



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

*Policy Guidance- A Framework for Action
December 2017*

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Section 1: Policy Guidance, a Framework for Action

The VulnerABLE project is a two-year pilot initiative of the European Commission (DG SANTE), implemented by ICF, in partnership with EuroHealthNet, the UCL Institute of Health Equity, the European Public Health Alliance, Social Platform and GfK. The project aims to increase understanding of how best to improve the health of people living in vulnerable and isolated situations, identify and recommend evidence-based policy strategies, and raise awareness of the findings and support capacity-building within Member States. As a final output of the project, this document has been developed to provide a framework for action for policy makers on methods of health improvement, prevention and service delivery in vulnerable and isolated situations.

Section 2 summarises the risk factors and barriers affecting those people who experience vulnerability.

Section 3 examines the scale of health inequality and vulnerable populations across the EU.

Section 4 describes the criteria for effective approaches, to be taken up by policy makers' at all governmental levels, which can improve the health and access to healthcare for people living in vulnerable and isolated situations.

To support these sections, a series of Annexes have been put together to better inform policy makers in the development of evidence based strategies for improving the health of people living in vulnerable and isolated situations. These are structured in the following way:

- **Annex 1** provides a table of additional resources which capture all of vulnerABLE's data and research. These can be used by policy makers and other relevant stakeholders to understand the scale of the issue and existing practices across Europe working to tackle them;
- **Annex 2** compiles a table, organised per vulnerable group explored in this project, summarising what EU-level and local initiatives exist to ameliorate those issues, and makes a preliminary link to the Tobias Framework for action- 'Evidence-based strategies to minimise the impact of social hierarchy on health'; and
- **Annex 3** lists the bibliography of literature used for this document.

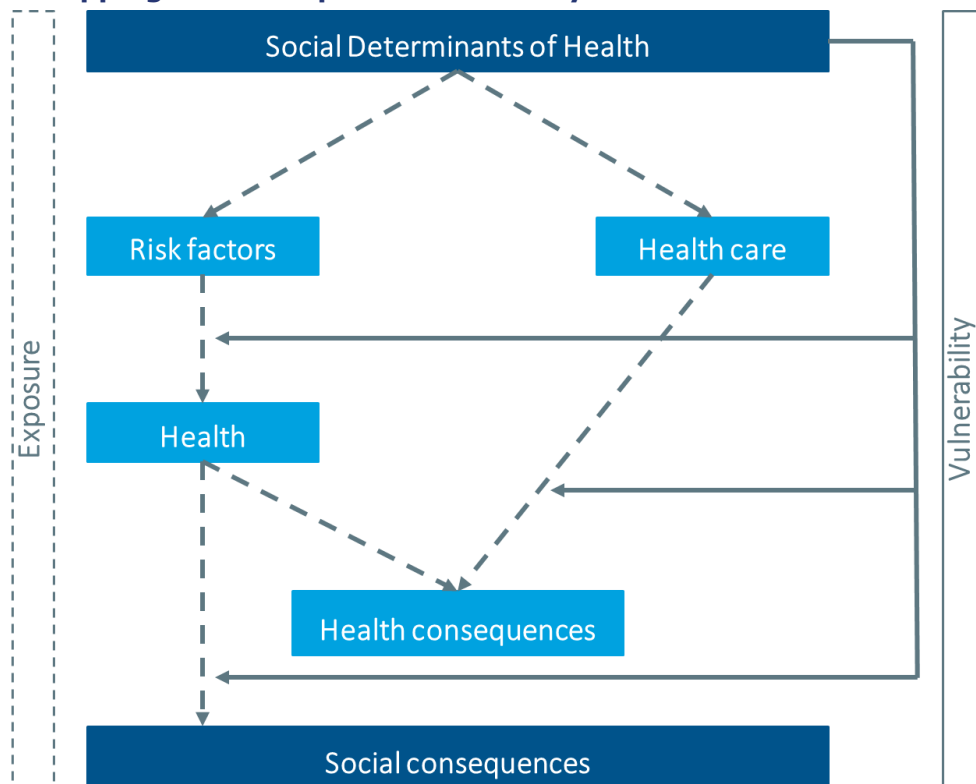
Section 2: Risk factors and barriers affecting those who experience vulnerability

This section examines the key risk factors and processes that can lead to vulnerability. The experience of vulnerability risk can lead to poor health. Likewise, poor health can also be a risk factor of vulnerability, in cases where no appropriate and effective approaches are implemented to address these risks. This section also highlights a wide range of issues relating to the varied healthcare needs of people in vulnerable situations. These include the barriers that reduce or prevent access to services (skills, literacy, affordability, stigma, discrimination); the level of service provided to meet their needs (social stereotyping, stigma, staffing levels, poor quality and resourcing of specialist services); and appropriateness of services (cultural appropriateness, failure to address complex health and social needs).

2.1 Defining vulnerability

Vulnerability is a complex social phenomenon that both influences, and is influenced by, a range of processes and risk factors that can lead to or result from poor health.

Figure 1. Mapping the concept of vulnerability



Source: Giuseppe Costa, 8th November 2017- vulnerABLE conference "Addressing the social determinants of health", [PowerPoint presentation]

The concept is not considered static, but rather fluid, with individuals being more or less at risk of being in a vulnerable situation depending on their exposure to a range of factors that can change throughout the life-course. These include personal factors (e.g. biological, inborn or acquired) and external factors (e.g. the social determinants of health). These factors either provide or deprive individuals from 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).

The social determinants of vulnerability are influenced by political, historical, cultural and environmental contexts. Building on this, 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 poor health.

2.2 Vulnerability and its root causes: the link between the social determinants of health and exposure to risk factors

The root causes of vulnerability are influenced by the complex interplay between the social determinants of health (i.e. the conditions in which people are born, grow, live, work and age), biological factors, and external circumstances and risk factors that affect access to, and the distribution of, resources (CSDH, 2008).

Key factors associated with vulnerability and its causes are explored below.

2.2.1 A poor start in life

Experiences during pregnancy and early life set the foundations for human development, including physical, cognitive and emotional development. These experiences have an impact on health outcomes, wellbeing and an individual's life chances, influencing academic attainment, social relationships and health behaviour, as well as increasing the likelihood of experiencing vulnerability throughout the life-course (The Marmot Review, 2010).

Adverse childhood experiences, such as child abuse and neglect, can significantly contribute to a poor start in life. Adverse childhood experiences are associated with poor physical (e.g. injury) and mental health (emotional wellbeing, self-harm, suicidal ideation) and the experiences can be detrimental to child development and may lead to perpetuated experiences of vulnerability and exclusion (UCL IHE, 2015).

2.2.2 Poverty

Poverty has a strong association with experiences of vulnerability, low income, reduced life chances and an inability to provide the basic necessities of life. Poverty can lead to poor standards of living, such as cramped and over populated housing which can exacerbate pre-existing physical and mental health conditions. It can also limit the choice on the type of physical environment people may live, which in turn can have a negative impact on the wider health determinants. For example, the environment in which people live can have a major impact on health. Areas which are highly polluted (such as air or water pollution), can pose a significant risk to health, as can a lack of open and green spaces. The environment can contribute to a range of negative health risks and conditions, including physical inactivity and respiratory problems (Heran et al., 2011; Allen and Balfour, 2014).

