market policies, in the form of minimum wages and wage policies in general. Assessing the effectiveness of these policies is however complex and research on the 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. Social protection programmes were found to be linked to health and health inequalities (Lundberg et al., 2013). For example, increasing the threshold for minimum wage is a potential way for Member States to reduce the risk of poverty amongst the population of low-paid employees.

A scheme implemented in Germany (Open.med Munich) targeting a range of vulnerable people experiencing barriers to healthcare due to low income (including the in-work poor) showed that specialised healthcare services can be effective in supporting access to healthcare in Member States where universal healthcare is not available.

Similar solutions were suggested during the Focus Group on the long term unemployed, inactive and in work poor:

- Measures tackling the structural causes of poverty and poor health;
- Measures reducing inequalities in determinants of health status or health care utilisation, such as providing services closer to the poor, subsidising travel costs, targeted health promotion;

- Implementation of measures to prevent, detect and manage health problems in the target-group, by primary health care/ awareness-raising of general practitioners in order to manage and support the health needs of these people;
- Promotion and implementation of education and programmes on health issues;
- Creation of structures and facilities where services (decentralised primary health care services in particular) are provided free of charge to the vulnerable population;
- Set up of networks of collaboration between all health service providers – governmental, non-governmental and private.

4.1.7 Prisoners

Health needs and challenges

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.

Vulnerable groups – also referred to as 'underserved' groups – are overrepresented amongst those 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**. People who end up in prison also generally have a lower level of educational attainment and have experienced higher levels of unemployment than the overall population.

Prisoners are also relatively likely to have a history of problem drug use, relative to the general population. This affects their health status and, in particular, their risk of having a communicable disease. One study found that detainees with a history of injection drug use (IDU) were nearly 12 times more likely than general detainees to have Hepatitis C.

Prisoners and ex-prisoners were the group of VulnerABLE survey respondents most likely to say that their health was affected by smoking (55%), and more likely than average to state that alcohol (28%) and drugs (16%) affected their health (overall averages for smoking, alcohol and drugs were: 26%, 11%, 5%). However, prisoners/ex-prisoners were the group who reported the highest levels of good health. 42% rated their health as 'good' or 'very good', compared to 31% of the overall survey respondents.

Prisoners/ex-prisoners were the group most likely to state they had not accessed healthcare services within the past year. 13% had not done so, compared to a survey average of 7%. Prisoners/ex-prisoners were also the group most dissatisfied with the healthcare services they received. Of prisoners who had accessed healthcare in the past 12 months 39% were dissatisfied with its quality, compared to 24% of all respondents. This was most frequently due to the length of waiting times.

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. Overcrowding in particular can increase stress. Other health risks in prison can include:

- Greater risk of infectious diseases;
- Greater risk of physical trauma;
- Greater risk of substance abusive behaviour;
- Greater risk of chronic disease; and,
- Severe mental health problems, reflected in high rates of self-harm and self-inflicted death in prisons.

Another challenge is that in Europe it is relatively rare for prison health to come under the responsibility of the Ministry of Health, which impacts the degree to which prisoner health is seen as a public health concern. 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 compared with the quality of care delivered to general public. Not having prison health under the remit of the Minister of Health can also result in additional cost/insurance issues when trying to deliver specialized treatments.

Policy responses

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.

Consequently, 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 management and healthcare service delivery 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. Another peer-support initiative is the health champions system in UK prisons. These champions are peer supporters for those with substance misuse issues. The peer supporters offer encouragement for individuals to attend appointments, which has led to a reduction in rate of Did Not Attend (DNAs).

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.

In Luxembourg an initiative focuses on offenders at a later stage in the care pathway. Specifically, mobile home-care services have been trialled for former prisoners, in order to support those with Tuberculosis (TB). This involves other former prisoners acting as trained focal persons and administering treatment. The big advantage of this initiative is that ex-prisoners are more likely to trust somebody who has had similar experiences to them. This was a collaboration between the Ministry of Health and Ministry of Justice, although NGOs also played an important role in the delivery of the programme.

4.1.8 Survivors of domestic violence and intimate partner violence

Health needs and challenges

Whilst women can be the perpetrators of violence, and men and boys can be survivors of violence at the hands of both sexes, **violence against women in the EU is predominantly committed by men** (FRA, 2014). It is recognised by the WHO as a **significant public health issue affecting one in three women the world over** (WHO, 2013a). Intimate partner violence and domestic violence can have **serious immediate and long-term consequences** for the survivors, 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). Focus group participants highlighted that **physiological health issues go in hand with mental health issues and can be difficult to separate.**

In one survey, 76% of women experiencing domestic violence and abuse were above the clinical threshold for a mental health diagnosis, including depression, anxiety and post-traumatic stress disorder (Ferrari et al, 2016). To many focus group participants, **women experiencing IPV never feel safe**, live with constant level of anxiety, and often, after leaving a situation of violence, experience post-traumatic stress disorder due to the high level of stress they lived in for many years. Participants noted that undiagnosed mental health problems are an important issue; indeed, one participant noted that "*[mental health issues] often dwarf all of the others".* The VulnerABLE survey suggests that, of **all the target groups, survivors of intimate partner/domestic violence were most likely to experience mental health problems** (45%) and to show signs of psychological stress, such as feeling particularly tense most or all of the time (reported by 41%) or being depressed (44%). Relative to other target groups, it is **also most common for this group to report very bad health.**

- Violent relationships are often characterised by **fear and controlling behaviours**. They are also associated with higher rates of **adverse reproductive events because 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). Living in an abusive environment and experiencing domestic violence is marked by stress, which is an important risk factor for maternal health and may increase the risk of low birth weight and premature births (Hill et al., 2016). Adverse sleep experience is also an important health consequence for women experiencing violence, as well as negative consequences for parenting.

Barriers to healthcare access:

Many women, regardless of their country's health system, are unable to seek health care for their injuries or escape their situation (FRA, 2014).The literature review and focus group suggest that several barriers prevent women from accessing appropriate health care services. Both the literature review and the focus group highlighted that **fear, shame and emotional dependency** can have undermine survivors' access health care services. Survivors 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 survivor of domestic violence. Survivors 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). Focus

group participants also emphasised other significant barriers that may arise to survivors' access to healthcare: namely, **fear for their own safety and that of others, as well as the active role played by partners to obstruct their access.**

According to the literature, **economic dependency** 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 highlighted in the focus group, they may also be unable to afford a place in a domestic violence refuge, if welfare benefits to cover this are non-existent and/or restrictive. According to the VulnerABLE survey, the main reason why survivors cannot access medical treatment is due to cost.

Even when individuals access services, **clinicians may fail to recognise the signs of intimate partner violence and domestic violence.** To focus group participants, when those experiencing violence are **unable to disclose this, it can undermine the appropriateness of the care that they receive, as well as the follow-up support.** Health care professionals often have little training or skills to identify and deal with survivors of domestic violence. Focus group participants pointed out that **clinicians have to manage competitive priorities and have limited time to deal with potential cases of IPV.** Moreover, participants noted that GPs are often not free from stereotypes on gender roles and IPV, and that these affect the treatment that women receive. Participants highlighted that usually women do recognise their situation, but **sometimes the agencies from whom they seek help do not believe them, do now know how to respond or do not know how to access support for them;** survivor blaming is still considered an important factor hindering survivors' access to healthcare. This situation may explain to some extent the result from the VulnerABLE survey that, of those who are dissatisfied with healthcare services, 40% put this down to not liking the attitude of the healthcare professional.

One study in the UK examined how psychiatric services respond to service users who have experienced domestic violence and found that **mental health services often fail to identify and facilitate disclosure of violence, and develop appropriate responses that prioritise the safety of the survivor**. 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). To focus group participants, **ongoing stigma and a lack of adequate programmes can act as specific barriers to mental health interventions**. Most often, mental health programmes deal with the symptoms rather than the causes, meaning, for example, that women may be offered antidepressants only. This perhaps partially explains the finding from the VulnerABLE survey that, of survivors dissatisfied with healthcare services, over one in three (36%) stated it was because the medical treatment had not improved their health.

The **impact of austerity measures on survivors' access to healthcare** was also mentioned in the focus group as an important issue, particularly in relation to cuts to specialist services. Focus group participants mentioned **particular groups of women that may face additional issues in accessing healthcare**, including migrant women; older adults; 'traveller' women in Ireland and elsewhere; women with disabilities; women in rural areas and women in extended families.

Policy responses

Supporting clinical inquiry in healthcare settings

It is widely thought that incidents of domestic and intimate partner violence go largely under-reported. **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 survivors 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 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. A meta-analysis 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). Initial contact with specialist domestic violence services can also play an important role in legitimising help-seeking via other formal and informal channels (Evans and Feder, 2016). 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). Focus group participants with knowledge of other GP training programmes noted, however, that the effectiveness of training partly depends on the motivation of the doctors.

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). There was general **agreement amongst focus group participants that universal screening and blanket prompts are not effective; this needs to occur on a more selective basis**. Consequently, they also preferred the language of 'clinical inquiry' or 'case-finding', as opposed to screening.

To facilitate survivor identification, focus group participants **discussed the utility of reminders/prompts for doctors** that identify potential survivors based upon the frequency of their visits; main clinical presentations; etc. There was discussion of the utility of automatic, blanket electronic prompts, with some participants dubious about their value. It was suggested **that computer systems use selective alerts**, for example targeted at GP patients who attend frequently with telling conditions (pelvic pain, etc).

Antenatal care, family planning and gynaecological services are potential avenues for clinical inquiry, as well as emergency services (more likely to encounter women with injuries) (Black, 2001; WHO, 2013c; García-Moreno et al., 2014). Focus group participants also pointed to the positive use of prompts within **abortion clinics** in the UK.

