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BRIDGING HEALTH AND HOMELESSNESS: EU PUBLIC HEALTH INITIATIVES AS DRIVERS OF CHANGE

FEANTSA

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Introduction

The connection between health and homelessness is as complex as it is profound. These two areas are closely interlinked, reinforcing each other as matters of public relevance. While poor mental and physical health can be a cause of homelessness, the lack of safe shelter has an immense impact on people's health. With an estimated 895,000 people experiencing homelessness on any given night in Europe, this is a European matter, connecting two areas which can complement each other in driving change to end homelessness and improving public health for all.

EU health initiatives hold great relevance for ending homelessness and EU work on health has strongly advanced in the past years. This gives us scope to analyse how these policies and measures can contribute to addressing the scarce access to healthcare of individuals facing homelessness. In this paper, we explore how homelessness and the EU health initiatives intersect, identifying where the relevance lies for addressing housing as a social determinant of health, and how ending homelessness interconnects with the goal of EU to protect and improve the health of EU citizens.

The role of the European Union in health policy is complementary to national policies, given that EU Member States are responsible for organising and delivering health services and medical care. That said, EU health policies are important in ensuring that all citizens have equal access to quality care, and they set out the direction for actions in public health. The aim of EU health policies is to protect and improve the health of EU citizens, support the modernisation of health infrastructure, improve the efficiency of Europe's health systems, as well as to strengthen preparedness and response measures to cross-border health threats. Over the years, the role of the EU has increased in relation to health policies and, against the backdrop of global health crises, such as most recently the COVID-19 pandemic, action for public health at EU level has amplified. One of the most prominent roles that the EU has is to reduce inequalities across Member States, including in the area of health.

People experiencing homelessness face deep inequalities and marginalisation in our societies, including when looking for access to healthcare. In some countries, their average age of death is estimated to be up to 30 years lower as compared to the general housed population.[1] Higher rates of morbidity and mortality among people who face homelessness compared to the general population highlight the life-or-death risks associated with such harsh living conditions.

Health inclusion for people experiencing homelessness can function as a tool in advancing the work towards ending homelessness across the EU. Using health as an initial contact with people who face homelessness can lead to ensuring stable housing. Simultaneously, the fight against homelessness holds significant relevance for EU health initiatives as it aligns with efforts to address health inequalities, promote preventive healthcare, implement integrated care approaches, support mental health, enhance emergency preparedness, address social determinants of health, and achieve cost-effective healthcare outcomes for all individuals within the European Union.

FEANTSA supports the recent claim of the Commission underlying that '[m]uch work remains to be done to further improve our health policies. Health therefore needs to remain a political priority.'[2] We further advocate for including homelessness as a point on the EU health agenda. To this end, in this paper we will proceed with an inventory of existing EU health initiatives and explore the extent to which they are relevant to homelessness.

1. Understanding Public Health in the EU

a. The role and scope of EU in health area

Health as an area of EU policy has not always been considered as relevant as it may appear today, considering the diversity of established initiatives and the EU funding allocated to health. Article 168 TFEU entitled "Public health" of the Treaty on the Functioning of the EU (TFEU, the Treaty of Lisbon) sets the basis for the EU health policy. However, the EU Treaty also emphasises limited EU actions in public health, minimising therefore how much policy could be made on this basis. The Treaty of Lisbon lays out the primary responsibility to organise national health systems and for the delivery of health care to the EU Member States.

Nonetheless, EU action in the field of health should be able to complement national policies and initiatives to ensure health protection in all EU policies (a 'Health in All Policies' approach). The EU has an important role to play in improving public health and to achieve its goals it follows three strategic objectives: **1. Fostering good health**, **2. Protecting citizens from health threats**, and **3. Supporting dynamic health systems**. EU health policies cover a wide diversity of areas, from prevention to ensuring preparedness in cases of health crisis and supporting the development of health systems at national level or specific programmes for non-communicable and infectious diseases. In the past years, as noted by the 2022 European Observatory on Health Systems and Policies report on EU health policies '(...) the health dimensions of EU policies are becoming more explicit and turned into a basis for action to create EU health policy.'[3]

The EU also helps to improve public health through funding and legislation on tackling cross-border health threats, medicines, patient's rights in cross-border healthcare, disease prevention, and the promotion of good health. In the field of health, the EU adopts laws and recommendations to protect people, covering for example health products and patients' rights. Coordination on public health issues is a necessary consequence of the free movement of people and goods in the internal market. EU cooperation in public health issues serves to tackle common health challenges resulting for example from antimicrobial resistance, preventable chronic diseases, and an ageing population.[4]

Under the **European Pillar of Social Rights (EPSR)**, a framework established by the European Union to promote and uphold social and economic rights across member states, principles aimed at ensuring access to high-quality healthcare for all EU citizens were included. This allows for further space to develop health initiatives, under the established key principle 16 - *Right to Healthcare* stating that: 'everyone has the right to timely access to affordable, preventive and curative health care of good quality.'[5] Many of the principles in the Pillar cover the social determinants of health, therefore attaching an important role in addressing health inequalities to the EPSR.

In the past years, as the COVID-19 pandemic highlighted the fragility of national health systems, the role of the EU has grown in the health area. The pandemic led to a strengthened coordination between Member States who have also agreed at that moment to increase the budget for health at EU level. Following the experience with the COVID-19 pandemic, EU countries have worked to improve the resilience of the EU in responding to future pandemics. To this end, in 2022, the EU adopted a set of regulations under the 'European Health Union' package to further strengthen the EU's health security framework, and to reinforce the crisis preparedness and response role of key EU agencies.[6] Under this new approach, Member States prepare for, prevent, and protect their citizens by acting together, where joint European action is necessary. It is based on a set of key pillars: a new health crisis framework- with effective rules to deal with health threats and a new **Health Emergency Preparedness and Response Authority** allowing the EU and Member States to better prepare for and respond to emerging crises together; security of medical supply- with affordable, accessible and innovative treatments and medicinal products for all; and modern and innovative health policies- better protecting the health of our citizens and drawing on the potential of new technologies.

'A high level of human health protection shall be ensured in all Union policies and activities.'[7]

The European Health Union is accompanied by what has been described by the EC as 'the most ambitious EU health funding programme in history'.[8] The **EU4Health**[9] programme was also adopted as a response to the COVID-19 pandemic with the goal to reinforce crisis preparedness in the EU. EU4Health aims to bring a contribution to the long-term health challenges by building stronger, more resilient, and more accessible health systems. Health is an investment and, with a €5.3 billion budget during the 2021-27 period, the EU4Health programme is an unparalleled EU financial support in the health area. EU4Health will pave the way to a European Health Union[10] by investing in urgent health priorities which have been set as follows: response to the COVID-19 crisis[11] and reinforcing the EU's resilience for cross-border health threats;[12] Europe's **Beating Cancer Plan**;[13] and the **Pharmaceutical Strategy for Europe.**[14] EU4Health is implemented by annual Work Programmes[15] supporting a broad range of actions that are clustered under four overarching "strands" with a cross-cutting focus on cancer.

To improve global health security and deliver better health for all in a changing world, the Commission adopted a new **EU Global Health Strategy** in November 2022.[16] The Strategy positions global health as an essential pillar of the EU's external policy. It promotes sustainable, meaningful partnerships of equals drawing on the **Global Gateway**,[17] as the external dimension of the European Health Union. Under the Global Gateway it is also stated that the EU and its Member States are helping to tackle inequalities, improve health security and increase health systems' resilience globally. They shall also engage with global partners to ensure equitable worldwide access to diagnostics, vaccines and treatments, pandemic preparedness, prevention, and early detection of health emergencies.

The strategy offers an agenda leading up to 2030. It sets three policy priorities, provides for twenty guiding principles to shape global health, makes concrete lines of action that operationalise those principles, and creates a new monitoring framework to assess the effectiveness and impact of EU policies and funding. The strategy stresses the importance of addressing important drivers of ill health such as climate change and environmental degradation, food security, conflict, and other humanitarian crises. Therefore, the Strategy introduces a robust "health-in-all-policies" approach to ensure that a wide variety of policies genuinely contribute to health goals. It identifies three key enablers for better health, namely digitalisation, research, and a skilled labour force with concrete actions to advance globally in these areas. *Guiding principle 1* of the Global health strategy aims to 'Prioritise tackling the root causes of ill health, paying particular attention to the rights of women and girls, and to vulnerable populations and disadvantaged groups.'[18]

b. Beyond the explicit scope for health policies at EU level

When working on public health at EU level we must also acknowledge that this is an area which bears interest from and to other policies, which is important when conducting targeted advocacy work. These dimensions will in practice translate in the involvement of different actors from the European Commission (different DGs such as DG AGRI, DG Environment) and different Committees and groups in the European Parliament.

