ProHabitatge®
INTERMEDIARI SOCIAL PER A L'ACCÉS A L'HABITATGE

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HEALTHCARE
& HOMELESSNESS

REPORT WRITTEN BY:

Associació ProHabitatge

THE PROHABITATGE ASSOCIATION *(ASSOCIACIÓ PROHABITATGE)*
THANKS THE FOLLOWING ORGANIZATIONS FOR CONTRIBUTING TO THIS REPORT AS RESPONDENTS TO OUR SURVEY:

Arrels Fundació

Associació ProHabitatge

Cáritas

FACIAM

FILOS

Fundación RAIS

Fundación LESMES

Provivienda

Rauxa

1. HEALTH PROFILE OF THE HOMELESS

1.1. Regarding the mental and physical health and drug abuse problems most common to the homeless, bearing in mind the ETHOS categorization.

As before, and in order to put health problems and the homeless within Spain in context, let us review the main results regarding health from the survey by the National Institute of Statistics (INE) "Survey Regarding the Homeless" carried out in 2005:

- 15.6% of the homeless community report being in bad or very bad health, while 52.7% report being in good or very good health. This subjective perception of one's health is poorer among women (54.6% of men report being in good or very good health to only 44.1% of women).

- 29.1% suffer a chronic or serious illness and 24.7% have taken sleeping pills or tranquilizers.

The first data from the INE refers to subjective perceptions. The majority of the organizations that responded to our survey consider the use of one's personal perception of health is not a good method for gathering information about the health of the homeless. The RAIS Foundation reported that when, in its experience, when asked such a question people tended to report being in good health, although later it became clear that this did not correspond with reality. The second bit of data supports this assertion. A medical diagnosis reveals that nearly a third of the homeless in Spain suffer a serious or chronic illness—double the percentage of those who report such poor health when asked.

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Our colleagues at the San Vicente Center for the Homeless in Andujar, Andalusia *(Centro de Acogida e Inserción para Transeüntes–San Vicente de Paúl)* offer a synthesis of the principal mental, physical and substance-abuse problems that the homeless suffer when they point out that *one must stress that the principal mental health problems facing the homeless involve personality disorders (antisocial behavior among them), depression, anxiety, paranoia and—in a smaller percentage—schizophrenia. At a physical level, the illnesses the homeless suffer are the result of poor nutrition and substance abuse (anemia, high cholesterol, mouth and liver problems); tuberculosis is also common; to this extent, many of these people are disabled; a smaller percentage include those who are HIV positive and those with hearing problems. Of the substances abused by the homeless, the most prevalent include alcohol-dependency, gambling and tobacco, and to a more minor extent dependency on cocaine and heroin.*

In short, the illnesses most commonly suffered by the homeless are personality disorders, nutritional imbalances, and problems deriving from poor nutrition and abuse of substance, with the most notable being tuberculosis.

It should be stressed that these illnesses are not as pronounced among women as among men. This is supported by the study "Homeless in Madrid. A Psychosocial & Epidemiological Report (*Personas sin techo en Madrid. Informe Psicosocial y Epidemiológico*) by professors Muñoz, Vázquez and Cruzado of the department of psychology at Universidad Compultense in Madrid and published in the journal Documentación Social number 127, edited by Cáritas Española.

The report found that incidences of illness were much higher among homeless women than among homeless men: The comparison across sexes was quite relevant as they identified women as a group that is especially vulnerable to illness. They display more sexually transmitted, circulatory, bone, muscle and skin diseases than their male counterparts. The women also suffered the accumulation of five or more disorders with greater frequency.

Regarding substance abuse, the Rauxa Association (Asociación Rauxa) in Barcelona points out that in the general population some 6-12% of people suffer from alcohol dependency. However, among the homeless, this percentage goes up, ever more in more serious cases. Rauxa

asserts that alcoholism sets in long before one is in the streets and it is qualitatively one of the most significant causes of marginalization and quantitatively—to the extent that such people are not offered adequate treatment—those who suffer alcoholism deteriorate to a point of maximum marginalization.

Rauxa posits that 50% of the homeless suffer from alcoholism and its consequences: hepatitis, alcoholic cirrhosis or alcoholic pancreatitis, the cause of mellitus diabetes. On the other hand, the survey by INE cited above suggests that 30% of the homeless abstain and have never used drugs. It suggests that some 10% consume a high or excessive amount of alcohol. There is a greater frequency of abstinence or light drinking among women than among men.

Rauxa asserts that alcoholism raises the risk of tuberculosis and hepatitis C and points out that among the homeless who suffer from alcoholism, 90% are also addicted to tobacco, which combined with alcoholism increases their risk of developing cancer, intermittent claudication or blindness caused by optic neuritis. Regarding the possibility of multiple drug abuse, the INE survey suggests that 6.2% of the homeless have taken drugs at one time and have consumed and excessive amount of alcohol.

The Survey of the Health of the Homeless (*Encuesta sobre la salud de las personas sin techo*) carried out by the Social Affairs Services (*Serveis d'Atenció Social de la Direcció de Serveis d'Afers Socials*) of the City of Barcelona and the other of the city's agencies that work with this collective (referenced in the journal Arrels Fundació number 49, 1999), gives us a profile of the state of health of the homeless.

They interviewed 483 people, 281 who live in the streets and 202 who live in centers, of which 90% were men.

- 67% of the men under 45 years of age reported being in good health, without any significant differences between those on the street and those in centers.

- When asked if they suffered any chronic disorders, there was a higher frequency among older people, but only 23% among those under 45 years of age and 12% of the older people suffered no disorder.