Delivering appropriate clinical interventions

The WHO has published detailed guidelines and quality standards for delivering care to those who have experienced domestic and intimate partner violence (WHO, 2013e). Beyond identification of domestic and intimate partner violence, **health-care providers must offer appropriate clinical interventions to support survivors, including post-rape care** (for example, pregnancy/STI prevention, access to abortion, long-term mental health services). The health system also has an important role to play

in **referring survivors on to specialist forms of support in the domestic violence sector** (García-Moreno et al., 2014).

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 survivors of domestic violence,** such as multi-agency risk assessment conferences (MARACS). These bring together statutory and voluntary agencies to discuss the cases of individual high-risk survivors, and formulate co-ordinated action plans for each of them. This method has been evaluated as working well (Co-ordinated Action Against Domestic Abuse, 2012). However, some studies have warned of the shortcomings of MARACs in that they may only focus on 'high-risk' survivors (Stanley and Humphreys, 2014). Focus group participants agreed that sometimes individuals are assessed at a level of risk that is not representative of their situation and real level of danger. In particular, some participants pointed out that agencies sometimes miss controlling behaviours. Other limits of MARACs discussed at the focus group include: agencies being unable to complete the DASH[46] risk assessments adequately; the limitations of agency representation at MARACs; and insufficient understanding of survivors' safety when offering support/actions.

One study (Stanley and Humphreys, 2014) explores multi-agency collaboration in relation to protection of child affected by domestic violence, and highlights the positive use of Multi-Agency Safeguarding Hubs (MASH).

Designing mental health interventions

Focus group participants discussed the **effectiveness of programmes that aim to provide women survivors with mental health support**. All agreed that **mental health support should be highly targeted** and offered to women who already understand the patterns of domestic violence. One study on psychological interventions found it is important to engage women who are 'ready' – some women are too caught up resolving practical issues to engage with psychological work (Brierley et al, 2013). It also found that women valued counselling and a specific focus on domestic violence over generic support. In addition, it concluded advocacy alone has positive effects and advocacy with mental health support has even greater effects.

Tailoring services to survivors' needs

Focus group participants noted that survivors' voices are often missing from health interventions that seek to support them. **As a rule, participants agreed that users should be involved in the development of services** and that survivors' perspectives should be better promoted within service design.

Transforming attitudes

Focus group participants considered it crucially important to foster **attitudinal changes** to challenge intimate partner violence, and some participants mentioned the need to **work more closely with perpetrators**. The **role of education** was highlighted by several participants as a key area for prevention work. Participants also highlighted the need to challenge **norms associated with negative masculinities,** such as in the White Ribbon campaign.

4.1.9 People with physical, mental and learning disabilities or poor mental health

The research into the target group of people with physical, mental and learning difficulties reflects the fact that target group is broad and covers a large number and

[46]Stands for domestic abuse, stalking and 'honour'-based violence.

wide range of people. The latest estimate, form 2012, based on the International Classification of Functioning, Disability and Health definition suggests that approximately **73 million people aged 15 and over people in the EU27 experience some kind of disability** and that 59% of these people are women (Eurostat, 2015e). Estimates on the level of those with mental health problems vary but an estimate from 2010 suggests that **a significant proportion (38.2%) of those in Europe are experiencing mental health difficulties** which would equal around 164.8 million people (Wittchen et al, 2011). In general, this target 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).

For those with disabilities there is significant legislation at the EU level enshrining equality. Since 2011 the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) has been part of European law, including article 25 which calls for high standards of equality in healthcare. The European Commission Disability Strategy 2010-2020 builds on the UNCRPD and supports its implementation.

Health challenges

According to the research key health challenges are related to the social perception and standing of those with physical, mental and learning disabilities. **The research indicates that violence at the hands of others is a serious concern for those in this target group.**

People with physical, mental and learning disabilities were less affected by the cost-factor of accessing medical care than other target groups. However, although the data from the VulnerABLE survey suggests that this is less of an issue than other vulnerable groups, economic factors remain a barrier for some within this group and **the literature shows that people with physical, mental, and learning difficulties have a greater risk of being exposed to poverty, poor housing conditions, unemployment, social disconnectedness and discrimination** (Nocon, 2006). The proportion of people with physical, mental, or learning disabilities reporting high cost as the main reason for not visiting medical practitioners, not receiving a dental examination/treatment or not getting medication was 21%, 27% & 21% respectively.

Research also shows that this group are at greater risk of negative health behaviours, including **poor diet, lack of exercise and substance use** (Emerson and Baines, 2010).

Members of this target group are at increased risk of developing secondary conditions to their disability (WHO, 2011). .People with learning disabilities may be at greater risk from genetic and biological factors for developing congenital abnormalities (Tyrer and McGrother, 2009). Furthermore, many of those with a physical disability experience depression as a secondary impairment (Prince et al, 2007; Khat et al., 2010; Ohayon and Schatzberg, 2010). This is reflected in the higher rates of mental difficulties seen among people in this target group in the VulnerABLE survey where a nearly third (32%) of respondents from this target group reported feeling down or depressed.

Access to healthcare

The VulnerABLE survey results showed that among the 24% of this target group who were **dissatisfied with their medical care** the perceived ineffectiveness of the medical treatment was the most mentioned cause of this dissatisfaction with 53% citing this and **43% expressed dissatisfaction with the attitude of the healthcare professionals**. The literature review suggested people in this target group may experience communication barriers when interacting with health care professionals (Emerson and Baines, 2010).

This disconnection to health care professionals may be particularly pronounced among those with mental health difficulties. **People with mental health issues may experience stigma in relation to their condition**, which can act as a disincentive in accessing health services. The focus group participants noted that a negative attitude form health professionals led to forced treatment or institutionalisation. Nearly half of people across Europe in need of mental health treatment do not access formal health services (Walhbeck and Huber, 2008).

Furthermore, participants in the focus groups stated that **the complexity of healthcare systems and the specialisation of health professionals led to an environment that was difficult for individuals with complex needs to navigate effectively.** Navigating the health system may be a particular issue for those with learning disabilities due to the complex nature of information and access procedures and reliance on carers for appointments. The results of the VulnerAble found that 23% of survey respondents in this target group of people with physical, mental and learning difficulties reported that they found health care information difficult or very difficult to understand. The focus group participants also noted that providing medical care in a silo format could also mean **that the relationship between a patient's mental and physical health is overlooked** at times.

The focus group findings also indicated that **in some situations access to healthcare may be restricted by age.** For example**,** appropriate health care provision may only be available for those under 18 experiencing the condition. Similarly, mental health service might be targeted at children or adults and may effectively miss adolescents, a serious issue considering that mental health issues often surface around this period.

The literature shows that people with mental and learning disabilities in this target group may suffer from a lack of access to preventive care in terms of physical health. Research has indicated that physical health checks of mental health patients in primary and secondary care are low (Hardy et al., 2011; DRC, 2007). Similarly, a systematic review of studies found that rates of mammography screening were lower for women with mental illness than the general population (Mitchell et al., 2014).

Care for those with physical, mental or learning disabilities

Many of those within this group will require care in some form and across Europe much of this will be provided by informal carers. This can be difficult for the carer who may not receive enough support. It may also pose socioeconomic issues for the family unit as members of the target group are more likely to experience material inequality, in that they are more likely to be exposed to poverty and unemployment making the income of the carer even more important to the welfare of the whole. (Nocon, 2006). Focus group participants pointed to employee support schemes in the private sector which recognise that their employees may have caring responsibilities as positive practices in achieving health parity for members of this target group.

Policy responses

Policy responses towards the health inequalities face by this target group are related to improving awareness and understanding of these issues among both healthcare professionals and the wider community and increasing patient centred care and involvement in health care.

The literature shows that **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). Focus groups participants mentioned campaigns and the media as **effective tools to raise awareness and change broader societal perceptions** around people living with physical and learning disabilities or poor mental health.

Healthcare services which look at the patients as an individual are receiving increasing attention in policy and the discussion in the focus group reflected this. Professionals were however concerned that health professionals may believe they are delivering person centred care whilst actually patients are not sufficiently involved in planning, developing and monitoring their care. An example of a practice that embodies the holistic approach of person-centred care is social prescribing. This was highlighted by participants in the focus group as an effective strategy for improving the quality of life for those with long-term health conditions.

Furthermore, **interventions seek to improve the relationship between the person with the disability and the community surrounding them**. Focus group participants noted a discussion technique known Trialogue being utilised increasingly to engage communities in talking about mental health, thereby improving understanding and reducing stigma and social isolation. Similarly, in Denmark, an NGO and three municipalities developed a support system for people suffering from rare diseases to promote health literacy in the most vulnerable patients. **This practice combines community engagement with person centred care as the volunteer 'navigators' acknowledging the patient's personal situation**, creating an overview of options and encouraging health literacy and support compliance Additionally, the navigators are either people suffering from a rare disease or a relative of a person with a rare disease meaning they are able to apply their experience-based knowledge to help the patients help themselves.

Practices which aim to **increase the overall standing and welfare of those with disabilities** in wider society have been observed in the research, such as interventions to promote healthy behaviours such as exercise. Although in general such interventions 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). There is also evidence that interventions on physical targeted at those with learning disabilities can have a positive impact (Holly, 2014).

4.2 Synopsis of findings

Table 13 presents a summary of the overall findings from the scientific report, highlighting the main health challenges facing vulnerable people across the EU, alongside the key policy responses aimed at addressing these issues. Further below, Table 14 presents a summary of findings from the scientific report broken down per target group.