Simultaneously it is important to underline that EU health policies extend far beyond Article 168 of the Treaty, and include environmental, social, and consumer protection policies. Understanding the different faces of EU health policies will contribute to understanding how and where advocacy for the fight against homelessness can be conducted in relation to health initiatives.

As analysed by the **European Observatory on Health Systems and Policies**,[19] the EU health policy has three broad sides and they each function in a different manner:

a. Explicit health policies which are based on the **Treaty on the Functioning of the EU Article 168 TFEU** entitled "Public health" and initiated by the European Commission, as mentioned above. This is done through the EC Directorate-General for Health and Food Safety, known as DG SANTE. Legislation is usually considered by the European Parliament **ENVI Committee** and the health formation within the **EPSCO** configuration of the Council of (health) Ministers. Supportive activity such as the joint procurement of equipment and vaccines during the COVID-19 pandemic or programmatic activity such as the EU4Health development is undertaken in this work stream.

b. Health policy made on the legal basis of the EU's internal market (Article 114 TFEU), far more consequential for health and healthcare than the first side (explicit health policies). Based on the logic that the EU has great power to promote the development and regulation of its internal market, this approach allows the development of an internal market, and it becomes the most effective way to regulate, for example, pharmaceuticals or professional qualifications as part of a market for services or goods. Regulating the cross-border mobility of patients or the EU food safety system are other examples of areas where measures adopted aimed at 'deepening market integration rather than as a means to better health.'[20]

c. Fiscal governance as a face of EU health policy: European surveillance of Member State fiscal policies including taxes, spending, and policies that affect the state's fiscal trajectory. Fiscal governance efforts have been strengthened after 2010, becoming more ambitious, automatic, and punitive in an effort to ensure that there would be no need for future bailouts because Member States would be deterred from short-sighted policies. For example, the fiscal governance implemented in 2011–2013 has led to Country Specific Recommendations (CSR) addressed national health concerns related to *umerus clausus*[21] for health professionals' education in France in 2015 and on the universalising in Cyprus, respectively on reducing north-south health care quality variations in Italy in 2019.

c. The roles of the EU health agencies and funding programmes

- The new **Health Emergency Response Authority (HERA)** was established to ensure the development, manufacturing, procurement and equitable distribution of key medical countermeasures within the EU. Monitoring, early warning, preparedness and response measures to combat serious cross-border threats to health are essential elements to ensure a high level of health protection in the European Union.

  Since its establishment, HERA has set up an expert group on COVID-19 variants to monitor mutations, made vaccine purchases against mpox, set up the **EU FAB** – a network of 'ever-warm' production capacities for vaccine and medicine manufacturing that can be activated in case of future crises – and begun stockpiling equipment and drugs against chemical and nuclear threats.

  According to the EC Communication on the European Health Union, HERA has launched the Global wastewater surveillance system, which has the potential to become an international lookout system for the early detection and real time monitoring of epidemic threats and outbreaks. The Commission and the European Investment Bank also created HERA Invest, a €100-million top-up to the InvestEU programme, to support research and development in the most pressing cross-border health threats, financed by the EU4Health programme.[22]

- The **European Centre for Disease prevention and Control (ECDC)** played a fundamental role in the EU's response to the COVID-19 pandemic, including on analysing the impact on the homelessness sector. A stronger mandate for the ECDC will make it possible not only to issue recommendations to Member States regarding health threats preparedness, but also to host a new excellence network of EU reference laboratories and establish an EU Health Task Force for rapid health interventions in the event of a major outbreak. During the COVID-19 pandemic, ECDC has paid specific attention to the

situation of people experiencing homelessness through issuing guidelines for services and raising awareness on the need for targeted health information for this population.[23]

- The **European Medicines Agency (EMA)** has also been reinforced in crisis preparedness and management for medicinal products and medical devices. The Agency is now able to closely monitor and mitigate shortages of medicines and medical devices during major events and public health emergencies, and facilitate faster approval of medicines which could treat or prevent a disease causing a public health crisis.
- **Health Inequalities Joint Action (Health Equity Europe - JAHEE)**[24] functioned as a joint action involving multiple member states and focused on:
  - » Monitoring health inequalities: collecting and analysing data to understand the extent and nature of health disparities
  - » Implementing interventions: developing and promoting policies and practices to reduce health inequalities
- **Funding**

  The EU4Health programme is a strategic plan[25] which outlines the political priorities and planning assumptions for DG Health and Food Safety (SANTE). The EU Health Programme provides funding and supports projects that aim to reduce health inequalities, such as:
  - » Joint actions on health inequalities: collaborative projects between member states to tackle specific health disparities
  - » Funding for NGOs and health organisations: supports organisations that work on reducing health inequalities

This strategic plan translates the priorities set by the President of the EU on health into concrete and operational strategies that will shape the work of DG SANTE. This plan therefore covers not only DG SANTE's strategy to deliver the political priorities, but also to modernise the way the administration of the DG functions and improve efficiency. It also describes DG SANTE's contribution to the recovery plan for Europe, notably through the new EU-4Health programme to strengthen health systems and prepare for future health crises. The strategy is expressed through general objectives (the headline ambitions) and Specific Objectives (reflecting the specific contribution of DG SANTE).

Funding for research is also available under the **Framework Programme (FP)** for Research and Innovation. The current Framework Programme is called **Horizon Europe**,[26] and spans the period of 2021 – 2027. The FPs provide funding for a variety of projects in the field of health equity. These funding programmes can be exploited to ensure financial support for initiatives and measures that can improve access to healthcare.

3. Homelessness as a Public Health Issue

Public health is the health of the population as a whole, be it at neighbourhood, national, or regional level. Public health has also been defined as 'the science of **protecting and improving the health of populations** (...) through education, promotion of healthy lifestyles, research toward prevention of disease and injury, and detecting, preventing, and responding to infectious diseases.'[27] At the core of public health lie the principles of 'social justice and equity, promoting and protecting better health for all, **leaving no-one behind**. This means that public health holds a resolute focus on tackling inequalities in health, including those driven by racism and discrimination.'[28] Work on public health includes, among others, working to develop programmes for controlling infections, supporting healthy behaviours, ensuring people have access to safe housing, as well as policy development and advocacy.[29]

Homelessness is highly connected to all the work areas of public health, and is of major importance for public health given its profound impact on the physical, mental, and social well-being of people who do not have safe shelter, as well for broader society. Beyond having a profound impact socially and economically, homelessness is a significant public health issue with far-reaching consequences.

In 2023, on any given night an estimated 895,000 people experienced homelessness in Europe.[30] This includes people sleeping rough, in emergency accommodation or in accommodation for people experiencing homelessness, covering people under **ETHOS Light** categories 1, 2, and 3.[31] The estimated number represents an **increase of 28% in three years**, given that in 2020 the number was at 700,000. Homelessness is multifaceted and affects everyone in our societies, men, women, young people, children, LGBTIQ+, racialised and ethnic communities, migrants, including asylum seekers and refugees.

While poor mental and physical health can be a cause of homelessness, the lack of safe shelter has an immense impact on people's health. Research has shown that even a short experience of homelessness can have a major negative impact on individuals' health statuses. Adults and children who face homelessness are more likely to suffer underlying health conditions than the general population. The experience of homelessness comes with extreme marginalisation and destitution that increases vulnerability to various health risks. When individuals lack stable housing, their health and well-being are jeopardised in numerous ways, leading to a cascade of health-related challenges. Living on the streets or in overcrowded shelters exposes people to extreme weather conditions and unsanitary environments, including a lack of access to basic hygiene facilities. These conditions can result in a range of health problems, including infectious diseases, such as tuberculosis, influenza, HIV/AIDS, hepatitis, COVID-19, malnutrition, respiratory issues, and mental health problems. Furthermore, sleeping in communal dormitories highly increases the transmission of infectious diseases, as so clearly revealed during the COVID-19 pandemic.[32] The spread of infectious diseases can also pose a public health threat to the broader community.

Researchers have found that '[t]he elevated mortality caused by homelessness qualifies homelessness as a public health issue, and applying common public health approaches to homelessness has promising potential in helping achieve "functional zero" (...) where homelessness is brief, rare, and non-recurring.'[33]

The lack of access to basic healthcare services and preventive care exacerbates health issues that people facing homelessness may suffer from, which in turn leads to higher rates of morbidity and mortality among people who face homelessness compared to the general population. Most importantly, these are preventable health problems that could be avoided if better measures would be implemented.