- Among those with chronic disorders, depression was high among them, ranging from 47% among those over 45 who lived in the street to 79% of those under 45 who live in the centers.

- Other issues: Back pain, migraines, cirrhosis of the liver, bronquitis, arthrosis, ulcers and circulatory problems.

- On the other hand, complications such as AIDS, sexually transmitted diseases, cancer and scabies were scarcely reported.

- Regarding mental health, 40% of men under 45 and 53% of women reported at least one disorder.

- Regarding the use of health resources as an indicator of the health of this population, of the 140 who checked into a hospital in the year preceding the interview, 64.3% had done so once and 18% twice. The reasons for seeking hospitalization were diverse, but can be grouped as those tied to the consumption of alcohol and illegal drugs, respiratory problems, altercations or accidents, and depression.

The following is a classification of the principal ailments the homeless suffer following the ETHOS typology. As such, the ailments have been organized into three categories: mental health, substance abuse and physical illnesses.

A. ROOFLESS

MENTAL HEALTH
- Personality disorders
- Scizophrenia
- Psychological disabilities
- Bipolar disorders

SUBSTANCE ABUSE
- Alcohol
- Cocaine
- Heroin
- Benzodiazepine
- Tabacco

PHYSICAL ILLNESSES
- Soriasis
- Scabies
- Tuberculosis
- Parasites
- Malnutrition
- Ophtalmologic problems
- Dental problems
- HIV/AIDS and other sexually transmitted diseases
- Hepatitis
- Cirrhosis of the liver
- Respiratory illnesses (bronchitis, pneumonia, etc.).

D. HOUSELESS

The homeless without shelter suffer the same health problems as the homeless without shelter, with the only difference being that they are accepted temporarily into centers such as prisons, hospitals and homeless shelters.

MENTAL HEALTH
- Personality disorders
- Scizophrenia
- Psychological disabilities

SUBSTANCE ABUSE
- Alcoholism
- Drug dependency

PHYSICAL ILLNESSES
- Soriasis
- HIV/AIDS and other sexually transmitted diseases
- Tuberculosis
- Ophthalmologic problems
- Dental problems
- Hepatitis

D. INSECURE HOUSING

MENTAL HEALTH
- Personality disorders
- Scizophrenia

- Dementia
- Psychological disabilities

SUBSTANCE ABUSE
- Alcoholism
- Drug dependency

PHYSICAL ILLNESSESS
- Hepatitis
- Tuberculosis
- HIV/AIDS and other sexually transmitted diseases
- Mental health problems (personality disorders, scizophrenia, trastornos de personalidad, esquizofrenia, mental deficiencies)

OTHERS
- Sleeping and eating disorders

D. INADEQUATE HOUSING

MENTAL HEALTH
- Personality disorders
- Scizophrenia
- Cognitive problems

SUBSTANCE ABUSE
- Alcoholism
- Drug dependency

PHYSICAL ILLNESSES
- Parasites
- Skin diseases
- Scabies
- Tuberculosis
- Hepatitis
- HIV/AIDS and other sexually transmitted diseases

1.2. Certain illnesses common to the homeless carry with them a risk to public health. Such is the case with tuberculosis. This disease is much more prevalent among the homeless than among the general population and this creates the possibility of an outbreak in incidences of this infectious disease. For this reason some countries have developed programs and specific strategies for combating tuberculosis among the homeless.

This reflects the risks to public health associated with the health of the homeless. Actions taken to prevent risks to public health associated with the homeless.

Measures taken to prevent risks to public health associated with the health of the homeless are not homogenous across Spain. In some territories, organizations that work with the homeless have teamed up with their public administration to establish protocols. In other areas, this has not been possible. Such is the case, for example, in Tarragona. The Transients' Shelter (*Casa d'Acollida del Transeünt*) contacted the department of public health of the Catalan government in Tarragona seeking consultation and in order to notify them of the identification of an outbreak of a skin disorder, but this communication was unilateral. In February 2005 they again attempted to coordinate their actions to prevent an outbreak of scabies but they were again unsuccessful.

In contrast, the RAIS Foundation (*Fundación RAIS*) of Madrid reports that the public administration has at its disposal the National Network of Epidemiological Monitoring (*Red Nacional de Vigilancia Epidemiológica*) and the protocols of a declaration regarding tuberculosis. These doctors are responsible for detecting and reporting cases to the health authorities of the respective Autonomous Community. Nonetheless, the RAIS Foundation reports that there *exists no specific measure for detection in high-frequency areas.*

The organizations that work with the homeless have in fact adopted preventative protocols for identifying illnesses suffered by those who come into their centers. In this way, the "Luz Casanova" shelter (Caritas Diocesana de Granada) carries out exams for tuberculosis, syphilis and hepatitis on everyone who checks into their center for a certain amount of time.

- Blood count
- Biochemistry
- Urine
- HIV, Hepatitis B and Hepatitis C serology
- Mantoux reactions and direct smears for bacilli and its cultivation

At the same time, the center is in constant contact with the corresponding epidemiological services and carries out all pertinent obligatory declarations. The control extends to the professionals who work in the center, as well, who are tested yearly for all possible illnesses that could be contracted through contact with the homeless.

The Rauxa Association (Barcelona) argues that *in all shelters and public cafeterias there should be protocols for detecting tuberculosis.* In Barcelona, this organization is responsible for implementing such a practice in all public cafeterias in the city after verifying the high frequency of tuberculosis among the homeless.

