**EAPN paper on the Access to Housing and Public Health Services**

***Template fiche for mapping national realities***

**Name of the person filling in the fiche:**

**National Network / European Organisation:**

1. ***What are the main obstacles facing people experiencing poverty and social exclusion in getting and retaining access to quality housing and public health services in your country?*** *(When assessing services listed below take in consideration different aspects of accessibility: affordability, geographical coverage, and factors of exclusion across different social groups).*
   1. ***Housing***

***EAPN Belgium****: There is a lack of rental houses, especially houses in good quality. This leads to incredible high prices to rent a quality accommodation.*

*There is a lot of discrimination, both against people experiencing poverty and migrants. Landlords refuse to accept people who depend on social benefits. (Or even only accept couples with 2 full time wages)*

*Prices are extremely high in Brussels (but also relatively high in other cities as Antwerp, Leuven,…)*

*The available houses are of bad quality (humid) and very inefficient in terms of energy consummation.*

***EAPN Finland****: Housing is expensive in bigger cities and that´s one of the biggest reasons for poverty in bigger cities. People are using so much money for housing, that they don´t have money for the rest of basic needs, and they need to go to « the food banks ».*

***EAPN Iceland:*** *There is a lack of safe, cheap housing, whether to rent or to buy, so low-income families and individuals, do not have access to good quality housing at an affordable price.Due to the lack of rental housing, second-rate and insanitary apartments are rented at extremely high prices.*

*People have no savings. Therefor they can´t buy their own homes, because they don´t have enough money for the down payment, even though the installment of the loan may be lower than the rental price they are paying. On the rental market, one has to pay a deposit equivalent of three month´s rent and people don´t have that money. Many don´t pass the bank´s credit rating for loans, so their position is hopeless.*

*Some people don´t know of or utilize the services that are available such as housing benefits that you can apply to the municipalities.*

**EAPN Ireland**

The main obstacle for many people on low incomes in accessing quality housing is affordability. In Ireland this is currently very much linked to the lack of availability of housing, both private and public, which is pushing up rents. The state has reduced its stock of public housing and over the past number of years has been providing housing supports for those on low incomes to rent in the private market. As rents have increased the state’s Rent Supplement support has not, pricing those dependent on this payment, and many others on low income, out of the market. This coupled with a decrease in supply in the private rented sector has led to growing numbers ending up homeless. About 80,000 people or one third of all those receiving state social housing provision and support are on Rent Supplement

Much of the existing social housing stock is also run down and in need of renovation. Some of this is taking place but much of the redevelopment was put on hold when the housing market collapsed in 2007/2008 as it was part of a public private partnership arrangements and private property developers pulled out at the time. Some of these have restarted.

***EAPN Latvia:*** *Limited access to housing for persons experiencing powerty, but very much housing stay empty in cities and rural area. No intention to rent, because of low property tax and no empty property taxa t all. No information for persons experiencing powerty about rent compensation via municipalities.*

***EAPN Norway:*** *Public housing has in a large extent been privatized by the municipalities during the last 15 years. Public regulation of rental prices in older flats ended 5 years ago and even public housing costs as much as in the private tennant market.*

*Weak accessibility and affordability is a problem. In the big cities is the provision of social housing too low in relative to the need. There are 5500 homeless people in Norway and the figures are stable. The municipal housing policy is bad especially in the capital Oslo. It must end to withdraw the proceeds of the municipal undertaking Boligbygg until maintenance backlog is taken again. The result today is that housing is not maintained and the standard is poor.*

***EAPN Portugal****: Poverty and social exclusion: According to last data of Statistics Portugal 27.5% of the Portuguese population was living in poverty and social exclusion and 10.6% were in severe material deprivation. According to FEANTSA Portugal was one the countries where, since the crisis, the proportion of disposable income spent on housing for poor households has increased most ; Portugal was one of the five countries where the percentage of poor households facing cost overburden has increased by more than 10 points since 2008. The same report highlighted that perhaps the presence of International institutions in some of these countries (Portugal was one of them) contributed to the worsening of inequality; In Portugal, Spain, Greece, Italy and Bulgaria, a “share of poor households are living in zones of average to low density; Within poor households, Portugal has the 4th place among Member States that have difficulties in maintaining the temperature of housing; also in Portugal, one in three of poor households live in damp conditions (in Europe is one in four); Portugal is also one of the countries where the general satisfaction with regards to housing is weakest. According to Eurostat “on a scale from 0 (“not satisfied at all”) to 10 (“fully satisfied”, EU residents aged 16 and over rated their satisfaction with accommodation at 7.5”. Portugal was 7.3/10 (2013).*

*In terms of groups we highlight in this point the situation of homeless people: the same report of FEANTSA indicates that “according to NGOs reports in Spain, Greece and Portugal, there has been a 25% to 30% increase in demand for homeless services in the aftermath of the crisis”. According to Statistics Portugal there were 696 homeless people (2011), but it’s important to highlight, like FEANTSAs report says “the available statistics underestimates the number of homeless people” and Portugal is one of the countries where this is a fact because in the last census they did not use the national concept of homelessness. For example, according to the Planning and Intervention Group for Homeless People living in Oporto City (NPISA Porto) it was identified 2500 homeless people only in Oporto city and we do not have the number of homeless people in Lisbon, where the phenomenon as also a great incidence. Even the official numbers are not the same: this year, 816 homeless people were identified in Lisbon by an official state organization.*

*Unemployment: unemployment rate is being decreasing since 2013. The last data reveals that in the third quarter of 2015 the unemployment rate was 11.9% (for the same period in 2014 it was 13.1%).*

*Youth unemployment is significantly high, but is also decreasing (32.2% in 3rd quarter of 2014 to 30.8% in the 3rd quarter of 2015). The same is happening for long term unemployment: 7.5% of population with 14 years and more, available to work, in the 3rd quarter of 2015 was in LTU. Less 1.3pp than 2014 (8.8%). Portugal was one of the countries in which young people were not inclined to leave parental home until the age of 28. In 2011, according to Eurostat Portugal was one of the countries (5th place) where young people with ages between 25 and 34 were living at parental home. The extension of studies, the unemployment and the difficulty to have sufficient money (financial independence) to pay a rent can explain this situation. According to Eurostat , “in 2014 in the EU, 17.1% of the population were living in overcrowded households, meaning they had a lack of space given the size of the household”. For Portugal the percentage was 10.3% (2014).*

*In terms of unemployment is also important to say that Portugal faced a period of high unemployment and many families found themselves in serious difficulties to pay their daily expenses. Housing included. Associated to this, there was the situation of over indebtedness. Many families had different loans, one of them to housing. With unemployment and indebtedness the impact in supporting housing costs was quite high. According to last national data (Portugal Bank), the number of people who overdue the credit payment decreased for the second consecutive quarter. In March it reached a maximum peak of 6 years (154 000). In the third quarter, 149 000 families were in default of paying house credit. Of the 2 292.924 families with housing loans granted by the banks, 6.5% were overdue. According to Eurostat , “in 2014, the housing cost overburdenwas by far the highest in Greece, where 40.7% of the population were living in a household where total housing costs represented more than 40% of total disposable household income”. In Portugal, we have assisted in these last years, to an increasing of the housing cost overburden:*

*PT EU*

*2014 9.2% 11.4%*

*2013 8.3% 11.0%*

*2012 8.3% 10.8%*

*2011 7.2% 11.3%*

*2010 4.2% 10.7%*

*Source: Eurostat (Code: tessi163)*

*Discrimination: this obstacle is quite significant when we take in consideration the exclusion of certain groups in access to housing, like Roma communities and Immigrants. “Although, many Roma families live in urban contexts in social/municipal quarters for social disadvantaged people, some Roma communities still live in poor housing conditions and sub-standard housing which worsen their social exclusion situation. According to available data ], 16%\* of the Portuguese Roma live in precarious housing, most of them living in rural areas, facing several problems namely the lack of potable water for domestic use, the non-existence of a proper sewerage system, etc. In fact, there is still Roma people living in “Roma settlements”, in geographical segregated places or even located near dump sites or industrial areas in the cities’ outskirts. These situations may originate environmental and public health problems on one side, but also produce strong prejudices and stereotypes that tend to pose difficulties in the access to rights and services and, therefore maintain them in vulnerability and exclusion.”*

*The situation for immigrants, especially those that are in an illegal situation, is quite vulnerable in what concerns the access to an adequate house. Discrimination is also an obstacle to these groups and sometimes forwards them to houses with higher rents, or are forced into overcrowded houses with poor living conditions.*

*High costs of housing: According to Statistics Portugal, in 2011, “the majority of normal residence housing, 73% is occupied by the owner. Rented houses represent less than 1/5, with approximately 20%, while the remaining situations, such as loans/concessions are 6.8%” . According to Eurostat , “A majority of people in the EU were owners of their dwellings, with over two-thirds (70.1%) of the population living in owner-occupied dwellings, while 29.9% were renting their dwelling”. For Portugal those percentages were 74.9% and 25.1%.*

*People living in poverty and social exclusion have high difficulties to access to private housing market, and even to rent a house with an affordable price. To rent a house in Portugal, generally, is required a guarantor and this is a major problem for people living in poverty and social exclusion. These people have also a major difficulty to pay the current expenses of a house, like energy, water...*

*According to Statistics Portugal in 2014 the median burden spending on housing was 13.4%. The highest value of the last 10 years. 9.2% lived in households with overburden of housing expenses (+ 2.0 pp more than in 2011); 10.3% of people were living with insufficient living space (2014); and 5.5% of people were confronted with severe conditions of housing deprivation (2014).*

***EAPN Slovakia:*** *The main obstacles are the small income or salary.*

***EAPN Sweden:*** *Lack of afforable housing.*

*Problems of beeing acepted as tenent due to debts or other economic reasons*

*To little options to rent instead of bying housing*

***EAPN UK****: Housing demand is rising due to population increase, a big factor in which is net migration. In the calendar year to May 2015 net migration was 318,000 (641,000 people immigrated in 2014 and 323,000 emigrated). Changes in household structure are leading to an increase in small and single person households, increasing the total housing demand for a given population. Another important and related factor is demographic ageing, including increased life expectancy which is running significantly ahead of healthy life expectancy, especially in poorer areas and for low-income people. There is an increase in numbers of people living in the community with chronic ill-health or disability who require suitable or adapted or supported housing at a price they can afford.*

*Housing tenure is changing rapidly. In England, home ownership is at 65%, a twenty-year low. More people now rent privately than from social landlords: there are 4 million households renting privately and 3.7 million renting from social landlords. The proportion of people in social rented housing has fallen from 31.4% in 1980 to 16.8% today (18% are private renters). While the trend is most evident in England the direction of travel is the same in the other three nations and regions of the UK. In Scotland private renting has doubled in ten years. People who rent privately pay about double what is paid by social housing renters, but twice as many live in homes that the government classes as “non-decent” (in disrepair or not meeting health and safety standards). High house price inflation, stagnant earnings and a rise in low-income jobs have driven people into the rental market, where rents are rising rapidly. 32% of working households who are social renters require help with their rent payment (“Housing Benefit”), up from 20% in 201o. 12% of private renters also require help (up from 9% in 2010) – which is currently less generous than for social housing tenants, but that will shortly change, as the government is putting help for social housing tenants onto the same less generous terms as private renters.*

*Thus the main obstacle facing low-income or socially vulnerable people is inadequate supply of affordable, quality, accessible housing, especially social rental housing.*

*Key aspects of inadequate supply are:*

*1. Overall fall in housebuilding of any tenure including for purchase, although the population is rising. Close to 140,000 units were built last year, an increase on previous years, but this is compared to the 250,000-plus most experts say is required annually. From the 1950s to the 1970s, 200,000 houses were built annually.*

*2. Rapid fall in the number of social houses at subsidised rent available from local authorities, who are legally bound to prioritise need, according to a number of criteria. Council (i.e. local authority) house-building declined precipitously from around 1980 and yet again in 1990 and 2000. In 2014-15 just 1890 council houses were started in England and 1190 in Scotland. In the same year 12,304 houses were sold off in England. The introduction of “right to buy” under Mrs. Thatcher meant a significant proportion of existing stock was sold off to sitting tenants at a discount. Between 1980 and 2013, more than 2.5 million houses were sold off in Great Britain. At first, local authorities could use capital receipts to finance new build, but restrictions were introduced in the mid-1980s and by 1990 local authorities could retain only 25% of receipts, leading to a large decline in social house-building. Right-to-buy sales had declined greatly in recent years as house prices rose, discounts reduced in value and more attractive stock had already been sold. In 2012 and 2013 the Coalition government increased discounts - up to £100,000 in London, and the new majority Conservative government is further reinvigorating right-to-buy with a shorter qualifying period to access the scheme.*

*3. Since 2010, total social house-building completions (local authority plus not-for-profit Housing Associations) have been around 30,000 per year.*

*4. There has been a change in the mix of social rental housing so that by 2011 more than half of social rental tenancies were provided by not-for-profit Housing Associations, (funded significantly by central government) often at higher, but still subsidized, rent and often with different requirements for access, but still related to need. Housing Associations now house about 8% of the population.*

*5. Increase in numbers of low-income people in private for-profit rental accommodation, including families. About 4 million households are private renters. Table 3 in Adams et al shows that average English weekly rents in private accommodation in 2015 are £172 (range £118 in the North-East region to £267 in London), compared to £96 in social rental accommodation (range £80 in the North-West to £123 in London).*

*6. Rapid fall in the proportion of young adults able to buy housing and therefore additional pressure on the rental market. Compared to twenty years ago, only half as many people aged in their twenties are home-owners. First-time buyer house prices are five times average earnings.*

*7. Years of rent increases, often above retail price inflation and earnings, in all types of rental housing. Private renters in the bottom fifth of the income distribution spend the highest proportion of their income on housing costs. Although rents in the private sector are higher, in recent years, social rents have increased more rapidly. Average rents in England are higher than average mortgage payments.*

* 1. ***Health services***

***EAPN Belgium****: A lot of people experiencing poverty postpone medical care because of financial reasons. Administrative thresholds: without the necessary documents, (ID card), it’s very hard to get access to health services. This is problematic for more and more people (not only homeless people & undocumented migrants, but also several other people experiencing poverty don’t have an ID card any more, for several reasons, amongst which the price of a new ID card).*

***EAPN Finland:*** *Health services has been seggregating in recent decades. Finland have public health services system, but also private or semi-private sector, which has been getting bigger. People who have jobs can go to the « job health services » and they are mainly public substituted for the employers. Some « job health services » are public, but private and multinational companies has started to offer these as well. Also people are started to take private insurances as well and to use private services. All of this has affect so, that private sector has been getting bigger (with healthier and wealthier « patients ») and public sector has started to struggle with not so much resources and sicker and poorer patients. In some communes, they have privatised the whole health servises because of this.*