The deaths of people facing homelessness recorded throughout Italy, in 215 municipalities, showed that **415 people have died in 2024, compared to 399 in 2023.**[34] The people registered were mainly men (93%) and foreign nationals (58%). To mark France's national tribute to those who died on the streets, La Croix has published the names of the 611 people who died on the streets in 2022 which counted 526 men, 80 women, and five children. The figure is **estimated to be five to six times lower than the reality.**[35]

The average age of death for people experiencing homelessness in some countries is estimated to be up to 30 years lower as compared to the general housed population. In 2021, England and Wales reported an average age of death for men facing homelessness at 45 years old and for women even lower at just 43 years old. This is compared to 76 years for men and 81 years for women in the housed population. In Denmark, people who live on the street die an average of 20 years earlier than the general population.[36] Homelessness takes away 30 years of life from more than 33,000 people in Spain.[37] In 2022, in Italy, the average age of death of people experiencing homelessness was at 46.9 years compared to 81.3 years for the general Italian population.[38]

In connection to mental health, homelessness is strongly associated with mental health problems such as depression, anxiety, and post-traumatic stress disorder (PTSD). The stress, trauma, and social isolation experienced by individuals facing homelessness contribute to the development and exacerbation of these mental health issues. Untreated mental illness can further impair individuals' ability to seek and maintain stable housing and employment, perpetuating the cycle of homelessness. Homelessness is often linked to substance abuse and addiction, as individuals may turn to drugs or alcohol as a coping mechanism for dealing with their everyday challenges. Substance abuse not only exacerbates existing health problems but also increases the risk of overdose, infectious diseases, and injury.

Among the different profiles of people experiencing homelessness, some experience specific health issues as pointed out by existing research. Gender is an important factor, as it has been shown that women register higher rates of psychiatric diagnosis, mental health problems, sexually transmitted infections (STI), and sexually transmitted diseases (STDs). Histories of child sexual abuse and domestic violence are also more often observed among women experiencing homelessness.[39] The health of young people who experience homelessness is also strongly affected by specific issues such as violence and traumatic injuries, and higher rates of post-traumatic stress disorder.[40] Mental health issues among children and young people facing homelessness are a main concern given that they are often diagnosed late, if at all.[41] High levels of conduct disorder, post-traumatic stress disorder, major depression, anxiety, behavioural issues, suicidality, and stress have been registered.[42]

Without assigning even more stigma and prejudices to people experiencing homelessness, **the impacts of lacking a safe shelter on people's health must be recognised** and a stronger collective commitment is required to ensure a real contribution to the goals of public health on eliminating inequalities and not leaving anyone behind.

Adding to the social justice argument, we can also argue that it makes financially good sense to invest in improving the access to healthcare for those living in extreme marginalisation and working to protect and improve their health. Without this, healthcare systems, including emergency departments, hospitals, and community health clinics, will eventually witness the consequences of rising number of people experiencing homelessness who lack access to prevention and primary health care. As deeply marginalised individuals, they do not have access to information and services. At the same time, experiences of stigmatisation and discrimination discourages people from seeking help, and they will often rely on emergency medical services for their healthcare needs, leading to high healthcare utilisation rates and increased costs. On the contrary, investing in primary healthcare needs or in managing substance use illnesses and the physical health of people has been concluded to lead to **reduced healthcare costs and reduced use of emergency services**.

Public safety concerns are also related to homelessness, and while the general perception is that people who sleep rough are predilect to crime and violence, or pose safety risks, evidence shows that in reality it is they themselves who are being attacked on the streets, and victims

of hate-speech and hate-crime. Furthermore, many countries are enforcing laws that criminalise people who experience street homelessness[43] pushing them even further into marginalisation and reducing their access to services in general as well as healthcare.

Addressing homelessness as a public health issue requires comprehensive strategies that will ensure an effective response to the underlying health needs, social determinants of health, and systemic inequalities contributing to homelessness. Furthermore, there is recent work emphasising that public health, the healthcare system, and healthcare providers have an important role in homelessness prevention.[44] It was also concluded that the field of public health can 'help us quantify the scope of the human cost that homelessness inflicts, but it also offers tools to address the problem',[45] and by applying public health principles we can get closer to ending homelessness.

Therefore, it is necessary to analyse existing opportunities at the European level, where developments on health policies and public health have been multiplying in the past years which brings about additional prospects for working towards ending homelessness thorough the health perspective.

4. Main health initiatives relevant to homelessness

By designing and including measures aimed at supporting people experiencing homelessness in existing health initiatives at European level, an important contribution can be made to both ending homelessness and to improving public health.

In our research, we have identified 15 key health initiatives that are particularly relevant to homelessness, though this is by no means an exhaustive list. These initiatives were found to be **critical due to their direct impact on common health challenges faced by people experiencing homelessness**, such as mental health issues, substance abuse, chronic illnesses, and barriers to accessing healthcare services.

Some of the policies presented already have included references to homelessness and FEANTSA has been issuing recommendations for several areas as well, which are summarised and referenced below. Other topics need to be further investigated and developed to effectively meet the needs of the most marginalised population in society, such as those experiencing homelessness.

This analysis will further represent the basis for our advocacy work on ending health inequities for people experiencing homelessness. By focusing on these targeted health strategies, we aim to enhance the well-being and stability of individuals experiencing homelessness, ultimately contributing to more comprehensive solutions to this pervasive issue.

Box 1.5 *Bricolage at work: Homelessness policy in the EU*

Readers of the EU Treaties will probably not expect to find much about homelessness, nor will they. A right to "housing of good quality" appears in the 2018 European Pillar of Social Rights but there is nothing obvious in the foundational TEU and TEFU. And why should there be? Addressing homelessness and its causes, which range from property markets to mental health systems, is traditionally local and not even necessarily national. The principle of subsidiarity (Box 2.5) suggests that the EU would not be the natural policy leader, Member State governments might not be eager to spend money on homeless people who might be in a different country entirely, and the logic of the internal market does not obviously point to a right to adequate housing.

That makes homelessness a perfect case study of an area that is important to health[a], far from the core of EU competencies, and yet an area where there is an EU effect. One of the principal civil society groups advocating for the homeless at the EU level, FEANTSA, constantly reiterates that it supports "making more effective use of existing policy instruments" as well as promoting constants of EU policy such as monitoring and benchmarking (just as in healthcare). Those existing policy instruments are actually impressive, if we look at them as a set of opportunities to affect a seemingly local problem like homelessness. Structural funds (Section 6.2.4) and EIB loans can directly support housing, or, if misdirected, can damage housing opportunities. The priorities of the EU fiscal governance system (Chapter 6) can have powerful effects on homelessness and homeless people, whether by deregulating housing markets (as the Troika promoted) or by encouraging more universal healthcare (as the Semester has in some cases). Indirectly, causes of homelessness such as untreated mental illness, poverty or discrimination all respond to EU policies. The result is that a policy area just about as far from the EU as it is possible to get turns out to have a significant EU dimension.

a Homelessness, particularly chronic homelessness, often reflects health problems, and being homeless is extremely bad for one's health. Willison C (2017). Shelter from the Storm: Roles, responsibilities, and challenges in United States housing policy governance. *Health Policy*, 121(11):1113–23. For European data and EU policy options, see FEANTSA and the Fondation Abbé Pierre (2019). Fourth Overview of Housing Exclusion in Europe 2019. Available at: https://www.feantsa.org/en/report/2019/04/01/ the-fourth-overview-of-housing-exclusion-in-europe-2019?bcParent=27. Brussels: FEANTSA; Clair A & Stuckler D (2016). Structured Review of the Evidence on the Intersection of Housing and Health Policy in the WHO European Region. *Public Health Panorama*, 2(2):160–83.

Source: 'Everything you always wanted to know about EU health policy but were afraid to ask'

Initiative 1: Healthier together – EU non-communicable diseases (NCD) initiative

Description:

The European Commission launched in December 2021 the **Healthier together – EU non-communicable diseases**[46] **(NCD)** initiative to support EU countries in identifying and implementing effective policies and actions to reduce the burden of major NCDs and improve citizens' health and well-being.[47]

The initiative covers the 2022-2027 period and includes 5 strands:

- health determinants
- cardiovascular diseases
- diabetes
- chronic respiratory diseases
- mental health and neurological disorders

All strands include a health equity dimension, thus supporting the reduction of health inequalities.

Different initiatives have been set up under each strand of the NCD chapter. Actions on cancer, which is also a major NCD, are covered in Europe's Beating Cancer Plan.

While the strands enable addressing particular challenges of each disease group, **the initiative as such promotes a holistic and coordinated approach to prevention and care**. It also supports better knowledge and data, screening and early detection, diagnosis and treatment management, and the improvement of quality of life for patients.

Relevance for homelessness:

Due to deep socio-economic exclusion, people experiencing homelessness often face increased exposure to risk factors associated with NCDs. These risk factors, including **low health literacy, social isolation, limited access to healthcare, poor living conditions, inadequate nutrition, unemployment, stigma and discrimination, poverty or immigration status** will increase vulnerability of developing NCDs. Recognising and addressing these socioeconomic determinants and their impact on health is pivotal for creating effective strategies that reduce health disparities and improve the overall well-being of marginalised populations.