2.2.3 Poor education

The extent of educational participation (in terms of years of formal education) and achievement (in terms of formal qualifications) vary greatly between Member States and between groups within Member States. Lack of participation and qualifications are linked both to poorer skills (e.g. numeracy and literacy) and employment prospects (i.e. due to lack of job-related skills or formal qualifications). Issues relating to skills and qualifications are of particular relevance to a number of groups in vulnerable situations. Many groups are excluded from or suffer restricted access to education– for example those with more severe physical disabilities, learning disabilities, health problems in childhood, or discrimination on the grounds of ethnicity or religion. Similarly, migrants may either lack the skills or qualifications needed in their new country or simply lack the right language skills.

The absence of relevant skills and qualifications affects health and healthcare in a number of ways. Firstly, it can lead to poverty and insecurity, which result in stresses that are both directly harmful to health or affect health through health behaviours that are ultimately harmful to health. Secondly, by impacting on health literacy they can result in reduced awareness of health promoting behaviours and early identification of potential health problems. Thirdly, a lack of basic skills can act as a barrier in gaining access to needed health services.

The latter manifests itself at every stage in the healthcare system. A lack of reading and writing skills can make it difficult to navigate bureaucratic processes that act as a gateway to services (for example, form filling, understanding complex rules and instructions). An inability to articulate signs and symptoms in language that is understood by health professionals can lead to serious early signs being overlooked and a denial of appropriate services. Even if treatment is provided, patient compliance requires an understanding of drug and treatment regimes by the patient. And this is often not conveyed in a way that is readily understood by those who lack a high degree of literacy and numeracy. Depending on the social protection regime, those who lack skills may not be in a position to afford treatment in view of their poverty or lack of appropriate social protection cover.

2.2.4 Social isolation and stigma

The conditions or circumstances that make an individual vulnerable include, or are generally made worse, by being stigmatised and discriminated against. An individual who differs from accepted norms of appearance, speech or behaviour is at high risk of being treated differently as they do not conform to these norms, frequently extending to overt stigmatisation or discrimination. This can happen as a result of either the behaviours of other individuals on a day-to-day basis or of systems that are set up to treat individuals in certain categories differently. Stigmatisation and discrimination lead to isolation from the rest of society. Where cohesive groups are discriminated against, this can lead to internal bonding within that group and their rejection of the rest of society. However, in many circumstances, vulnerable individuals are left isolated from all of society.

In both of these situations there are potentially adverse health consequences. Both are stressful for the individuals concerned, leading to adverse health outcomes and behaviours as discussed above. Both reduce contact with best available health advice. Both can lead to poorer access to the labour market and hence, in many circumstances greater poverty and poorer social protection. Stigmatisation by gatekeepers to healthcare is a barrier to receiving (or being willing to seek) appropriate care. Stereotyping of particular groups (as a form of stigmatisation and discrimination) by health professionals delivering health care can also result in sub-standard treatment, akin to that discussed above for those with lower skill levels. This can equally deter individuals affected from seeking or participating in treatment.

Emphasis within policy approaches should aim to address discrimination and stigmatisation, both in the delivery of health systems and other formal systems (such as education and social protection), but also in the wider society – in particular in relation to employment. In short, it is important to reduce the scale and impact of the key sources of social exclusion for individuals in vulnerable situations and promote their inclusion both by society and the systems that provide access to services.

2.2.3 Poor physical and mental health

Poor physical and mental health is often associated with vulnerability. Those closer to the bottom of the socio-economic ladder are more likely to experience poorer health, and vulnerability as a result. For example, poor health can make it difficult to perform normal tasks of everyday life. Additionally, it can reduce an individual's ability to participate in the labour market, social networks and maintain good living conditions. Poor physical and mental health can also be a result of vulnerable experiences, or can influence other risk factors, such as stigma, which can act to perpetuate experiences of vulnerability.

2.3 Overarching barriers faced by vulnerable groups

2.3.1 Lack of adequate social protection

Universal social protection is strongly correlated with levels of self-perceived health in the population as a whole (Ferrari et al). It has been argued that this is because it is seen by all as providing a safety net should the worst happen, even though it is the more vulnerable within the population who are most likely to draw on this provision (Lundberg et al). Moreover, the greater the level of social provision funding the higher the level of self-perceived health. But, where there is universal provision, this relationship is socially graded (Lundberg) – the self-perceived health of those with lower levels of education is more sharply influenced by levels of provision than the more educated. In other words the health effect is strongest in those with the greatest likelihood of needing social protection.

While this is a graded effect, the implications for those who are most vulnerable are considerable. Many types of vulnerability are associated with an increased need to draw on sources of social protection. However, in many countries where social protection is not universally available, it is individuals in vulnerable situations who lose out. For example, where recipients of social protection are required to have a home address, the homeless do not receive protection. Where social protection relies on current employment or accumulated employment benefits, those with no, or interrupted employment histories (for example as a result of physical disabilities or mental health issues), will be denied these benefits. This will not only disadvantage them in denying protection when needed but will also create stress and anxiety when they are only just managing to be self-sufficient.

With austerity, levels of social protection have fallen dramatically and it is two groups who suffer particularly. First those with the greatest degree of vulnerability have seen cuts in the extent to which their complex needs are met. Second, those whose vulnerability is slightly less severe have seen mechanisms put in place to exclude them from receipt of social protection.

The welfare regime in place within a Member State also has an impact on the availability of social protection to those in specific vulnerable situations. Where social protection is principally provided through employment rights either by the employer or the state, those who are excluded from employment are likely to lose some or all of the social protection provided to those in employment (Siegrist). This can be particularly severe for those whose vulnerability has always excluded or hindered their participation in the labour market (e.g. disabled, those with learning difficulties or longstanding mental health problems). Equally those whose social exclusion marginalises them into the informal economy may also lose out on full social protection (e.g. Roma, undocumented migrants, refugees).

Within those welfare regimes in which critical aspects of social protection, such as healthcare, is dependent on personal insurance contributions, vulnerabilities can either make it difficult to afford normal contribution rates (due to low paid employment or economic inactivity) or require unaffordable enhancements to contributions (because of pre-existing health conditions) or preclude cover for existing health conditions or otherwise preclude people in certain vulnerable situations (e.g. homelessness).

Universal social protection is needed to provide a safety net when people develop increased levels of need due to vulnerability. Similar arguments apply specifically to healthcare coverage. However, the specialist needs of some of the causes of vulnerability (e.g. specific disabilities) lead to the need for specialist or enhanced levels of service. Where resources are limited or mainstream services are narrowly focused on wider population needs, there is an argument for targeted services. These can provide a cost-efficient method of addressing specific health needs in relatively small patient groups (relative to the size of the groups served by mainstream services).