*Main obstacles is seggregation of services and bigger lines and waiting times for poorer people in public services.*

***EAPN Iceland:*** *Low-income families and individuals, have less access to healthcare because there have been increased costs for individuals in health care system.*

*Ambulatory resources are being used more frequently, but it costs more for the patient than admission.*

*The state has reduced health care services in rural areas and the people need to go to the capital Reykjavik and only get a fraction of the travellig cost paid by the state.*

***EAPN Ireland***

**The following is a description of the Health System in Ireland**

* Ireland has a two tier health system. Many people have private health insurance (about 43.8% of the population) while another large percentage have medical cards ( about 40% in January 2014). The rest of the population pay for care at point of access as they go. Those with private health insurance get faster access to diagnosis and treatment as they pay for access to consultants instead of joining a waiting list in the public health system preferential treatment in the system. Currently there are extensive waiting lists for treatment in almost all areas of medical care and those with health insurance get priority. This means that the health system in Ireland is based on a fundamental inequality. It is predicated on income as those with income which allows them to purchase private health insurance get quicker access. This system is not based on equal access to equal care based on need.
* For those on lower incomes there are medical cards which are means tested based on family income. This permits the holders to free medical care, apart from the recently introduced charges for prescriptions. For those on a slightly higher income bracket there are GP (Doctor) Visit Cards which allow people to visit their doctor for free (The usual cost of a visit to doctors is €50-€55 or higher)For those over 70 years there are higher means test levels. People/families experiencing hardship, with incomes above the income thresholds but with high costs, can also apply for medical cards or GP Visit cards. This hardship may be caused by medical or health costs. These are popularly known as discretionary medical cards. On 1st January 2014 about 40% of the population had medical cards and almost 9% GP Visit Cards but the number of GP visit cards will have grown under new schemes introduced in 2014 and 2015.
* In 2014/2015 the Government also introduced GP Visit Cards for all children under 6 years and people over 70 years, irrespective of a family’s income. Budget 2016 has expanded this scheme to give free GP cards for all children under 12 years but this is subject to negotiations with the Irish Medical Organisation. Progress is likely to be slow..
* For non-medical card holders it costs on average €50–€55 for a visit to the Doctor (General Practitioner), and they must also then pay market prices, above the European average cost, for prescriptions.
* Up until 2010 there were no prescription charges for people on medical cards. However as part of austerity measures, with limited exceptions, a new €0.50 prescription charge was introduced in 2010 on each item that is dispensed under the medical card scheme. This increased to €1.50 in 2013 and €2.50 in 2014. There is a monthly cap on the total charges a family has to pay which also rose from €10 in 2010 to €19.50 in 2013 and €25 in 2014. This has a direct impact on the disposable income of those on the lowest incomes and has meant that some people are choosing to go without their medication or to take shortcuts with their treatment. Research has shown that it is cohorts with complex needs and multiple problems such as elderly, those with chemical addictions and mental health issues who are most likely to be less compliant with medication. This can lead to admission into Accident and Emergency units when their conditions become chronic resulting in poor use of very scarce resources.

**Health Inequalities**

Ireland’s two tier health service, which gives priority to those with health insurance, results in income related health inequalities due to the fact that all but the poorest pay for health care at point of use. Those on the lowest incomes have the worst health outcomes, status, morbidity and mortality and are dependent on public health services which involve long waiting times for often explicitly rationed services. These long waiting times delay diagnosis and treatment and perpetuate the steep social gradient of the health inequalities.

In 2011 the Institute of Public Health in Ireland estimated that eliminating socio-economic mortality differentials in Ireland would mean over 13.5 million extra years of life for the Irish population.

The analysis of Ireland’s 2006 Census by the Central Statistics Office demonstrated the link between deprivation and life expectancy. It found the affluence of the area of residence to be the strongest predictor of shorter life expectancy for both men and women. Men living in the poorest areas lived four-and-a-half years less (73.5 years) than men who lived in the most affluent areas (78 years). Women living in the poorest areas had a life expectancy of 80, and those in the wealthiest had a life expectancy of 82.7 years.

**Medical cards**

The medical card system has shown itself to be unfit for purpose with anomalies, discrepancies and errors in administration which have resulted in people in both income and medical need not getting a medical card and therefore not being able to access to primary care.

**An** **over focus on cost effectiveness** ignores many of the long term unintended consequences of deterioration in health caused by reduction and rationing of access to public health services. It is essential that any cost-effectiveness and savings does not result in making health services less accessible or effective by displacing costs to other government departments or individuals, or passing costs around health services.

***EAPN Latvia:*** *Very small part of medical services and for short term and for very limited quantity of persons are free of charge. Big queues. Very limited access to prevention what create hard diagnoses discovered afterwards.*

***EAPN Norway:*** *Hospital services are of good quality. National health services are generally of good quality. The problem is when the municipalities take over the services because of health reform programs. Especially in the field of substance abuse and psychiatric aftercare which is often a municipal responsibility is quality deficient. Money which the government contributes to the municipalities is provided as general allocation without earmarking for this purpose. Only 3 percent of frame allocations are earmarked. Therefore, the priorities from one municipality to another very different and depends on where you live. Regarding dental health it’s in generally not affordable for poor people. Only a few diagnoses are covered by the public health system and you have to belong to special groups with special diagnoses to get some reimbursement from The Norwegian Health Economics Administration (HELFO).*

**EAPN Portugal**

**National and geographical coverage of National Health System**:

According to the Portuguese Observatory of Health Systems, Portugal has a total number of physicians (in public and private sector) per 1000 inhabitants higher than the average of OECD. It’s the forth country with higher number of physicians, but Portugal also has one of the biggest inequalities in the geographical distribution of them. There are 5.1 physicians per 1000 inhabitants in urban areas and 2.2 physicians per 1000 inhabitants in rural areas.

There is no available data on the geographical distribution of the physicians working in the National Health System (NHS), but it is important to highlight that the density of physicians working in the NHS is only 1.87 per 1000 inhabitants, in 2013, and there was a decrease in relation to 2012 (1.89). Another important aspect is the close down of some health services, such as emergency services and obstetrics and neonatology department. Some of these closures occurred at urban cities, where there are multiples services, but there were also many services that have been closed at rural areas. It was defined that until the end of 2015, 25 childbirth services in hospitals should be closed down, concentrating the remaining childbirth services in 8 districts (the Portuguese continental land has 18 districts) (Jornal Médico, de 2 de Maio de 2014 <http://www.jornalmedico.pt/2014/05/02/reforma-hospitalar-impoe-o-encerramento-de-centenas-de-servicos/>)

The access of the health services in rural areas is hindered by the weak public transport system. Also the transport of patients in need of non-urgent healthcare (transport for medical appointment or treatment) had a cut of 1/3 in its costs due to the negotiation with troika.

Another important data on the access to National Health Services is the decrease in the number of hospital beds. According to Eurostat data, in 2008 there has 26,368 beds in public hospitals and in 2013 there was 1,339 beds fewer. On the other side, the hospital beds in the private hospitals have been increased. In 2008, there were 2,845 beds in for-profit private hospitals and 6,590 in not-for-profit hospitals. In 2013, there were more 583 beds in for-profit hospitals and more 456 beds in not-for-profit hospitals.

According to the Portuguese Observatory of Health Systems, it is estimated that 15% of the Portuguese population doesn’t have family doctor, what puts even greater pressure on emergency services. But, on the other side, since 2010 there is a decrease on the access to the emergency services. If it is true that part of the people that go to emergency services are not in an emergency situation, it is also true that the decrease in the access to emergency services was not compensated by an increase in primary health services. It is also important to highlight that, with the austerity measures, user charges have increased significantly in Portugal. The Portuguese Observatory of Health Systems also states that the number of doctor consultation has been decreasing.

According to Portuguese Observatory of Health Systems, Portugal has one of the highest prevalence of mental disorder. Despite the fact, the State’s expenditure on Mental Health services is very low. In 2007, the National Committee of the Coordination Mental Health identified serious shortcomings in mental health services in terms of access, equity and quality of services.

The oral health care is another sector with high deficient access. The almost inexistence of dentists in the public health services leaded to the creation of a dentist-cheque program. But this programme does not allow to a widespread access to this kind of health services. The social groups that can access to this programme are children (under 18), pregnant women, elderly and HIV/AIDS patients.

**Affordability**

The Eurostat data on self-reported unmet needs for medical examination shows an important increase in this self-assessment. In 2008, 1.1% of the population self-reported unmet needs, less 1.9 percentage points than 2013. The unmet needs for medical examination due to economic reasons (it is too expensive) if reported by 2.4% of population and 4.2% of the population in the first quintile of the equivalised income (more 2 percentage points in comparison with 2008).

In 2011, Portugal faced a high increase in the user charges. A doctor consultancy in a health centre increased from 2.25€ to 5€. The emergency services in hospital had an increase from 9.60€ to 20€.

These increases are one of the reasons why Portugal raised from the 6th country with higher out-of-pocket health expenditure, in 2007, to the 4th position in 2012. Other reasons are related with the changes in personal income tax and the decrease in the access to non-emergency transport. It means that the population started to pay more for health services at the same time that the medium income of the population decreased due to economic crises.

On the positive side, is important to highlight that since 2015, all children (under 18 years) became exempt from the user charge. Another positive aspect was a higher prescription of generic drugs, decreasing the cost of medicine.

**Factors of exclusion across different social groups**

The communication and literacy are important barriers in the access to quality health services. There is difficulty in communication of some groups (such as elderly, people with low qualifications, immigrant population, ethnic minorities) with the health professionals and administrative personnel with impacts in the access to the services or the correct maintenance of treatments/services.

The Ordinance No. 25.360/2001 of 12th of December determines that foreigner citizens legally residing in Portugal have access to health care and medicine assistance in equal treatment with Portuguese citizens. In relation to undocumented immigrants, the national health services (SNS) cannot deny their access to health care. However, to have access to SNS user number/card these immigrants should ask for a residence certificate in their parish councils, proving that live in Portugal for more than 90 days (should present two witnesses). Without the NHS user card, the undocumented immigrants must pay for all health services provided. The undocumented minors, on the other hand, have the same rights as the minors with legal residence in Portugal: children under 13 years old have free access to health services. Although Portuguese law provides a good access to health care to undocumented foreigner, the lack of knowledge of the law by the administrative staff of some services and the fear of complaint of being arrested or of being expelled by these foreigners, are barriers in the access to health services by undocumented migrants (Médecins du Monde, 2006).

For the homeless people, the lack of documentation is also a barrier in accessing health services, together with lack of economic income to access to the medicine and continue the treatment, and the feeling of discrimination. The access of the homeless people to health services is made often in emergency situations. (<http://repositorio-cientifico.uatlantica.pt/jspui/bitstream/10884/916/1/Monografia%20FINAL-Tiago%20Fatia.pdf>)

Cultural aspects also have an impact in the access to health services. Inside Roma communities, for example, it is not perceived the importance of accessing to preventive health and the access to health services is made mostly in emergency situations. (Vicente, 2009).

***EAPN Slovakia:*** *The public heath services are concentrated in the town or in the central village. The people experiencing poverty and social exclusion have small income or salary, so they have not enough money for the transport.*

***EAPN Sweden****: Uneaqual distribution of health.More acsses in well established and urban areas*

1. ***What are the main causes for limited access and exclusion from quality, affordable housing and public health services in your country?***

***Housing:***

***EAPN Belgium:***

* *Lack of social houses*
* *During many years, housing politics were focused on supporting house owners (tax measures, energy measures,…) and not tenants*

***EAPN Finland:*** *Main reason are high rents and not enough building of social and cheap houses, Finland would need more social investments for social housing.*

***EAPN Iceland****: Lack of rental housing resulting in rising rent prices.*

*The lack of social housing.*

**EAPN Ireland**: Traditionally Ireland has a high level of home ownership rather than rental. From the late 1990’s until 2007 however house prices rose dramatically with many people borrowing very heavily from financial institutions to pay for these, with some getting mortgages in excess of 100% of the value of their homes. When the financial crisis hit in 2007 house prices plummeted as did people’s incomes, with many people also losing their jobs. This meant that people were left with unsustainable mortgages. Initially the Government moved to prevent financial institutions from repossessing houses and eventually put in place the Personal Insolvency Service in 2012 so that people in difficulty with debt could negotiate with their lender. However while there were few repossessions earlier in the crisis this has increased, alongside increases in house prices, particularly in Dublin, other cities and their surrounding areas. In 2014 14.5% of all residential mortgages were in arrears and there were 1,063 house repossessions, either voluntary or granted by the courts. Repossessions are likely to increase in 2015. At the end of June 2015, lenders had 1,825 residential properties in their possession[[1]](#footnote-1).

For those on the lowest incomes the states provides social housing through local authorities and to a lesser extent through housing associations. However, in recent years the stock of social houses has been depleted with very few new social houses being built in the past seven years in particular and tenants allowed to purchase their homes at reduced rates below the market value. Instead of investing in a stock of social housing, and repairing the existing stock, the focus has been on providing housing supports so that families can rent from private landlords. There is currently about 90,000 people on the social housing waiting list of local authorities. 75% of those who qualified for social housing were living in the private rented sector. 42,109 with rent supplement and 24,774 without rent supplement[[2]](#footnote-2)

Alongside the lack of social housing there is also a shortage of housing generally. This is due to the collapse of the housing market during the crisis resulting in few house completions and an increased dependency on the private rental market. The increased demand for renting has meant that rents have increased pushing out those on low incomes, including those on housing supports. This is particularly acute in Dublin and in other urban centres but is now beginning to spread to other areas of the country.

The majority of people who are traditionally homeless are in this situation because they face a wide range of problems. Many of these relate to addiction and mental health, family conflict etc, with a number who are homeless because they simply cannot afford any suitable accommodation. Currently, however there are a rapidly growing number of people, including whole families who are homeless because they cannot afford a home and state’s Rent Supplement levels, which support people to rent from private landlords, is not sufficient to cover the cost of rent in many areas, particularly in Dublin.

In Dublin rents increased by up to 30% in the last three years and increased by over 20% nationwide from July 2013 to July 2015. However, Rent Supplement levels, which vary from region to region, have not increased in that time. (Approximately 4,000 recipients have had their Rent Supplement level increased on an individualised basis). While it is not supposed to happen, many recipients on Rent Supplement are topping up their rents with their social welfare payments and going without other needs.

Many landlords will also not consider taking tenants on Rent Supplement.