Table 13. Synopsis of overall findings

Overall findings		
Health challenges / scale of the problem	**Policy responses / Recommendations for action at the EU level**	**Examples of policy responses at the Member State level**
• **Despite population health indicators improving across the European Union in the last decade, there remain widespread inequalities in health and access to healthcare within and between Member States**: data shows persistent and significant differences in life expectancy between Member States. For example, there is a gap of 8.5 years between the Member States with the lowest life expectancy (Lithuania) and the Member States with the highest life expectancy (Spain) (Eurostat, 2017a). • **Unlike life expectancy, healthy life years have remained fairly stable across the EU for both sexes:** however, despite women being expected to live on average longer than men, they are also more likely to experience more years living with poor health (Eurostat, 2017a). • **The prevalence of ill health also varies across Member States:** for example,	• **In 2007, the European Union adopted the first comprehensive EU Health Strategy:** 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). • **In 2013 the European Commission proposed a new policy framework entitled 'Social Investment Package for Growth and Cohesion':** which includes a staff working document entitled 'Investing in Health', extending the previous EU Health Strategy	• **Strategies addressing health inequalities experienced by different vulnerable groups:** France's City Health Workshops, which focus on improving the health of disadvantage groups.[47] • **Population-wide health strategies, which may also include a focus on some vulnerable groups:** Ireland's National Cardiovascular health policy[48]; France's National Cancer Plan[49]. • **Multi-faceted strategies targeting vulnerable groups, within which health is**

[47] See http://www.cred.ro/v3/images/conference/Prezentare%20Franta_Hervieu.pdf

[48] See http://health.gov.ie/blog/publications/changing-cardiovascular-health-national-cardiovascular-health-policy-2010-2019/

[49] See http://en.e-cancer.fr/The-Cancer-Plan-2014-2019

Estonia reported the highest rates of long-standing illness or health problems (83.4%) among its older population. This is in contrast to Member states such as Belgium (39.5%) and Denmark (40.2%), which reported much lower figures (Eurostat, 2017c). • **Despite EU support for equality in access to healthcare, differences in access to healthcare are experienced by people across Europe:** data indicates that in 2015, 5% of people reported having unmet healthcare needs. The greatest level of unmet need was reported in Poland (12.8 %), whilst the lowest was reported in Slovenia (0.4%) (Eurostat, 2017dc). In 2015, the most common reason for unmet healthcare needs was the cost of treatment (2%) (Eurostat, 2017d).	explaining how EU action in the field of health helps to reach the Europe 2020 objectives. • **The European Commission has also taken specific action aiming to reduce health inequalities:** through the Communication, 'Solidarity in Health: reducing health inequalities in the EU' which also involved the exchange of best practices and sharing of understanding about the effects of social exclusions. • **The European Commission has also sought to improve access to healthcare:** a Communication on the 'Effective, accessible and resilient health systems' focuses actions to strengthen the effectiveness of health care systems by developing indicators and increasing the accessibility and resilience of healthcare systems.	**key component:** examples include anti-poverty strategies in the UK and Portugal that aim to address health issues, but also employment, housing, income and other poverty related issues. • **National health strategies to aiming to improve access to healthcare: i**n 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.

Table 14 outlines the **key findings from the review of the evidence-base on each of the target groups**. This details the major health challenges affecting each group and the scale of the problem, evidence on existing policy responses and key recommendations for action on how to address these issues, and examples of good practice. It is broken down per target group:

- Older people;
- Children and families from disadvantaged backgrounds;
- People living in rural/isolated areas;
- People with unstable housing situations (the homeless);
- The long-term unemployed and inactive;
- The 'in-work poor';
- Prisoners;
- Survivors of domestic violence and intimate partner violence; and
- Persons with physical, mental and learning disabilities or poor mental health.

Table 14. Synopsis of key findings in relation each vulnerable group

Older people		
Health challenges / scale of the problem	**Policy responses / Recommendations for action**	**Examples of good practice**
• **The prevalence of illness or health problems is significantly higher among people aged 65+ compared to the general population:** over 60.6% of the EU population 65+ had at least one long-standing illness or health problem (Eurostat, 2017c). • **Rates of long-standing illness or health problems among people aged 65+ differ between Member States:** from 40% in Belgium and Denmark, to 83% in Estonia. • **Findings from the VulnerABLE survey suggest high levels of health and wellbeing problems among this group:** highest rate of problems with mobility (56%) and stamina, breathing or fatigue; second highest rate of bad health (38%) and long-term illness and infirmity (73%) among target groups surveyed. • **Older people experience barriers in accessing health care:** the main barriers include structural ageism, low levels of health literacy and low income.	• **At the EU level, policy has increasingly focused on healthy and active ageing:** the European Innovation Partnership for Active Ageing, established in 2011, is a key policy action aimed at improving the lives of older people. The partnership has brought together more than 3,000 partners across the EU to contribute to the development of policy and support good practice. • **Four solutions were proposed during the VulnerABLE focus group:** promotion of age-friendly environments (e.g. dementia friendly municipalities); develop better inter-sectoral collaboration (i.e. Health in All Policies approach); focus on holistic approaches to health and wellbeing considering older people in a wider social impact and how this may affect health; and, provide person-centred care aiming to tailor care and support to individual needs.	• **Promoting healthier lifestyles:** The Europe wide Healthy Ageing Supported by the Internet and the Community (HASIC)[50] aims to empower and improve the lifestyle of older people through encouraging health dietary habits, increased levels of physical activity, reducing alcohol consumptions and offering opportunities for social interaction. The programme also aims to improve cooperation between service providers through policy recommendations to support communal services for older people. • **Improving healthcare for older people:** The Our Life as Elderly (OLE

[50] http://www.hasicproject.eu/en/node/31

		II) programme was delivered in several countries across Scandinavia. It aims to identify the needs and wished of older people and develop special services to respond to these needs. The programme also focuses on other aspects which might affect health, including staff competency, social service provision, housing and social networks.

Children and families from disadvantaged backgrounds		
Health challenges / scale of the problem	**Policy responses / Recommendations for action**	**Examples of good practice**
• **Families and children (including lone parent households) in the EU are at a greater risk of poverty or social exclusion than the general population:** in the EU-28, 26.9% of children were living in households at risk of poverty or social exclusion in 2015 (Eurostat, 2016b). • **However, there is a significant body of evidence linking vulnerable families, poverty and health:** research has found an association with income inequality and childhood injury mortality (Sengogegle et al., 2013), adverse childhood experiences, respiratory disease, circulatory disease, oncological disease, mental health problems and negative health behaviours (UCL IHE, 2015). • **The VulnerABLE survey found that:** 25% of at risk families reported bad health, with 58% reporting a long-standing illness, disability or infirmity and 26% reporting experiencing mental health issues. • **Children and families from disadvantaged backgrounds also experience barriers to accessing healthcare:** low household incomes and the cost of healthcare treatment are the main barriers to accessing healthcare for this group.	• **Policy responses at the EU level focus on children's rights and reducing poverty:** alongside international legislation on the rights of children, the European Commission has demonstrated its commitment to improving the health of children, young people and their families, through policies such as, the Social Investment Package and Recommendations aimed at supporting families to be economically better off, and action plans to prevent and reduce childhood obesity. • **A variety of approaches exist at the national and local level which aim to improve the health of at risk families:** promotion of work-life balance (e.g. supporting lone-parents to get back to work and manage childcare responsibilities) can support families to increase household incomes (RAND, 2014); provision of free school meals can improve child nutrition and health; and, the use of Family Centres which provide a wide range of services to support the health, wellbeing and income of vulnerable families (Abrahamsson et al., 2009). • **Recommendations for action were also proposed during the VulnerABLE focus group:** the importance of	• **The Guardian Angel project aims to both address the holistic needs of at-risk families and prevent disadvantage:** launched in Germany in 2000, the project aims to provide disadvantaged children the best possible start in life. • **The Food Aid and Promotion of Healthy Nutrition (DIATROFI) programme aims to address specific needs of vulnerable families:** launched in Greece in 2012, the programme provides free, daily, health and nutritious meals to pupils from disadvantaged areas in schools, tackling hunger and malnutrition (Kastorini, 2016).

	promoting work life balance policies; developing better community-based care; the provision of free school meals; and, creating environments that support preventative action, improving parenting skills and life chances for children.	

People living in rural/isolated areas		
Health challenges / scale of the problem	**Policy responses / Recommendations for action**	**Examples of good practice**
• **The state of rural populations across the EU paints a mixed picture:** around 27.5% of the EU-28 population live in rural areas (compared to 72.5% of the urban and suburban areas), with an estimated 27.4% of rural people being at risk of poverty or social exclusion compared to those living in cities (24.4%). However, despite a common understanding of a rural population, there is no clear definition among policymakers meaning that comparability within the EU can be complex and challenging. Nevertheless, available data estimates that within most Central and Northern European Member States, rural populations, on average, enjoy greater life expectancy than those living in urban areas. In contrast, rural populations in Member States who joined the EU after 2004 (e.g. Bulgaria, Romania, Croatia) were more likely to have a life expectancy lower than their urban counterparts. • **The VulnerABLE survey found that:** the majority (59%) of respondents living in rural/isolated areas reported having a long-standing illness, disability or infirmity, of which 46% reported mobility problems. • **Access to quality healthcare is a major problem for many rural populations in**	• **Currently, there is no specific EU-level approach to addressing the health of rural populations:** each Member State follows a different approach according to the physical environment, political, economic and cultural factors affecting the issues experienced in rural areas. • **However, the WHO (2010a) has set out a number of approaches which Member States should follow to support good health and healthcare provision in rural areas:** for example, improve the level of human resources within rural populations (i.e. increase recruitment of healthcare professionals) (WHO, 2010b; Straume and Shaw, 2010); improve the regulation and monitoring of rural areas (i.e. focus groups highlighted the need for Member States to take full account of the differences in needs between urban and rural areas when implementing national policies); and improve service delivery in rural areas (i.e. implement a wide range of strategies to guarantee health service provision in rural areas and address geographical inequities in access to healthcare)(Davies et al., 2008).	• **Supporting healthcare professionals and patients in rural areas to overcome geographical and travel barriers, making healthcare more accessible to rural populations:** the AGnES community medicine nursing programme ran from 2005 to 2008 in Germany. Funded by the Ministry of Health and Social Affairs, the programme aims to reduce the travel time spent by GPs conducting home visits to patients in rural areas, through training nurses in the treatment of chronic diseases, eHealth equipment and operational procedures, to provide health information to patients using electronic resources and video