There is a network for the detection and treatment of tuberculosis in Barcelona available to all citizens: the Drassanes Center for Chest Diseases (*Centre de Malalties del Tòrax Drassanes)*, where diagnosis are carried out and the Sant Gervasi Residential Tuberculosis Treatment Center of the Generalitat of Catalonia (*Centre Residencial de Tractament de la Tuberculosi de la Generalitat de Catalunya Sant Gervasi)*, where patients are treated. There are street teams that work in tandem with these centers distributing medicine to those who live independently. Normally after 15 days of treatment tuberculosis is not contagious. The Arrels Foundation (Arrels Fundació) reports that there is also the Pere Camps Emergency Center (Centre d'Urgències Pere Camps), which monitors those patients who are not connected to any social center and who repeatedly use the service.

It should be mentioned that under Spanish law tuberculosis and HIV infections must be reported to the health authorities. Recently, the Spanish Society of Pneumology and Chest Surgery (*Sociedad Española de Neumología y Cirugía Torácica [SEPAR]*) declared that incidents of tuberculosis in Spain, with 25 cases annually for every 100,000 inhabitants, is four times that of Holland, Germany or the Nordic countries, which report finding 5 cases for every 100,000 inhabitants. In 2003, 6,743 cases of tuberculosis were reported in Spain, but 40% of cases are not reported. SEPAR adds that in the big cities like Barcelona and Madrid, between 20% and 50% of detected cases correspond to immigrants, the majority of whom are unable to follow the prescribed treatment.

LIST OF GENERIC METHODS THAT HAVE BEEN ADOPTED TO PREVENT DISEASES FROM SPREADING

- Injection rooms
- Needle exchanges
- Low-maintenance resources
- Public cafeterias
- Condom distribution among at-risk groups

- Execution of protocols for disinfecting clothing and following prescribed treatments.
- Tuberculosis testing
- Vaccinations
- Specific programs for the detection and treatment of tuberculosis
- Madrid: Two mental-health teams working in the streets that facilitates starting homeless tuberculosis patients on a treatment program.

1.3. Certain health conditions among the homeless can hinder efforts to provide them with treatment. For example, treating tuberculosis is more difficult in a patient whose life is chaotic. That is to say, the specifics of each patient can make their treatment more difficult (multiple needs, diverse illnesses, etc.). Specify the problems you find when trying to offer health services to the homeless.

Before elaborating on the specific difficulties organizations come across when trying to provide assistance to the homeless, it is important to highlight the importance in Spain of having official identification documents when seeking health services. Everyone who registers with their municipality has the right to a health card, which guarantees ambulance and hospital services. In this regard, it should be noted that according to an INE survey, 66.9% of the homeless have such a health card.

Nonetheless, even with a health card, one still has to pay 40% of all costs of medication included in the catalog of social security medications and 100% of that which is not included. The case of Hidroxil is an example. This medication for the treatment of alcoholism is not included on the National Social Security list of free medicine

People without any kind of identification, because they are not registered with any municipality and therefore do not qualify for such a card, are treated primarily through emergency rooms. Caritas Bizkaia concurs–-*the homeless are always accepted by emergency services, and stressed that problems arise with illnesses that do not require urgent care and that cannot be treated for a variety of reasons: a lack of a health card; lack of knowledge that there is a problem; an inability to maintain treatment; lack of proper health-care practices; difficulty maintaining convalescents in good conditions; inability to find proper rest*, *etc.*

In effect, the homeless for the most part do not seek primary care (for various reasons), but rather are treated through emergency services. But by the time they seek such services they are in a very critical state of health and often there is no solution for the illness they suffer.

Two other obstacles to the homeless accessing public healthcare:

- A lack of health protocols for quickly and smoothly getting patients to public health facilities.

- A lack of health services that offer holistic evaluations of patients.

Putting the protocols into practice leads to, among other advantages, a short-term saving of resources. This principle is shared by the Rauxo Association (Barcelona), which stresses that it is essential to make it clear that the homeless show clear signs of pathologies that should be tackled when they first surface. *If things were done this way, it would be more effective and more efficient with a drop in personal costs for the homeless, and human and economic costs for public administration and related organizations.*

Likewise, the Arrels Foundation (Barcelona) adds that the homeless have particular difficulty accessing mental health services, which is the least developed health sector. The "Síndic de Greuges" of Catalonia concurs in their 2005 special report on the homeless where they report that the (Catalan) mental health program comes up short and must be improved upon, *by such a program as the ones that have mental health professional working directly in the streets. The* "Síndic de Greuges" stresses that such a program should be oriented in two directions:

- *Offer direct medical attention to the people with illnesses who live in the street*
- *Sensitize society at large about this problem.*

CLASSIFICATION OF THE MAIN BARRIERS TO RECEIVING CARE FROM HEALTH SERVICES

Classification:

1. **Lack of documentation to verify one's identity**, which makes it difficult to get primary care, with emergency care being the alternative
    - Lack of proper registration at the municipal level
    - Lack of an Individual Health Card *(Tarjeta Individual Sanitaria [TIS])*, which works in place of the Social Security Card

2. **Poor habits regarding one's personal health and hygiene.**
    - Lack of awareness of any problem
    - Difficulty maintaining adequate hygienic and dietary standards
    - Difficulty maintaining proper treatment

3. **Lack of awareness of any sickness or of the need to follow a treatment plan.** Often the homeless require such complicated medications that an assistant is needed.
    - Transience (making it more difficult to follow a long-term treatment plan)
    - Lack of familiar ties (making it more difficult to follow treatment plans that require support from family)
    - Resistance to treatment plans on the part of the patient
    - Lack of trust in the health system

4. **Difficulty starting treatment plans for financial reasons**
    - No facilities offering medication free of charge
    - Difficulty paying for prescriptions

5. **Health administration deficits**
    - Social and healthcare are separate departments
    - Lack of social/health cordination
    - Bureaucracy in the healthcare system (need for a health card, a scheduled appointment, etc.).
    - Lack of reference people within the healthcare system (there is the need, in some cases, for educators and volunteers to accompany the homeless)
    - Total lack of attention to patients referred to mental health services
    - Resistance on the part of professionals
    - The homeless are not received in the same manner by healthcare personnel. They need to be accompanied by a professional from a shelter in order to be tended to properly.