**Large Social housing developments**: This varies from place to place. The majority of social housing tenants in Ireland live in large social housing developments. Many of these developments face a range of issues such as poor access to services, high unemployment levels, anti-social behaviour and high drug usage. Residents in many also face a stigma when accessing services and looking for jobs, which further compounds their situation.

**Traveller Community**

The issue of appropriate and adequate accommodation has been an issue for Travellers for many decades. Many Travellers prefer to live in Traveller specific accommodation with their extended families in halting sites (serviced sites with caravans or mobile homes) or in group housing schemes. All local authorities are obliged to draw up 5 year Traveller Accommodation Plans to reflect the needs of all Traveller families in their area. However, many Travellers find their preference for Traveller specific accommodation is not respected with many being forced to accept into local authority housing if they want to be accommodated. There is a high level of discrimination and resistance at local level to the provision of Traveller specific accommodation and despite the budget being made available from central government to local authorities to build Traveller accommodation, the vast majority of it goes unspent.

There are approximately 4,500 Traveller families in Ireland and according to a count by local authorities in 2014 there are 1,536 Traveller families living in overcrowded or unsafe conditions. This includes 445 on the side of the road, 104 on basic services sites, 223 sharing halting site bays, 37 sharing basic site bays and 727 sharing houses.

In September 2015 a fire in one of these temporary services sited in Dublin resulted in the deaths of ten people, including five children.

***EAPN Latvia:*** *No information how to get municipal reimbursement of rent to persons in powerty, loyal legislation to empty buildings owners, no extra taxes.*

***EAPN Norway:*** *Housing policies have been week. Total number of municipal disposed dwellings are less than 5 percent.*

**EAPN Portugal**: This is quite related to the obstacles. In the previous question is already visible some of the causes for the limited access and exclusion to an adequate housing. It’s important to highlight that the period of crises and the existence of an Economic and Adjustment Programme (together with strong austerity measures) contributed to the deterioration of people living conditions. According to the Report Social Housing in the EU[[3]](#footnote-3) the crisis “has worsened the socio-economic conditions of an increasing share of the population, leading to higher demand for affordable housing and social allowances in the majority of European countries”. Like it was explained, poverty and social exclusion increased at national level. The same for unemployment rate. Both situations contributed to greater difficulty of families in paying their housing loans. Banks put more restrictions on lending, which lead to a considerable increase in looking for houses to rent.

***EAPN Slovakia:*** *In Slovakia 90,3 % of the populations are the owners of their dwellings. There are small amount of the tenant dwellings and there is the long waiting time to accessing it. The tenant dwellings are overcrowded.*

*The people experiencing poverty and social exclusion with their small income or salary cannot afford to buy the flat or house and they also have not enough money to pay the rent for the commercial dwellings.*

*In the villages are the problems with the owners of the lands. The lands belongs to more small owners. There are the problems with the settlement of these lands. The municipalities have not money to fund the process of the settlement and for the purchase of the land from the owners.*

*The municipalities have the small budget, it depends from the amount of the inhabitants. The municipalities do not want to go to the dept.*

***EAPN Sweden:*** *To expensive houses and to high rents which gives to limited access to by or rent housing*

*To high demands on byers and tenants regarding income, having an secure employment with acceptable income, demands for paying big money in advance and not having any misbehavior in paying debts.*

*Your social situation and problems ( big families, mental or abuse problems etc)can also lead to that you are not accepted as a tenant.*

***EAPN UK****: The main causes are:*

*1. The housing policy framework has shifted in the 21c and shifted dramatically in the last five years.*

*2. There have been two big ideological changes in housing policy:*

*a. the shift from subsidizing ‘bricks and mortar’ (provision of dwellings) to subsidizing people through the tax and benefits system, which essentially subsidises rents paid to landlords*

*b. the reduction in the role of local authorities (municipalities) in housing provision for low-income people and greater reliance on private sector provision and other tenures.*

*3. The government’s post-financial crisis ‘austerity’ strategy combined with a Conservative aspiration to shrink and reshape the state by 2020 have driven the recent policy context, including spending cuts and changes in spending distribution and in the legal capacity of various actors in housing provision.*

*4. Housing affordability has worsened significantly, with knock-on effects on government social budgets that subsidise incomes and rents. Generally, real wages fell after the financial crisis and were then stagnant. Real wages have only begun to rise again in the last 1-2 years. Low-paid work is an increasing proportion of new jobs. The bill for ‘tax credits’ which top-up low incomes from paid work, rose dramatically. State-provided minimum incomes for working-age people who are not in paid work (“welfare benefits” such as job-seekers’ allowance and employment and support allowance) did not fall in the crisis, but have since been cut. The bill for Housing Benefit, which subsidises rents, also rose dramatically. It is now £25 billion per annum and has been one of the fastest growing elements of the welfare state.*

***Public health services:***

***EAPN Belgium****: Budgetary considerations often prioritized over health/welfare considerations.*

***EAPN Finland:*** *Not enough resources in every commune.*

***EAPN Iceland:*** *There have been increased costs for individuals in public health care system and there has been increased privatization of health care. Services are not applied because people can´t afford them. People have to choose between releasing their medications or buying food.*

*There is lack of general practitioners. Psychologists are not a part of the public health care system, so their services are very expensive.*

*Some aspects of the service are only available in Reykjavík. The population is small (320.000) and villages and towns are scattered around the country. Traveling is expensive and only a small portion of the travel expenses are paid by the state.*

*There have been significant cuts in public health care. Expenses increasingly passed on to patients / those who use the service.*

*People can not afford to go to the dentist, their service must be paid in full, but then there is such a small part refunded (for people with disabilities).*

**EAPN Ireland**: As stated above the Irish health system is fundamentally unequal where those on the lowest incomes have the worst health outcomes, status, morbidity and mortality and are dependent on public health services which involve long waiting times for often explicitly rationed services. These long waiting times delay diagnosis and treatment and perpetuate the steep social gradient of the health inequalities.

Those with private health insurance get priority in the Irish health system.

Despite Ireland being a low spending country compared to the EU average it has about average spending in the area of health. Although this is not to say that funding is adequate. However, during the crisis there was a reduction in expenditure on health (over 6% between 2009 and 2011). Some of this was due to reduced wages and cost of pharmaceuticals. However a key focus for Ireland is still where it focuses its spending. For example, Ireland has a very under-resourced primary, community and continuing care sector. Focusing greater resources on these areas would be more effective in responding to the health needs of communities, particularly those who are most vulnerable while also addressing prevention. There has been a welcome investment in Primary Health Care Centres over the past number of years but many are still under-resourced in terms of the coverage of medical specialities.

However, the low tax-take (10% below the EU average) and spend (39% of GDP compared to an EU average of 48.9%) on public services and social protection generally results in inequality, poverty and social exclusion and has a direct impact on health outcomes for those who most depend on them.

In the past seven years poverty has increased with material deprivation growing from 13.7% in 2008 to over 30% in 2013. Apart from unemployment and reductions in pay this was caused by cuts to welfare supports as part of austerity measures. Living in enforced deprivation has a direct impact on people’s mental and physical health.

***EAPN Latvia:*** *Private medicine based on State Hospitals and state bought equipment, usage of State infrastructure. Same personnel works in both.*

***EAPN Norway:*** *Dental Health: Dental health in general have been seen as a private responsibility and not a part of a body approach from the politicians. It’s mainly not a part of the public health system when you have passed 18 years of age.*

**EAPN Portugal**: Many of the causes are related with what was stressed in the answer to the previous question, such as deficit in the geographical coverage of National Health System, mainly in the rural areas; weak public transport system, specially outside the urban areas; low public expenditure in some medical specialties, such as mental and oral Health (low priority of these areas for the political decision-makers); the increase of the user charges and cuts in the public expenditure due to austerity measures and public deficit (in 2009, the health care expenditure by general government was 6.92% of GDP; in 2011, it was 6.33% - Eurostat data); the low qualification of part of population and literacy skills (or Portuguese proficiency in the case of migrant population) together with a difficulty for the medical professionals to make communication easier to understand.

In terms of some specific health services or medical specialties, the stigma and lack of knowledge also make difficult the access to services. This happens in terms of mental health services, for example.

***EAPN Slovakia****: The main causes are the small income or salary. The state pays the health insurance only for the people who are unemployment and registered at the Office of Labour, Social Affairs and Family or who have the income.*

*For those who are not registered on this office and who have not the income, the state did not pay the health insurance. If this aim group does not pay alone this health insurance they can allow only the basic health care.*

***EAPN Sweden****: Uequal distribution of healthservice.More acsses in well established and urban areas due to privatisation. The lokalisation of healthcarecenter is conected to how profitable the area is.*

*Acces to affordable medication is a problem. The limit for how much you have to pay beore you gete subsidies ar to high for man people.*

*Dental care are not included. This subsidies are even lower for that, which leaves many vunerable groups out of the possibilties to dental care.*

1. ***How do changes in accessibility and exclusion from housing and public health services affect the situation of poverty and social exclusion in your country?***

***Housing:***

***EAPN Belgium***

* *Because of the lack of affordable quality housing, several people (also families with children) are forced to live with a lot of people in bad quality, small places. This affects also their general situation: health problems, difficult environment for children and young people to study…)*
* *Some people and families end up living on the streets or “staying with friends”*

***EAPN Finland:*** *Expensive housing is reason for increasing poverty.*

***EAPN Iceland:*** *The lack of rental housing in the private market and social housing.*

**EAPN Ireland**: While those with unsustainable mortgages have been impacted on and many are losing their homes, the main issue is for those who cannot afford to rent on the private market and are now experiencing homelessness.

Between January and September 2015 the number of homeless families grew by 84% from 401 to 738 families. In September 2015 there were 4,999 people in homeless accommodation, including 1,570 children. In September 401 families in the Dublin region alone were accommodated in commercial hotels.

***EAPN Latvia:*** *Do inform about and do administration of rent and communal payments for persons in poverty by Municipalities. Do involve private house owners to create offer.*

***EAPN Norway:*** *Harder for people to move forward for employment. Dental health becomes a major problem when applying for jobs. Housing- high rents makes a lot of people working poor*

**EAPN Portugal**: With more restrictions to lending and overindebtedness of families, one of the things that we noticed in Portugal was that several families returned to their parents home, or pick their elderly family member, who was in a nursing home, in order to have his pension as a financial strengthening of the family budget. The Portuguese Association for Victim Support highlighted that this situation, together with unemployment, led to an increase of elder abuse.

Portugal is one of the countries characterized by a high rate of home ownerships and small rental sector. The rental market is limited, prices are high, and they require deposits and guarantees for the conclusion of a lease. These criteria contribute for the exclusion from housing of people living in poverty and social exclusion.

Another effect was visible in the increase of homeless people. NGOs, working with this group, highlighted, during the period of economic crises, an increase in the number of people requesting their services.

People living in poverty that are excluded from decent housing face other kind of problems and obstacles in the access to other services. For example: access to social protection – homeless people can’t access to social insertion income[[4]](#footnote-4) if they don’t have an address to receive this support. Sometimes homeless people have to use the address of the pension where they live or of the social services. In both cases people have to expose their private lives. Other example is related to Roma Communities: living in tents or in slums where there are poor housing conditions, without running water, without electricity, have a clear impact in health, in the labour market and even in school. For example, children without good conditions to study have more difficult to succeed in school; adults that don’t have conditions to have a proper hygiene will have more difficulties to go to a job interview.

By this way it’s clear that having good housing conditions it’s a step to the social inclusion of people living in poverty and social exclusion. Also, if the house is well located or with access to transports, for example, it will be an added value to guarantee their access to other important services.

***EAPN Slovakia:*** *The important factor is to support the accessing the dignity job with adequate salary or create the social environment to help the people in poverty and social exclusion to break out.*

***EAPN UK:*** *After the second World War, the state’s major role in house-building and subsidizing and regulating fair rents was a major factor in breaking the link between low incomes and multiple vulnerabilities to poverty and social exclusion as well as reducing the risks of inter-generational poverty and its consequences.*

*There are three core functions of social housing:*

*1. Subsidising rents for households in sufficient need*

*2. Subsidising or directly undertaking new housing construction*

*3. Enabling government to regulate and and/or directly provide landlord services.*

*Even if it were accessible to all, which it is not, home ownership is no guarantee against poverty, as people’s circumstances change. Over twenty years, home-owners have been more than half the people in poverty (before housing costs). The government has more or less withdrawn from social house-building. The social housing stocks sold off have not been replaced. Rent subsidies are being cut and security of tenure in social housing is being reduced. Since the deregulation of 1989, the government has little or no concept of ‘fair rents’ in the private sector. Yet private renting is in many cases no longer just a precursor to home ownership, but a life-long tenure. Thus risks of poverty and exclusion have increased, especially in an environment of high and rising house prices and a declining share of wages in national income.*

***Public health services:***

***EAPN Belgium****: Because people avoid to go to the doctor or to the hospital (because of financial reasons), their health situation deteriorates.*

***EAPN Finland:*** *Poor people don´t have so good services they would need in everywhere in Finland.*

***EAPN Iceland****: There has been significant cuts in health care. Expenses increasingly passed on to patients / those who use the service.*

**EAPN Ireland**: Answered under other headings

The issue of health prevention is crucial. For many this not only involves the health service alone but addressing the wide range of factors that can lead to bad health. This relates to accommodation, poverty, care, education, employment and access to public utilities. The negative health outcomes can be both physical and mental.

***EAPN Latvia:*** *Do separate private and public medicine as personnel, equipment and rooming.*

*Do vitally necessary examinations and treatment at public structures with state coverage, free of charge*

***EAPN Norway:*** *Dental health and lack of affordability to maintain the oral health make the way back to labor life harder to achieve because bad dental health makes it harder to do a good figure in the interviews by the employers.*

*Otherwise there occurs a localization reform for hospitals where a number of hospital departments centralized and residents get longer travel Accessible to essential services. Norway is geographically a large country and especially in rural areas is access to healthcare poorer because specialization functions in hospitals are centralized.*

**EAPN Portugal**: The close down of some health services, together with the close down of justice services and schools in some rural Municipalities, leads to close down of local satellite enterprises surrounding these public services and higher unemployment. In the medium term, it leads to a desertification of these areas and unequal opportunities for these populations.

At national level, although there was not an increase in the price of medicinal products, the cuts in some social benefits (i.e. Minimum Income system; unemployment benefit after 6 months), the increase of long term unemployment and impoverishment of part of population created some difficulty in buying medicinal products. Some EAPN Portugal’ members report the situation where families do not afford the acquisition of medicinal products, including for mental disease. The inadequate use of the medicine (or its lack) for mental health problems, has important impacts on the family relations (including the accompaniment of minors), as well as in the capability to enter again on the labor market.