2.3.2 Low income and insecurity of work

For reasons discussed above, individuals in many vulnerable situations are in poverty. This can be the result of a lack of access to the labour market (for example due to lack of skills or qualifications, disability, migrant status or other forms of discrimination). Others may, for similar reasons, only have access to low paid, insecure and/or part time work, often in the informal or black economy, which does not provide an income sufficient for healthy living for themselves and their families. Depending on the welfare regime type, it may also not provide adequate social protection (see earlier discussion above).

Income and employment related poverty requires action on two interlinked fronts. Firstly, by ensuring a minimum wage for any work done by a worker. The adequacy of minimum wage legislation, in relation to local living costs, varies considerably across Europe. Levels need to be set at a rate that allows anyone, but particularly those who are too vulnerable to obtain wages above the statutory minimum, to live healthily on their wages if they do a full week's work. Secondly, for those who are not able to do a full week's work, the social protection system needs to provide a sufficient safety net for those in these vulnerable situations such that they can live healthily – including having access to affordable and quality healthcare.

2.3.3 Lack of essential services and frontline staff

Services for those who are vulnerable, for one reason or another, should be appropriate to their needs. This may simply be appropriate training and skills for front-line staff. Or it may require additional services or facilities linked to the causes of vulnerability (e.g. disability or a lack of specific skills or qualifications). In either case these staffing and service requirements are additional to those that are required as part of a service to members of the public who do not experience the vulnerability in question. As such they are generally seen as additional expense or burden on the systems providing them, this can either lead to non-provision of the necessary training or level of service or of sub-standard provision. This is often both inadequate and stigmatising as mainstream services are often inadequate to address these complex needs. Not surprisingly, working in professions that specifically face these issues in delivering the required services is becoming less “appealing”, creating additional capacity issues. This problem has been further increased by austerity measures in services in many countries and the increase in demand due to demographic pressures. This highlights both training and capacity building issues in health and related services.

Section 3: The scale of health inequalities across the European Union

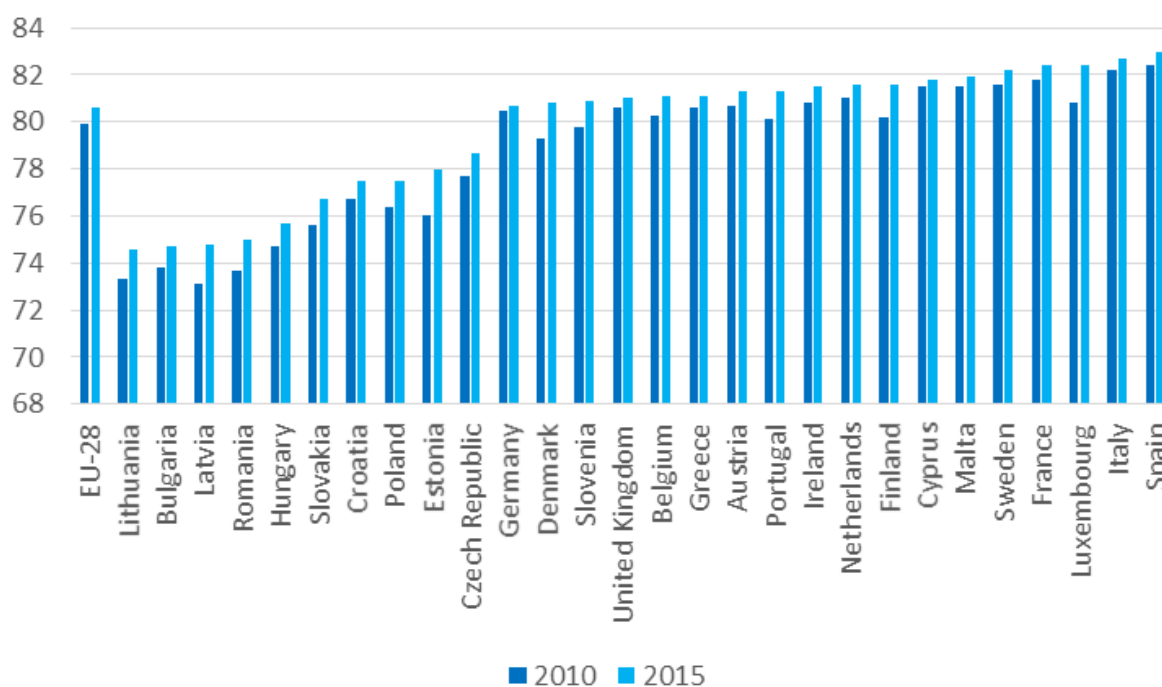
This section presents an overview of the scale of health inequalities across the EU drawing on key findings from the VulnerABLE project, which are available in Annex 1. It also provides illustrative examples of the scale and variance of vulnerable groups across Member States. This section is intended to provide policy makers and other relevant stakeholders with a snapshot of the scale of this problem, ahead of providing specific criteria for effective approaches to address these issues (Section 4 of this document).

3.1 The scale of health inequalities across the EU

Despite population health indicators showing improvements across the European Union over the last decade, widespread inequalities in health remain, both within and between Member States. This reflects the difference conditions in which people are born, grow, live and work (European Commission, 2013).

Data on life expectancy at birth show persistent and significant differences in health between Member States, as presented in Figure 2. Typically, those Member States in Eastern Europe have considerably lower life expectancy compared to the rest of the EU. For example, in 2010, there was a difference of 9.1 years between the Member States with the lowest (Lithuania) and highest (Spain) life expectancy. In 2015, data show the gap had narrowed slightly but was still a difference of 8.4 years (Eurostat, 2017a).

Figure 2. Life expectancy at birth, by country, 2010 and 2015



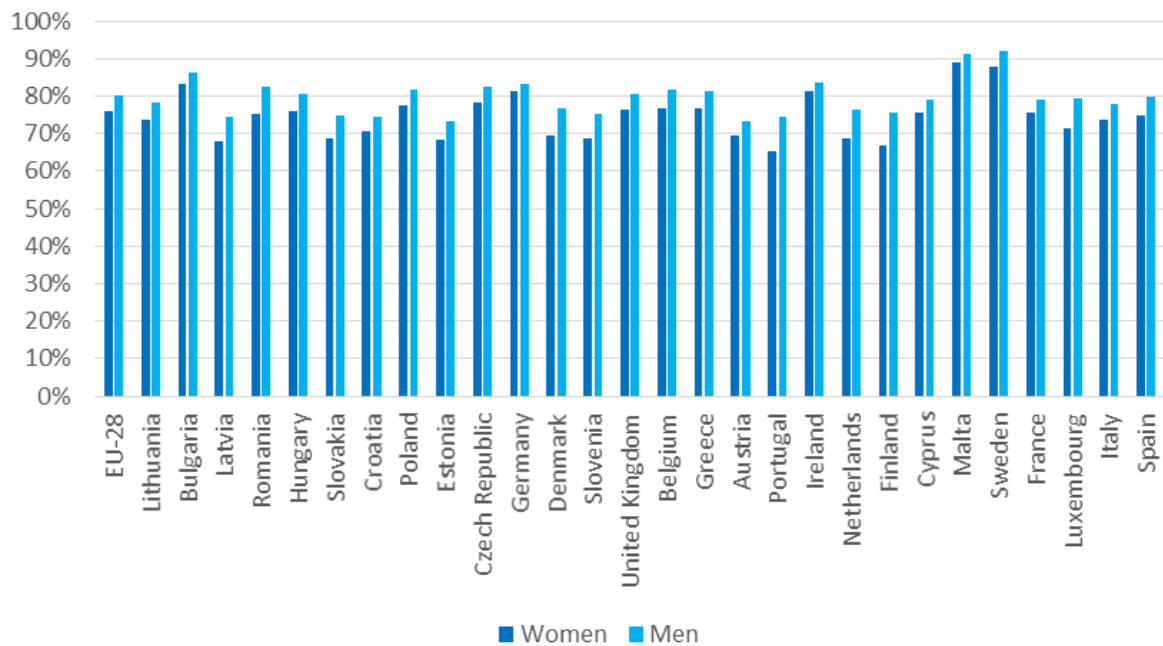
Source: Eurostat (2017a)