the EU, caused by: difficulties in recruiting and retaining health care professionals (WHO, 2010a); lack of public transport infrastructure (Gartner, Gibbon and Riley, 2007); lack of healthcare provision (often caused by low economies of scale), in terms of available treatment and pharmaceuticals (Vladescu et al., 2008); inequalities in access to other essential services, such as childcare, mental health care, and maternal care (Katz et al., 2002). • **Rural populations are more likely to report unmet healthcare needs compared to the general population (Eurostat, 2017f):** treatment costs and long distances were cited as the two most important reasons for unmet health needs (Eurostat, 2017f).	• **Recommendations for action were also proposed during the VulnerABLE focus group:** specifically, it was suggested that Member states focus on improving disease prevention efforts in rural areas (e.g. cancer screening) and the provision of mobile health services (including eHealth and technological solutions) which have been found to be more accessible in rural areas than fixed location health services.	conferencing (OECD, 2010). • **Providing specialised outreach healthcare services which meet patients in locations convenient for them:** the "Mallu does the Rounds" project in Finland provides a mobile service offering social and healthcare for people in Finland's rural areas. It aims to improve the health and wellbeing of rural people (particularly older people), providing a wide range of services, including vaccinations, minor operations, health monitoring, health advice, health promotion and data collection (Wikström-Koikkalainen et al., 2014).

People with unstable housing situations (the homeless)		
Health challenges / scale of the problem	**Policy responses / Recommendations for action**	**Examples of good practice**
• **The scale of homelessness across the EU is unknown:** 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 at the Member State level, making identifying and understanding the scale of this issue a major challenge. • **The health needs of people living in unstable conditions is characterised by multiple physical and mental health needs:** this includes communicable diseases (e.g. tuberculosis), respiratory and circulatory diseases, injury as a result of violence, poor oral health, feet problems, skin diseases and infections, drug and alcohol addiction, and sever mental health problems (Griffiths, 2002). • **This group often experience barriers in accessing mainstream health services:** this group have an overreliance on secondary care services (as a result of chaotic lifestyles) (Homeless Link, 2014); bureaucratic barriers often prevent homeless people from accessing healthcare (i.e. requirement to provide information of a fixed address) (Médecins du monde, 2015a); stigma and lack of trust by this	• **There is no overarching approach at the EU level aimed to address the health challenges of people with unstable housing situations:** however, a leading aspect of homelessness policy has focused on a Housing First approach. Taking a preventative model, this approach aims to provide homeless people are provided with a non-conditional offer of permanent housing, which is in contrast to traditional stair case models where individuals moves through a shelter system into permanent housing (Pleace, 2016). The model is promoted by the European Federation of National Organisations Working with the Homeless (FEANTSA) who have produced a toolkit to support policy makers implement the model. • **At the national level, policy tends to target the specific health needs of this group:** the implementation of specialist services and interventions aims to address specific types of homelessness (e.g. roofless), or the specific health needs of homeless (e.g. Tuberculosis), and has been found to be effective in addressing health specific challenges of homeless populations (Sleed et al., 2011).	• **Implementing models with proven transferability across different countries:** the Housing First model has been adopted in a wide range of countries across the world, with the main aim of providing permanent housing to homeless people with high support needs. • **Outreach programmes targeting specific health needs:** the Find & Treat programme in the UK aims to locate and ensure treatment of Tuberculosis among the social vulnerable through a range of activities, including condition awareness raising, recruitment and training of peer advocates, treatment of Tuberculosis and provision of accommodation advice (UCL, 2014).

group can prevent them accessing healthcare services (Rae and Rees, 2015). • **The VulnerABLE survey found that:** low income played a greater role for people living in an unstable housing situation (71%). Similarly, high costs were often mentioned among this group as the main reason for not visiting medical practitioners, getting dental examination/treatment or getting medication people with unstable housing (40%).	• **Recommendations for action were also proposed during the VulnerABLE focus group:** this includes, improving the understanding of homelessness and its causes; improving the skills of people who deal with homeless people to understand their needs; improving the integration of mental health service in programmes targeting homeless people; improving the coordination between social and healthcare services to homeless people.	

The long-term unemployed and inactive		
Health challenges / scale of the problem	**Policy responses / Recommendations for action**	**Examples of good practice**
• **Long-term unemployment and inactivity are key concerns for policy makers:** recent data suggests that around 4% of the EU labour force was long-term unemployed in 2016 (Eurostat, 2017j), whilst 27.1% of the EU working age population was inactive in 2016 (Eurostat, 2017k). • **Non-participation in the labour market can have significant implications for health:** unemployment is closely linked to poverty and can lead to premature ageing (Ala-Mursula et al., 2013), poor mental health (Dubois and Anderson, 2013), and poor health behaviours (Bosque-Prous et al., 2015). • **The unmet health needs of unemployed people are consistently higher than unmet needs of employed people:** between 2008 and 2015 the prevalence of unmet needs for unemployed people has been 4-5% points higher than for employed individuals (Eurostat, 2017e). • **The VulnerABLE survey found that:** unemployed people were more likely to report bad health than the average respondent (31% vs. 28%) and 66% of respondents within this group reported that	• **At the EU level, the Europe 2020 Strategy has set an employment target of 75%:** among other things, the strategy aims to support Member States to create sustainable jobs (through the Commission's Employment Package) enhance the employability skills of individuals and reduce poverty, which are likely to have a positive impact on health. • **A range of activities promoting good health and employment have been implemented by Member States:** across the EU, welfare systems have focused on supporting people claiming unemployment benefits back into work, whilst addressing health and wellbeing issues at the same time. This includes interventions to promote and develop positive health behaviours, exercise (Kreuzfeld et al., 2013). • **Recommendations for action were also proposed during the VulnerABLE focus group:** this includes, further action to combat unemployment and the structural causes of poverty; improve the utilisation of healthcare services, particularly primary healthcare, among this target group; implement health education and promotion programmes to	• **Improving the employability of individuals:** the "Sortir de soi, sortir de chez soi" programme in Belgium aims to support inactive or long-term unemployed women back into work, through the provision of information and advice and the delivery of training sessions. **Addressing immediate needs of people on low incomes:** 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 and affordable food. Alongside this, the programme supports the long-term unemployed by providing them with

lack of money had an impact on their health. • **The cost of healthcare treatment can be a key barriers to accessing healthcare:** this group are more likely to have low levels of income and within Member States where access 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, cost may be a particular problem (Crepaldi et al., 2009).	prevent health problems in the future; and, greater collaboration between governmental, non-governmental and private organisations.	work placements and employment (A.N.D.E.S., 2009).

The 'in-work poor'		
Health challenges / scale of the problem	**Policy responses / Recommendations for action**	**Examples of good practice**
• **In-work poverty is driven by low-pay, low work intensity and single earner households:** recent data shows that 9.5% of the employed population in the EU-28 were at risk of poverty in 2015 (Eurostat, 2017l). • **There is a lack of evidence directly examining the in-work poor and their health needs, nevertheless, it is possible to draw inferences on the health challenges of this group:** households on low-incomes are likely to experience poverty which can be detrimental to health (Harkins and Egan, 2013); low paid employment is often associated with stress and poor mental health (Karlasson et al., 2010; Vives et al., 2013); and, health issues experiences by other target groups, such as the long-term unemployed. • **The VulnerABLE survey found that:** access to healthcare was considered by the respondents within this this group as: quite or very difficult (27%), quite or very easy (36%), neutral (36%). The main issues encountered when trying to access healthcare were: lack of affordability (32%), too long waiting times (24%),	• **Up to now, policies to address issues relating to the in-work poor have made little impact at the EU level and research in this area is scarce:** the Commission's Annual Review on Social Developments in the EU stressed a need to address the increase in numbers of in-work poor. Yet in 2010, the EU Network of Independent Experts on Social Exclusion found no evidence that EU level initiatives had influenced Member Stets to focus more on policies to address in-work poverty. • **At the Member State level, policies can indirectly influence the in-work poor:** the majority of policies relate to the in-work poor are often included in wider policies to tackle poverty and social exclusion (EuroFound, 2010). These policies can be group in to two main forms of response: welfare transfer (i.e. social benefits); and, labour market policies (i.e. minimum wage). • **Specialist health services have been effective in supporting access to healthcare where universal provision is not available:** programmes providing free healthcare treatment for people on low incomes or not covered by health insurance.	• **Programmes specially targeting people on low incomes providing free healthcare services:** the Open.med Munich scheme in Germany, is a charity run programme that aims to improve access to healthcare for people on low incomes or who do not have adequate health insurance, and who struggle to meet the costs of treatment. The scheme provides free medical and psychological consultation services to vulnerable people who experience difficulties in accessing healthcare (Aertxe der Welt, 2014).

inability to take time off work (21%), inability to get an appointment (20%). • **Evidence suggests that this group often underutilise healthcare services:** low-paid work is likely to come with employment benefits (such as health insurance), requiring upfront treatment costs where no universal healthcare is offered; workers in temporary employment are less likely to use health services compared to those in permanent employment (Virtnanen et al., 2006).	•	