Traditionally, in Portugal, the oral health is a luxury that part of the population doesn’t have access. Apart from the health impact, there is also consequences in the image of these persons (lack of teeth, for example) with an impact the way there are accepted by society (i.e. in some jobs interviews) and in their self-image/ self-esteem.

The increase of the user charges didn’t necessarily impact on the most vulnerable. It is possible to be free of user charges if the family average monthly income, divided by the number of family members, is lower than €628,83. Also, since 2015, the minors under 18 years became free of user charges. Apart from this, there is a middle class that faces a big tax increase and indebtedness. Although the gross income is not low, the real disposable income of some households is very low. The increase of the user charges had impact in these households, increasing the financial pressure there are living in.

***EAPN Slovakia:*** *The important factor in this sector is that the mandatory contributions for the health insurance cannot create the profit of the Private Health insurance institutions.*

1. ***Which aspects of housing and public health services (e.g. social housing, affordable private renting, publically funded health care) have faced the biggest regression in terms of their accessibility and increasing exclusion in recent years and what were the causes for the regression? Are there specific examples of negative new developments?***

***Housing:***

***EAPN Belgium****: The same problems are known to us since a very long time, but only increased. Also because of the general financial situation of people, (more unemployment, less sufficient benefits…) the situation got worst. People have to choose between “eating or heating”. More people are looking for less available quality housing.*

*Energy prices recently went up (and also taxes on energy).*

***EAPN Finland:*** *Not enough social investments for affordable housing, the government don´t do investments event its economical depression and Finland could get cheap loans.*

***EAPN Iceland:*** *Private rental companies, operated with a profit motive dominate the rental market. Rent apartments for high prices (can it due to lack of rental housing) and constantly raise the rent.*

**EAPN Ireland**: Covered above

***EAPN Latvia:*** *Bouth - social housing: no sufficient quantity and expensive to build and cover communal payments,*

* *affordable private renting: are exist lot of empty buildings, but no political wish to support such activity to support private sector, to transfer any sources to them. Wish to keep all possible sources in the public circle*

***EAPN Norway:*** *A lot of public houses have been sold from the municipalities to private during the last decades. The renting prices on public flats are unregulated and often they are priced very high in the bigger cities. The private sector has the same rental prices.*

*What happened in 2014 was that e.g. disability pension was taken out of the pension system and seen as a benefit instead. The gross amount payment increased with 4,7 percent and the benefit was taxed more. The housing benefit was not up regulated. Limits for receiving housing benefit was not up regulated in line with invalidity insurance rates so it meant that many lost the requirement for housing benefits and got a lot less to live by .*

**EAPN Portugal**: According to the Report Social Housing in the EU “between 2008-2009, social housing expenditures had a negative variation in Belgium, Ireland, Slovenia, while rent benefits decreased in Greece, Ireland; Latvia, Poland, Portugal and Slovenia”. The same report highlighted that “Public funds for social housing have recently been reduced in England, Portugal, Poland, Austria and Greece”.

In 2012 it was published the new Tenancy Law (Law nº 31/2012, 12th November) as an answer to the growing demand for rental supply and the absence of an adequate response, with accessible market prices”[[5]](#footnote-5). The goal was to create a rental market, which together with boost to urban rehabilitation, can offer to the Portuguese people more adjust housing solutions to their needs, less consuming of their resources and therefore also promoting savings and their mobility in searching for employment. The measures of this new Tenancy Law are: 1. more freedom in stipulating contract duration; 2. greater importance in the negotiation process between parties in updating old rents; 3. shortening the duration of the transition period for old contracts to the new regime; 4. new rules for carry out works in rented buildings; 5. special procedure to eviction (made easier).

For the item nº 2 and 3 the new law indicates that people living in poverty needed to be protected. For the item 3 it must be the social security institute that must find an answer to the situations of economic disadvantage. One of the things that it was noticed was that these new orientations affected in particular the elderly with low income, because they couldn’t afford the new rents.

There are few information on the real impact of this new law on people living in poverty and social exclusion. According to some newspapers the new National Rental Desk[[6]](#footnote-6) (*Balcão Nacional do Arrendamento*) issued, until June of 2015, 929 evictions (in 2014 it were 1868). According to the responsible of *Associação dos Inquilinos Lisbonenses* the income failure during the crises period, and situations of illness or aging have contributed for the no payment of the rent (even realising that rents are the last expense that people fails to pay)[[7]](#footnote-7).

In the scope of the National Emergency Plan it was implemented the Social Rental Market (SRM)[[8]](#footnote-8). This SRM is a partnership between the State, Local Authorities and Banking entities (that decided to take part) and aims social classes, with incomes higher than those that allow the attribution of a social housing, but that don’t have financial capacity to rent a house on the open market. Until August, 2800 families benefit from this measure. It would be important to extend this measure also to people living in poverty and social exclusion.

In terms of regression it’s important to highlight that during the crisis the construction and property sector collapsed with several companies closing. This sector was already in difficulty since 2001/2002 but the impact of crisis it was significant: “the shrinkage observed during 10 years until 2012, exceeded 50% and the sector lost more than 350000 jobs, representing more than 23% of the total national unemployment”[[9]](#footnote-9).

It’s also important to highlight that the reduction of social protection benefits, like social insertion income (reduction in terms of amounts and more stricter rules) had impact in the lives of the most vulnerable. Even people, benefiting from Social Insertion Income, being able to receive an additional support for housing, this support are not enough for all the expenses. During the focus group of Project DRIVERS some of the participants indicated that “*with an housing rent to pay and other expenses. When the expenses are too much we have to ask someone to help* ...” Even for homeless people the situation is worse, because the support that is given to accommodationconsists of placing people into hostels. “Without this support these people would still live in the street. [but] These hostels are paid by Social Security and in some cases are paid partially by the users; however, this only allows them to sleep and does not allow them to cook, wash clothes, and so on. These last services are paid outside, in other institutions and supported by users. According to them it should be possible to change this situation and save money to the State, if they had opportunity to receive this money that is given to private entities (hostels) and being responsible to manage their own daily budget. (...)*“(...) I’m receiving support for the bedroom and I pay 30€ to eat. (...) the hostel doesn’t have kitchen, doesn’t have anything, we have to eat somewhere else. It’s just sleeping and bath.”[[10]](#footnote-10)*

***EAPN Slovakia:*** *The main aspect is the privatization of the sector. The private or commercial housing are not accessible for the people who are in the situation of poverty and social exclusion.*

*The rental dwellings are overcrowded. The new rental housing is built very rare. There is the opportunity for municipalities to build such dwellings but the main problem is the funding and lands.*

*The rent in the tenant dwellings is high in comparison with their income or salary.*

***EAPN Sweden:*** *Affordable private and public renting has decreased which has caused big problem. This was a result of a political strategy from the former rightwing government aimed at make more people become owner of their housing.*

***EAPN UK:*** *Social housing provided by local authorities (i.e. municipalities) has faced the biggest regression. The Conservative government in particular has made clear its preference for private sector provision and has legislated to bring that about. Due to central government constraints local authorities have built very few houses and have now had their capital grant to do so removed. They have to raise rents and borrow on the basis of that income stream to be able to build. For years social housing providers have had to increase social housing rents. Local authorities had to increase rents by the Retail Price Index plus 0.5% even when earnings were falling in the years following the financial crash. The government has recently implemented a four-year nominal reduction of 1% in social housing rents. However this will reduce providers’ incomes below the CPI inflation-adjusted receipts they had planned for under the most recent regime. Given the tightened housing budget constraints (and 40% cuts in local authorities’ overall budgets) the rate of new social housing construction is likely to reduce further.*

*The government is also legislating for social housing providers to sell off higher value properties – those in the top third of the market value locally. Providers must use the revenue to build cheaper social housing. The government has said that housing sold off will be replaced one-for-one, however there is skepticism as a previous scheme in 2012 replaced only one in ten or so of houses sold off. In addition, if social housing providers can get hold of the land on which to build, it may be in unsuitable locations to support employment, transport and schooling and access to healthcare. As well, the government will require providers to pay them a fixed charge annually to cover assumed sales (no details yet), but as higher valued properties are sold off, social housing providers will have to lower the bar on what constitutes higher value housing, in order to meet the continuing charge they must pay to the government.*

*Since low income people have their rents subsidised, the Housing Benefit bill has increased. The government has responded by making cuts to rent and other housing support. The Housing benefit ‘taper rate’ is 65 pence in the pound for every pound of income above the threshold, a disincentive to getting more hours of paid work or better paying work.*

*Some other changes to social housing affordability, adequacy and accessibility:*

*1. The government has introduced the concept of “Affordable Rents” – which are up to 80% of regional market rents, compared to around 60%-70% of market rents that were common before. These Affordable Rents must be charged in new properties and re-lets in Housing Association and local authority housing. The concept is closely tied to the Affordable Homes Programme, which is intended to increase social landlords’ ability to borrow to build as capital grants have been cut. It will take some time for Affordable Rents to be a large share of all rents. But in the long term, “Affordable” rents may change the profile of social renters and drive some people into overcrowded and unfit accommodation. Table 2 in Adams et al shows that new ‘Affordable’ renters are a bit more likely than social renters to be economically active (57% compared to 54%), more likely to be full-time, less likely to be unemployed and more likely to be younger (46% aged 25-39 compared to 38% of social renters) and much more likely to have children (59% compared to 40%). But incomes are relatively low: 76% of Affordable renters and 77% of social renters are eligible for housing benefit.*

*2. Younger people - up to age 35, are not entitled to have rent subsidy for rent of a one-bedroom flat in any sector. They are subsidised only for a room in a shared house, which inhibits family formation.*

*3. People in social housing deemed to under-occupy their home have their Housing Benefit reduced. If they have a ‘spare bedroom’ (meaning one room or more unoccupied with male and female children expected to share until they are teenagers) they have their benefits reduced by 14% for one room and 25% for two or more. This affects people whose children have left home, but who cannot now, without reducing their income significantly, keep a ‘spare bedroom’ for children or other family and friends to visit; “split” families where the parent without daily care cannot have a bedroom to receive their children overnight. A high court case found in favour of those disabled people who might need a ‘spare room’ for a carer, which was previously excluded. Since there are too few one and two bedroom properties, especially in the North of England where municipalities tended to build family homes with gardens, people have to pay and stay. Even where smaller properties are available they are often in the private sector and at higher rent, increasing the Housing Benefit bill.*

*4. Most local authorities have offered permanent tenancies, giving people security to build their lives and networks. The government has now introduced fixed term-tenancies, in which people are expected to move out of social housing when their circumstances change.*

*5. The government is now proposing ‘pay to stay’ where people in social housing with family incomes greater than £30,000 outside London will have their rents increased towards market rent. This is one of many measures over time have made social housing a “second-class” residual tenure. Post war, one-third of people lived in permanent social h0using tenancies.*

*The government strategy appears to be two-fold.*

*1. Changes to housing policy and finance are part of the overall strategy to “shrink the state” and reduce people’s expectations of it. Chancellor Osborne aims to reduce the share of public spending in GDP from 40.9% in 2014-15 to 36.5% by 2020. This scale of change has not been attempted in modern times.*

*2. Regarding housing itself, first, the government aims for an “asset-based” approach, in which people own homes from which they can draw down wealth from their housing asset to support themselves in later life. Second, the government aims to use the remaining social stock more “efficiently” by redistributing stock and increasing turnover of tenancies. More than half of people aged under 35 are renters. Many people cannot access house purchase, even with government schemes to support first-time buyers and shared ownership. The private rental sector has increased rapidly, especially as housing is seen as a sound investment not only by big companies, but by many small landlords in the “buy-to-let” market. Small landlords are often using income and value increase from rental properties as a form of pension provision. Rents are rising faster than earnings and very low interest rates means other returns on savings are small. This situation has caused something of a “generation conflict” with some young people referring to it as “lie-to-bet”.*

***Public health services:***

***EAPN Belgium****: The general medical insurance covers less and less health services, for a lot of health related problems, people need an extra (private) hospitalization insurance. Few people experiencing poverty have this kind of insurance.*

***EAPN Finland:*** *There has been Social welfare and health care reform going on for some many years, but because it has not went on, problems has been growing. Also austerity politics affect the resources of communes and health services.*

***EAPN Iceland:*** *There has been significant cuts in the public health care system. Expenses have been increasingly passed on to patients / those who use the service.*

*Long-term cuts at the public hospital results in long waiting lists for operations and many of the devices are old and obsolete. There is a lack of nursing homes for the elderly.*

**EAPN Ireland**: Introduction of Prescription charges for those on Medical cards (See 1 above)

- cuts to health services in the past number of year has led to a reduction in services and cuts to the salaries of staff has led to many health professionals choosing not to work in Ireland, resulting in an understaffing in many public health services. There are now longer waiting lists for assessments and treatment.

Many community based primary care services have unacceptable waiting lists.

- Access and entitlement to many community based health services have been explicitly eroded during the crisis for example dental care.

***EAPN Latvia:*** *Publically funded health care should be developed to assure free of charge prevention and essential treatment in short term (no queues) for every person in need.*

***EAPN Norway:*** *The poorest still don’t get any help. You have to belong to certain small patient groups to receive public coverage regarding dental health.*

**EAPN Portugal**: The close down of services, namely emergency services and/or some specialties in some hospitals and night services in some health care centers had an important impact in accessibility to health services, especially outside municipalities with higher number of inhabitants. The news of child being delivered in ambulances has been increasing. A news from 2009 (Diário de Notícias de 14 de Outubro “Metade das corporações de bombeiros já foi 'parteira'”), referring the close down of the Maternity Hospital in Mirandela, in 2006, states that between 2006 and 2009 half of the 14 fire brigades of the region have delivered babies in ambulances.

Apart from the impact on the access to health, these kind of measures has also an important impact in local economy, especially in small municipalities.

The close down of health services was previous to the economic crises in Portugal, but the austerity measures and the need to cut down the public expenditures also leaded to a higher pressure to a reorganization of health services based on economic rationalities.