2. SOCIAL PROTECTION: HOMELESS PEOPLE'S RIGHT TO HEALTHCARE

2.1. What are the healthcare rights guaranteed to the homeless under Spanish law (be they Spanish, foreign, asylum seekers, or undocumented immigrants)? What are the requirements (registration, etc.)?

In principle, the Basic Healthcare Law of Spain *(Ley General de Sanidad española)* states that access to healthcare is a universal right, therefore the homeless should have the same access to healthcare as the rest of the population.

The right to access and use of healthcare services is established in the Basic Healthcare Law *(Ley General de Sanidad)* of 1986, Law 14/1986 of April 25, with the preliminary title of "The Right to Healthcare Protection" *("Del derecho a la protección de la salud")*, and consists of a single chapter.

ARTICLE ONE.

1. This law has as its objective the general regulation of all activity related to securing the right to healthcare as recognized in Article 43 and related agreements within the constitution:
    a. Recognizes the right to healthcare.
    b. Assigns public institutions with the responsibility for organizing and guiding public health initiatives involving preventative measures and vital services. The law established the rights and responsibilities of all parties.
    c. Public institutions will develop healthcare education, physical education and sports. Furthermore, such institutions will facilitate an adequate use of leisure activities.

2. All Spaniards and foreign citizens who have established residency within national territory are entitled to healthcare.

3. Foreign citizens who do not have residency in Spain, as well as Spaniards residing outside national territory, will also be guaranteed this right to the extent that it is established under international law and conventions.

THE SPECIFIC CASE OF FOREIGN CITIZENS

Nonetheless, regarding foreign citizens, the law delves into a series of specifics. The Constitutional Law 4/2000, of January 11 regarding the rights and freedoms of foreign citizens in Spain and their social integration, reformed by Law 8/2000 of December 22 (the article regarding the right to healthcare is not reformed) establishes in Article 12 (The Right to Healthcare):

1. All who are registered with their municipality have the same right to healthcare as Spanish citizens. That is to say, whether they are working and enjoying regular services from their healthcare coverage or they are not working, they shall still receive medical attention if they can demonstrate that they lack sufficient financial resources.

2. All emergency cases involving extreme illness or injury.

3. Those under 18 enjoy full access to medical care.

4. Pregnant women enjoy medical assistance for the length of the pregnancy, the birth, and postpartum.

The requirements are the following:

1. The following documents are needed in order to request a healthcare card and, as a consequence, to be able to access primary medical care:

    - Certificate attesting to one's registration at the municipal level
    - Registration with Social Security
    - Documentation attesting to the identification of the applicant.

    To request such documents, one needs a document establishing their identity.

    Nonetheless, these requirements do not apply to the guarantee of primary healthcare to pregnant women and to those under 18.

2. For those without a health card, their right to healthcare is guaranteed through open access to emergency rooms in cases of extreme illness or injury and all relevant medical services until being given a medical discharge.

We have already discussed the direct relationship between having identifying documents and getting access to medical care, although this does not violate the principle that within Spain access to healthcare is a universal right. It is also clear, as stated by Caritas Granada, that there are cases in which those "without papers" can still get access to healthcare: There are organizations under the authority of *the provincial administration (Diputación) which can process patients without papers, such as drug-treatment centers and centers for the detection and treatment of sexually transmitted diseases.*

As with everything, and as cited in the book The Homeless Population in Spain: An Extreme Case of Social Exclusion *(La población 'sin techo' en España: un caso extremo de exclusión social)* by Maria del Rosario Sánchez Morales, *the deficiencies in the public health system are most blatant in reference to this social group and they describe it as a dramatic caricature of reality. The same can be said of dentistry and podiatry, which demonstrates the interesting conclusion that the processes of extreme exclusion can reveal the shortcomings of any system, including a healthcare system."*

2.2. Is the Spanish healthcare system organizes in such a way that it is difficult for the homeless to access it?

A distinction should be made between two different situations: the documented and the undocumented homeless, who are primarily immigrants. Although both groups share the same problem of not having a home, homeless immigrants suffer the still more in not having the required documentation in order to receive healthcare and are therefore limited to only emergency services.

No specific measures have been adopted in Spain to facilitate homeless people's access to the healthcare system. This collective must satisfy the same conditions as the rest of the population, which presents a challenge. The specifics of each homeless person make satisfying the requirements more difficult, particularly at the bureaucratic level—a necessity in order to benefit from the healthcare system. Despite this, perhaps the most difficulty arises not in accessing the healthcare system, but in following a prescribed treatment plan.

The universality of healthcare does not exclude, by any measure, the recognition that there are obstacles to the homeless receiving medical care. Regarding the requirement that one be registered at the municipal level and be in possession of identifying papers, the "problem of bureaucratization": The healthcare card requirement, the requirement of an appointment in order to be treated or the obligation to pay for certain prescriptions. The high quantity of required paperwork discourages the homeless from seeking healthcare, who end up accessing it exclusively through emergency services.