3.1.1 Differences in health by gender

As well as data on life expectancy showing inequalities in health between Member States, the data also show differences in life expectancy between women and men. For example, in 2015, the difference in average life expectancy between women (83.3 years) and men (77.9 years) across the EU-28 was 5.4 years. Lithuania had the greatest difference in life expectancy between EU women and men (10.5 years), whilst the Netherlands had the smallest difference between women and men (3.3 years) (Eurostat, 2017b).

Healthy life years (HLY) is another important health indicator, measuring the average age at which a person can expect to live free from moderate or severe health problems. In contrast to life expectancy where, on average, women live longer than men, men are more likely to spend a greater proportion of their lives in good health compared to women. Figure 3 shows the average percentage of expected life that a person will live healthy for men and women across EU Member States. The data show a clear difference between women and men across all Member States (difference of 4.3 percentage points at EU-28 level), with the greatest difference between women and men in Portugal (9.3 percentage points) and the smallest difference in Ireland and Germany (2.1 percentage points) (Eurostat, 2017b).

Figure 3. Healthy Life Years at birth in percentage of total life expectancy for women and men, 2010-2015

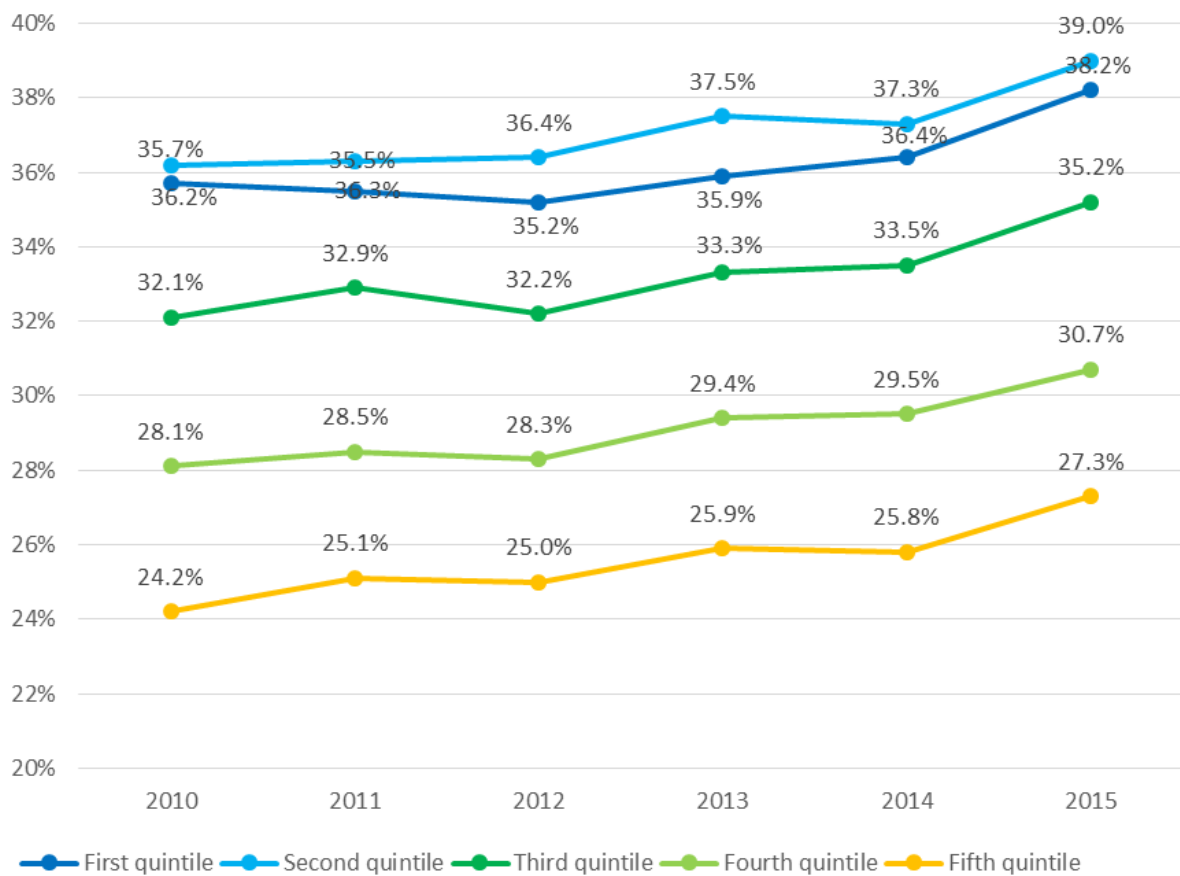


Source: Eurostat (2017b)

3.1.2 Prevalence of health problems by income

Level of income can also have an impact on health. Data show that people on lower incomes are more likely to report higher rates of longstanding illness or health problems. For example, Figure 4 shows that those with the highest incomes (fifth quintile) have a significantly lower rate of long-standing illness or health problems compared to those with the lower incomes (first and second quintiles) – a difference of 10.9 between the first and fifth income quintile.