***EAPN Slovakia:*** *The main aspect is the privatization of the sector. The private or commercial services are not accessible for the people who are in the situation of poverty and social exclusion. The private sector is affected with the conditions or support (decision) of the Health insurance (institutions) which are private. For the Health insurance institutions flow the money from the employed people and from the state (state insurance for the people who are in the bad social situation and who meet the conditions). These contributions are mandatory (required).*

***EAPN Sweden:*** *Less acces to health services i poor and rural areas due to privatisation.*

1. ***Which groups of people face the biggest problems in accessing and retaining quality housing and public health services in your country?***

***Housing:***

***EAPN Belgium***

* *Undocumented migrants*
* *Migrants in general*
* *Roma people*
* *People depending on benefits (or excluded from the system)*

***EAPN Finland****: Poor people, expecially men.*

***EAPN Iceland:*** *People with disabilities, immigrants, the long-term unemployed, single parents on low wages, low-income families, workers on the lowest wages, some of the elderly are in financial difficulties.*

*Young people are living longer with their parents than in the past because they can not afford to buy or rent.*

***EAPN Ireland***

**People on social housing waiting list** face particular problems in accessing appropriate accommodation and remain for years in temporary accommodation while waiting for access to a social house.

**Social housing tenants**: This varies from place to place. The majority of social housing tenants in Ireland live in large social housing developments. Many of these developments face a range of issues such as poor access to services, high unemployment levels, anti-social behaviour and high drug usage. Residents in many also face a stigma when accessing services and looking for jobs which further compounds their situation.

**People who are Homeless:** People who are homeless are trapped in emergency accommodation far longer than is needed as they have no accommodation to move to. This is due to the lack of supply in social housing but also the lack of properties available to rent within rent supplement and HAP limits. This is coupled with landlords not willing to accept people on rent supplement.

**Travellers** face an ongoing problem of inadequate and inappropriate accommodation. (As stated above) There are approximately 4,500 Traveller families in Ireland and according to a count by local authorities in 2014 there are 1,536 Traveller families living in overcrowded or unsafe conditions. This includes 445 on the side of the road, 104 on basic services sites, 223 sharing halting site bays, 37 sharing basic site bays and 727 sharing houses.

Between 2008 and 2013, 25 local authorities failed to meet their targets for accommodation provision and there are no sanctions against those which failed to achieve their target. The Traveller accommodation budget was cut from 40 million in 2008 to 4 million in 2013.

Most **Roma** in Ireland live in private rented accommodation. A report of 2012, based on engagement with service providers working with Roma, highlighted issues of inadequate living conditions and families living in severely overcrowded accommodation. This is linked to lack of access to financial resources and difficulties in applying for local authority housing due to lack of documentation. Social workers have reported cases of families living in unsafe accommodation with no electricity or heating. In 2015, the Gardai (police) reported a case, in which over 20 Roma adults were living in a derelict warehouse with no electricity or water. There has been no coordinated State response to address housing issues faced by Roma in Ireland.

**Asylum seekers:** Asylum seekers in Ireland have to stay in Direct Provision accommodation. The quality of this accommodation varies but in general is not adequate with families sharing a small space and individuals sharing a room with others who are strangers, often with very different cultures and backgrounds. Adults are not allowed to work and are given an allowance of €19.10 per week with an allowance of half of this for children. Food is provided. People can remain up to 11 years in this situation with detailed reports of the negative impact these conditions have on people’s mental health and well-being.

**People with Disabilities:** There is an ongoing issue of accessible accommodation for people with disabilities, particularly those who use wheelchairs. There were 3,919 households on the social housing waiting list in 2013 (ref. Housing Agency) where a family member had an enduring disability, this was up from 455 in 2005, 1,155 in 2008 and 1,315 in 2011. Many people with disabilities also need a personal assistant to be able to live independently. This service is still under-resourced but proposed cuts to existing services were not implemented by the Government in 2012 after protests by people dependent on the service.

**Young people leaving care institutions:** There are inadequate follow-up services for young people who become adults and have to leave the care institutions where they have been living. Many end up with no accommodation and homeless.

**Distressed mortgage holders**: Those who can no longer afford to pay their mortgages face great difficulties. This includes people who are both working and who might have been when they got their mortgages but have since lost their jobs.

***EAPN Latvia:*** *Young families, elderly, disabled, some in extraordinary situations*

***EAPN Norway:*** *Poor people, (the last months refugees) . People on social assistance.*

*Young people with no assistance from their parents.*

*Public housing is often of bad quality since the municipalities don’t rehabilitate sufficiently and make profit on the public houses instead.*

**EAPN Portugal**: Following what was presented in the previous questions, Roma Communities, Immigrants and Homeless people can be selected as groups facing the biggest problems in accessing quality housing, because associated to their situation of monetary deprivation there are other obstacles like discrimination.

However it’s important to highlight that, generally, people in poverty and social exclusion usually live in poor housing conditions and taking in consideration the high prices of rents, the rules and conditions to access bank credit, or establish a contract, is quite difficult to them to change this situation. We would like to make a further remark in relation to elderly people: there are a lot of elderly people living alone in houses with poor accessibility that contributes for their isolation and exclusion. The same for disabled people. According to Census 2011, “More than half of the buildings are not accessible to people with wheelchairs”[[11]](#footnote-11).

***EAPN Slovakia:*** *All people who have small income or salary.*

***EAPN Sweden:*** *Poor, unemployed, student, people with depts. Social and mental problem*

*And sometimes also due ethnical background*

***EAPN UK****: Low income families, single parent households, many young people.*

*There are other groups facing greater difficulties with housing access and housing security, particularly due to the severe cuts in local authority funding, with more to come between now and 2020. There has been a real terms cut of close to 40% since 2010 but there is very great variation, with the local authorities in the poorest areas having the largest cuts and some wealthy areas having cuts in low single figures. Many of the groups suffering greatly from the cuts are those for whom there have been positive changes in awareness and in the policy environment, which have been undermined by the cuts:*

*• People who are homeless, most often men, or insecurely housed (men, women and children), and those, mainly women and children, escaping domestic violence. These groups have suffered from the closure of direct provision or much reduced services as well as the severe reductions or total removal of funding to NGO providers. For example:*

*o In 2013 in England, 112,070 people declared themselves homeless, a 26% rise over four years. The number of people sleeping rough in London in 2013 rose to 6,437, a 75% increase. Across England, the Department of Communities and Local Government estimated that in 2013, 2,414 slept rough on any one night. As a snap-shot, this is likely to be a significant underestimate.*

*o in 2013 Women’s Aid said that 1.2m women experienced some form of domestic violence the previous year and two women a week are killed by their partners. Women’s Aid runs 150 refuges and lost 112 specialist posts in 2012. Women were turned away because the service was at breaking point, despite half running some services with no government funding. Despite severe cuts in previous years, one-third of facilities expected more cuts in the coming year. Cuts have since continued.*

*• Vulnerable elderly people in local authority care homes. Local authorities have closed some of their direct provision care homes and repeatedly reduced funding for places in private provision. The sector is close to crisis, investment returns are just about 3% and some big providers are closing significant numbers of homes that are loss-making (often because there is not sufficient cross-subsidy from private individuals paying for their own care). Elderly and vulnerable people are being moved to the detriment of their mental and physical health. The government has just announced a precept – local authorities can charge and retain more of their business tax to be ring-fenced for spending on social care, but regions and areas with a low tax base (e.g. because there are few businesses, usually poor areas and some rural areas) cannot raise anywhere near what they have lost to government cuts.*

*• People with a disability, who are more likely to be poor and to live in unsuitable housing. Counties such as Derbyshire and Shropshire have commissioned reports that have shown that they have a shortage of suitable housing for people with a disability and that budget cuts mean they are unable to provide it. As well, in 2013 a group of English local authorities commissioned a report which showed an increasingly challenging housing environment for people with a disability. Changes already implemented to cut “red tape” have removed design and access statements from most planning applications and have weakened choice-based housing allocation that helped disabled people to access appropriate accommodation. There are costs to the National Health Service arising from poor housing, but Housing Associations have not got involved in the new Health and Well-being local boards. People with a disability have suffered disproportionately from cuts to benefits, including Disability Living Allowance as well as Employment and Support Allowance for those of working age currently not able to work. They are thus less able to purchase their own housing and living adaptations. Further cuts under Universal Credit (which replaces six existing benefits and is still being rolled out) will not allow people with a disability to claim back housing related charges for equipment or services. Social housing providers are restricted in accessing central government grants for housing adaptation, but are not able to fund large scale changes themselves. There are a number of reports showing that integration of housing, health and care services would provide better and cheaper service, but there is little sign of implementation, although the city of Bristol is one which has made progress.*

***Public health services:***

***EAPN Belgium***

* *Undocumented migrants*
* *Migrants in general*
* *Roma people*
* *People depending on benefits (or excluded from the system)*

***EAPN Finland:*** *Poor people, people living in “poor communes”, old people*

***EAPN Iceland:*** *People with disabilities and long-term illnesses who have no other income than the disability benefits.*

***EAPN Ireland***

**People with a disability**

The cost of **living with a disability** in Ireland has been estimated at one third of the average weekly wage. This includes need for extra heating, transport, medical services and therapies that are not available uniformly across the country. Given the fact that consumer prices in Ireland are 18% ahead of the EU average, it is clear that the costs of coping with a chronic illness which necessitates equipment, in-hospital stays, medication and various therapies exerts enormous pressure on the budgets of those with illness or disability.

**Travellers**

Travellers have a much lower health status than the general population. Information from the All Ireland Traveller Health Study in 2010 revealed the following:

- 42% of Travellers under 15 years of age compared with 21% of the general population

- 63% of Travellers under 25 years compared with 35% of the general population

- 3% of Travellers are aged 65 years and over compared with 13% of the general population and only 8 Travellers were found over 85 years of age

Life Expectancy

- The gap in life expectancy between Traveller women and settled women in 2008 was 11 years

- The gap in life expectancy between Traveller men and settled men in 2008 was 15 years.

Mortality

- Traveller men have four times the mortality rate of the general population.

- Traveller women have three times the mortality rate of the general population.

- If Travellers had the same health status as the general population, the number of deaths expected in the year would be 54, the actual number of deaths was 188

- Suicide is 6 times the rate of general population and accounts for approx 11% of all Traveller deaths.

- The infant mortality rate for Travellers is 3.5 times the rate of the general population (4 infant deaths per 1,000 in the national population compared to 14 infant deaths per 1,000 in the Traveller population)

Both Travellers and health service providers interviewed acknowledged that social determinants were the main cause of the poor health status of Travellers. This included accommodation, education, employment, poverty, discrimination, lifestyle and access and utilisation of services

**Literacy**

40% of Irish **adults experience health literacy issues**. One in five Irish people are not fully confident that they understand all the information they receive from their healthcare professional (doctor, nurse or pharmacist). 43 percent of people would only sometimes ask their healthcare professional to clarify the information if they did not understand something they had said. One in 10 people have taken the wrong dose of medication because they didn’t understand instructions.

**Drug dependency**

Drug dependency is a particular issue in more marginalised communities. This is a direct effect of poverty and exclusion in these communities and must involve a holistic response to the needs of marginalised communities. It is an element of the wider negative health outcomes experienced by these communities but requires that prevention and treatment services are adequately resourced.

Low income households and those who cannot afford access to private health insurance are disadvantaged by their inability to buy access to private assessments (to diagnose the need for an intervention such as Speech and Language Therapy, Occupational Therapy, mental health services, dental/ orthodontic et al.) Those with higher incomes circumvent the long waiting times in the over stretched public health system by buying the consultation needed to secure resources. Those who cannot pay wait. There are over 11,000 teenagers waiting for corrective orthodontic treatment, 2,500 of them waiting over a year. 8,000 children are waiting for Speech and Language intervention, These delays can lead to very negative and ultimately costly outcomes if treatment is not accessed in the appropriate timeframe.

***EAPN Latvia:*** *Elderly and disabled, youngsters*

***EAPN Norway:*** *Poor people, (the last months refugees)*

**EAPN Portugal**: As stressed before, the population living in rural areas, mainly in the inner regions of the country compared to coastal and urban areas, faces more problems in accessing a quality health services. The distance from the primary health services and hospital are higher, and even if the distance is not particularly high, the road conditions and the public transport system makes travel longer or more expensive. On the other side, the number of physicians by inhabitant is much lower than in urban areas, and is more likely to lack some specialties. On the other side, the most innovative therapeutics are concentrated in the big cities such as Lisbon, Porto and Coimbra.

People experiencing poverty, although can have access to public health services free of user charges, are constrained to use only the public health system. It means very limited access to oral and mental health services, lack of family doctors and waiting lists for accessing some services and medical exams. For example, Health Regulator Entity (ERS) is checking the long waiting list for doing a colonoscopy through the National Health System. In Lisbon Region a person in the waiting list for a colonoscopy have to wait eight months.

As stated in the answer to the first question, there are also some specific groups facing problems in accessing quality health services, such as elderly, homeless, undocumented migrants and Roma communities.

***EAPN Slovakia:*** *The basic health care is secure for all population in Slovakia. But the special needs, special services, special medicaments, special arrangements is affected by small income or salary. In more cases it is not accessible for such aim group. The financial support depends from the decision of the Private Health insurance institutions.*

***EAPN Sweden:*** *To limited resources for people with mental problems, abuse problems,*

*Immigrants with language problems and cultural understanding*

*Migrants without documents*

*Expensive medication and dental care is also a problem*

1. ***How is the EU helping? Are there examples of positive/negative CSRs with regard to access/exclusion from housing and public health services? Please give us any examples.***

***Housing:***

***EAPN Iceland:*** *Iceland is not an EU country.*

**EAPN Ireland:**

**Ireland received a housing CSR in 2015 as follows:**

*Finalise durable restructuring solutions for a vast majority of mortgages in arrears by end-2015 and strengthen the monitoring arrangements by the Central Bank of Ireland. Ensure that restructuring solutions for loans to distressed SMEs and residual commercial real-estate loans are sustainable by further assessing banksʼ performance against own targets. Take the necessary steps to ensure that a central credit registry is operational by 2016.*

While the issue of distressed mortgages is important this CSR missed the current key housing issues for Ireland by not addressing the shortage of private and public housing and the resulting impact of homelessness for so many families who cannot afford to rent on the private market. It therefore represented a missed opportunity, considering the prominence this issue has in Ireland currently.