Prisoners		
Health challenges / scale of the problem	**Policy responses / Recommendations for action**	**Examples of good practice**
• **An overview of the EU's prison population indicates that there are some 643,000 prisoners in the EU (in 2012):** this figure excludes Scotland and suggests that the prison population increased by 7% from 2007 (Eurostat, 2016m). Many prisons across Europe are now thought to experience overcrowding (Aebi and Delgrande, 2013). • **There is a distinct lack of data on the state the EU's prison population:** the majority of data is collected at Member State level and is often inconsistent and disjointed, particularly in relation to the use of quality standards and prison health indicators. • **Prisoners are at greater risk to a wide range of health issues compared to the general population:** including infectious diseases; physical trauma; substance abusive behaviours, chronic disease; and, sever mental health problems (Barry, 2010). • **The prison environment is also likely to aggravate health issues:** research indicates that the majority of mental health needs go unmet whilst an individual is in custody and may become worse (Macula et al., 2013).	• **At the EU level, the safeguarding of prisoner health is primarily addressed by the non-binding European Prison Rules:** this sets out standards and principles for the treatment of prisoners, including specific considerations for health problems such as drug addition, mental health and communicable diseases (Maculan et al., 2013). • **A good prison healthcare system is an opportunity to address ill health and reduce health inequalities:** the WHO propose a range of policy approaches to improve prisoner healthcare that include, a holistic approach to prison healthcare (i.e. coordination between government departments to deliver quality care), accountability and provision of prison health under health ministries, and health ministry's actively advocating for healthy prison conditions (WHO, 2013d). • **Recommendations for action were also proposed during the VulnerABLE focus group:** this includes, bringing prison health onto the public health agenda; promote peer-led initiatives for prisoners to take greater responsibility of their health and health decisions;	• **Support the equivalence of care in prisons:** in the UK, a sexual health and blood-borne viruses screening and management programme was implemented in one region to address communicable diseases. A nurse-led service was established in each prison to identify and treat symptoms, providing similar access to sexual health and blood-borne viruses' services as the non-prison population. • **Encourage a normality approach to prisons:** in Norway, the principle of normality runs through the Norwegian prison system. The ultimate aim is to reintegrate people back into society, meaning that prisoners are ensured a level of

• **Barriers to healthcare for this group often result from poor practice:** examples include, prisoners' right to health being frequently disregarded, failure to meet special care of duty for prisoners (e.g. covering basic needs and safety, human rights), healthcare staff involved in the discipline of prisoners rather than acting independently (WHO, 2013d). • **The VulnerABLE survey found that:** prisoners/ex-prisoners were the group most likely to state they had not accessed healthcare services within the past year (13% had not done so, compared to a survey average of 7%). Prisoners/ex-prisoners were also the group most dissatisfied with the healthcare services they received. Of prisoners who had accessed healthcare in the past 12 months 39% were dissatisfied with its quality, compared to 24% of all respondents. This was most frequently due to the length of waiting times.	normalise prison life (i.e. make prison conditions as similar as possible to life outside of prison); increased health screening on arrival to prison; and, improving the monitoring, evaluation and quality standards of prisons.	security and access to service which enable them to reform, including improve/sustain (good) health.[51]

[51] http://www.kriminalomsorgen.no/information-in-english.265199.no.html

Survivors of domestic violence and intimate partner violence		
Health challenges / scale of the problem	**Policy responses / Recommendations for action**	**Examples of good practice**
• **Domestic and intimate partner violence is a widespread phenomenon in all Member States:** primarily affecting women and children, it is a significant public health issue estimated to affect one in three women the world over (WHO, 2013a). • **Reliable and comparable data on the prevalence of domestic violence in the EU and its Member States is lacking:** this is partly due to difficulties in collecting this data, but also to the issue being underreported by survivors (FRA, 2014). • **There are considerable health issues associated with this group:** in the immediate term, domestic violence can result in physical injury and trauma (e.g. musculoskeletal injuries to head, neck and face). In the medium to long-term, it can affect mental health, sexual health, reproductive health, and at its worst, lead to death (WHO, 2010c). • **The VulnerABLE survey found that:** a greater proportion of this group (33%) have a poor overall health than the average amongst the target groups (28%). Of all the groups, survivors of intimate partner/domestic violence were most likely to experience mental health problems (45%) and to show signs of psychological stress, such as feeling particularly tense	• **There is no EU level legal instrument specifically designed to protect women from domestic violence:** however, the passage of the Council of Europe Convention on Preventing and Combating violence against Women and Domestic Violence in 2011 outline key measures to be enacted based on policies to prevent, protect women from violence, provide services for survivors and prosecute perpetrators (Council of Europe). • **At the Member State level, there is good evidence of policies being used to support this group:** these include, providing tools to healthcare professionals to identify and respond to incidents of domestic and intimate partner violence more effectively; improving the provision of appropriate clinical care; and, adopting multi-sectoral responses, including collaboration between health, judicial, child and social care services. • **Recommendations for action were also proposed during the VulnerABLE focus group:** aside from policies mentioned above, the focus group highlighted the importance of tailoring services to the specific needs of survivors	• **Building capacity within the health service to better meet survivor needs:** The Identification and Referral to Improve Safety (IRIS) programme is a domestic violence and abuse training support and referral programme in the UK. It is based in general practices and aims to build capacity of professional to best identify and support women who are experiencing abuse. This model has also been trialled in several other Member States under the IMPLEMENT project. • **Assessing the specific needs of this group:** the Health Needs Assessment of Sexual Assault Referral Centres (SARCs) were set up in the UK to provide medical care and other

most or all of the time (reported by 41%) or being depressed (44%). • **This group also experience significant barriers in accessing healthcare:** these include, psychological barriers (e.g. fear, shame and stigma); failure of health services to detect the signs of domestic violence; the economic dependency of women; and, logistical and cost barriers.	and efforts to challenge attitudes towards domestic violence.	support to survivors of sexual violence. The project also involved a multi-agency steering group, including the health, social, voluntary and police sectors, supporting survivors within a particular region of the UK.[52]

[52] www.northumberland.gov.uk/WAMDocuments/259D5658-FA97-4A77-BAB4-87A9D2802DB2_1_0.doc?nccredirect=1

Persons with physical, mental and learning disabilities or poor mental health		
Health challenges / scale of the problem	**Policy responses / Recommendations for action**	**Examples of good practice**
• **Approximately 73 million people aged 15 and over in the EU-27 experience some kind of disability:** however, exact 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 (Eurostat, 2017u). • **It is estimated that those experiencing mental health problems totalled around 164.8 million across the EU in 2010**: including anxiety, depression, dementia and substance abuse (Wittchen et al., 2011). • **This group typically experience worse health compared to the general population:** they are at greater risk of negative health behaviours, exposure to poverty, secondary conditions to their prime disability/mental health problem, congenital abnormalities (Emerson and Baines, 2010). • **This group also experience significant barriers to healthcare:** this includes poor health literacy, poor treatment by healthcare professionals in responding to wider health needs, physical barriers to travelling to, or accessing healthcare buildings and facilities (DRC, 2007).	• **The EU has adopted United Nations Convention on the Rights of Persons with Disabilities:** the Commission has built on the Convention with its Disability Strategy 2010-2020, which stresses the right to the highest standards of healthcare for those with a disability. • **The EU also has a joint action on mental health and wellbeing 2013-2016:** this focuses on seven priority areas including prevention and promoting resilience, improving access to healthcare services and mental health at work and within schools. • **At the Member State level, policy responses have focused on addressing a range of issues to improve the health of this group:** these include, improving the understanding of disability among healthcare professionals to improve healthcare provision and better meet the needs of this group; tackle unhealthy behaviours among this group (e.g. increase levels of physical activity); and, engaging service users in the design of services (e.g. person-centred care) (Nilsen et al., 2006). • **Recommendations for action were also proposed during the VulnerABLE focus**	• **Encouraging healthy behaviours and active lifestyles:** the Special Olympics Youth Unified Sports programme is a Europe wide programme which aims to help children and young people with intellectual and physical disabilities participate in sport and lead a healthier lifestyle. **Improving good health awareness among this group:** the "I See! About Soul and Body for Women with Intellectual Disabilities" which ran in the Czech Republic from 2015 to 2016 seeks to improve health awareness amongst women with learning disabilities by producing easily understandable information for them about sex and the female body.

• **The VulnerABLE survey found that: a**round a quarter (24%) of this target group reported being dissatisfied with health services they received. The issues contributing to the dissatisfaction of this group with medical care were the perceived ineffectiveness of the medical treatment and long waiting times. Of all groups those with physical, mental and learning disabilities were most likely to cite dissatisfaction with the attitude of the healthcare professional (43%). A further barrier experienced by some members of this group is the ability to understand health care information with 23% of survey respondents in this target group reporting that they found this difficult or very difficult.	**group:** these included, providing social prescribing through general practice to help improve the quality of life; improving community engagement to better improve the lives of people with mental health problems; using technology to overcome barriers to healthcare (e.g. mobile applications to monitor emotions); and, improving the public image of this group (i.e. raising awareness of issues).	