NCD initiatives at EU level must recognise that **housing as a determinant of health** has a significant impact on the predisposition to non-communicable diseases. The lack of shelter, living in communal dormitories or in poor and unsafe housing will have great impact on people's mental and physical health leading to more chances of developing NCDs. Additionally, homelessness also prevents people from taking up treatment and engaging properly with healthy life habits which lead to aggravating chronic diseases.

Furthermore, collecting data and developing knowledge on the needs and healthcare access of people who experience homelessness continues to be needed, including by engaging with a participatory approach of experts with lived experience.

Initiative 2: Comprehensive approach for mental health

Description:

On the 7th of June 2023, the European Commission (EC) launched a Communication to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on a **comprehensive approach to mental health**. This initiative marks a turning point in the way mental health is addressed in the EU, the beginning of a new strategic approach to mental health. It aims to put mental health on par with physical, in a cross-sectoral manner which goes beyond health policy.[48]

The Communication on a comprehensive approach to mental health focuses on both how to bring relief to people suffering from mental health issues, and on prevention policies. It draws on three guiding principles that should apply to every EU citizen: **(i) to have access to adequate and effective prevention, (ii) to have access to high quality and affordable mental healthcare and treatment**, and **(iii) to be able to reintegrate into society after recovery**.

EU programmes offer €1.23 billion in funding opportunities for 20 flagship initiatives to support Member States and EU stakeholders. For instance, the EU Best Practices Portal showcases leading and promising mental health practices, which can inspire others to act.

Relevance for homelessness:

The trauma of not having a safe shelter has a huge impact on people's mental wellbeing, can be a trigger for addictions, and have a significant impact on the individuals' overall health status. International studies conducted in the last 20 years have found lifetime prevalence rates for mental health problems for between **60 to 93.3% of people experiencing homelessness**[49] – a much higher frequency compared to the general population. The mental health of homeless children and young people is a focal issue of concern, especially considering the frequency of late diagnosis and treatment - if a diagnosis is made at all.[50]

Evidence points to the need of more consideration to be given to marginalised communities in the recent Communication on mental health. For this, targeted measures should be formulated under a flagship initiative that should work towards ensuring that people in vulnerable situations, including those experiencing homelessness, have access to mental health care. As the needs of, and subsequently successful support measures for, marginalised groups vary, such a flagship initiative should be developed and implemented in close collaboration with organisations representing people in marginalised communities in Europe.[51]

In their follow up work under the comprehensive approach to mental health, the EC and Member States need to also include **measures which consider housing as a social determinant of health across the established flagship initiatives**. Cross-cutting actions concerning homelessness can be implemented, for example, under flagship initiatives aimed at addressing capacity building, promoting mental health, depression and suicide prevention, helping people navigate through available support services, boosting the mental health of children and young people, reinforcing mental health systems, improving access to treatment and care, or breaking through stigma.

Initiative 3: Promoting health and tackling diseases - Cancer

Description:

In 2003 the European Council approved a recommendation on cancer screening,[52] encouraging EU countries to implement population-based, quality-assured screening programmes. Whereas the previous cancer screening recommendation from 2003 was limited to breast, cervical, and colorectal cancer, in 2022 member states agreed to broaden the focus also to lung, prostate, and gastric cancer. On 9 December 2022, the Council adopted a new recommendation on cancer screening[53] to bring down the mortality of cancer and cut the incidence of invasive cancers.

Europe's Beating Cancer Plan[54] aims to prevent cancer and ensure that cancer patients, survivors, their families and carers can enjoy a high quality of life. By tapping into a broad array of EU policies, notably digitalisation, research and innovation, the cancer plan helps EU countries turn the tide against cancer.

In February 2021, in the most acute phase of the pandemic, the Commission presented Europe's Beating Cancer Plan, reinforcing its political commitment to turn the tide against cancer. The EU **Mission on Cancer** was launched in September 2021, generating crucial knowledge and evidence to help Member States implement effective cancer control strategies. Europe's Beating Cancer Plan, backed by €4 billion in funding, a record number of projects, actions, and initiatives have been launched addressing the four key pillars of the Cancer Plan, always with a people-first approach: prevention, early detection, equal access to treatment, and quality of life.[55]

In 2024, the Commission presented a proposal for a Council Recommendation on **vaccine-preventable cancers** to help EU Member States to increase the uptake of vaccination against Human Papillomaviruses (HPV) and Hepatitis B virus (HBV). When it comes to prevention, knowledge is power, and the Commission is working to update and expand the evidence-based recommendations of the **European Code against Cancer** and is developing a Mobile App for Cancer Prevention to communicate clear and accessible information on the risk factors of cancer.[56]

The **European Cancer Inequalities Registry**[57] is one of the flagship initiatives of Europe's Beating Cancer Plan, and as such reflects the Plan's commitment to understand, address, and reduce cancer inequalities between and among Member States. The registry aims at identifying trends and disparities between Member States and regions. It also sheds light on inequalities in cancer prevention and care due to gender, educational attainment, and income level, as well as disparities between urban and rural areas. The Registry will guide investment and interventions at EU, national and regional level.

DG SANTE will also continue its current work on the development of cancer guidelines and cooperate with national and regional authorities through the European Network of Cancer Registries[58] (ENCR). The ENCR promotes collaboration between cancer registries, defines data collection standards, provides training for cancer registry personnel and regularly disseminates information on incidence and mortality from cancer in the European Union and Europe. The first **EU Network of Comprehensive Cancer Centres** will be established by 2025 with the aim to ensure that 90% of all eligible patients have access to these centres thus reducing cancer care disparities.

Relevance for homelessness:

Research shows that nearly one in three deaths of homeless people were due to causes amenable to timely and effective health care, and has found **cancer to be the second most common cause of death among the homeless population.**[59] Cancer mortality is two times higher among homeless people compared to the general adult population in high-income countries.[60] People experiencing homelessness are at high risk of suffering from cancer and often they are deprived of primary or secondary cancer prevention, combined with difficulties in navigating complex and often fragmented health care systems.

To overcome the barriers and risks faced by people experiencing homeless, EU health policies on cancer should include the element of housing as an important determinant of health and include specific, targeted measures to reach the most marginalised individuals in our societies. The European beating cancer plan should include specific measures for support of people in vulnerable situations who do not have access to primary healthcare and remain therefore highly excluded from cancer screenings.

The **CANCERLESS** project[61] proposed a vision to prevent cancer and allow for early diagnoses in the homeless population by delivering the Health Navigator Model, a person-centred intervention to overcome health inequalities and facilitate timely access to quality cancer prevention and screening services for homeless people, leaving no one behind in Europe. The project aimed to overcome health inequalities and further close the gap in cancer related outcomes for homeless people, by implementing a "bottom-up" and "co-designing" approach. Based on CANCERLESS pilot work and data collection, policy recommendations[62] to improve cancer care for people experiencing homelessness have been published. These policy recommendations address several pathways to results: **1. Less exposure to health risk factors among people experiencing homelessness; 2. Access to integrated care; 3. Access to information and awareness of cancer prevention; 4. Access to healthcare services; 5. Effective communication; 6. Availability of resources for people experiencing homelessness; 7. Availability of practical support for people experiencing homelessness.**

The Screening recommendation mentions that '[d]ue account should be taken of specific needs of women, older people, persons with disabilities, and disadvantaged or marginalised groups, like people with a minority racial or ethnic background, and difficult to reach persons, of low-income groups, cancers survivors and of individuals who may be at higher cancer risk for particular reasons, for instance persons with chronic liver conditions, with genetic or familiar predisposition, or with lifestyle, environmental, and occupational risks.' Adding to the mention of marginalised groups, further attention should be given to increasing screening for people facing homelessness specifically, as they are among the most excluded and face deep barriers in accessing primary health care.

Furthermore, including 'housing situation' as one of the dimensions of the Cancer Registry would contribute to ensuring that objective number 1 of the European Commission in the fight against cancer - 'Everyone in the European Union should get the cancer treatment they need' - is successfully achieved and that people experiencing homelessness are not excluded from the process of identifying inequalities in the cancer care pathway from prevention to end-of-life care.

Initiative 4: Antimicrobial resistance

Description:

Antimicrobial resistance (AMR) is a global challenge with significant consequences for the economy and human health unless tough action is taken to address it. Currently, **around 700,000 deaths in the world each year are linked to antimicrobial resistance**; the associated economic cost is estimated to be €1.5 billion in loss of productivity and healthcare costs. By 2050, recent projections suggest that lives lost to AMR will rise to 10 million and the cumulative economic cost will be around 1.5 times the world's GDP today.