***EAPN Latvia:*** *Do not known*

***EAPN Portugal****: Considering the CSR 2015 there are no examples or recommendations related to housing or public health services. The main focus is on employment services.*

***EAPN Slovakia:*** *The EU helps with their funds. But there is the problem with the co-financing and with the owner of the land.*

***EAPN Sweden:*** *The demands for more liberalization on the housing market will affect the vulnerable and poor groups negative*

***EAPN UK:*** *The UK has received recommendations on housing, which are welcome, but they are focused on macro-prudential concerns and are not adequate to the housing problem and not focused on combating housing poverty and exclusion. The two sets of comments below are drawn from material submitted to EAPN by UK EAPN in February and June 2015, starting with the more recent.*

*The comments below are an extract from the UK comment on the CSRs 2015, supplied to EAPN in June 2015. They are a response to, and refer to, COM (2015) 277 final, titled “Recommendation for a Council Recommendation on the 2015 National Reform Programme of the United Kingdom and delivering a Council opinion on the 2015 Convergence Programme of the United Kingdom.*

*Shortage of affordable housing and the risks of indebtedness related to mortgage costs are referred to in #6 and #9. However, the European Commission recommendation regarding changes to the planning framework is wholly inadequate to address the UK housing situation. The annual gap between new housing need and supply is close to 150,000 houses pa. Home ownership has fallen to 65%. A generation is locked out of home ownership. Rents are historically high relative to incomes. Buy-to let-property owners have very advantageous tax and allowance terms and over the past forty years have achieved much better returns than shares and bonds. Social housing rents have been raised and there is a new definition of ‘affordable’ rents: 80% rather than 50% of market rents. Poor tenants have now to pay towards local taxes. Evictions are rising. Government measures so far have inflated prices as much as they have contributed to supply. Government are likely to make matters worse through their proposal to reinforce ‘right to buy’, forcing housing associations to sell properties to tenants at a discount of up to £100,000 - an unearned windfall for the tenant and loss of the property from the social rented sector. After the five-year period in which the property is to be held by the tenant, it is likely many of these properties will be sold to buy-to-let investors, especially given the recent legislation allowing people to cash in their pension plans. It is proposed to force local authorities to sell off their higher valued properties, resulting in further loss of property to the social rented sector. Both these measures also increase the likelihood of further residential segregation. The government has said that there should be one-for-one rebuilding of social sector housing, but the same promise was made in the Thatcherite introduction of right-to-buy and the outcome was only one in ten replaced. There has been considerable opposition to the proposed housing measures, including within the governing party’s local government authorities and some disquiet about the government’s legal position in forcing private organisations (social housing associations) to sell off assets; the government has recently said sell-off will be ‘voluntary’.*

*Therefore, on current policy and proposals, it is very unlikely that there will be an adequate increase in affordable housing. CSR2 suggests only ‘further steps to boost supply in the housing sector’ which is a pretty low bar in a housing crisis.*

*The comments below ae an extract from the UK submission inputting to the 2015 CSRs, comparing them with our Alternative CSRs from 2014. They were supplied to EAPN in February 2015.*

*Q2a Highlight the Commission’s positive proposals for poverty reduction in the CSRs (if any) and similarities with your own proposals above (specify)*

*Commission/Council CSR number 2*

*Increase the transparency of the use and impact of macro‐prudential regulation in respect of the housing sector by the Bank of England's Financial Policy Committee. Deploy appropriate measures to respond to the rapid increases in property prices in areas that account for a substantial share of economic growth in the United Kingdom, particularly London, and mitigate risks related to high mortgage indebtedness. Monitor the Help to Buy 2 scheme and adjust it if deemed necessary. Consider reforms to the taxation of land and property including measures on the revaluation of property to alleviate distortions in the housing market. Continue efforts to increase the supply of housing.*

*EAPN’s Alternative CSR 3 on access to adequate, affordable housing addresses some of the same issues as Commission/Council CSR 2, especially housing supply, house price increases relative to incomes, risks of mortgage indebtedness and the specific issues of the London property market.*

*Commission/Council CSR number 2 refers to macro-prudential regulation, property prices and debt risks and suggests a number of measures. Quantitative easing (QE, a programme of government bond purchase to push cash into the economy to stimulate growth) has inflated asset prices and reduced yields on savings. Therefore, it is a key driver of property price and rent rises. It is behind the burgeoning buy-to-let sector as well as the specific London ‘buy-to-leave’ market (empty property, merely benefitting from asset security and asset inflation especially by overseas investors).*

*Overall, the Commission/ Council CSR 2 is much more concerned with macro-economic risk than with combating housing lack, affordability and quality. Despite the massive longer term social and economic implications of the chronic UK problems of access to adequate, affordable housing, the Commission/ Council CSR 2 is not concerned with the poverty risks of the housing crisis and does not directly address distributional issues, fairness or inclusion. Thus:*

*Housing supply*

*Commission/Council CSR number 2 refers, like EAPN UK Alternative CSR 3, to the need to increase the supply of housing. But it does not offer any specific measures.*

*• The net supply of UK housing rose in 2014 compared to 2013. Net housing supply rose to 136,610, of which 130,000 was new-build . Scottish new-builds for the year to June 2014 were 15% up at 15,824. But house-building is still below pre-crash levels and well below the 250,000 per year needed to meet housing demand. Government spending on new homes fell 44%. There is insufficient overall supply due a lack of new builds, high land values, restrictions on local authority house building, high income multiples and other problems in access to mortgage finance.*

*• Social house-building was down on the previous year in both England and Scotland. It has fallen for the last three years.*

*• A 2013 report by the NGO Shelter stressed that demand could not be met without significant central government direct investment of about 1% of GNP; increased local authority capacity to borrow; new ‘garden cities’; measures to support self-build and affordable rural housing, as well as building in the ‘green belt’ (the ‘green lungs’ around towns and cities). There have been no serious developments, except the politically controversial changes to planning laws which enable building on the green belt and allow central government to over-rule local government refusals of planning permission.*

*Home ownership*

*Commission/Council CSR number 2 refers, like EAPN UK Alternative CSR 3, to home ownership, but mainly in terms of macro-prudential risks linked to asset price inflation and over-indebtedness.*

*• Property prices increased at an annual rate of 8% in November 2014, but 21% in London, though there are signs now that the market has cooled.*

*• In rural areas, average annual earnings are about £19,000 per annum but average rural house prices are eleven times average salary.*

*• The Commission/ Council seem less directly concerned with affordability of home ownership. There are 17 million homeowners and 8.2 million renters. Rates of home ownership (and therefore assets which can be drawn on in retirement) are in decline. They peaked in 2002 at 69.7% but by 2012 had dropped to 64.7%, one million fewer homeowners.*

*• Post-crash, there are high deposits required to access mortgages – often 20% rather than pre-crisis 5% and mortgages are at much higher multiples of income. By November 2014 the Coalition government’s scheme ‘Help to Buy’ had assisted about 71,000 buyers by providing guarantees to lenders that offset some of the risk of lending. This has enabled eligible potential homeowners to access loans with lower mortgage deposits and lower interest rates. Most of those helped have bought lower value homes outside London. The scheme has helped first time buyers to re-enter the market, but it meets a fraction of need. However, there are now more mortgage deals across the market offered at lower interest rates and with smaller deposits.*

*• But affordability remains a problem because of falling real wages and insecure employment, especially for people under age 35. For example, In Scotland, private renting has doubled in ten years and trebled for those aged under 35.*

*Affordable housing*

*• In England in 2013-2014, gross ‘affordable housing supply’ ‘for eligible households whose needs are not met by the market’ including bed-spaces in multiple occupation units, was 42,710, a little below 2012-2013 (42,920). The figure, as gross, does not account for demolitions or other losses of existing stock, e.g. through sales. The 36,520 new-build homes were 86% of all affordable homes supplied, but this was a drop of 8% on the previous year’s build. Of supply delivered, at 30,590, there was a 24% increase in units supplied of social rented housing, but still much too little to meet need; at 11,330, there was a 34% decrease in affordable home ownership.*

*• The Coalition government has exempted developers of empty buildings from providing affordable housing as part of the deal. They have also enabled developers to appeal against the standard requirements for affordable housing in new developments, adding hundreds of millions of pounds to developers’ profits. The measures were announced to stimulate house-building. However, they will reduce the cash available to local authorities to provide affordable housing; in 2014, English councils gained £1.9b billion from developers. The Conservative leader of Westminster City Council has described the new policy as ‘insane’ after his council lost £29 million in one planning meeting in one month. In 2015, some of Britain’s biggest property companies have themselves objected to the new policy, some in writing to the Department of Communities and Local Government, saying that the new policy will destroy the social mix of London.*

*Social housing*

*Commission/Council CSR 2 does not refer to issues concerning stock of social housing and access to it.*

*UK EAPN Alternative CSR 3 on housing specifically refers to measures to make it easier for local authorities to build social housing for rent and to charge affordable rents. Our CSR 3 referred to the importance of new business models to stimulate affordable house-building. There has been little or no progress on social house-building or on new approaches and social rent affordability has worsened.*

*• There is an overall shortage of social housing. Social housing starts have now increased, but while all types of ‘affordable’ house building have fallen by a third below the 2010 level, social rented housing has fallen by two-thirds, from 35,000 units a year to 10,000 in 2014.*

*• There is a lack of access to social sector housing due to ‘right-to buy’ removing social housing stock and the controls on local authorities’ capacity to retain rents or to borrow to build. In 2012, the Coalition government committed to replacing every home sold under ‘right-to-buy’. But since then, only one in five of these homes which have been sold have been replaced by a new affordable house.*

*• The UK EMIN report outlined a number of major changes to housing benefit levels and eligibility and to local housing allowances plus the introduction of individual and national benefits’ caps, which have affected rental housing affordability and security.*

*• Our UK EMIN report referred also to the effect of rent increases above inflation and the government’s changed criteria for ‘affordability’ (80% rather than 50% of typical social rented housing. ‘Affordable rent’ of 80% was established in 2011 and according to Shelter is now the default form of government support for new rented homes, accounting for 43% of completions in 2014.*

*• Our UK EMIN report referred to some local authorities’ changes to eligibility for council housing, which dramatically reduced waiting lists without housing those made ineligible. The Coalition government has aimed to increase social tenant mobility as a means of better matching demand and supply, through introducing fixed-term social tenancies and cutting benefit payments if households are deemed to ‘under-occupy’ their housing (the ‘bedroom tax’). The outcome of these measures has been punitive for some vulnerable groups including people with a disability as smaller appropriate accommodation is not available especially in the private sector.*

*Private renting*

*The Commission/ Council CSR 2 does not address the overall impact of private renting although there is a reference to security of tenure. EAPN made specific proposals to increase tenancy security and control rent rises. There has been little or no positive progress from the Coalition government on rents or security of tenure.*

*• There has been liberalisation of the rental market and a rapid rise in buy-to-let housing investments as an alternative to traditional private pensions (where annuity rates have fallen dramatically).*

*• The pressure of demand on the private rented sector has increased and landlords can be ‘choosy’. Our UK EMIN report of October 2014 showed that some landlords, including the largest, are no longer willing to accept tenants on benefits because of changes to the benefits’ system and payments methods.*

*• The rapidly growing private rented sector is filling the housing gap and trapping young people in insecure and often overcrowded and poor quality accommodation. A Shelter report of October 2014 refers to government figures that renters spend 40% of their income on rent and that two-thirds of private renters (3.8 million households or about 5 million people at that time), were unable to save anything at all towards a deposit, a 13% rise in two years. Also in 2014, Shelter and Crisis published longitudinal research on the private rented sector in three English localities. They found that: private renting did not provide secure and decent homes; two-thirds of people were unhappy with their tenancies and low income and vulnerable people had worse experience.*

*• The 2015 Civitas report on the future of private renting showed that private renting has increased (to over 4 million tenancies) alongside declining access to social housing and to home ownership. They have shown distortions in the market that arise from measures that address housing demand rather than housing supply. They have pointed to the rapidly rising cost of housing benefit subsidies, which go to private landlords who are able to set rents at artificially high levels. They show that the private rented sector has expanded largely through the purchase of existing housing stock, inflating house prices and inhibiting private renters from moving in to home-ownership. They share EAPN’s concerns for a new regulatory framework and greater security of tenure than the current 6-12 months.*

*• Young people’s capacity to live in secure accommodation, to form families and to save for retirement is especially compromised.*

*Homelessness*

*• Homelessness figures are not comparable in the different parts of the UK. Homelessness in Northern Ireland and Wales has risen in recent years but it is still below its mid-2000s peak. The major contingent reasons were family breakdown/loss of accommodation with friends and family. Between 2012-13 and 2013-14, homelessness applications in Scotland fell by 8%, the major contingent reasons were the same as in Northern Ireland and Wales. However, there was a significant increase in evictions, mainly for rent arrears.*

*• In England too, statutory homelessness peaked earlier (in 2003) but has been rising for the last three years. The housing and policy environment is tougher in England. The major reasons people stay homeless is lack of support to get into secure accommodation and lack of availability of accommodation. Only 50% of those who applied to English local authorities met the criteria to be accepted as homeless (i.e. there is a legal duty to address their housing need). The most frequent reason for becoming homeless was loss of an assured short-hold tenancy – these are offered by the private sector and need last only six months. This change probably reflects the doubling in size of the private rented sector, reflecting the knock-on effects of insufficient social housing, rent increases and local authority service cuts. Homeless rates in London are double those of the rest of England. Of those accepted as homeless in England, 60% were placed in temporary accommodation. Placement in temporary accommodation is increasing faster than the increase in numbers accepted as homeless. However placement in temporary accommodation has not increased in Scotland and Wales.*

*• Homelessness of families is increasing. At the end of 2014, over 90,000 children in the UK were statutorily homeless (a nearly 14000 rise since 2011). The number of families in Bed and Breakfast accommodation had doubled in a year to more than 2000.*

*• A newspaper article about the hardening of attitudes to poverty and homelessness and the rise of ‘defensive architecture’ (spikes, barriers, water sprinklers etc., designed to prevent ‘loitering’ by ‘undesirables’) referred to Joseph Rowntree/ Crisis research. It says UK homelessness has risen by one-third in five years and that the single biggest reason cited is welfare benefits’ sanctions.*

***Public health services:***

***EAPN Belgium****: Negative CSR’s on the “sustainability” and “efficiency” of our system*

*Under the pressure of Europe, in the framework of austerity fury, the quality of and access to public services are undermined. This goes hand in hand with an decrease of budgets, and the services organized by the state, and an increasing privatization. Not only the services suffer from this, also the collective wealth. More and more people are excluded (from the system of unemployment, disability,…). Accessible services should include (with special attention for very vulnerable groups as homeless, people with a disability,…), not exclude*

***EAPN Finland:*** *There´s CSR about finalizing the Social welfare and health care reform, which has been going on for years.*

***EAPN Iceland:*** *Iceland is not an EU country.*

**EAPN Ireland**: Ireland received a health CSR in 2015 as follows:

*Take measures to increase the cost-effectiveness of the healthcare system, including by reducing spending on patented medicines and gradually implementing adequate prescription practices. Roll out activity-based funding throughout the health system.*

This is the second year in a row that Ireland received a CSR on healthcare and in both years the focus has been on cost effectiveness. While the proposals can have some benefit it does not address the concern of health inequalities and the worse outcomes for those on lower incomes or experiencing higher levels of social exclusion. The issue of cost-effectiveness and eliminating ‘cost over-runs’ in health expenditure was a particular focus of the troika programme in Ireland.