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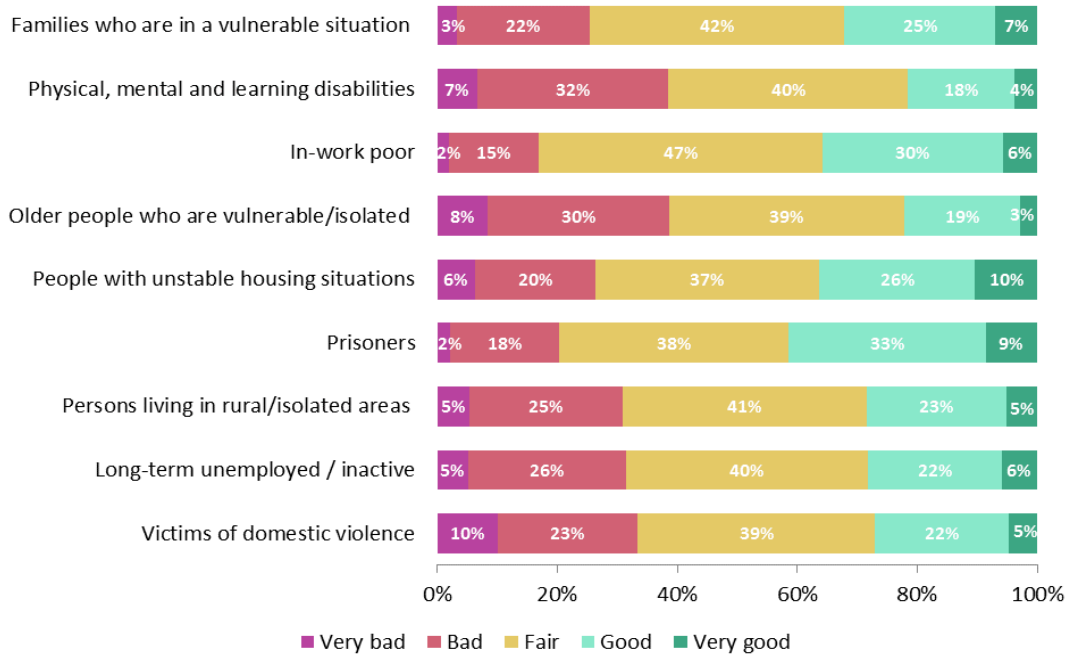
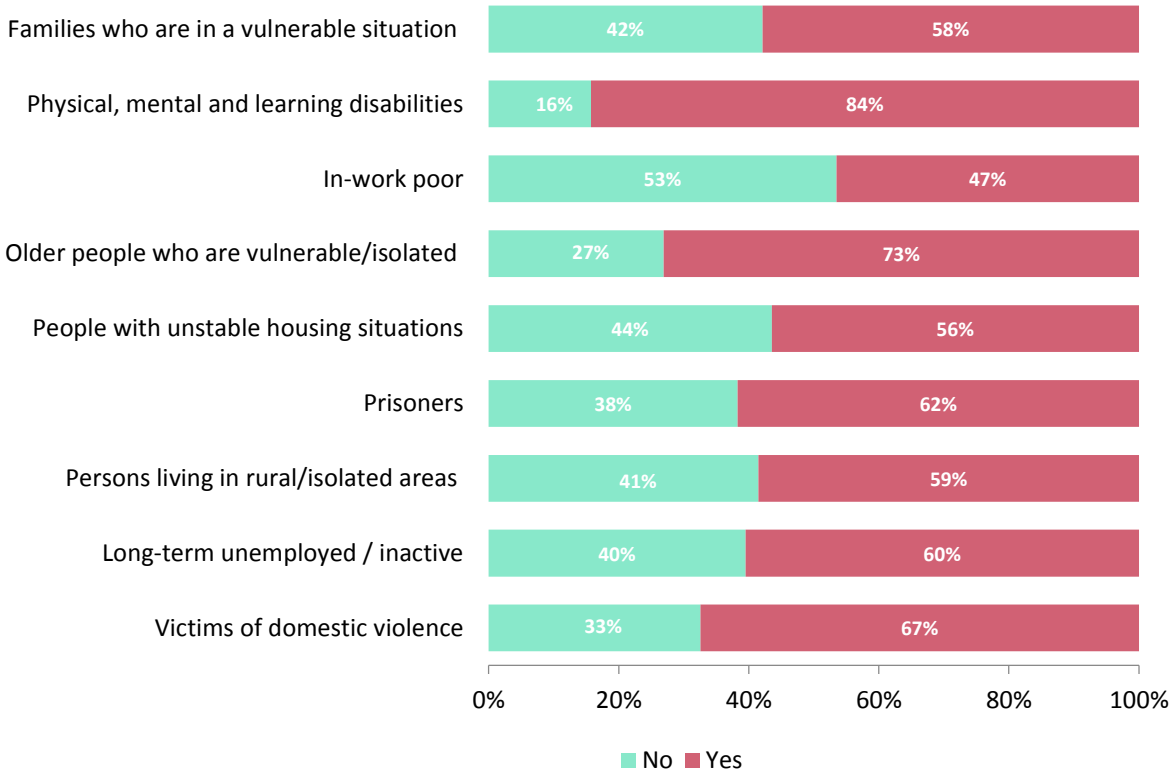
6 Additional data and tables and figures from Section 2.2

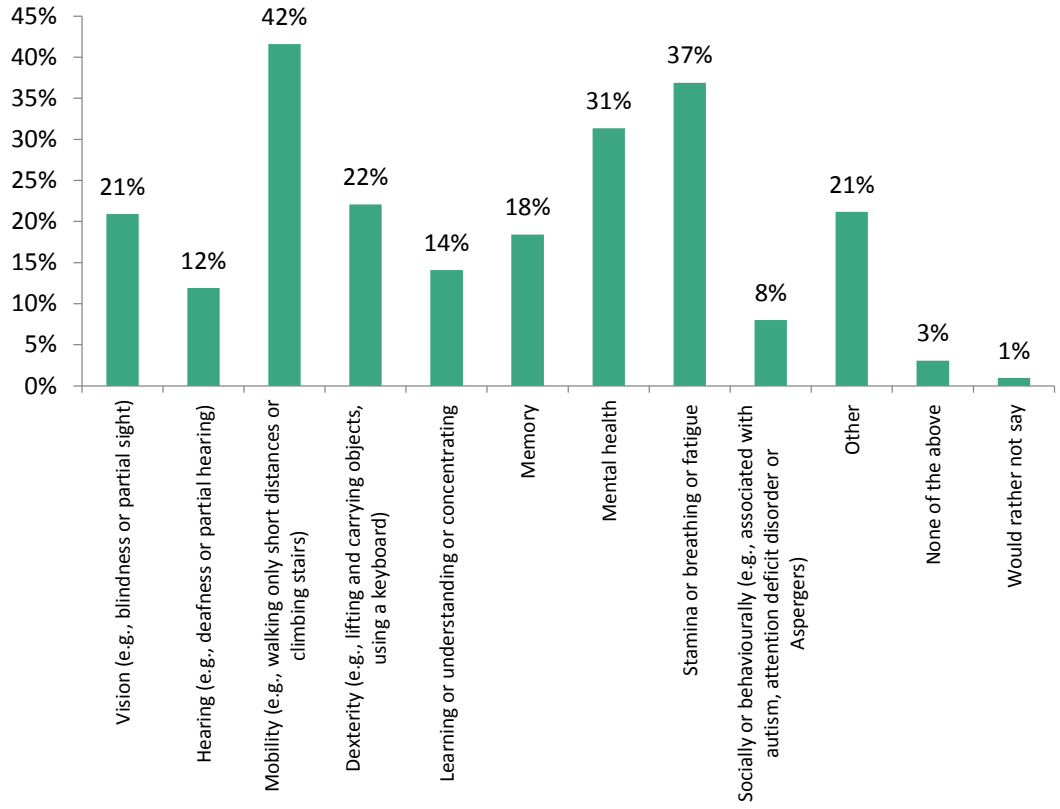
Health status

Self-reported health status by target group

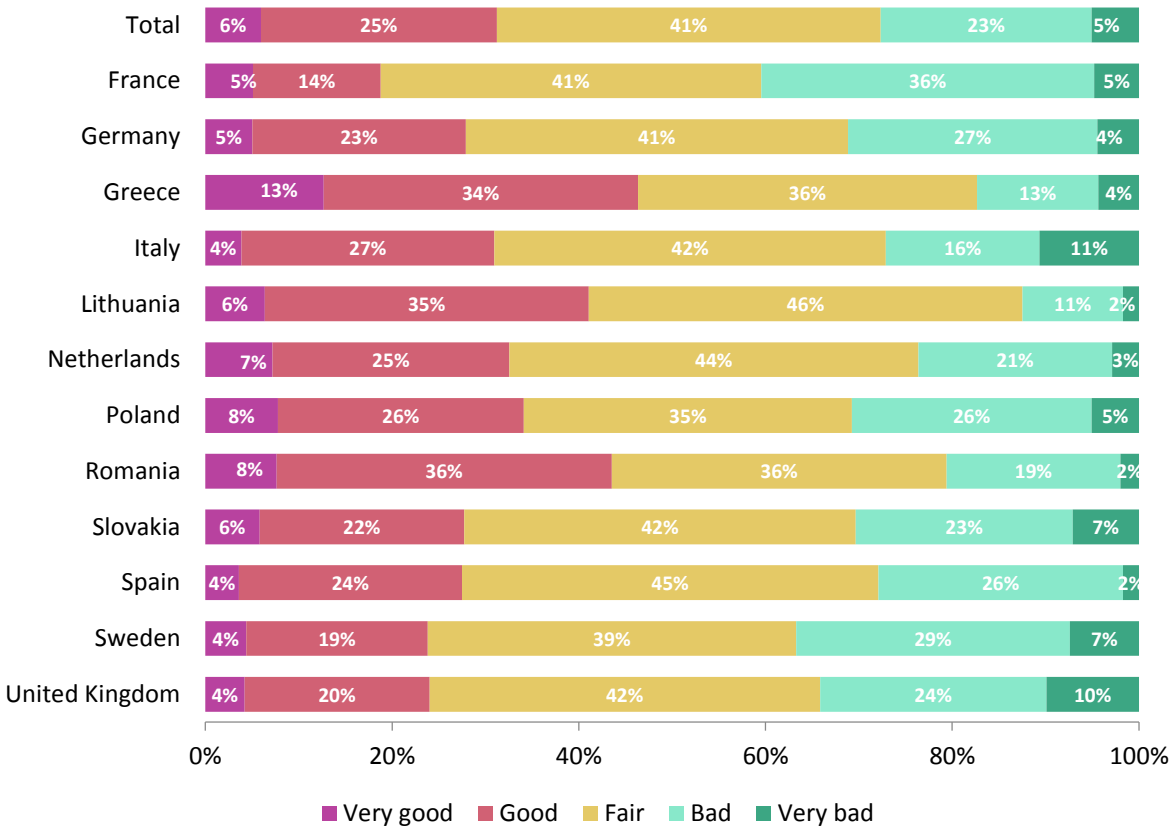




Respondents with long-standing illnesses, disabilities or infirmity for target groups