2.3. What do you find are principal obstacles to accessing healthcare that the homeless face (stigmatization, economic/administrative barriers, etc.)?

One important problem is the stigmatization on the part of the professionals who tend to the homeless regarding their physical appearance and personal hygiene. On example is the situation condemned by FACIAM (Madrid) in their statement that *if one requests a healthcare card while not registered as employed, the application goes under the category "person lacking sufficient economic resources", although such a status should not exclude someone from enjoying access to the healthcare system.* This is confirmed by Caritas Granadas in their claim that *within the healthcare community there is a great deal of ignorance regarding the reality of the homeless.*

Nonetheless, on the matter of ignorance on the part of healthcare professionals about the reality of the homeless, the opinion among the surveyed organizations is not unanimous. For example, the Arrels Foundation (Barcelona) states that *their experience accompanying the homeless to primary healthcare facilities has been fully satisfactory to the point that some professionals make such visits a requirement for their professionals.* Furthermore, Arrels reports that on one occasion they participated in a clinical session in which the characteristics of the homeless and the principal problems they face when trying to access public healthcare were explored.

One important method that should be adopted in order to approximate the health of the homeless would be to organize healthcare teams that would work directly in the streets (treating both mental and physical problems) since a lack of understanding of proper hygiene tends to lead such people to be unaware of when to seek medical attention, under what conditions they might be treated or even simple risk prevention and detection methods.

One method that contributed to reducing these obstacles was the establishment of the universality of healthcare. But this did not eliminate all the obstacles.

Those that still persist can by classified into two basic categories:

1. **Difficulties brought on by a homeless person's own condition**
    a. Financial difficulties paying for medications (homeless people typically have quite unstable financial resources, a fact which makes it more difficult for them to acquire doctor-prescribed medications and impossible to follow a particular diet).
    b. Lack of trust or outright rejection of healthcare services on the part of the homeless (perhaps over feelings of being poorly received on previous occasions, feelings of exclusion, or a lack of understanding about healthcare services.).
    c. Not understanding where to go for help or what paperwork is involved.
2. **Difficulties attributed to the healthcare system**
    a. Bureaucracy in the healthcare system.
    b. Normative and administrative barriers. The populations most vulnerable to such risk are foreign citizens lacking residency papers and unregistered with their municipality, thereby lacking any healthcare card.
    c. Linguistic and communicative barriers, especially in the case of immigrants.
    d. Cultural and religious barriers.
    e. Passive rejection of the system or of healthcare professionals.
    f. Many difficulties in accessing medical specialists (due to the geographic mobility of the homeless, which limits them to centralized medical facilities).

g. Discrepancies when determining whether responsibility lies with social services or health services.

h. Long waiting lists that create another obstacle to the homeless accessing healthcare services.

2.4. Have efforts been made to remove these barriers? Were they successful?

There have still not been any measures adopted in order to eliminate the obstacles that hinder homeless people's ability to access the healthcare system. Perhaps the most innovative measure that has been adopted, as mentioned above, was the approval of the Law of the Universality of Healthcare.

That said, in some areas measures have been adopted that facilitate the homeless accessing the healthcare system. For example, regarding the linguistic barrier faced by some, some hospitals have contracted translators to facilitate understanding between staff and patients. They have also processed conditional, provisional healthcare cards to be renewed after a certain amount of time or processed fictitious municipal registrations in order to receive a health card.

It must be stressed that the authorities have not always been receptive when approached by organizations regarding homeless people's inability to access the healthcare system. The RAIS Foundation (Madrid) reports that *people who work in shelters have had several meetings with people who work in the mental health sector in order to improve coordination between the two but there has been a lack of interest on the part of the healthcare institutions.*

3. TO GUARANTEE QUALITY HEALTHCARE SERVICES

3.1 Are there any centers that have modeled there services specifically with the homeless in mind? Is this a good way to provide the healthcare that they need? What are the advantages and costs of such projects?

Before tackling this question let us reflect on the transcendent nature of the principle of equality. That is to say, one should look carefully at the suitability of creating healthcare services specific to the homeless. As mentioned earlier, the homeless enjoy the same rights as all citizens, so for this reason it makes little sense that they should have services special to them.

If we are discussing equality and, by the same token, the dignity of each individual, healthcare services—as established under law—is one of equality independent of one's personal situation, and for this reason it would be a contradiction to establish a healthcare center specific to this collective. Healthcare centers are for all people, not simply for transients, immigrants or schizophrenics, which does not exclude by any measure the need for public health facilities to take care to have professionals sufficiently prepared to tend to the multiple problems associated with the homeless. The "Síndic de Greuges" concurs in pointing out that *if the homeless use the public healthcare system like any other user, specific procedures would be needed.*

Caritas de Granada makes the same point, arguing that *the homeless need specific healthcare professionals that understand the problems unique to them. At the same time, a healthcare service adjusted to the needs of the homeless would make work in other areas—such as health education—and not simply treatment.*

This is to say, the institutionalization of healthcare services specific to the homeless would allow work on areas beyond simply medical attention, such as health education. Nonetheless, such an approach has its negative aspects, including the potential for stigmatization and difficulties with financing.