The current narrow focus on structural reform of the financial systems, particularly within acute hospitals, while necessary, is a partial solution which does not address the wider and historic problem of a neglected primary, community and continuing care sector, which is failing the Irish population, particularly those who must depend on rationed and reduced service levels.

The current focus on activity based funding, which while a neccessary financial reform to improve efficiencies and outcomes in the acute sector, is being prioritised at the expense of the development of the current poorly resourced primary, community and continuing care sectors. It will not be possible to improve discharges from acute settings unless adequate and appropriate settings are available into which to move patients ready to move onto the next phase of their rehabilitation.

***EAPN Latvia:*** *Ministry do not accept, justify oneself with on sources/money*

***EAPN Slovakia:*** *The public health´s services are supported only throw the infrastructure. But there are also the factors/conditions where it is effective e.g. the amount of the citizens.*

1. ***What could be the policy solutions to tackle the inaccessibility and exclusion from housing and public health services at national level?***

***Housing:***

***EAPN Belgium***

* *Building social houses*
* *Buying social houses, renovate them and rent them as social houses*
* *In the meantime: extra benefits for renting*

***EAPN Finland:*** *More social investments for public, social, affordable and cheap housing, both rental housing and private owned housing in communal and national level.*

*Also communes and state could start public building companies, because one problem is, that big private building companies are only interested about making money, and they also make poor quality.*

***EAPN Iceland:*** *Low-income families and individuals should get help with the burden of housing costs. The Welfare Watch believes that the state should aim for that the payments for low-income families on housing should go well below 40% of their disposable income. We look to the Danish housing system, where the rent is approximately 20% of the household income after tax.*

*Furthermore, increased security in the private rental market by:*

*a) Municipalities have available rental housing for low-income families and individuals and offer apartments with long-term contracts.*

*b) The laws on rent be revised and will clearly set out the role, rights and obligations of tenants as well as landlords.*

*c) Amounts of the housing benefits should be based on total household income, but not the number of adults in the household.*

*d) Money should be put in the construction of social housing that allows low-income families and individuals to live in long-term housing security on manageable terms.*

**EAPN Ireland**: In general the Irish government must take steps to promote a more sustainable housing market by promoting supply across all tenures in areas of high market demand and by taking particular steps to ensure that the housing needs of disadvantaged and vulnerable groups are met e.g. people with disabilities, older people , Travellers etc.

There needs to be care to ensure that the increase in housing is not also matched by an increase in house prices as happened during the ‘Celtic Tiger’ years from the late 1990’s until 2007. There is also a need to make renting, in quality accommodation at affordable prices, a more viable option in Ireland than is currently the case with rent control to prevent rents from getting out of reach of tenants.

Housing and homeless organisations have also called for a level of ‘rent certainty’ which would result in some control in the increase in rental levels. However, the Government has been slow to address this issue. In November they finally agreed on a limited measure whereby residential rents levels could not be reviewed for two years, instead of the years that currently applies. However there is no benchmark for how much rents can be increased by.

In the short term, to prevent people from falling into homelessness the Government needs to increase the Rent Supplement support to ensure that those who are dependent on it can afford their rent.

In November 2014 the Government published a Social Housing Strategy. In Budget 2015 they also agreed a budget of €2.2 billion (€1.5 billion exchequer) to provide 10,000 new social houses by 2018. There is also a programme to renovate existing closed up social houses. Alongside this was an increased budget allocation for homeless services. While these measures were welcomed by housing and homeless organisations it was recognized that they are too little to deal with the size of the social housing and homeless problem.

Non-Governmental social housing providers also play an important role in the provision of social housing and should be supported in playing this role by Government.

**Large social housing developments:** Successive Governments have been very conscious of the need to avoid large segregated social housing developments which reproduce the social exclusion and disadvantage of the residents. However to date measures to address it have had limited effect. For example Part V of the Planning and Development Act 2000 was meant to ensure that local authorities could purchase 20% of land and properties in all large housing developments for social housing. In effect amendments to part 5 over time means that housing developers could buy their way out of this resulting in much less integrated social housing that was envisaged. Therefore this is an ongoing issue to be addressed if segregated social housing is to be avoided into the future.

**Homelessness**

The Way Home – A Strategy to Address Adult Homelessness 2008-2013 is still the Government’s overall strategy and policy. In February 2013 the Government also issued a Homelessness Policy Statement which makes the explicit recognition of the housing-led approach as the main approach.

The statement provided for the setting up of the Homelessness Oversight Group which was set up and this was followed by the establishment of a Homelessness Policy Implementation Team.

An Implementation Plan on the State's Response to Homelessness – May 2014 to December 2016 was then published and in December 2014, as the crisis deepened, they published an Action Plan to Address Homelessness.

Despite all of these measures however the number of individuals and families entering homelessness continues to grow (numbers above).

**Traveller accommodation**

The Government needs to establish an independent Traveller Accommodation Agency which will oversee the provision of appropriate and quality accommodation, including Traveller specific accommodation, that meets the needs of all Traveller families in a reasonable timeframe.

***EAPN Latvia:*** *Empty property tax, support private owners, inform society reimbursement via Municipality possibilities*

***EAPN Norway:*** *More cooperative ownership, More investment in public housing, upregulate the limits for housing benefit so more people can get access to the benefit.*

**EAPN Portugal**: First it would be important to define and implement a National Strategy to Fight Poverty and Social Exclusion. This is important for both areas that we are analysing in this questionnaire. Like we have already presented in other documents: “it is not possible to fight poverty and social exclusion with an emergency programme structured on piece-meal policies with no intrinsic coherence. It is also not possible to detach social policies from other policies (including employment and education and training policies but also fiscal, economic and demographic policies), as the current situation clearly demonstrates the strong negative influence of the policies currently implemented and makes the case for the poverty proofing of those. Only under a comprehensive and coherent strategy will be possible to fight poverty and social exclusion with better and improved social policies that are not questioned and endangered by other relevant (and most of the predominant) policies.”

It would be fundamental to maintain and reinforce the National Strategy for the Inclusion of Homeless People. This national strategy has received a positive feedback from other member states and other European entities. However, the national strategy never had a legal background and this is a major drawback for the intervention in this matter. It would be important if this Strategy could be a measure within NRP. In this moment it was just identified in NRP as an integrated methodology for a vulnerable group, but in fact, it has a deadline – 2015 – and there are no information about its follow up.

Since we have highlighted stereotypes as an obstacle to access to housing it would be important to develop national campaigns to combat these stereotypes and exchange good practices. It would be important to put on rental market empty houses at decent/accessible prices and expand social housing: the National Housing Strategy highlights that “the number of social housing dwellings around 120.000 proves to be insufficient to tackle the needs and makes it necessary to develop models to ensure the mobility of social housing stock and making it available for families whose incomes do not allow them to access adequate housing in the market. (...) it should ensure a management that promotes the preservation and the maintenance of the housing stock and promote co-responsibility models for the tenants, with accomplishment of their duties, either in the preservation, either in the payment of the rent. It is also necessary to promote rehabilitation measures of the most deprived urban areas and the eradication of precarious accommodation houses”.

It would be important to have an adequate social protection system that could cover all the needs of people – especially vulnerable people – and contribute for an equal access to all the basic needs and services.

***EAPN Slovakia****: The public policy will support the housing and jobs.*

***EAPN Sweden:*** *Public financial support for building more affordable housing*

*Limitation of rules and regulation that excludes people from being accepted as tennants*

***Public health services:***

***EAPN Belgium***

* *We have a “third party pay” system: people who have access to this system only have to pay the amount of money left after deduction of the reimbursement of the insurance. But people have to ask for it themselves, which is stigmatizing, and some doctors refuse. This should be generalized*
* *Higher health compensation is part of our social protection system, this makes it possible for people with low incomes, to have access to affordable health care. Also other rights are based on this system. It is a very interesting system, thought it could be improved, it should be granted automatically, which is not the case.*

***EAPN Finland:*** *To stop public substitutions/funding for private health sector, so that all public money would benefit public health sector.*

*To finalize the Social welfare and health care reform in a way, that it would secure the services in all around the country and reduce health and wellbeign inequalities. Now the reform is going on, but not with so strong commitments for these goals.*

***EAPN Iceland:*** *All costs in the health care system, such as medical appointments, physiotherapy and other health care costs should be in one discount arrangement, and thus set a limit on payments for health care.*

*Employing psychologists, occupational therapists and social workers to work in local health care clinics. It requires interdisciplinary cooperation, but not just doctors and nurses.*

*We need new laws, where coded together law on social services and health care services, ie legislation on welfare.*

**EAPN Ireland**

**Universal Healthcare**

There is a need for the stepped roll out of universal healthcare, including an adequately resourced primary care strategy, as a priority to begin to dismantle the inequitable and two tier health system which is currently based on ability to pay rather than need. The current phased and very partial approach to extending access to primary care has not tackled the fundamental flaws of the current General Practitioner (GP) model. A preventative model of primary care, access to which must be based on need, must be a fundamental building block of a fit for purpose primary care system. Aligning access to GP care, in an equitable and timely way, with appropriate access to other primary care health care practitioners, continues to pose implementation issues and is not a reality for many people.

The principle of achieving measurable patient health outcomes should be integrated and used as the driver across all elements of the public health system rather than the current focus on financial efficiencies.

The system must also address health inequalities and recognize the need to address its causes. These causes are in the structure of the two tier health system and access to health services when they are needed but also in areas related to poverty, accommodation, education etc. It must response to the specific health needs of different groups in society.

Overall the levels of taxation and expenditure on public services and social protection in Ireland are low and need to move towards the EU average. This needs to be done in a progressive and equitable manner. This will help to address inequality and the social determinants of ill health.

The Irish Government has published Healthy Ireland- A framework for improved health and wellbeing 2013-2025. While the document lacks detail it does outline a positive approach for addressing many issues related to health and well-being. This includes tackling health inequalities. However, there is a big gap between the publication of this framework and the implementation of measures to implement it.

In recent days the Minister for Health has announced that the move to Universal Health Care (UHC) will be further delayed in Ireland. This election commitment, made by the current Government, has been dogged by controversy since it was made. There is deep unease and disappointment at the amount of funds which have been poorly used by the previous Minister to research a narrow range of options for UHC. Further delays have now been announced due to the unsatisfactory status quo of the current intelligence available. There was a very narrow and flawed consultation process a year ago in which a model of UHC was presented for discussion. This did not allow a robust and detailed enough exploration of the elements needed to put in place a coherent and sustainable funding model for Ireland. There is a very deep unease that the issue has become highly politicised which is hindering progress.

***EAPN Latvia:*** *Stronger supervision funds given, involving social NGO-s and most clear direction funds given and aim/rules afterwards usage for which type of society (poor or wealthy)*

***EAPN Norway:*** *Make dental health as a right based service on the same level as ordinary health services.*

**EAPN Portugal**: Is urgent the development of local development politics and measures to fight the desertification of inland areas. The close down of the public services in these municipalities promotes a vicious circle in the social exclusion of these population.

Widespread information on the groups free of user charges in health services. For some groups, they are automatically free of user charges (i.e. minor of 18 years), but in other cases the person should request this right. It is important that the information on the groups that could access this right should be displayed in the social health services in a visible place. On the other side, the application for people with low income is made online. This is an obstacle in accessing this right. The application process should be easier to people without internet and with low literacy skills.

Although the price of medicine didn’t increased, with the cuts in some social benefits the most vulnerable population also suffered an impoverishment. Due to the harsh condition of part of the population, the access to medicine became a problem of access to health. It is important the development of public measures to promote the access to medicine by most vulnerable.

***EAPN Slovakia:*** *The public policy which will not allow to make the profit from the mandatory health insurance for the private Health insurance institutions. The heath services need to be support by public policy. The health policy should be not tied to status of the people.*

***EAPN Sweden:*** *More equally spread health care centers due to f ex better systems for financing and public funding or the care given.*

*Higher subsidies for medicines and dental care*

1. ***What could be the policy solutions to tackle the inaccessibility and exclusion from housing and public health services at EU level?***

***Housing:***

***EAPN Belgium***

*Minimum quality standards for all housing.*

*Minimum energy efficiency standards.*

***EAPN Finland:*** *Less austerity, more social investments, more attention for social rights like subjective right for housing.*

***EAPN Iceland:*** *Iceland is not an EU country.*

**EAPN Ireland**: Social investment must be prioritised at EU level and supported at national level. Currently there is inadequate investment in many areas of services in Ireland including in social housing and in early childhood care and education.

The rules of the Growth and Stability Pack need to be looked at to see how they can support rather than hinder social investment. This can be done while supporting member states to be fiscally responsible.

***EAPN Latvia:*** *Empty property tax, support private owners, inform society reimbursement via Municipality possibilities*

***EAPN Norway****: Requirements for earmarking interests of Member States' budgets which membership of the Union build on the strategies adopted by the countries of the EU – e.g. Lisbon Treaty and targets in the 2020 strategy. Today often leaves EU Commission established strategies and changes they or silence the policies to keep silent about policy targets in step with choices the winds*

**EAPN Portugal**: The commitment with the eradication of poverty and social exclusion must be European. So, when we present the need for a national strategy to fight poverty and social exclusion it would be important to develop a European directive at this level.

It would be important if some of the recommendations of the Commission presented in the Social Investment Package – Confronting Homelessness in the European Union – could be assumed by member states. For example, the document “argues for more urgent concerted action to take preventative measures that can reduce the risk and magnitude of homelessness”, so the National strategy for the inclusion of homeless people is fundamental. If the Commission’s recommendations were directives perhaps there would be a commitment of the national government for the follow up of the strategy.

An EU recommendation for the need to an adequate and affordable housing for all, especially for those living in poverty and social exclusion could be a solution.

***EAPN Slovakia:*** *The individual, family support.*

***Public health services:***

***EAPN Belgium****: Obligation for Member States to realize access for ALL people residing in the country to basic health services.*

***EAPN Finland:*** *Limit the space of private health services, no public money for private companies.*

***EAPN Iceland:*** *Iceland is not an EU country.*

**EAPN Ireland:** The EU focus needs to be on ensuring universal access to healthcare based on need across the EU. It must be based on the principle of equality of access to health services and address prevention and the causes of health inequalities.

The current over focus on cost-effectiveness without addressing the issue of access and inequality will result in more negative outcomes for those on the lowest incomes and the most vulnerable groups in society.