Specific areas affected by long-standing illnesses, disabilities or infirmity



Health status by country

Health status by socio-economic profiles

	Very bad	Bad	Fair	Good	Very good
Total	**5%**	**23%**	**41%**	**25%**	**6%**
Male	5%	23%	40%	26%	7%
Female	5%	22%	42%	25%	5%
18-34	3%	14%	37%	35%	12%
35-54	6%	24%	43%	23%	4%
55+	7%	30%	43%	18%	2%
Basic education	8%	29%	36%	21%	6%
Medium education	4%	23%	43%	25%	5%

High education	4%	18%	41%	28%	9%

(Very) difficult financial situation	7%	29%	41%	20%	4%
(Very) easy financial situation	2%	13%	42%	34%	9%

Specific areas affected by long-standing illnesses, disabilities or infirmity by target group

	Vision	Hearing	Mobility	Dexterity	Learning, understanding or concentrating	Memory	Mental health	Stamina, breathing or fatigue	Socially or behaviourally	Other	None of the above	Would rather not say
Total	**21%**	**12%**	**42%**	**22%**	**14%**	**18%**	**31%**	**37%**	**8%**	**21%**	**3%**	**1%**
Families who are in a vulnerable situation	25%	13%	43%	27%	15%	16%	26%	35%	10%	18%	3%	1%
Physical, mental and learning disabilities	22%	12%	51%	28%	20%	23%	44%	40%	12%	18%	1%	1%
In-work poor	25%	12%	31%	17%	10%	18%	23%	37%	8%	18%	6%	0%
Older people who are vulnerable/isolated	29%	23%	56%	34%	13%	23%	21%	48%	5%	27%	3%	1%
People with unstable housing situations	24%	15%	36%	20%	20%	24%	39%	35%	12%	23%	2%	1%
Prisoners	36%	16%	26%	14%	17%	16%	24%	40%	12%	28%	5%	0%
Persons living in rural/isolated areas	21%	15%	46%	22%	10%	13%	25%	42%	7%	30%	3%	1%
Long-term unemployed / inactive	16%	9%	39%	21%	14%	16%	34%	40%	9%	24%	5%	2%

Victims of domestic violence	19%	17%	39%	21%	16%	20%	45%	37%	16%	14%	2%	1%

Aspect of feeling healthy/unhealthy ('most of the time' and 'all of the time') by target group

	I woke up feeling fresh and rested	I have felt particularly tense	I have felt lonely	I have felt downhearted and depressed
Total	21%	30%	27%	28%
Families who are in a vulnerable situation	19%	38%	32%	35%
Physical, mental and learning disabilities	21%	30%	27%	32%
In-work poor	17%	30%	23%	26%
Older people who are vulnerable/isolated	19%	26%	31%	24%
People with unstable housing situations	18%	39%	40%	39%
Prisoners	29%	25%	26%	16%
Persons living in rural/isolated areas	15%	33%	29%	30%
Long-term unemployed / inactive	21%	29%	27%	31%
Survivors of domestic violence	17%	41%	39%	44%

Factors affecting people's health by target group

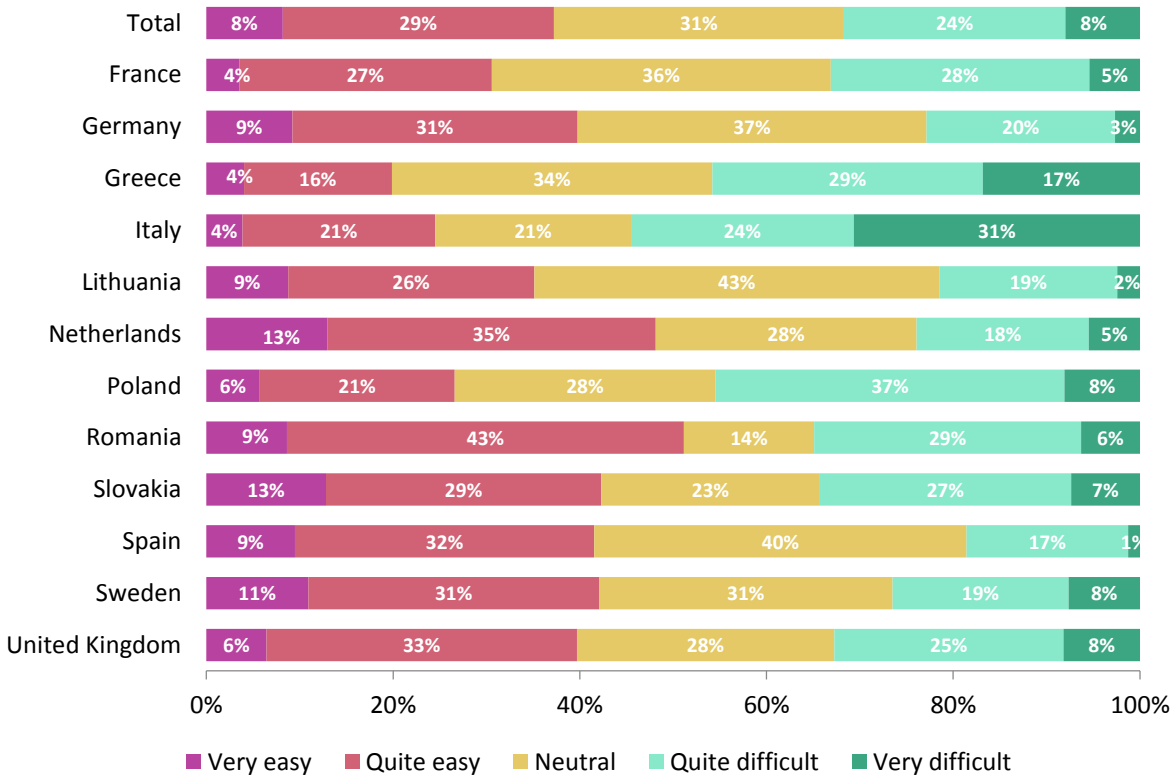
	Lack of Good [illegible]	Lack of money	Work (or lack of [illegible])	Concern about [illegible]	Lack of exercise	Food/Diet - [illegible]	Smoking	Alcohol	Drugs	Stress	Other	None of the [illegible]
Total	**23 %**	**62 %**	**36 %**	**22 %**	**32 %**	**25 %**	**26 %**	**11 %**	**5 %**	**53 %**	**5 %**	**6 %**

Families who are in a vulnerable situation	28 %	68 %	39 %	27 %	33 %	26 %	31 %	12 %	5%	59 %	7%	3%
Physical, mental and learning disabilities	20 %	57 %	31 %	24 %	37 %	25 %	25 %	10 %	4%	55 %	8%	7%
In-work poor	23 %	72 %	37 %	23 %	34 %	31 %	27 %	14 %	4%	56 %	1%	4%
Older people who are vulnerable/isolated	23 %	63 %	17 %	17 %	29 %	19 %	22 %	7%	1%	40 %	10 %	6%
People with unstable housing situations	53 %	71 %	45 %	27 %	27 %	29 %	35 %	18 %	9%	58 %	2%	5%
Prisoners	34 %	41 %	24 %	20 %	38 %	26 %	55 %	28 %	16 %	54 %	2%	4%
Persons living in rural/isolated areas	29 %	67 %	39 %	27 %	33 %	29 %	29 %	14 %	6%	51 %	14 %	5%
Long-term unemployed / inactive	23 %	66 %	49 %	24 %	36 %	29 %	25 %	12 %	5%	54 %	7%	6%
Survivors of domestic violence	30 %	66 %	34 %	37 %	37 %	31 %	34 %	18 %	12 %	62 %	4%	6%

Factors affecting people's health by country

	Lack of Good Housing Conditions	Lack of money	Work (or lack of work)	Concern about Relation ships	Lack of exercise	Too much food / too little food / unhealthy diet	Smoking	Alcohol	Drugs	Stress	Other - please specify	None of the above
Total	**23%**	**62%**	**36%**	**22%**	**32%**	**25%**	**26%**	**11%**	**5%**	**53%**	**5%**	**6%**
France	20%	72%	41%	20%	32%	33%	20%	7%	2%	49%	4%	6%
Germany	24%	68%	34%	31%	39%	29%	37%	19%	10%	51%	2%	6%
Greece	31%	73%	52%	26%	36%	32%	33%	8%	3%	72%	10%	3%
Italy	34%	57%	53%	26%	31%	19%	25%	10%	4%	54%	3%	3%
Lithuania	28%	71%	35%	20%	30%	32%	25%	15%	2%	58%	1%	5%
Netherlands	18%	60%	32%	29%	29%	24%	25%	10%	7%	44%	5%	9%
Poland	24%	55%	25%	16%	29%	19%	33%	12%	5%	56%	2%	5%
Romania	16%	50%	19%	4%	23%	19%	23%	8%	4%	59%	1%	4%
Slovakia	17%	50%	23%	8%	14%	10%	15%	4%	1%	28%	10%	15%
Spain	20%	59%	42%	23%	37%	18%	31%	13%	7%	53%	3%	6%
Sweden	22%	62%	37%	32%	40%	30%	20%	11%	3%	45%	9%	8%
United	25%	61%	31%	25%	38%	33%	26%	15%	9%	65%	8%	7%

Accessing healthcare services



Ease of accessing healthcare services by country

Effect of health status on the ease of accessing healthcare services

		Ease of accessing health care				
		Very difficult	**Quite difficult**	**Neutral**	**Quite easy**	**Very easy**
Total		**8%**	**24%**	**31%**	**29%**	**8%**
General health situation	(Very) bad	15%	35%	28%	17%	5%
	Fair	6%	24%	37%	29%	5%
	(Very) good	5%	14%	26%	40%	16%