The '**European One Health Action Plan against Antimicrobial Resistance**'[63] was adopted in June 2017. It is built on three pillars: **(i) making the EU a best practice region**; **(ii) boosting research, development and innovation**; and **(iii) shaping the global agenda**. The action plan is delivering tangible results, and DG SANTE produces regular progress reports on implementation. Over the coming five years, DG SANTE will continue to implement the Action Plan and maintain the EU's global leadership role in the fight against AMR, promoting cooperation across Member States and actively engaging at international level.

The European Commission put forward a Council Recommendation on stepping up EU actions to combat AMR to provide solutions for human, animal, and environmental health. The Council adopted the proposed Recommendation on 13 June 2023[64]. The Recommendation focuses on infection prevention and control, surveillance and monitoring, innovation and availability of efficient antimicrobials, prudent use, and cooperation among Member States and globally. It sets targets to be achieved by 2030 – including a 20% reduction in antibiotic consumption in humans by 2030 in the EU, advocating for stronger global commitments on AMR.

The Commission is supporting research and development of new antibiotics and alternative treatments to address AMR. In this context, the future European partnership on One Health Antimicrobial Resistance[65] will be instrumental. It is also enhancing access to newly developed antimicrobials, including via future joint procurement for antimicrobials and is launching a pull incentive pilot project, taking the form of a revenue guarantee.

Relevance for homelessness:

Antimicrobial resistance (AMR) is largely caused by the overuse and misuse of antibiotics in agriculture and healthcare. People experiencing homelessness are even more exposed to AMR due to their limited access to quality healthcare, which leaves them more susceptible to infections and the abuse of medications that follows. This includes misuse and overuse of antibiotics, which are prescribed by health care practitioners as the sole modality in clinical care or self-medicated by individuals.

Drug-resistant illnesses are also more likely to develop in shelters due to overcrowding, shared airspaces, poor hygiene conditions as well as restricted access to sanitary facilities and clean water. This will have in turn a collateral damage to public health as drug-resistant diseases are not limited in their occurrence within homeless communities. AMR is borderless, able to infect entire communities through medical facilities, personal connections, and environmental reservoirs. This puts everyone's access to antibiotics at risk, i.e., need for non/judicious use, prescription, dependence and resistance of antibiotics, or jeopardising public health beyond individuals' housing situation.

The AMR plan does include 'support activities jointly funded by the EU and Member States for infection prevention and control in vulnerable groups, in particular to tackle resistant tuberculosis strains.'

However, given the far-reaching consequences of AMR among people experiencing homelessness, there is a need to strengthen information and awareness activities among healthcare professionals and the homelessness sector about the risks associated with AMR. Giving people the knowledge they need to prevent infections and use antibiotics appropriately can have a big impact.

Recognising and tackling AMR confluence with homelessness in European health initiatives is a critical first step towards a future where everyone is healthier and has fair access to healthcare. Further measures should be included which aim specifically at reaching people facing homelessness.

Initiative 5: Tobacco

Description:

Tobacco consumption is the single largest avoidable health risk, and the most significant cause of premature death in the EU, responsible for nearly 700,000 deaths every year. Around 50% of smokers die prematurely (on average 14 years earlier). Despite considerable progress made in recent years, the number of smokers in the EU is still high – 26% of the overall population and 29% of young Europeans aged 15-24 smoke.

To address this situation, the European Union and national governments have taken various tobacco control measures in the form of legislation, recommendations and, previously, information campaigns. These policy measures include in particular:

- The regulation of tobacco products[66] (e.g. packaging, labelling, and ingredients)
- Advertising restrictions for tobacco products[67]
- The creation of smoke-free environments[68]
- Tax measures and activities against illicit trade[69]

These protect citizens from the hazardous effects of smoking and other forms of tobacco consumption, including against second-hand smoke.

The Council Recommendation (2003/54/EC) on the Prevention of Smoking and on Initiatives to improve tobacco control[70] put forward recommendations for prevention, especially focusing on children and adolescences.

Relevance for homelessness:

International studies have shown that smoking prevalence for people experiencing homelessness ranges from 57% to 82%,[71] estimating it to be three or four times higher than in the general population.[72] Simultaneously, challenges to smoking cessation for those facing homelessness are complex, starting from the deep social exclusion to the use of tobacco as a coping mechanism to their living situation. It is for these reasons precisely why targeted smoking cessation programs should be developed for people experiencing homelessness, which could offer an important opportunity to address preventable mortality and morbidity.

EU legislation on tobacco products and for smoking prevention must include a focus on people experiencing homelessness. This can be done by considering vulnerable situations when developing messaging and health warnings, for example in technical specifications of the general warning and the information message on tobacco products. These measures should be adapted to situations of exclusion to make sure they reach those individuals who mostly need them. Additionally, considering the lack of access to primary care for people experiencing homelessness, tailored measures for smoking cessation and prevention among this population should be developed under the EU health policies.

The support study to the report on the application of Directive 2014/40/EU[73] published in May 2021 notes that the Tobacco Products Directive (TPD) partially addressed the problem of smoking in the EU among vulnerable populations, particularly among young people. 'Other vulnerable populations' are mentioned in the study but are not defined; furthermore, it is considered that more evidence is needed as 'to determine how the TPD can remain relevant to addressing the issue of smoking in the EU, particularly among young people and specific vulnerable populations, and in relation to e-cigarettes, HTPs and novel tobacco products.'

Initiative 6: Alcohol

Description:

Alcohol-related harm is a major public health concern in the EU, accounting for over 7% of all ill health and early deaths. In 2006, the EC issued its Communication for An EU strategy to support Member States in reducing alcohol-related harm[74] which addressed the adverse health effects related to harmful and hazardous alcohol consumption. The implementation of the 2006 EU alcohol strategy to support Member States in reducing alcohol-related harm was assessed in 2009[75] and 2013.[76]

Trends and developments in alcohol consumption and alcohol-related harm in the EU are monitored by the European Information System on Alcohol and Health[77] (EUSAH). EUSAH is maintained through cooperation between the European Commission and the World Health Organization (WHO) within the framework of the EU Health Programme. Issued regularly within the EU-WHO cooperation framework, the country profiles give an overview of the situation in individual EU countries.[78] The Committee on National Alcohol Policy and Action (CNAPA) plays a major role in facilitating cooperation and coordination between EU countries and contributing to further policy development.

The Commission's Health Programme funds projects and other initiatives addressing alcohol-related harm.[79] The 2014-2016 Joint Action supported EU countries in reducing alcohol-related harm.

In 2015, Council Conclusions on an EU Strategy on the reduction of alcohol-related harm[80] were drafted and European Parliament resolution on Alcohol Strategy[81] was also published.

Relevance for homelessness:

Researchers in Western countries report that people experiencing homelessness have alcohol dependence issues at a range between 8% to 59%.[82] A study of retrospective administrative data on adults experiencing homelessness in Stockholm reported that 42% of men and 41% of women experiencing homelessness were diagnosed with problematic alcohol or illicit drug use.[83]

As in the case of tobacco, alcohol and substance use in general is employed as a coping mechanism by people experiencing homelessness and the environments in which people are living often expose them to substance use. At the same time, challenges to accessing adequate treatment remain complex as abstinence from alcohol is usually required in order to receive assistance, or people do not have knowledge/access to alternative support programmes in the first place.

The existing policies on reducing alcohol-related harm give some attention to the 'most vulnerable groups' and 'socio-economically vulnerable groups and young people' who are mentioned as being at greater risk of poor health. The 2006 EU strategy mentions 'Harmful effects of alcohol tend to be greater in less advantaged social groups, and therefore contribute to inequalities in health.'

In the 2013 assessment of the alcohol strategy, it is noted as one of the Commitments Classified by the EU Strategy to work on a Resource tool on alcohol addiction and homelessness under *Aim 5*: *To decrease alcohol-related physical and mental disorders*. For the current paper, it was not possible to track down this tool, but we consider it of high importance. More focus on people experiencing homelessness is needed in EU and national policies that address alcohol consumption, given the disproportionate level of alcohol-related problems that affecting these individuals.

Initiative 7: Drug-use

Description:

Over the past two decades, the European Union and its member states have developed together a common approach to address the security and health implications of drug trafficking and drug use.

The EU approach is based on:

- the evidence of what works and what does not work in terms of policy and measures
- the balance between drug supply reduction and drug demand reduction
- a multidisciplinary approach, given the cross-cutting nature of the drugs phenomenon
- innovation and foresight, given the complexity of the drugs situation and market
- respect for human rights, gender equality and health equity
- the participation and involvement of civil society

This approach was enshrined in the EU Drugs Strategy 2013-2020 and reaffirmed in the EU Drugs Strategy 2021-2025,[84] approved by the Council in December 2020. The new strategy for 2021-2025 sets out the political framework and priorities for the EU's drug policy and complements national policies. Its main objective is to ensure a high level of health protection, social stability, and security, as well as contribute to awareness raising.