That said, it should be added that there is no healthcare service specific to the homeless in Spain. Nonetheless, and bearing in mind that it is not a perfect system, it is true that the present

system does allow for immediate medical attention, but this is not to say that the network of healthcare services could not be improved upon. That is to say, as the ProHabitatge Association points out, *specific services are not enough, because the homeless suffer a range of pathologies that require the intervention from the whole range of healthcare services.*

Despite this, some centers for the homeless have established their own healthcare services. For example, the shelter in Granada receives services from volunteers. There are also several centers for the treatment of alcohol (Rauxa, Barcelona) and other drugs, and there are shelters for those suffering with HIV infections. Many centers test for tuberculosis, as well.

The City of Madrid relies on the "Project for the Rehabilitation and Social Integration of the Homeless with Chronic Mental Illness *(Proyecto de rehabilitación e inserción social de enfermos mentales crónicos sin hogar ([PRISEMI])*. The service offers individual psychosocial rehabilitation programs and community support to homeless people with chronic mental illnesses who also suffer social marginalization, in order to promote the most autonomy, the best possible quality of life, and their progressive reinsertion into society. It also has at its disposal several supervised apartments suitable for housing and support in order to facilitate this process of rehabilitation and social reinsertion.

The service is aimed at people of both sexes between the ages of 18 and 65 who suffer chronic mental illnesses and who find themselves homeless and socially marginalized and is carried out by the San Isidro Municipal Shelter *(Centro de Acogida San Isidro)* under the auspices of the Madrid City Council.

This project has a specific team that works both on the development of the rehabilitation programs at the San Isidro Municipal Shelter with the people being attended to, and in the support and supervision of the supervised apartments (18 spaces in four apartments) run by the project. The team, made up of a coordinator, a psychologist and six monitors/educators, also offers support and technical advice to the professionals in their shelter, UMES, and at other service centers in order to help them handle and promote the rehabilitation of this collective.

The Rauxa Association also looks over the personalized healthcare needs of the homeless. In the Association, as well as in the Coordinator of Therapeutic Communities and Reinsertion Homes of Catalonia, the following is carried out:

- Detection and treatment of tuberculosis
- Hepatitis vaccinations
- Flu vaccinations
- Tetanis vaccinations where needed

The Valencia city council counts on the Center for the Homeless *(Centro de Atención Social de Personas Sin Techo ([CAST])*, which administers tuberculosis testing. The results are immediate, limiting any risk to public health.

3.2 Are you aware of any initiatives regarding health or preventative health with particular focus on the homeless? Do you think such initiatives have directly led to homeless people finding employment?

It was mentioned in the previous question that various Spanish city councils rely on specific health services for the homeless. But there is no data to suggest that such services contribute favorably to the reinsertion of the homeless into the workforce. That aside, the Homeless Shelter *(Casa de Acogida de Personas Sin Hogar)* of Tarragona reports that they work closely with mental health centers, both regarding treatment and family doctors and assistants, and that these *initiatives regarding healthcare give greater stability to the people, which facilitates their reinsertion in the workforce*.

Although there are city councils that have created healthcare centers for the homeless, these are for the most part social reinsertion centers, with the San Vicente de Paúl of Andújar

(Andalucía) being a prime example, which cover the health of the homeless as part of an integrated program. It functions in this way in order to have a place for the homeless to stay and working in coordination with the other institutions allows for total support of the homeless, helping them to recuperate from whatever illness they may suffer. Such a structure of support aids the recuperation of lost habits and facilitates social reinsertion.

3.3 What is homeless people's access to healthcare like in rural areas?

Homeless people get access to healthcare through emergency services in rural areas, as well. The services are the same as in the cities, since in Spain the healthcare system is the same throughout the territory. Nonetheless, there are some problems unique to rural areas:

- In order to access a healthcare center normally one has to travel to the largest city in the area.

- For this purpose, one needs public transportation, which is not always available and even where available it is often prohibitively expensive for the homeless.

To get around these obstacles, one possible solution would be to create a single roving post to facilitate access to healthcare for the homeless who "reside" in rural areas.

3.4 Do you feel that the healthcare the homeless receive in Spain is equal to that received by the general population? What areas of healthcare do the homeless have the most difficulty accessing and for what reasons?

Generally speaking, the healthcare the homeless receive is no different from that of the general public. Their right to healthcare is the same, as the law establishes. This being well-established, it is still true that the homeless face more obstacles when seeking healthcare. The main deficits being the mistreatment they face from healthcare professionals and the stigmatization they suffer. It would be prudent for the professionals who provide healthcare services to be sensitized to the situation of the homeless and, for example, to be more conscious that for them it is not at all easy to carry out a task as seemingly simple as taking a pill with every meal, as they may well only eat once a day.

These obstacles can be overcome with the appointment of a professional responsible for looking after the needs of the homeless: to inform them of the available services, to help them with paperwork in order to access healthcare and to take care that the patient follows the prescribed treatment plan.

It is a given that medical assistance should be the same for all citizens, but it should be recognized that this presents a challenge. This is because of the specific characteristics of the homeless. Recovering fully from an illness often requires that a patient receive support from friends and family and be situated in one place. These are two resources which the homeless cannot depend on, as they are often on the move and without support from their families. What is more, waiting lists pose a particular obstacle to this collective.

The areas of healthcare that are most inaccessible to the homeless are those involving treatments requiring more than one visit: all areas involving extended or long-term treatment. That is to say, there is easier access to generalists than to specialists. The homeless are also unable to access orthodontic, optical or orthopedic services because these are not covered under the public healthcare system and, as a consequence, these services must be paid for in full.