Figure 4. Prevalence of longstanding illness or health problem by income quintile, 2010-2015



Source: (Eurostat, 2017c)

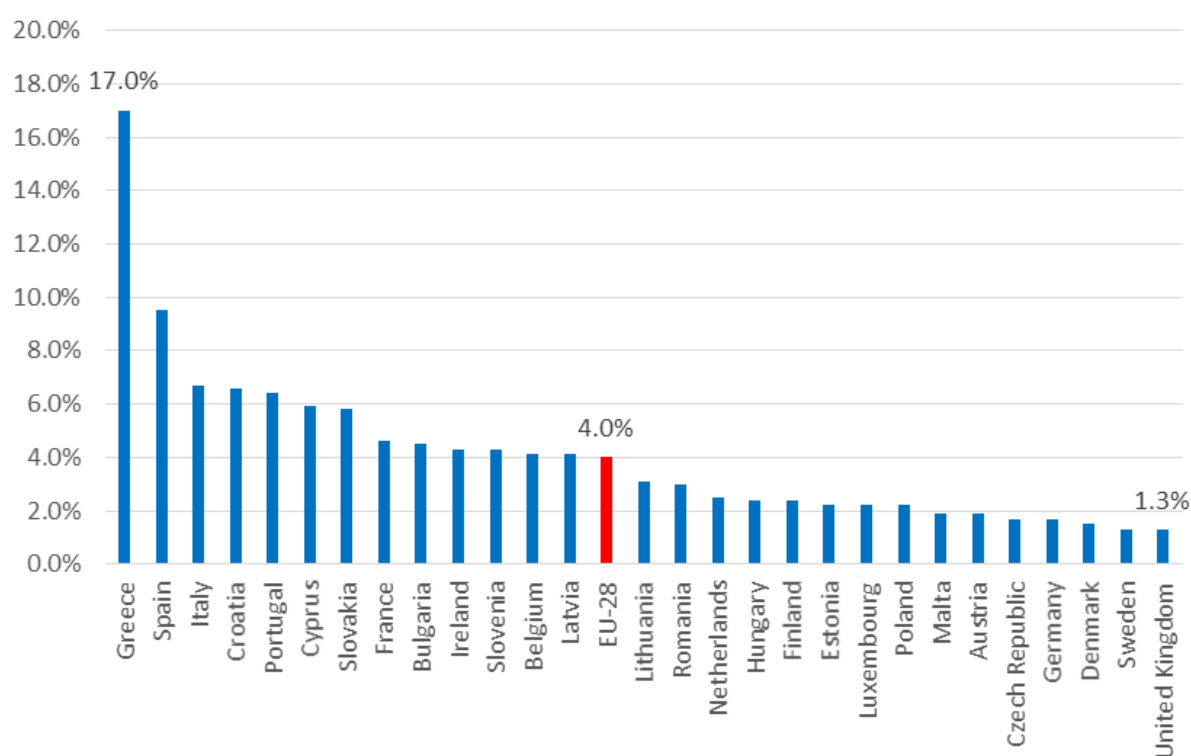
Interestingly, individuals in the second quintile are slightly more likely to experience a long-standing illness or health problem compared to those in the first income quintile, which may reflect the negative health impacts of low-paid employment (Eurostat, 2017c).

3.2 Examples of vulnerable populations in numbers

As circumstances differ across Member States, so does the level of vulnerability and the groups of people who may find themselves in vulnerable situations. Some of these differences, including the scale of some vulnerable groups, are illustrated in this subsection below.

Employment provides a key source of income for people across Europe, and tends to act as a buffer against the risks of vulnerability. Those people who spend long periods of time in unemployment, however, face a greater risk of vulnerability. In 2016, it was estimated that there were over nine million long-term unemployed people in the EU (aged 20-64), representing a relatively large potential vulnerable population. Figure 5 shows the percentage of long-term unemployed within the active age population (20-64 years) across EU Member States. It illustrates a significant variance in the long-term unemployed populations, with considerably high unemployment in most Southern European Member States, in contrast with relatively low level of unemployment in the UK and Scandinavia.

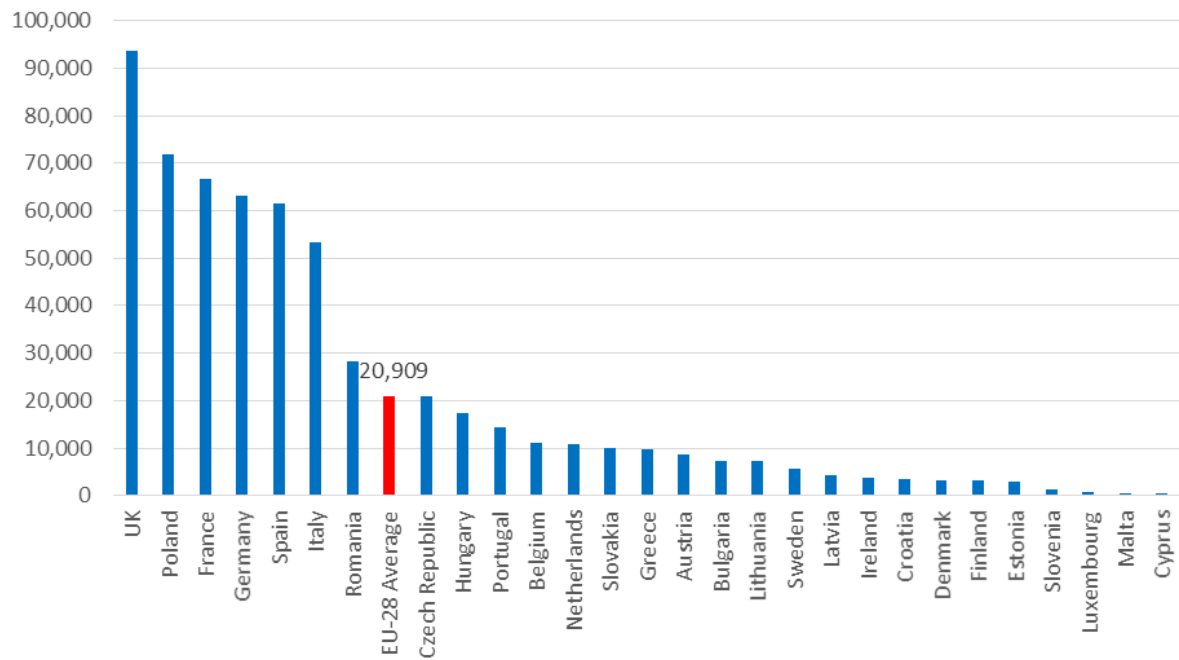
Figure 5. Percentage of long-term unemployed people of population aged 20-64 years



Source: (Eurostat, 2017d)

At around 585,000, the EU prisoner population is relatively small compared to some other vulnerable groups. However, prisoner populations can host some of the most vulnerable people in society, as well as the prison experience contributing to vulnerability. In addition, the number who have been imprisoned in their lives is considerably larger. Figure 6 shows a considerable variance in the number of prisoners across Member States providing some indication as to the size of the group. As the graph below shows, there are considerably higher populations of prisoners in the more populous Member States (the UK, Poland, Germany, France, Spain and Italy), whilst the majority of the other Member States have relatively fewer numbers of prisoners in comparison.

Figure 6. Number of prisoners by Member State, (including adult and juvenile populations)



Source: (Eurostat 2017e)

Section 4: Criteria for effective approaches: A framework for action

4.1 Introduction

Sections 2 and 3 above presented an overview of the factors that influence vulnerability and an indication of the scale of health inequalities and vulnerable populations across the EU. The key issues presented in those sections can be summarised as follows:

- People are vulnerable when they experience multiple processes of exclusion (e.g. poor start in life, poverty, poor health, physical impairment, discrimination);
- Vulnerability can result from both social and health adversity across the life course (e.g. adverse birth outcomes, adverse childhood experiences, lack of education and employment);
- The extent and impact of being in a potentially vulnerable situation depends on the environment in which that occurs (e.g. exposure to risk factors, access to support services).