Problems when trying to get medical treatment by target group

	Couldn't get an	Couldn't afford it	Couldn't take time off	Due to a lack of	There wasn't a	Uncertain about	Did not know where to	The wait was too long	Did not trust doctors /	Changed mind and	Unable to arrange care	Other	No
Total	**20 %**	**25 %**	**9 %**	**11 %**	**5 %**	**9 %**	**8 %**	**19 %**	**5 %**	**8 %**	**5 %**	**5 %**	**35 %**
Families who are in a vulnerable situation	30 %	41 %	16 %	19 %	13 %	20 %	14 %	24 %	7 %	9 %	17 %	4 %	19 %
Physical, mental and learning disabilities	22 %	21 %	8 %	14 %	7 %	10 %	9 %	19 %	7 %	10 %	4 %	7 %	36 %
In-work poor	20 %	32 %	21 %	10 %	6 %	10 %	8 %	24 %	5 %	9 %	6 %	1 %	30 %
Older people who are vulnerable/isolated	26 %	33 %	4 %	14 %	7 %	12 %	12 %	24 %	3 %	6 %	2 %	3 %	33 %
People with unstable housing situations	19 %	33 %	9 %	11 %	5 %	12 %	9 %	21 %	6 %	11 %	5 %	6 %	31 %
Prisoners	28 %	22 %	7 %	10 %	7 %	7 %	6 %	18 %	15 %	9 %	4 %	6 %	32 %
Persons living in rural/isolated areas	26 %	40 %	12 %	29 %	18 %	17 %	14 %	24 %	9 %	11 %	12 %	5 %	23 %
Long-term unemployed / inactive	18 %	23 %	2 %	11 %	5 %	11 %	9 %	16 %	6 %	9 %	5 %	5 %	44 %
Survivors of domestic violence	24 %	26 %	15 %	18 %	8 %	10 %	11 %	21 %	9 %	13 %	9 %	6 %	27 %

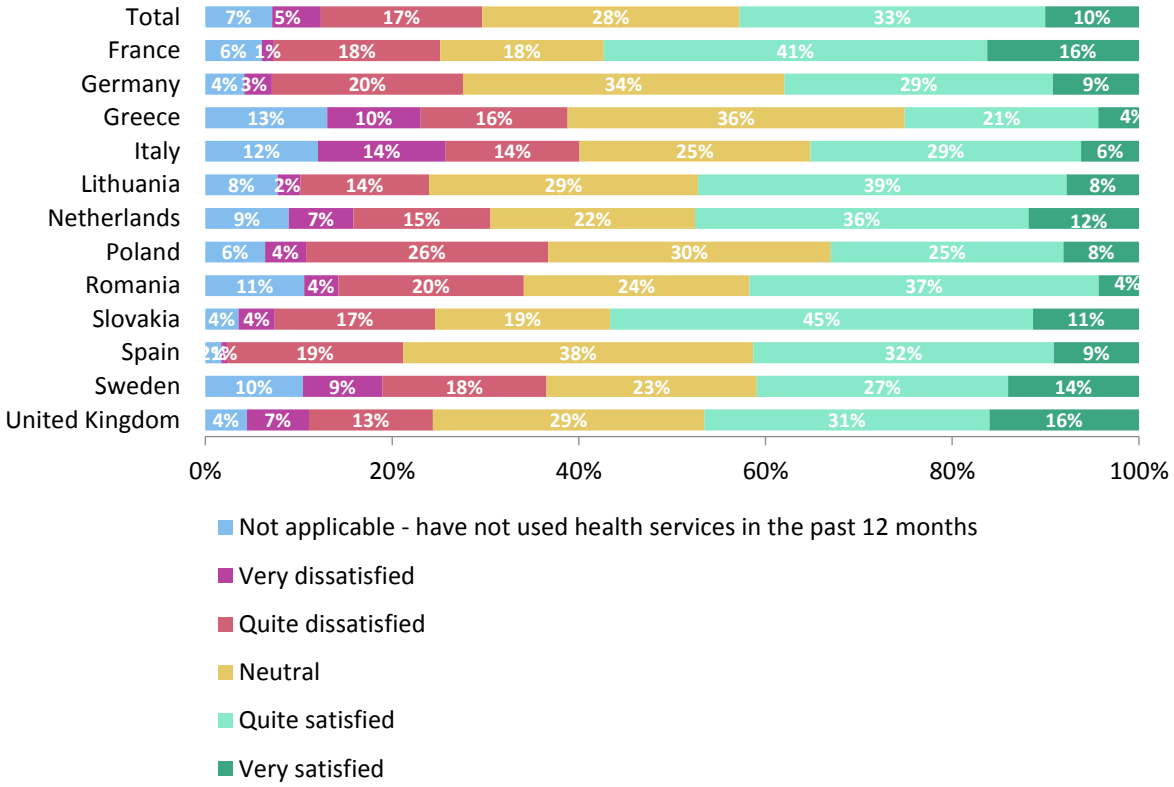
Problems when seeking dental treatment or examination by target group

	I couldn't get an	I couldn't afford it	I couldn't take time	Due to a lack of	There wasn't a	I did not know if it	I did not know where	The wait was too long	I did not trust	I changed my mind	I was unable to	Other	No
Total	**9 %**	**30 %**	**5 %**	**4 %**	**4 %**	**7 %**	**4 %**	**8 %**	**3 %**	**4 %**	**3 %**	**4 %**	**48 %**
Families who are in a vulnerable situation	18 %	45 %	11 %	12 %	10 %	15 %	8 %	12 %	5 %	6 %	9 %	4 %	28 %
Physical, mental and learning disabilities	9 %	27 %	4 %	6 %	4 %	7 %	5 %	6 %	4 %	5 %	3 %	6 %	49 %
In-work poor	11 %	42 %	10 %	5 %	5 %	7 %	5 %	13 %	3 %	6 %	4 %	1 %	37 %
Older people who are vulnerable/isolated	6 %	29 %	1 %	4 %	3 %	6 %	4 %	3 %	1 %	2 %	1 %	4 %	58 %
People with unstable housing situations	14 %	40 %	5 %	5 %	3 %	11 %	7 %	12 %	4 %	4 %	3 %	4 %	37 %
Prisoners	14 %	28 %	6 %	4 %	17 %	7 %	6 %	15 %	14 %	5 %	4 %	11 %	43 %
Persons living in rural/isolated areas	18 %	40 %	5 %	13 %	11 %	11 %	7 %	13 %	4 %	3 %	8 %	4 %	39 %
Long-term unemployed / inactive	7 %	29 %	1 %	4 %	4 %	7 %	4 %	6 %	4 %	3 %	2 %	3 %	55 %
Survivors of domestic violence	13 %	34 %	9 %	10 %	5 %	8 %	7 %	9 %	5 %	7 %	6 %	6 %	42 %

Problems when trying to get medication by target group

	I couldn't afford it	Due to a lack of transportation	There wasn't a pharmacy or other source of	I did not know if it would be covered by the	I did not know where to get advice	The wait was too long	I did not trust pharmacists or other medical	I changed my mind and decided not to obtain it	Other reason	No
Total	**26 %**	**6%**	**5%**	**7%**	**4%**	**6%**	**2%**	**3%**	**4%**	**55 %**
Families who are in a vulnerable situation	39%	13 %	14 %	18 %	8%	9%	4%	7%	4%	38%
Physical, mental and learning disabilities	21%	7%	6%	8%	4%	5%	2%	3%	7%	57%
In-work poor	31%	5%	6%	8%	7%	7%	2%	5%	1%	52%
Older people who are vulnerable/isolated	32%	5%	5%	9%	3%	5%	1%	3%	2%	50%
People with unstable housing situations	35%	5%	4%	9%	7%	6%	2%	5%	4%	48%
Prisoners	20%	3%	20 %	11 %	5%	15 %	4%	9%	14 %	47%
Persons living in rural/isolated areas	36%	17 %	17 %	18 %	4%	7%	2%	7%	4%	41%
Long-term unemployed / inactive	24%	5%	4%	9%	3%	4%	1%	3%	4%	62%
Survivors of domestic violence	27%	10 %	9%	10 %	10 %	6%	5%	8%	5%	48%

Satisfaction with healthcare services



Satisfaction with healthcare services by country

Satisfaction with healthcare services by health status

		Satisfaction with medical treatment					
		Very dissatisfied	Quite dissatisfied	Neutral	Quite satisfied	Very satisfied	N/a
Total		**5%**	**17%**	**28%**	**33%**	**10%**	**7%**
General health situation	(Very) bad	11%	29%	28%	22%	7%	3%
	Fair	4%	17%	31%	36%	7%	5%
	(Very) good	2%	8%	22%	38%	16%	13%

Satisfaction with healthcare services by health condition

			Satisfaction with medical treatment					
		Occurrence of problem	Very dissatisfied	Quite dissatisfied	Neutral	Quite satisfied	Very satisfied	N/a
Total			**7%**	**22%**	**28%**	**31%**	**10%**	**3%**
General health situation	Vision	21%	7%	26%	29%	27%	8%	2%
	Hearing	12%	6%	25%	30%	27%	10%	2%
	Mobility	42%	8%	23%	27%	31%	9%	3%
	Dexterity	22%	8%	26%	26%	30%	9%	2%
	Learning or understanding or concentrating	14%	9%	25%	25%	28%	10%	4%
	Memory	18%	8%	26%	26%	28%	9%	2%
	Mental health	31%	8%	22%	28%	30%	10%	2%
	Stamina, breathing or fatigue	37%	7%	25%	29%	30%	7%	2%
	Socially or behaviourally	8%	9%	28%	24%	24%	10%	4%
	Other	21%	8%	23%	27%	29%	9%	4%
	None of the above	3%	3%	15%	30%	32%	19%	1%
	Would rather not say	1%	4%	16%	28%	40%	12%	0%

Base: respondents that reported long-standing illnesses, disabilities or infirmity (Q2) and answered Q8 (n = 2.557)