The ProHabitatge Association (Barcelona) argues that at the time of providing healthcare to the homeless it is vital that there also be the intervention of professionals who, while not trained specifically in healthcare, can nonetheless contribute to an improved state of health (such as educators, psychologists, therapists or simply people who are willing to act as good listeners). Often the homeless are suspicious of certain professionals or institutions from whom they have

received treatment in other contexts and are therefore more receptive to other types of professionals.

3.5 In some countries policies have been put in place that deal specifically with healthcare and the homeless, with the goal of guaranteeing effective healthcare for this collective. Has anything similar taken place in Spain?

If we consider that in Spain homeless people enjoy viable access to the healthcare system, it is only logical that no special public health policies have been enacted specifically for the homeless.

4. THE PREPERATION OF HEALTHCARE PROFESSIONALS

4.1 Are there any courses in Spain for healthcare professionals dealing with care for the homeless (be they courses for nurses, doctors, mental healthcare workers, dentists, etc.)?

In Spain there are no courses for preparing healthcare professionals to tend to the homeless. The little that has been done in this regard has been done by the same associations that are already dedicated to caring for the homeless.

The psychologist at the San Vicente Center for the Homeless in Andujar (Andalusia), in October 2005 at a meeting of mental health teams, gave a lecture to healthcare professionals. Likewise, in the Autonomous Community of Andalusia courses have been organized that specifically deal with mental illnesses suffered by the homeless.

The RAIS Foundation (Madrid) help a course titled "Social Skills in Mental Healthcare *("Habilidades sociales en salud mental")* in which experts from both public and private institutions participated.

5. NETWORKING

5.1. Are there any services of this type working in a networked system?

There is not a tradition in Spain of working with networks, nor is there any service that coordinates the healthcare system with assistance programs for the homeless and social services. There are no administrative procedures that would allow the coordination or the interchange of information in any regular or formalized manner. This kind of coordinated model only exists for very specialized services. Despite this, there are a few projects at very early stages that are working toward such a system. For example, this year in Tarragona, from the Shelter for Transients *("Centre d'Acolliment al Transeünt")* a group has been formed to establish action plans.

Although there is no formal network that coordinates the various related services, it is true that these various groups are aware of each other and share patients. This is a typical practice and we could say that it is the closest to anything resembling a network that exists in Spain. For example, it is common for hospitals to contact shelters for the homeless so they can take over responsibilities for someone who has recently been operated on. This is what happens, for example, with the Rauxa Association (Barcelona); hospitals refer homeless alcoholic patients to them after they undergo detoxification, and the same occurs in Huelca; hospital social workers contact Cáritas when dispatching a patient without a home when they have no other place to send them.

The "Síndic de Greuges" of Catalunya condemns such practices in their special report on the homeless. In the case of the Catalan Healthcare Network *(Red de Salud Catalana)*, they stress that *there is a lack of an overall vision of healthcare and the individual, and they give as an example the fact that hospitals dispatch patients without any guarantee that they have a home to go to.*

In turn, it is so rare for homeless shelters to receive convalescents from hospitals that it at time creates serious problems as such shelters are not prepared for such work, either for lack of preparation, of personnel or of the necessary material resources. The result is that from an administrative point of view it is unclear what the best course of action would be since from a clinical point of view the patient has been discharged from the hospital but they are not in a good enough state of health to be admitted into an institution that has neither the means nor the personnel necessary to care for people who have recently been released from hospital care. These dysfunctions in the system result because hardly any intermediate resources have been created to tend to people who require prolonged convalescence.

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In Valencia, the professionals who work with the homeless coordinate with other professionals working in both the health and the social services. But it is not so much a structured network since the coordination depends on the initiative of the people who carry out social work with the homeless. This is not anecdotal. In Spain, the norm is not that the healthcare system works to coordinate with the centers for the homeless, but rather that the people and associations that work in the streets are the ones who make efforts to introduce the homeless into the healthcare system.

There is a Health Board (Consejos de Salud) in Madrid, under the auspices of the Center for Primary Healthcare and present in every district, that aims to create a space for community intervention that brings together the various associations and social services in the area in order to analyze trends in social-health needs that appear in each district and to develop programs and actions to confront them.

6. SIGNS OF HEALTH, STATISTICS AND RESEARCH

6.1. Does Spain have any branch of statistics dedicated to systemizing information related to the health of the homeless? For example, how many homeless use specialized healthcare services, how many are ill with tuberculosis, how many use general services, how many dysfunctions are there among the homeless, etc? If so, who gathers this data? (Hospitals, those associations that work with the homeless, etc.)?

There is no branch of statistics dedicated to systemizing information relating to the homeless. Nonetheless, the associations that work with this collective often develop there own statistics, which they publish annual and which they use to plan their actions.

In 2005, the National Institute of Statistics *(Instituto Nacional de Estadística [INS])* published the "Survey of the Homeless" *("Encuesta sobre las personas sin hogar")* which included a section dedicated to the health of the homeless.
www.ine.es/inebase/cgi/um?M=%2Ft25%2Fp454%2Fe02%2Fa2005%2F&O=pcaxis&N=&L=0
http://www.ine.es/prensa/np398.pdf

Equally, the Minister of Health and Commerce presents relevant statistics annually in the National Health Survey *(Encuesta Nacional de Salud)*, in the Spanish Drug Observatory (Observatorio Español sobre Drogas) and in Epidemic Watch (Vigilancia Epidemiológica), but there is nothing specific to the homeless in any of these studies.

6.2. Are you aware of any scientific studies on the topic of the healthcare of the homeless? (From the government, NGO's, scientific papers, etc.).