Whilst these issues present a considerable challenge for policy makers, direct operational actions can be taken to address the immediate and long-term consequences of vulnerability. Preventative actions can also be taken to address the causes of vulnerability and reduce the level of exposure to risk factors which may lead to vulnerability and focus on making best use of “Whole of Government/Whole of Society” approaches to improve the social determinants of health and population health outcomes.

Actions also support the achievement of, and are aligned with, international, cross-cutting, sustainability goals focused on improving healthcare and reducing health inequalities: the most recent ones include the [United Nation Sustainable Development Goals](#), and [The European Pillar of Social Rights](#).

Against this backdrop, and in order to support policy makers to take appropriate action, a set of criteria are necessary for effective approaches to improve health and access to services for people in vulnerable situations, on the basis of existing knowledge and findings captured through this pilot project.

These criteria, or ‘key design principles’ are discussed in the sub-sections below and take the form of guidance for implementing effective approaches in tackling vulnerability. The guidance presents the main issues at stake, criteria for effective approaches and high-level recommendations for policy makers to implement action.

To facilitate application of such approaches, this section has been divided into sub-sections, starting with general principles underpinning effective approaches, and then focusing on specific stages of a policy cycle: planning, implementation and evaluation.

When considering the sub-sections below, it is important to recognise that while there is an emphasis on Healthcare Systems, this issue lies firmly within the context of multi-sectoral collaboration which is essential to achieving the desired outcomes.

4.2 General principles

A number of general principles that underpin effective approaches to addressing vulnerability and health inequalities have been recognised, and should form the basis of policy-oriented action.

4.2.1 Understanding of vulnerability

Issues

People experience multiple levels and processes of exclusion, often leading to experiences of vulnerability and the development of complex needs. Policy responses should focus on addressing the complexity of needs (multi-morbidity or social needs).

Principles for effective approaches

Effective policy approaches must encompass not just healthcare but health prevention, social care and wider actions across the “Whole of society/Whole of Government”. The processes that result in people experiencing vulnerability generally extend beyond the healthcare system and include issues such as: social exclusion; discrimination and isolation; coverage and adequacy of social protection safety nets; adequacy of wider social and community services to meet complex needs; access to education and employment (availability and non-discrimination); and, adequacy of incomes (minimum wages and levels of social protection).

A rights-based approach should underpin policy development. This should cover both the right to health but also those rights that relate to the capability to live a healthy life and one that is worth living (e.g. education, employment and a good work environment, freedom from fear and discrimination, physical and mental safety and wellbeing).

Recommendations for policy makers

Action must be agreed and co-ordinated across sectors to reduce the multiple factors that lead to vulnerability and the environment in which it is perpetuated (see, for example, the [United Nations Sustainable Development Goals](#); [The European Pillar of Social Rights](#)).

4.2.2 Design of services and interventions

Issues

The demands and needs of specific groups vary according to the context and type of vulnerability. These will vary according to the needs that exist within groups and the environment in which they experience vulnerability, recognising that everyone in a specific group will also have the same needs and rights as everyone else in society.

Principles for effective approaches

Integration of specialist interventions with mainstream provision is therefore essential, not only for the needs of vulnerable groups but also in supporting sustainable health systems. Furthermore, cultural pre-conceptions related to an integrated approach need to be addressed among planners, front line staff and the wider public as well as service users. An additional element when exploring such interventions is to ensure a life-course perspective, as it is important to consider that both the causes and consequences of vulnerability span different stages of a persons’ life, including the importance of early years’ development.

To this end, capacity building and training are needed to develop holistic services and overcome stigmatising and exclusionary behaviours.

Recommendations for policy makers

Action must be agreed and implemented to increase the knowledge of a broad range of actors (from policy makers to front-line staff) to understand the causes and consequences of vulnerability over the life course, improve existing service structures and provide a mandate for new types of provision.

4.2.2 Multi-sectoral partnerships

Issues

The responsibility for most forms of vulnerability do not rest with healthcare services alone. Nonetheless, healthcare staff have a central role in dealing with many of the consequences of vulnerability (e.g. poor health and barriers to accessing care) as well as having a key role in providing a focus for ameliorating future problems and advocating for effective action on problems experienced by the vulnerable. These often include exclusion and discrimination by housing, social care and health agencies, poorer quality of services, not recognising the complex health needs that require both multi agency action and the provision of specialist services that are integrated with mainstream services to avoid gaps or duplication in provision.

Principles for effective approaches

Integrated services must address a range of issues – stigmatisation, cultural acceptability of a non-standard service, affordability (by patients and insurers/social protection coverage, requirement for out of pocket payments), ensuring awareness of the existence of non-standard services by both staff and clients, and rationing if demand for services exceeds supply (either through price, lengthy queues or gateways based on severity or other eligibility criteria) in order to secure access to services for vulnerable groups.

Recommendations for policy makers

Action must be agreed and taken to build on existing good practice and facilitate new inter-agency and inter-disciplinary working both at the policy level and among front-line staff at all stages from assessment, planning, implementation to evaluation.

4.3 Planning stage

4.3.1 Mandate

Issues

The type of organisations and actors to be involved in development and implementation of approaches needs to be clearly set out. This should be based on a whole of society and whole of government approach (see The WHO's Health 2020 Health Policy Framework¹).

Principles for effective approaches

Achieving this holistic approach needs the involvement of all relevant stakeholders – from citizens, local implementation agencies and NGOs to government Ministries (particularly Health, Education, Employment, Transport, Housing, and Finance).

¹ <http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/about-health-2020>

Involvement of the private sector is also essential, both as providers of many services but also in terms of non-discriminatory provision of employment, transport and other aspects of participation in the wider society.

Positive action is needed to change cultural attitudes across the whole of society, to reduce stigmatisation and discrimination and create a climate of belief that no one should be left behind.

A higher level of policy is needed to address long-term unemployment, in-work poverty and early childhood development. When working with other groups (e.g. prisoners) action can be more locally initiated, but needs to link to wider initiatives on employment, rehabilitation, affordable housing, and adult education.

Recommendations for policy makers

Actions must be agreed and implemented which support and develop existing positive and effective partnerships and where required to build new partnerships, both through a whole system approach and at all levels, that are premised on empowering vulnerable groups to participate fully in society.

4.3.2 Budget flexibility and coordination

Issues

The way existing resources are currently deployed must be reviewed to maximise their effectiveness. New forms of funding to address specific issues will also be needed. These include income protection, housing, education and training provision for the vulnerable and, for service providers, capacity building and integration of specialist services.

Sustainability of funding and other resources (e.g. staff and premises); is essential – avoiding short term initiatives in favour of either realignment of existing resources; rolling programmes or ring-fenced integration in mainstream funding streams (e.g. pooled budgets).

Principles for effective approaches

Breaking down budget silos – not only horizontally within and between organisations, but also the vertical silos between local, regional, national and European budgets (alignment).