The Council has also agreed an EU Drugs Action Plan 2021-2025[85] setting out 85 specific measures to achieve the priorities of the EU drugs strategy.

In the Council, EU member states are joining efforts to better support people with mental health and substance use disorders. On 5 December 2023, the Council approved conclusions on drug abuse and mental health disorders.[86] The Council invites member states to consider substance use disorders co-occurring with other mental health disorders as an important challenge. Member states, the Commission, and other relevant players should aim to develop personalised and integrated interventions for people with co-morbidity adjusted to the special needs of such individuals.

Relevance for homelessness:

While the prevalence of drug consumption and dependency among people experiencing homelessness may wary, it is a worrying and particularly risky issue, specifically regarding drug overdose and the unsafe environments where people may live.

The same research quoted above for Western countries found drug dependence to range from 4.5% to 54.2% among people facing homelessness across seven studies, six of which were European.[87] In a report of the European Monitoring Centre for Drugs and Drug Addiction[88] (EMCDDA) it was also noted 'that people who experience homelessness and use drugs (PEHAD) are concentrated in a relatively small, long-term and recurrently homeless population that also presents with a high prevalence of serious mental illness and psychiatric disorders.'

Additionally, the deep marginalisation and stigmatisation will leave people in isolation and without needed support in case of an overdose.

Several of the EU drug policies already include measures connected to homelessness. In the new strategy, for example, homelessness is addressed under the point regarding barriers to access. It is also noted that '[t]he diversity evident among people who use drugs should be recognised and steps should be taken to provide services that can address this diversity and reflect the needs of different groups in relation to problem drug use. Specific groups of people who use drugs and who have drug-use disorders that involve potentially more complex or specific care needs include: (...) and homeless people.'

In the Council action plan homelessness is mentioned in relation to several Strategic priorities that have to do with providing for and increasing the partnership approach in the provision of effective evidence-based selective and indicated prevention measures (Action 29); access to effective evidence-based drug treatment, including person-centred opioid maintenance therapy, risk and harm reduction, rehabilitation services, social reintegration and recovery support (Action 32); Maintain and, where needed, scale up measures to reduce the prevalence of drug-related infectious diseases, in particular the early diagnosis of Hepatitis C and HIV/AIDS, promoting rapid testing and self-testing for HIV and outreach programmes. Promote the diagnosis of tuberculosis among people who use drugs and homeless people (Action 44).

Council conclusions mention homelessness as a factor in the rates of dual disorders and note that '[t]here is a need to improve and develop further efforts geared towards people with dual disorders in special and vulnerable situations: such as (...) homelessness.'

In 2022, the European Monitoring Centre for Drugs and Drug Addiction published a miniguide on Homelessness and drugs: health and social responses.[89] This miniguide provides an overview of what to consider when planning or delivering health and social responses for people experiencing homelessness and using drugs, reviewing the available interventions and their effectiveness. It also considers implications for policy and practice

Initiative 8: Vaccination

Description:

The EU provides assistance to member states in coordinating their policies and programmes on vaccination. In December 2018, the Council adopted a recommendation to strengthen the EU cooperation on vaccine-preventable diseases.[90]

On 17 June 2020, the European Commission presented the EU Vaccines Strategy[91] to accelerate the development, manufacturing, and deployment of vaccines against COVID-19. With the Vaccines Strategy, the Commission supported efforts to make the process more efficient, resulting in the time frame being reduced to less than one year for most vaccines.

In December 2022, EU ministers of health approved Council conclusions on vaccination as one of the most effective tools for preventing disease and improving public health.[92]

DG SANTE has been assigned to improve communication on vaccination - to explain their benefits and combat the myths, misconceptions, and scepticism that surround the issue. The Commission stepped up action on vaccination with the adoption of a Communication and Council Recommendation on strengthened cooperation against vaccine-preventable diseases. EU action aims to (1) help tackle vaccine hesitancy and improve vaccination coverage (2) promote sustainable vaccination policies (3) contribute to global health. The key actions in the Communication and Council Recommendation include: establishing a European Vaccination Information System to provide reliable and evidence-based data; developing guidelines for a core EU vaccination schedule; a virtual warehouse on vaccine needs and stocks; and reaching vulnerable groups and addressing knowledge gaps, specifically through research (behavioural, social).

An ongoing Joint Action (project) with Member States, co-funded by the EU Health Programme, is strengthening national responses to vaccination challenges in Europe. It will establish an EU Vaccine Network of national programme managers and policymakers to improve vaccine forecasting and stakeholder dialogue.

Relevance for homelessness:

Council Recommendation of December 2018 mentions that work should be developed for 'ensuring targeted outreach to the most vulnerable groups, including socially excluded groups, so as to bridge inequalities and gaps in vaccination coverage.'

The 2020 European Commission vaccination strategy recommends that Member States consider priority groups for vaccine deployment when drawing up their vaccination strategies. At least three of these priority groups cover people experiencing homelessness: 'persons whose state of health makes them particularly at risk; persons who cannot socially distance; and more disadvantaged socio-economic groups'.[93]

Clinical vulnerability together with high risk of outbreaks in homeless settings and reducing COVID-19 related health inequalities makes the case for Member States to include people facing homelessness in their priority groups, as certain countries, regions, and cities have done (Ireland, Germany and Denmark). Introducing targeted policies on homelessness in the EU policies aiming at improving vaccine take up would encourage Member States to develop their work on what concerns vaccination and people experiencing homelessness. Specific strategies to distribute vaccines should be developed to ensure that they have access to and that they are able to receive the vaccination.

The COVID-19 pandemic serves as the most recent and perhaps eloquent example in learning lessons about the vaccination of people experiencing homelessness. In this period, discussion and work around increasing vaccination take up among marginalised groups has intensified, starting from identifying barriers and challenges to implementing solutions.

For further recommendations, which can be of use when developing vaccination policies and support programmes, FEANTSA research with members and medical staff is available online.[94]

Initiative 9: Crisis preparedness

Description:

The Commission, working closely with Member States and the relevant Union agencies, is developing a comprehensive Union Prevention, Preparedness, and Response Plan.

The Serious cross-border threats to health Regulation,[95] adopted by the Council on 24 October 2022, ensures that the EU will have:

- a robust preparedness planning and a more integrated surveillance system
- a better capacity for accurate risk assessment and targeted response
- solid mechanisms for joint procurement of medical countermeasures
- the possibility to adopt common measures at the EU level to address future cross-border health threats

Relevance for homelessness:

The word "preparedness" has been at the centre of various discussions and analyses reflecting on recent years and those considering any potential future pandemics.

Research regarding the response and challenges faced in the homelessness sector during the COVID-19 pandemic has shown that while there was a lack of readiness initially, the associations have generally demonstrated a good level of reaction towards the emergency. The disinformation and confusion of the first period were replaced by a fast-paced reassessment of staff and resources. Some innovative measures (like the use of hotels to assist people experiencing homelessness) and new skills acquired (like the strengthening of old bridges and the building of new ones between the healthcare system and the Third Sector), demonstrated how solutions are possible to achieve in a time of urgent need.

In some cases, the national healthcare services, when facing a relatively new type of vulnerability, developed new approaches, while at the same time collaborating with associations on the ground. The pandemic underlined the need for systematic training on the different types of target audiences, which are often still invisible to institutions. The lack of knowledge and the structural organisation of public and national services is often the first barrier between citizens and their journey to well-being. The health crisis rapidly became a social one, highlighting the difficulties in realising basic rights for the 'hard to reach'.

These lessons learned must be incorporated in future preparedness work to ensure that people who are marginalised and deeply excluded can be reached during any potential health crisis.

Initiative 10: Health security and infectious diseases[96]

Description:

EU action against HIV/AIDS has a long history, with viral hepatitis and tuberculosis initially considered HIV co-infections and gradually taken up as diseases in their own right.

The EU first delivered a policy instrument to address HIV/AIDS at European level in 2005 with its Commission communication on combating HIV/AIDS.[97] This was the basis for EU action from 2006 to 2009. With HIV/AIDS remaining a public health concern and a political priority for the European Union and neighbouring countries, a second Communication on Combating HIV/AIDS in the European Union and neighbouring countries[98] was adopted in 2009 and accompanied by two successive action plans.[99]

In 2015, world leaders agreed on global action to end the epidemics of HIV/AIDS and tuberculosis and to combat viral hepatitis under the SDGs by 2030. With these global targets in place, the EU expressed its political commitment to support Member States in reaching them in the 2016 Communication on Next Steps for a Sustainable European Future.[100]

Ahead of the 22nd International AIDS Conference,[101] in 2018, the European Commission published a Staff working document,[102] showing the EU-level state of play, policy instruments across several policy areas, and EU-funded good practices to combat HIV/AIDS, viral hepatitis, and tuberculosis in the European Union and the neighbouring countries.