There are very few scientific studies that deal exclusively with the issue of healthcare for the homeless. On the other hand, there are studies that deal more broadly with the situation of the homeless. For example, "A Room and a Future: A Manual of Good Practice in Social Intervention with the Homeless ("Un techo y un futuro. Manual de buenas prácticas de

intervención social con personas sin hogar [OSAPS]"). Telefonica Foundation (Fundación Telefónica).

Of the few studies that exist, some deserve attention:

- Research from D. Manuel Muñoz López of the Department of Psychology at the Compultense University in Madrid. "Without a Home" Project*: Psychosocial factors among the People without a Home (1992-2003)*. Financing: National R&D Plan; Autonomous Community of Madrid; European Union (Programas Pobreza-3; Leonardo; DG5).

- MUÑOZ, M., VÁZQUEZ, C., VÁZQUEZ J. (2002): The Limits of Exclusion: A Study of Economic, Psychosocial and Health Factors that Affect the Homeless of Madrid *(Los límites de la exclusión: estudio sobre los factores económicos, psicosociales y de salud que afectan a las personas sin hogar de Madrid).* Caja Madrid.

- JANSÀ, J.M., SÀNCHEZ, M (1999): The Health of the Homeless Population in the City of Barcelona *(La salud de la població sense sostre a la ciutat de Barcelona)*, Municipal Institute of Public Health *(Institut Municipal de Salut Pública)*, Director of Social Affairs, City Council of Barcelona.

- The RAIS Foundation has published material to aid those professionals who work with the homeless to know how to detect various kinds of mental-health problems and how to act accordingly.

- ROMERO, M., RAMOS, M., MARCH, J.C.: Profile of Young Transients: Difficulty Using Social-Health Services and Suggestions for Improvements *(Perfil de los jóvenes transeúntes .Dificultades para la utilización de los servicios sociosanitarios y propuestas de mejora),* Andalusia School of Public Health *(Escuela Andaluza de Salud Pública)*. Granada.

Cáritas in Granada is carrying out an epidemiological study of lifestyles and substance consumption in an effort to find connections between individual life histories, histories of mental illness, drug addiction, dual pathologies and homelessness.

The inter-institutional group for working with the homeless in Valencia carried out a study based on data culled from several different associations regarding the mental health of the homeless.

6.4. Do you know if any of these indicators are used to gauge the effectiveness of policies or of the services in the following categories and if they could be used to gather information related to the health and welfare of the homeless?

- **Health factors, such as lifestyle and the abuse of drugs, alcohol or tobacco.**
- **Environment and health.**
- **Access to healthcare.**
- **Mental health.**

It is not know if in Spain any of these indicators are used.

At times the simple personal perception of one's own health is used as an indicator for establishing information about the health of an individual.

Do you think this model can work for the homeless?
As the INE survey showed, the subjective perception of one's state of health does no coincide with the real situation. Nonetheless, as RAIS (Madrid) points out, depending on the type of intervention with the homeless one is carrying out, there may be no other method if no other information is available.

6.5. Regarding housing, are you aware of any reports comparing the health situation of people who enjoy adequate housing and those who do not? Regarding employment, are you aware of any similar comparisons between the health of the homeless or formerly homeless who have found employment and those who have not?

There is no report of this nature in Spain.

7. THE RIGHT TO HEALTHCARE

The right to healthcare is recognized by several international treaties. More information on this topic can be found in FEANTSA's report on the right to healthcare. Tackling the problem of inequality in the area of healthcare is one of the priorities on the European agenda. For this reason the issue of healthcare as it relates to the homeless could be a political tool of interest. The right to housing, to work and to necessary services is, in turn, reinforced by the right to enjoy good health and an optimal state of well being.

7.1. Are you aware of any cases in which the health of the homeless or other vulnerable groups played a role a legal case or a political campaign?

The Plan for Quality in the National Health System, *(Plan de Calidad del Sistema Nacional de Salud)* includes in the section PROMOTING EQUALITY, strategy 4, "to analyze healthcare policies and propose actions for reducing inequalities in healthcare with an emphasis on the inequality in cases of gender 1".

- Promote understanding of gender inequalities in healthcare and strengthen the focus on gender in healthcare policy and in the training of healthcare personnel.

- To encourage and spread an understanding of the inequalities in healthcare and encourage good practices in the promotion of equality in matters of healthcare and the reduction of inequalities in healthcare, thereby improving the attention given to members of the most disadvantaged groups who are at risk of exclusion.

This is the only reference in the entire Plan for Quality in the National Health System to the most disadvantaged groups.

7.2. Is the health of the homeless on the political agenda in Spain? Could it form a part of a campaign? Why? Why not?

Healthcare and the homeless are not topics on the political agenda in Spain. And that is not all. Cáritas Granada points out that there is a good deal of misunderstanding within mainstream society about just who the homeless are. In this regard, it should be noted that municipal administrations, which subsidize projects for the homeless, do not expand their services for this collective. What is more, from Granada it was noted that there is no state-wide policy regarding the homeless. If such policy existed, it would help to unify practices and establish a foundation for constructing a network of healthcare services for the homeless.

Most of the organizations expressed interest in promoting a campaign regarding healthcare and the homeless, since, they argue, with an example from Cáritas Solsona (Barcelona), that *if we live in a welfare state, people should enjoy the best state of health possible and efforts should be made to reduce inequality at all levels.*

Regarding the campaign, FACIAM (Madrid) points out that the health of the homeless is tightly bound to their other needs in other regards, and for this reason, as a start, efforts should be made to improve the quality of life of the homeless, which in itself would have a positive impact on their health.

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