These realignments of budgets should take account of the need to engage NGOs, civil society and private organisations in a more holistic approach.

Recommendations for policy makers

Action must be agreed and implemented to review existing funding sources and other resources to maximise their effectiveness to address multiple needs, rather than isolated issues that are premised on creating seamless services for vulnerable groups that facilitate them participating fully in society.

4.3.3 Needs assessments

Issues

The social and health needs of individuals vary according to their circumstances. Although there are some commonalities within each of the vulnerable groups explored as part of this project, the specific needs of individuals will depend both on the multiple processes of exclusion that led to their vulnerability and the differing health and social consequences of their situation. Providing services that empower individuals and adequately addresses their situation requires individualised assessments of need.

Principles for effective approaches

Such assessments should be made for specific types of vulnerability, to be able to formulate an integrated response, recognising that individuals are likely to experience multiple types of vulnerability, across the life-course. Ongoing needs assessments, that adapt service provision to changing personal situations, benefit not only the user, but also the service itself, especially in view of restricted budgets and professional skills.

An asset-based approach to identifying and addresses needs is one which focuses on:

- Engaging people in vulnerable situations through active participation in implementation development and processes, so that their voices are heard;
- Ensuring self-empowerment is an important factor which can affect the success of approaches/services;
- Co-production of a policy response; and,
- Peer-to-peer action.

Recommendations for policy makers

Action must be agreed and implemented to ensure that staff are in place and adequately trained to undertake ongoing assessments of health and social needs. This includes ensuring appropriate data systems are in place to collect, monitoring and securely share data for the benefit of service delivery. It is also important that staff and vulnerable individuals work together to identify solutions using an asset-based approach.

4.4 Implementation stage

4.4.1 Balance of policy implementation

Issues

It is important to ensure that policies developed at higher levels do not impose, from above, local implementations that are un-related to the reality of the needs of vulnerable groups.

Principles for effective approaches

Implementation of policies, however developed, should be culturally appropriate both to the location and the groups covered. This requires participation in policy development by such groups, stretching from the outset of policy development through to fine tuning of implementation on the ground.

Recommendations for policy makers

Action must be agreed and implemented to ensure policies, where possible, are integrated at local level. This should include appropriate exchange of informant and access to data, through established data sharing agreements across sectors and agencies with clearly defined lines of accountability.

4.4.2 Outreach

Issues

This relates, in particular, to addressing the needs of people at risk of falling through the cracks in systems. On paper, universal healthcare coverage works, but in reality, people may not know how to use it or meet all the eligibility criteria (e.g. having an address or appropriate papers). Therefore, the Universalist approach is not enough, and needs to be tailored and resourced to meet the needs of groups and individuals who are poorly or inadequately served by the basic offer provided by a mainstream service.

Principles for effective approaches

Even in situations in which universal services are available, it is important to identify those individuals who experience barriers in accessing or using these services. Outreach services should seek out individuals who are less able to make use of mainstream services and ideally assist them to overcome these barriers or, where this is impossible, ensure that the services they need “go to them”.

Recommendations for policy makers

Action must be agreed and implemented to put outreach services in place to ensure that “no one is left behind”.

4.4.3 Flexibility of Interventions

Issues

All interventions need to be adaptive. To ensure that learning takes place – from the approach, the outcomes and processes of implementation – the intervention should be subjected to early review, so that fine tuning (or more radical changes) can be made in good time. It is equally important to listen to the views of users and include them in adapting the intervention at every stage in its development and implementation.

Principles for effective approaches

Evaluation of interventions should be put in place at the beginning of the process, ideally at the policy development stage, so that baseline measurement of qualitative and quantitative factors can be agreed and systems put in place to monitor achievements. Progress should be monitored regularly to an agreed timeframe and must feed into fine tuning of the intervention.

Recommendations for policy makers

Adequate plans must be agreed and put in place to ensure that thorough evaluation is undertaken from the start and that the intervention should be adapted as findings of preliminary evaluation become available.

4.5 Evaluation stage

4.5.1 Evaluation

Issues

Evaluation is essential for all policies and interventions and must be undertaken across the lifetime of such policies. At a minimum, evaluation needs to include qualitative and quantitative assessments of processes, outputs and outcomes that, realistically, can be achieved within a specific timescale. In addition, especially for new policies and long term interventions, appropriate resources need to be identified and agreed to support longer term evaluation process to be instigated and reported to further influence future policies.

Principles for effective approaches

As well as ensuring that the evaluation process is initiated as early as possible, evaluation should be completed and published in as timely fashion as practical, so that subsequent interventions (and mainstream developments) can take appropriate account of the results.

Recommendations for policy makers

Evaluations must be designed and agreed around the aim of improving practice both within the intervention being evaluated and more widely in similar evaluations. This should include the dissemination of lessons learnt and good practices to relevant agencies.

4.5.2 Sustainability

Issues

Many approaches on the ground are short term, based on availability and duration of funding. As discussed above, funding and resourcing needs to occur on a rolling basis or with a plan for mainstreaming and integrating funding and resources.

Principles for effective approaches

Long term interventions and those embedded within mainstream activities are preferable to short term projects that cannot be developed into mainstream activities.

Recommendations for policy makers

Interventions must be agreed, planned and implemented with sufficient attention paid to their long term sustainability and consideration given to how good practice can be integrated into routine systems and existing structures.

Annex 1 Additional resources accompanying this document

As part of this policy guidance, a resource table has been developed in order to provide a set of additional documentation for further reading. It captures the main outputs of this pilot project, which have been produced in order to better understand the main barriers faced by vulnerable groups across the EU when accessing healthcare, and aim to provide an evidence base for policy makers to act.

Underlying questions	Supporting resources
<p>What is the evidence base for this policy guidance document?</p>	<p>This document is informed by a comprehensive examination of the evidence base.</p> <p>More information about the data and evidence that informs this Framework is available in the following reports:</p> <ol style="list-style-type: none"> 1. Literature and Policy Review 2. Survey of vulnerable groups across 12 Member States 3. A Scientific Report summarising all research conducted within this pilot project 4. A series of thematic concept papers exploring underlying issues related to vulnerability and health. <p>https://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en#fragment0</p>
<p>What is the reality of those organisations and practitioners operating at the grassroots level?</p>	<p>A series of Focus Groups were held throughout the course of this pilot project. The Focus Group Report brings together in-depth findings from actors across Europe on the health needs and barriers to healthcare affecting vulnerable people.</p> <p>https://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en#fragment0</p>
<p>What good practices exist across Europe that address the barriers faced by vulnerable groups in accessing healthcare?</p>	<p>A good practice inventory, assessing over 100 good practices from across the EU has been produced. It provides 31 in-depth case studies focusing on the aims, outcomes and impacts of good practices.</p> <p>https://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en#fragment0</p> <p>http://www.health-inequalities.eu/projects/vulnerable-groups/</p>
<p>What resources are there for action?</p>	<p>Action plan templates and resource toolkits were tested during a series of Capacity Building workshops. Templates are available to help progress stakeholder thinking on what action to take and how.</p> <p>https://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en#fragment0</p> <p>http://www.health-inequalities.eu/projects/vulnerable-groups/</p>

Annex 2 Key research results per vulnerable group and corresponding actions

The purpose of this annex is to summarise the main policy responses and recommendations for action at the EU level in relation to improving access to and quality of healthcare for vulnerable and isolated populations. It also provides examples found during the research of good practice examples across the EU.