Relevance for homelessness:

People experiencing homelessness are facing specific life conditions and challenges which predispose them to infectious diseases, such as respiratory infections and outbreaks of tuberculosis, increased risk of contracting HIV, and hepatitis infections.[103]

HIV prevention and control is difficult to achieve when experiencing homelessness, while those who receive an HIV diagnosis are at high risk of homelessness or housing instability. When people contract TB in homeless shelters, it is difficult to ensure evaluation and treatment, as infection may be latent, or people may not be tracked for testing. Poor hygiene conditions and lack of knowledge on available testing and treatment options, compounded by difficult access to health care, leaves people facing homelessness highly exposed to hepatitis infection.

There is a crucial need for public health authorities to further expand the traditional methods they implement for tracing contacts.[104] Particularly in the case of people experiencing homelessness, outreach and flexibility in these policies are extremely needed.

HIV and hepatitis B and C viruses (HBV and HCV) are also drug-related infectious diseases which can be found in high prevalence among people experiencing homelessness, as shown above. This co-occurrence of health issues makes it the more relevant to address homelessness in these policies.

Generally, the initiatives set up at EU level for infectious diseases mention 'the populations most-at-risk and most vulnerable' regarding established measures and focus. More specifically, the 2018 European Commission Staff working document recognises a greater risk of HIV/AIDS and a higher incidence of tuberculosis among people facing homelessness. The document also presents project examples where homelessness was considered when implementing support measures for the early detection of hepatitis and tuberculosis. In the framework of these policies, such work can be enhanced.

Initiative 11: Health systems' digitalisation[105]

Description:

Digital health and care refer to tools and services that use information and communication technologies (ICTs) to improve prevention, diagnosis, treatment, monitoring, and management of health-related issues and to monitor and manage lifestyle habits that impact health.

Digital health and care mechanisms are innovative and can improve access to care and the quality of that care, in addition to increasing the overall efficiency of the health sector. The Commission's Communication on the Transformation of Digital Health and Care[106] of April 2018 aims to enhance the digitisation of the health and care sectors. The Communication identifies 3 pillars around which activities will be based:

Pillar 1: Secure data access and sharing

To facilitate greater access to cross-border healthcare, the Commission is building the eHealth Digital Service Infrastructure to allow e-prescriptions and patient summaries to be exchanged between healthcare providers.[107] The first cross-border exchanges started in 2019, aiming to have all other EU countries on board by 2025. In the longer term, the Commission is working towards establishing a European electronic health record exchange format accessible to all EU citizens.

Pillar 2: Connecting and sharing health data for research, faster diagnosis and improved health

The second pillar of the 2018 Communication intends to tap into the huge potential of health data to support medical research, to improve prevention, diagnosis, treatments, drugs and medical devices.

Pillar 3: Strengthening citizen empowerment and individual care through digital services.

Digital services can empower citizens, making it easier for them to take a greater role in the management of their own health, from following prevention guidelines and being motivated to lead healthier lifestyles, to managing chronic conditions and providing feedback to healthcare providers.

Relevance for homelessness:

In the context of the high and rapid digitalisation processes currently implemented across our societies, serious concerns appear that these may lead to further exclusion of people facing homelessness. The health area is a field where such concerns have been confirmed in recent years. For example, the introduction of COVID-19 digital certificates which were inaccessible for people experiencing homelessness.

Concerns are justified also by a scarcity of research and political measures addressed specifically to the digital inclusion of people facing homelessness. Homelessness service providers have addressed this issue as part of the support they offer to their beneficiaries, either by facilitating access to equipment (e.g., smartphones, laptops, or internet sources) or by building digital skills among service users. Moving forward, as the digitalisation of Europe advances, the need for structural support for the digital inclusion of homelessness services and the people they work with is mandatory.[108]

Examples from the COVID-19 pandemic also showed us how technology impacts the lives and the health of people facing homelessness. For example, those who used mobile phones could be contacted by their GPs or social workers or receive notifications on vaccination and health advice through text messages and/or app notifications. However, it was also highlighted how not all people experiencing homelessness can access digital tools and, even if they might have access to a device, they still face challenges. Digital inclusion is not only about having access to devices, but also about connection, data poverty, skills, and receiving specialised support when using ICT tools, among other factors.[109]

Ethical considerations are also extremely important when working on data collection and sharing of information about people experiencing destitution and compounded vulnerabilities.

These factors and more need to be considered in existing and upcoming opportunities on digitalisation, including in the health area. It is crucial that no further challenges or exclusion are created by new initiatives which aim to facilitate data access and sharing or research, faster diagnosis, and improved health.

Initiative 12: E-Health European Health Data Space

Description:

The European Health Data Space (EHDS)[110] is one of the central building blocks of the European Health Union and a milestone in the EU's digital transformation. eHealth refers to tools and services that use information and communication technologies (ICTs) to improve the prevention, diagnosis, treatment, monitoring, and management of diseases. On 3 May 2022, the European Commission proposed a regulation to set up a European health data space which was adopted by the European Parliament in April 2024.

The EHDS aims at introducing clear rules for the use of electronic health data, and will facilitate better healthcare delivery, research, innovation, and policymaking, in full compliance with the EU's data protection standards. The EHDS should allow patients to have immediate, free, and easy access to their data in electronic form, and will be able to share this data with healthcare professionals across Member States. Healthcare documents, such as patient summaries, e-prescriptions laboratory results, images, image reports, and discharge reports, will be exchanged in a common European format. This will improve the healthcare that patients receive, wherever they are in the EU and will also reduce needless and costly repetitions, of what are at times invasive medical procedures and tests. In parallel, the EHDS will empower the use of health data for research, innovation, policy-making, and regulatory activities, under strict conditions protecting those personal data. This will advance research and innovation, support the development of important new treatments, identify side effects of medicines and help to fortify health systems.

Relevance for homelessness:

While the developments under the EHDS aim at facilitating access to health data and sharing data for research, concerns have been raised about the lack of clarity on the type of information to be used and some of the measures imposed by the new initiative. For example, it is not clear what types of patient data are going to be shared between hospitals and doctors.

Furthermore, there is concern regarding the 'opt out' option on secondary data use. More attention needs to be given to the social dimensions of people's lives when decision processes are set in place. In the case of automatic decisions which can be stopped by people only through an 'opt-out' option, this can turn into problematic situations for those who lack access to information or who may find themselves in emergency pressing situations. Understanding consent and accepting to be involved in research may be daunting for people who have been excluded from society and stigmatised frequently when interacting with health services.

The EHDS also establishes that 'for certain important public interests and under strict safeguards, including transparency requirements, your data may still be used'[111] which can be used to override the opt out.

The EU and member states should take into consideration these concerns in the follow up work on implementation of the EHDS.

Initiative 13: Patients' rights in cross-border healthcare

Description:

Under EU law, EU citizens have the right to access healthcare in any EU member state and to be reimbursed for care abroad by their home country. The European Health Insurance Card (EHIC)[112] ensures that necessary healthcare is provided under the same conditions and at the same cost as people insured in that country. Additionally, an EU directive on patients' rights in cross-border healthcare[113] is setting out the conditions under which a patient may travel to another EU country to receive medical care and reimbursement.

DG SANTE will carry out a comprehensive evaluation of the Directive 2011/24/EU on the application of patient rights in healthcare to review the Directive's impact regarding patient rights; reimbursement of healthcare costs; e-health; European Reference Networks for rare, low prevalence, and complex diseases; and to propose areas for improvement.

Relevance for homelessness:

The EU directive on patients' rights in cross-border healthcare and the EHIC card are both relevant for mobile EU citizens who experience destitution and homelessness.

As researched by FEANTSA and its members in recent years, and proved by data from media, EU citizens are over-represented among people experiencing homelessness in big cities in Europe[114] and often they will find themselves in situations where they will require medical attention but without the possibility to pay for services or without health insurance. Generally, access to health services can be hindered and made more difficult for people who have recently moved to a new country as they may face difficulties in understanding the system and what conditions they should meet or what rights they may possess.

Therefore, the EU initiatives that set up health entitlements and conditions to access cross-border healthcare need to include targeted measures to support mobile EU citizens who will be confronted with health issues while they experience destitution and homelessness. Allocating resources for people without health insurance to allow for access to primary and emergency care, remove language barriers through interpretation (by phone or video-call), ensuring free access to reproductive health can be some measures of support to explore.

The use of EHIC could also be further exploited by allowing for some basic services for people experiencing homelessness when they try to access healthcare. Currently, the EHIC is only available for people who have a health insurance or who are employed and pay taxes in their country of origin. It thus remains inaccessible to those are in most need of health support and who cannot pay for it.

Initiative 14: The pharmaceutical strategy[115]

Description:

The pharmaceutical strategy was presented by the Commission in November 2020 and it aims to modernise the regulatory framework and support research and technologies that reach patients.