The European Council conclusions in June 2011 are useful in terms of recognizing the need to address health inequalities: <https://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/122395.pdf>

Paragraph 3 ‘RECALLS the Council conclusions on common values and principles in EU health systems adopted on 2 June 2006 , and particularly the overarching values of universality, access to good quality care, equity and solidarity’

***EAPN Latvia:*** *Stronger supervision funds given, involving social NGO-s and most clear direction funds given and aim/rules afterwards usage for which type of society (poor or wealthy)*

***EAPN Norway:*** *same as above regarding housing. Eyemark budget posts and increase the demands for the member states.*

**EAPN Portugal**: Higher transparency of the lobby of pharmaceutic industry in European Commission and a higher capability of the EU to negotiate better prices for costly medicine treatments.

***EAPN Slovakia:*** *The important is not the economic aims, but the social, responsible and human aims. E.g. the recommendation to reduce the health costs do not support the accessibility.*

1. ***What good practices can you highlight in increasing access and preventing exclusion to housing and public health services? Were EU Funds used – in particularly*** [***EU Programme for Employment and Social Innovation***](http://ec.europa.eu/social/main.jsp?catId=1081&langId=en) ***and*** [***European Social Fund***](http://ec.europa.eu/esf/home.jsp?langId=en)***? If yes, very briefly, how well?***

**Housing :**

**EAPN Finland:** « Housing first » –principle, so that housing is first thing and other support and services (fe. to solve alcohol/drug problems) comes only after that.  
ESF has been used to « housing first » -projects in Finland.

« Housing help », so that people got support when they have questions or problems with housing, so that they don´t get kicked out from their homes.

**EAPN Iceland**: Special housing benefits. The municipalities pay them to low income families and individuals.

Reykjavík plans to build more social apartments to try to reduce the housing problem.

**EAPN Ireland**: There are a number of measures in the two Irish European Regional Development Programmes focused on housing. Both have similar infrastructural programmes including:

* The Better Energy Warmer Homes scheme which aims to deliver a range of energy efficiency measures to a number of households that are vulnerable to energy poverty.
* An insulation retrofitting programme for occupied social housing units
* Retrofitting vacant social housing (currently 4,000 such homes in Ireland) to bring them back into use.
* Early in 2015 the **European Investment Bank** has invested €150 million into a new investment fund for social housing. This will be matched by the Housing Finance Agency (HFA) in Ireland. The €300 million in funds is then available as a loan to voluntary housing associations at preferential rates to build social housing.

**EAPN Portugal**: According to the National Housing Strategy «the new EU cycle of funding (2014-2020) and the Partnership Agreement *Portugal 2020* “opens for the first time the possibility to fund housing projects around urban rehabilitation”. Finally, after 30 years of European integration, it can be said that housing begins to appear on the eligible operations of the Community policy funding, associated with energy efficiency and urban regeneration.»

There is also a national and local experience promoted by the Portuguese Association of Large Families (*Associação Portuguesa de Famílias Numerosas*). This Association started in 2002, in collaboration with local authorities a process for the definition and implementation of Family Local Policy (*Política Autarquica de Família*). With this work it was possible to implement the Family Fare Water in some districts of the country and it appeared the concept of Family Friends Municipalities (*Autarquias Amigas da Família*). This concept was extended to other areas like: Local Authority + Family Responsible (*Autarquia + Familiarmente Responsável*) as employer and Local Authority + Family Responsible for citizens (through the adoption of measures enabling the family life of local citizens). Since 2007 is being identified good practices at local level and local authorities can receive a symbol for their commitment with these areas. Housing and Urban Development is one of the areas of practice that is suggested to be included in local plans (it’s suggested some practices like: make discounts on local taxes for families with 3 or more children; support the rehabilitation of degraded houses for families with 3 or more children; and so on)[[12]](#footnote-12)

*Housing First* is also a good practice that can be presented. The project started in 2009 to promote the inclusion of homeless people with mental health problems, providing support in selecting, acquiring and maintaining a single, integrated and decent home within the community. This programme was implemented by AEIPS – Associação para o Estudo e Integração Psicossocial and according to same information available by this entity, between January 2011 and December 2012, 74 homeless people with mental health problems have used this program. In terms of results. “the impacts of housing in participants’ perceived quality of life are clearly significant, in terms of personal safety (98%), nutrition and sleeping habits (82%), health and mental health (78%) and social life (52%)[[13]](#footnote-13).

There are already other experiences of Housing First in other local districts of the country.

It’s also important to highlight that it was defined and implemented this year a National Housing Strategy[[14]](#footnote-14). This strategy has a more operative nature, structured in 3 pillars: Urban rehabilitation; Housing Rental; Accommodation Qualification. Poverty and Social Exclusion is one of the areas that is analysed in the Strategy (please see previous answers).

**EAPN Slovakia:** E.g. the financial support to build the housing for Roma people, young families, families with disability person, support for municipalities to build the rental housing.

**Public health services :**

**EAPN Belgium**

Community health centers

<http://www.vwgc.be/media/Documenten/OPEN%20GEDEELTE/De%20vereniging/What%20does%20the%20Organisation%20of%20Community%20Health%20Centers%20do.pdf>

These centers are very affordable, accessible, and people experiencing poverty are very positive on the quality of these centers.

**EAPN Finland:** « Health kiosks », « low threshold services » etc. so that fe. poor and old people don´t need to go to the separate health services, but they can talk and measure about some things when they go to the shops, library and other places like that.

**EAPN Portugal**: Access to health services free of user charges by the minors was an important measure to widespread the access to public health services, especially in a context of economic crises.

This week, in the moment that Portugal is changing Government (right wing to left wing), the right wing party decided that “from this Thursday [26/11/2015] users charges in the permanent care services (SAP) of health Centers are now extinct” (...) “who uses the health centers services after 20H goes to pay only 5€ applied to any medical appointment and not eh 10.30€ that used to pay for using emergency services”[[15]](#footnote-15).

**EAPN Slovakia:** The support of the health infrastructure.

1. ***What actions do your network/organization play in supporting greater access and fighting exclusion from these services? (please mark with a cross the relevant service/s you provide).***
   1. ***direct services***

***EAPN Finland***

* 1. ***support and advise services***

***EAPN Finland***

* 1. ***advocacy actions***

***EAPN Finland, EAPN Ireland***

* 1. ***supporting the direct participation of users in these services***

***EAPN Finland***

***e) other.***

***Please give some examples/with links if possible etc.:***

***Housing:***

***EAPN Belgium***

*b) support and advise services*

*c) advocacy actions*

***EAPN Finland:*** *Some members of EAPN-Fin provide those services especially around housing, but I don´t have time to start telling about them (too many and complicated to mention in this survey).*

**EAPN Ireland** does not provide direct services but does policy and advocacy work on a range of issues including on services.

A number of EAPN Ireland’s members are organisations working directly on issues of housing and homelessness and through this EAPN Ireland is able to ensure that issues of housing and homelessness are kept on our agenda and in our policy and advocacy work.

**EAPN Ireland** membership also includes a range of other organisations representing groups which face ongoing issues in relation to housing and accommodation. This includes Travellers, people with disabilities, refugees and asylum seekers etc.

***EAPN Latvia:*** *Government listening, but continue their own policy*

***EAPN Norway***

*b) support and advise services*

*c) advocacy actions*

*d) supporting the direct participation of users in these services*

**EAPN Portugal**: In 2009 EAPN Portugal implemented the National and Local Councils of Citizens. These groups are composed by citizens that lived or are living in situation of poverty and social exclusion and have as main aims to give them voice in the matters that are directly related to their situation. They have also an increasing role in the definition of EAPN Portugal priorities through a National Council and the National meetings of people experiencing poverty. Subjects like housing, health, obstacles in the access to these services and others, are being discussed internally, not only to clarify these citizens, but also to fight stereotypes, and support some of our documents[[16]](#footnote-16).

In 2013 EAPN Portugal participated in the Project DRIVERS[[17]](#footnote-17) and through the development of focus groups with people living in poverty and social exclusion (especially homeless people and drug addicts) it was possible to understand their relation and also their difficulties when accessing to social protection services and health services. Through the debate on social protection services, the area of housing was also analyzed.

Through our research department it is planned to develop in 2016 a national research on Poverty Impact in People Mental Health. The aim of the research is understand the relation between poverty and social exclusion and mental health problems in vulnerable groups[[18]](#footnote-18).

Although the National Strategy for the Inclusion of Homeless People has no developments, EAPN with other NGO are lobbying for its reinforcement and evaluation once it ends in 2015.

**EAPN Slovakia**

1. *Individual, family support*
2. *Accessible information*
3. *The public hearing with the people who have the competence to change this situation*
4. *Active participations of the people on the creation of the development plans in the municipalities - and Acceptation of the needs of the inhabitants*
5. *Acceptation of the Social aims, create the helpful social environment*

***Public health services:***

***EAPN Belgium***

*b) support and advise services*

*c) advocacy actions*

***EAPN Finland:*** *Some members of EAPN-Fin provide those services especially around housing, but I don´t have time to start telling about them (too many and complicated to mention in this survey).*

***EAPN Iceland:*** *EAPN has a representative in the Welfare Watch. The Welfare Watch is a part of the Icelandic Presidency Programme 2014. It is a 3 year project which aims at promoting and strengthening the sustainability of Nordic welfare systems through cooperation, research and mutual exchange of the experience and knowledge acquired. The objective is also to develop solutions and coordinate actions to meet future*

**EAPN Ireland** has not been so engaged in addressing policies related to health inequalities although the issue of increasing mental health has been raised in our reports on the impact of the crisis on marginalised groups and communities.

***EAPN Latvia:*** *Government listening, but continue their own policy*

***EAPN Norway:***

*b) support and advise services*

*c) advocacy actions*

*d) supporting the direct participation of users in these services*

***EAPN Slovakia:*** *The important is the participation of the people on the health policy. The acceptation also the social aims, not only the economic aims. From the mandatory contributions cannot make the profit, it can serve for the people.*

1. **Do you have any additional comments on the situation of public social services in general or of some other public social services besides housing and health services?**

**EAPN Belgium**

More & more privatization leading to higher prices and lower accessibility

Services suffer austerity measures, which have a negative impact on their availability and quality

More and more people are excluded from all systems giving them right to different services

**EAPN Finland**: Ministry of Social and Health says about “Social welfare and health care reform”:

“The objective of the reform of social welfare and health care services is to reduce inequalities in well-being and health, and to manage costs. The social welfare and health care services will be combined on all levels in order to reach the objective. The aim is to create seamless service chains for the provision of key social welfare and health care services, and to improve the functioning of basic services. The organisers' service capacity will also be improved. This will have a significant impact on the sustainability gap of public finances.”

-http://stm.fi/sote-uudistus?p\_p\_id=56\_INSTANCE\_iOt1FzeDeZRP&p\_p\_lifecycle=0&p\_p\_state=normal&p\_p\_mode=view&p\_p\_col\_id=column-2&p\_p\_col\_count=5&\_56\_INSTANCE\_iOt1FzeDeZRP\_languageId=en\_US

But now the centre-right –government has made political deal, that they will form 15-18 SOTE areas (experts said 12 would be good, but the Centre party needed more for they power-reasons) and that there will be “Swedish model”, where patient can “freely” decide to choose private or public services (the Rught party wanted that to secure the interests of private companies), so seggregation can go further.

**EAPN Latvia:** To influence legislation at least European social NGO-s should be involved into legislation creation process as the Social Partner (SP) for Government with veto vote to be able to block creation of socially unresponsible lows and rules.

**EAPN Slovakia:** The responsible approach from both sides – from the individuals and from the public authorities (rights and duties from both sides).

1. Central Bank Residential Mortgage Arrears and Repossession Statistics Q2 2015 <http://www.centralbank.ie/polstats/stats/mortgagearrears/Pages/releases.aspx> [↑](#footnote-ref-1)
2. Summary of Housing Needs Assessment 2013 Housing Agency [www.housingagency.ie](http://www.housingagency.ie) [↑](#footnote-ref-2)
3. European Parliament, *Social Housing in the EU*, January, 2013, p. 14. [↑](#footnote-ref-3)
4. Social Insertion Income is a social protection measure designed to support individuals or families who are living in a situation of severe economic distress and in risk of social exclusion. [↑](#footnote-ref-4)
5. In <http://www.portaldahabitacao.pt/pt/nrau/home/apresentacao_nnrau.html> [↑](#footnote-ref-5)
6. <https://bna.mj.pt/Entrada.aspx> [↑](#footnote-ref-6)
7. *Cinco famílias são despejadas por dia por rendas em atraso*, DN – 27/07/2015 - <http://www.dn.pt/economia/interior/cinco-familias-sao-despejadas-por-dia-por-rendas-em-atraso-4700684.html> [↑](#footnote-ref-7)
8. <http://www.mercadosocialarrendamento.msss.pt/mercado_social_arrendamento.jsp> [↑](#footnote-ref-8)
9. National Housing Strategy, p. 12 [↑](#footnote-ref-9)
10. In Paula Cruz; Fátima Veiga, *Project DRIVERS – Portugal Case Study*, EAPN Portugal, 2013 [↑](#footnote-ref-10)
11. In *Habitação em Portugal: evolução e tendências*, João Branco Pedro, 12/11/2013 (available: <file:///C:/Users/paulacruz/Downloads/JoaoBrancoPedro%20(1).pdf> [↑](#footnote-ref-11)
12. For more information (only in Portuguese): <http://www.observatorioafr.org/sobre.asp>; <http://www.observatorioafr.org/documentos/QuadroReferencia2015.pdf> [↑](#footnote-ref-12)
13. In: <http://hf.aeips.pt/wp-content/uploads/2013/10/Jose_Ornelas.pdf> [↑](#footnote-ref-13)
14. Resolução de Conselho de Ministros nº 48/2015 de 15 de Julho; More informations (in portuguese): <https://www.portaldahabitacao.pt/pt/portal/habitacao/EstNacHabitacao> [↑](#footnote-ref-14)
15. In Saúde. Governo aprova medidas na véspera da despedida, Jornal Expresso, 2671172015 (available - <http://expresso.sapo.pt/politica/2015-11-26-Saude.-Governo-aprova-medidas-na-vespera-da-despedida-1>) [↑](#footnote-ref-15)
16. Participation web page - <http://participacao.eapn.pt/apresentacao/>; EAPN Portugal web page: <http://www.eapn.pt/index.php> [↑](#footnote-ref-16)
17. <http://www.eapn.pt/projectos_visualizar.php?ID=151>; <http://health-gradient.eu> [↑](#footnote-ref-17)
18. Since this research will start only in 2016 there is no information on our web page. In January we will put some information on the EAPN Portugal web page: <http://www.eapn.pt/projectos.php?ID=4> [↑](#footnote-ref-18)