For further information, please consult the *vulnerABLE Scientific Report, section 4 (conclusions), page 138 onwards*.

Overall findings

The table below presents a summary of the key policy responses aimed at addressing the health barriers faced by vulnerable and isolated groups.

Overall findings	
Policy responses / Recommendations for action at the EU level	Examples of policy responses at the Member State level
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Strategies addressing health inequalities experienced by different vulnerable groups: France's City Health Workshops, which focus on improving the health of disadvantage groups.² Population-wide health strategies, which may also include a focus on some vulnerable groups: Ireland's National Cardiovascular health policy³; France's National Cancer Plan⁴.

² See http://www.cred.ro/v3/images/conference/Prezentare%20Franta_Hervieu.pdf

³ See <http://health.gov.ie/blog/publications/changing-cardiovascular-health-national-cardiovascular-health-policy-2010-2019/>

⁴ See <http://en.e-cancer.fr/The-Cancer-Plan-2014-2019>

Cohesion': which includes a staff working document entitled 'Investing in Health', extending the previous EU Health Strategy 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.

- **Multi-faceted strategies targeting vulnerable groups, within which health is 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:** 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.

Findings per target group

Below, the key findings from the review of the evidence-base on each of the target groups is summarised. This details the evidence on existing policy responses and key recommendations for action on how to address these issues, and examples of good practice. Finally, these tables provide a preliminary link to aspects of the Tobias Framework for Action⁵. 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.

⁵ Martin, Tobias (2017), 'Social rank: a risk factor whose time has come?'. The Lancet, Volume 389, Issue 10075, pp. 1172-1174

Older people

Policy responses / Recommendations for action	Examples of good practice	Links to Tobias Framework for Action
<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Promoting healthier lifestyles: The Europe wide Healthy Ageing Supported by the Internet and the Community (HASIC)⁶ 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 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. 	<ul style="list-style-type: none"> • Strengthen local communities • Provide wrap-around services for the multiply disadvantaged • Promote healthy lifestyles • Ensure universal access to high quality primary health care

⁶<http://www.hasicproject.eu/en/node/31>

Children and families from disadvantaged backgrounds

Policy responses / Recommendations for action	Examples of good practice	Links to Tobias Framework for Action
<ul style="list-style-type: none"> • 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 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. 	<ul style="list-style-type: none"> • 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). 	<ul style="list-style-type: none"> • Invest in children • Provide a safety net • Implement active labour market policies • Provide wrap-around services for the multiply disadvantaged • Promote healthy lifestyles

People living in rural/isolated areas

Policy responses / Recommendations for action	Examples of good practice	Links to Tobias Framework for Action
<ul style="list-style-type: none"> • 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). • 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 	<ul style="list-style-type: none"> • 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 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). 	<ul style="list-style-type: none"> • Strengthen local communities • Provide wrap-around services for the multiply disadvantaged • Ensure universal access to high quality primary health care

<p>technological solutions) which have been found to be more accessible in rural areas than fixed location health services.</p>		
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People with unstable housing situations (the homeless)

<p>Policy responses / Recommendations for action</p>	<p>Examples of good practice</p>	<p>Links to Tobias Framework for Action</p>
<ul style="list-style-type: none"> • 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 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). 	<ul style="list-style-type: none"> • 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). 	<ul style="list-style-type: none"> • Get the welfare mix right • Provide a safety net • Provide wrap-around services for the multiply disadvantaged • Ensure universal access to high quality primary health care

<ul style="list-style-type: none"> • 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. 		
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The long-term unemployed and inactive

Policy responses / Recommendations for action	Examples of good practice	Links to Tobias Framework for Action
<ul style="list-style-type: none"> • 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). 	<ul style="list-style-type: none"> • 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 healthy foods 	<ul style="list-style-type: none"> • Get the welfare mix right • Provide a safety net • Implement active labour market policies • Provide wrap-around services for the multiply disadvantaged • Promote healthy lifestyles • Ensure universal access to high quality primary health care

<ul style="list-style-type: none"> • 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 prevent health problems in the future; and, greater collaboration between governmental, non-governmental and private organisations. 	<p>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 work placements and employment (A.N.D.E.S., 2009).</p>	
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The 'in-work poor'

Policy responses / Recommendations for action	Examples of good practice	Links to Tobias Framework for Action
<ul style="list-style-type: none"> • 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 States 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 grouped in to two main forms of response: welfare transfer (i.e. social benefits); and, labour market policies (i.e. 	<ul style="list-style-type: none"> • 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 (Aertse der 	<ul style="list-style-type: none"> • Get the welfare mix right • Provide a safety net • Implement active labour market policies • Provide wrap-around services for the multiply disadvantaged • Ensure universal access to high quality primary health care

<p>minimum wage).</p> <ul style="list-style-type: none"> • 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. 	<p>Welt, 2014).</p>	
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Prisoners

Policy responses / Recommendations for action	Examples of good practice	Links to Tobias Framework for Action
<ul style="list-style-type: none"> • 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: 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Provide a safety net • Strengthen local communities • Provide wrap-around services for the multiply disadvantaged • Ensure universal access to high quality primary health care

<p>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; 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.</p>	<p>society, meaning that prisoners are ensured a level of security and access to service which enable them to reform, including improve/sustain (good) health.⁷</p>	
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Survivors of domestic violence and intimate partner violence

Policy responses / Recommendations for action	Examples of good practice	Links to the Tobias Framework for Action
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Provide a safety net • Strengthen local communities • Provide wrap-around services for the multiply disadvantaged • Ensure universal access to high quality primary health care

⁷ <http://www.kriminalomsorgen.no/information-in-english.265199.no.html>

<p>and social care services.</p> <ul style="list-style-type: none"> • 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 and efforts to challenge attitudes towards domestic violence. 	<p>Assessment of Sexual Assault Referral Centres (SARCs) were set up in the UK to provide medical care and other 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.⁸</p>	
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Persons with physical, mental and learning disabilities or poor mental health

Policy responses / Recommendations for action	Examples of good practice	Links to the Tobias Framework for Action
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Invest in children • Get the welfare mix right • Provide a safety net • Implement active labour market policies • Provide wrap-around services for the multiply disadvantaged • Promote healthy lifestyles • Ensure universal access to high

⁸ www.northumberland.gov.uk/WAMDocuments/259D5658-FA97-4A77-BAB4-87A9D2802DB2_1_0.doc?nccredirect=1

<p>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).</p> <ul style="list-style-type: none"> • Recommendations for action were also proposed during the VulnerABLE focus 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). 	<p>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.</p>	<p>quality primary health care</p>
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