Further, in April 2023, the European Commission proposed the most significant **reform of the EU's pharmaceutical rules**[116] in over two decades. The European Commission is proposing to modernise the pharmaceutical sector with a patient-centred approach, that also fully supports an innovative and competitive industry. Its approach will preserve the EU's high standards for the authorisation of safe, effective, and quality medicines. It should bring quicker access to products that are cheaper, yet of high quality. Among others, it will contribute to reducing the administrative burden for medicines to reach patients faster, ensuring better access to affordable medicines and tackling antimicrobial resistance (AMR).

Putting patients at the centre means making sure that all patients across the EU have timely and equitable access to safe, effective, and affordable medicines. To this end, new incentives encourage companies to make their medicines available to patients in all EU countries, while EU legislation on medicines for children and rare diseases will also be revised. Putting patients first also means enhancing the security of supply and ensuring medicines are always available to patients, regardless of where they live in the EU.

Relevance for homelessness:

The revision of the pharmaceutical sector and the focus on patients is very much welcome. The EU and member states must consider in the follow up and implementation phases the specific needs of people living in marginalised situations.

As it has been pointed out in connection to the previous initiatives analysed in this paper, access to primary care and health information in general is difficult for people experiencing homelessness. The deep exclusion they experience maintains them in a precarious situation in relation to accessing services. Therefore, their access to medicine included will be restricted and further complicated by the lack of financial resources that may be needed to cover for medication and further treatments.

Equitable access to safe, effective, and affordable medicines may require some innovative strategies to make sure that those individuals in financially precarious situations and who face marginalisation are not left behind in the reform process of the pharmaceutical rules.

Initiative 15: Climate change and environmental pollution

Description:

Environmental pollution and climate change have crucial impacts on the health of individuals by creating factors that are worsening all NCDs. Despite significant improvements in air quality during the past few decades, air pollution continues to be the largest environment-related health risk, with significant associated mortality (with over 250,000 estimated premature deaths in the European Union each year) and morbidity.[117] According to WHO, climate change presents a fundamental threat to human health. It affects the physical environment as well as all aspects of both natural and human systems – including social and economic conditions and the functioning of health systems. It is therefore a threat multiplier, undermining and potentially reversing decades of health progress.[118]

The EU has put forward initiatives for **Reducing pollution in EU groundwater and surface waters.**[119] In line with the European Green Deal[120]'s zero pollution ambition, the Commission tabled in October 2022 a proposal to revise the lists of surface water and groundwater pollutants that need to be monitored and controlled to protect the EU's freshwater bodies.[121] The new legislation updates the Water Framework Directive,[122] the Groundwater Directive[123] and the Environmental Quality Standards Directive (Surface Water Directive).[124]

Launched in 2021 under the EU Strategy on Adaptation to Climate Change,[125] the European Climate and Health Observatory gathers evidence and expertise to guide policymaking on climate change's health impacts. At the climate COP28 in November 2023, the Commission endorsed for EU Member States the first-ever Declaration on Climate and Health.[126] This Declaration outlined vital actions to strengthen health systems, promote research, and adapt behaviours to mitigate climate-related health risks.

Relevance for homelessness:

While the impact of extreme weather, climate events, and pollution on the health of people who experience homelessness still needs to be further researched, it is widely recognised that those who are sleeping rough are particularly affected by these phenomena. Sleeping and conducting everyday activities in the street leaves people exposed to pollution and extreme temperatures. It also poses major difficulties in adopting protection measures and being properly informed on the warnings and guidance which may be issued in such situations.

In the context of working towards mitigating the impacts of pollution and climate change on people's health, there is a major need to consider targeted measures for those who experience homelessness or who are at risk of homelessness.

5. POLICY RECOMMENDATIONS AND CONCLUSION

Homelessness has been widely recognised as a public health issue which requires a comprehensive and multi-faceted solution. Poor physical and mental health can lead people to homelessness, which is the most severe form of exclusion and a human rights violation - including the right to health. If ignored, homelessness can also have huge consequences on public health, something exposed by COVID-19, with its responses and measures for protection revolving around housing.

Deep marginalisation and consequently many health risks are associated with homelessness. Research has shown that even a short experience of homelessness can have a major negative impact on an individual's health status. Adults and children who face homelessness are more likely to suffer underlying health conditions than the general population. The lack of access to basic healthcare services and preventive care exacerbates health issues that people facing homelessness may suffer from, which in turn leads to higher rates of morbidity and mortality among people who face homelessness compared to the general population. The average age of death for people experiencing homelessness in some countries is estimated to be up to 30 years lower as compared to the general housed population.

The spread of infectious diseases, including tuberculosis, HIV/AIDS, hepatitis, or COVID-19 can happen faster when people are facing homelessness, when they are living in crowded shelters or on the streets which will lead to worsening individual health and increases the likelihood of disease transmission. Furthermore, from a public health perspective, homelessness can also lead to pressure on hospitals, particularly emergency rooms, and consequently to higher costs for the health systems. It is therefore imperative from both the human rights and an economic perspective to increase action to ensure equity for people facing homelessness in accessing healthcare.

A comprehensive and multi-faceted approach is needed to put an end to homelessness, which requires strengthened partnerships and collaboration between existing stakeholders at the European level. In the health area, such stakeholders can be the ECDC, the Health Emergency Response Authority, or the European Commission's Joint Research Centre. More specialised agencies are also important in ensuring that progress is achieved, such as the European Monitoring Centre for Drugs and Drug Addiction which has been already engaged with homelessness in their work.

EU health initiatives can play an important role in addressing the health needs of people in vulnerable situations, including those experiencing homelessness. A minimum of 15 health policies have been identified for this paper which hold relevance for the fight against homelessness. By incorporating measures to facilitate access to healthcare for people facing homelessness in these policies, and allocating funding to support their implementation, we can advance on both improving health for marginalised communities and public health, in general. Consequently, contributions will be made to lifting people from homelessness by using health as a tool.

Policies must focus on prevention, such as increasing affordable housing, improving mental health and substance abuse services, and enhancing social support systems. Healthcare access should be expanded, with an emphasis on preventive care and mobile health services that can reach people facing homelessness where they are. Public health interventions should also include harm reduction strategies, such as needle exchange programs and supervised consumption sites, which can mitigate some of the health risks associated with substance abuse. Collaboration between healthcare providers, social services, and law enforcement is essential to create a coordinated response that addresses both the immediate needs and underlying causes of homelessness. Community education and advocacy are crucial in changing public perceptions and reducing stigma. Programs that promote social integration, job training, and educational opportunities are needed to regain stability and self-sufficiency. Importantly, involving those with lived experiences of homelessness in the development and implementation of policies can ensure that solutions are both effective and respectful.

Box 1.1 *EU health policies*

	Health legal bases				Market and wider policies shaping health					
	Public health	Environment	Health and safety	Consumer protection	Euratom	Food safety	Agriculture	Statistics	Social policy	Civil protection
Essential public health operations										
Surveillance of population health and well-being	X	X	X	X	X	X		X	X	
Monitoring and response to health hazards and emergencies	X					X				X
Health protection including environmental, occupational, food safety and others		X	X	X	X	X				
Health promotion	X						X			
Disease prevention	X	X				X				
Assuring governance for health and well-being								X		
Assuring a sufficient and competent public health workforce			X						X	
Assuring sustainable organizational structures and financing										
Advocacy communication and social mobilization for health	X								X	
Advancing public health research to inform policy and practice										
Domains of health systems										
Service delivery					X					
Health workforce			X						X	X
Information	X							X		
Medical products, vaccines and technologies	X									
Financing										
Leadership/governance										

Box 1.1 shows how the EU is engaged in many ways in the essential functions of a health system.

Source: 'Everything you always wanted to know about EU health policy but were afraid to ask'

Box 1.1 *EU health policies [continued]*

	Market and wider policies shaping health								European Semester and funds	
	Free movement – goods	Free movement – workers	Free movement – services	Research	Competition	Procurement	Taxation	Freedom, security and justice	European Semester and RRF	Cohesion policy
Essential public health operations										
Surveillance of population health and well-being				X					X	
Monitoring and response to health hazards and emergencies										
Health protection including environmental, occupational, food safety and others	X									
Health promotion							X			X
Disease prevention										
Assuring governance for health and well-being									X	
Assuring a sufficient and competent public health workforce		X						X		X
Assuring sustainable organizational structures and financing									X	X
Advocacy communication and social mobilization for health										X
Advancing public health research to inform policy and practice				X						
Domains of health systems										
Service delivery	X	X	X	X	X	X			X	X
Health workforce		X	X					X	X	
Information			X							
Medical products, vaccines and technologies	X			X		X			X	
Financing					X	X			X	X
Leadership/governance									X	

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