EAPN
EUROPEAN ANTI POVERTY NETWORK

NOBODY LEFT BEHIND

Ensuring access for all to affordable, quality housing and public health services

TABLE OF CONTENTS

1.INTRODUCTION

EAPN members are increasingly alarmed about the declining access to quality public services (Services of General Interest) for ordinary people, in the context of increasing privatization and liberalization. With the onset of the crisis and austerity measures, access to key public services have been hit particularly hard, impacting on poverty and inequality. When asked to identify the services mainly at risk, EAPN members highlighted **access to affordable, quality housing (particularly a lack of social housing) and public health services** as the main priority challenges facing people on the ground, and in particular those facing poverty and social exclusion. The provision of universal services are a vital element of social protection and welfare states; preventing and tackling poverty and social exclusion, and acting as a lynchpin for the EU social model. Equal and affordable access to quality services (i.e. housing, health services, social services, education, etc.) is also one of the three main pillars (in addition to income support and inclusive labour market) of the Active Inclusion Strategy[1] promoted by the EU (EC, 2008), which could ensure greater social inclusion and participation for people who are currently excluded from the labour market. This was confirmed in the Social Investment Package in 2013 and is now underpinned by the European Commission's new proposals on the European Pillar of Social Rights (EC, 2016).

EAPN affirms that equal and affordable access to quality services is a fundamental right. It also forms a key pillar of an integrated strategy to ensure an effective reduction of poverty in Europe, as reflected in the poverty target[2] set by the Europe 2020 Strategy, as well as a key means to reduce inequality. In setting future policies and strategies for implementing rights, accessibility of services, affordability, coverage and quality must be key criteria. There is also a need to ensure universality, guaranteeing the right for all as part of an essential social compact to ensure quality services for everybody, combined with targeted measures to ensure rights of access for vulnerable groups and antidiscrimination measures (targeted universalism). EAPN believes that the new European Pillar of Social Rights linked to the UN Sustainable Development Goals Agenda for 2030 should provide an overarching rights-based framework and a global call for action to implement human rights, giving a key role to the EU. EAPN will work together with other EU stakeholders and decision-makers to ensure that the pledge 'nobody is left behind' is made a reality.

This EAPN mapping report on access to housing and public health services aims to explore what is happening to key public services and their changing access for people experiencing poverty (access, affordability, coverage, quality, increasing exclusion) and to propose policy solutions at EU and national level. It hopes to help build common understanding amongst EAPN members and other stakeholders on what are the current country-specific realities in the context of the access to housing and public health services, as experienced by people in poverty and their organisations. It will also explore how EAPN can support its members in bringing positive developments to their countries through engagement with national and EU Institutions.

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[1] COMMUNICATION FROM THE COMMISSION TO THE COUNCIL, THE EUROPEAN PARLIAMENT, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS on a Commission Recommendation on the active inclusion of people excluded from the labour market (2008) (here)
[2] The target set in 2010 is to reduce the number of people at risk of poverty and social exclusion by at least 20 million by 2020, according to 3 indicators: at risk of poverty, severe material deprivation and low work intensity.

OBJECTIVES

∇   Map the reality of access to housing and health services (or exclusion from them), and analyse the impact on people experiencing poverty and social exclusion.

∇   Draw on national realities and members' experiences to provide national examples and high-light new developments, as an example of ensuring access to key Services of General interest.

∇   Propose key messages and recommendations to national and EU policy makers in the context of current EU policy developments.

METHODOLOGY

This report is based on primary source material obtained through dedicated sessions of structured discussion and mutual exchange with EAPN members during the meetings of EAPN's EU Inclusion Strategies Group (EU ISG) in October 2015, February 2016 and June 2016. A questionnaire was developed with the members of the EUISG. The questionnaire template fiche was completed by 10 EAPN National Networks: Belgium, Finland, Iceland, Ireland, Latvia, Norway, Portugal, Slovakia, Sweden and the United Kingdom. The draft was sent for input to EU ISG members and written comments were received additionally from EAPN Austria, Croatia, Cyprus, Czech Republic, Estonia, France, Germany, Iceland, Italy, Macedonia, the Netherlands, Poland, Romania and Serbia. Additional secondary sources include EU and national reports/articles. The report was drafted by Viola Shahini, with support from the EAPN Policy Team: Sian Jones and Amana Ferro.

2. KEY MESSAGES AND RECOMMENDATIONS

KEY MESSAGES

▽ **Public services have become increasingly a target for policy reform**, focused on austerity, and restructuring public services and as a driver to promote growth, rather than as an investment in quality universal services for all.

▽ **Privatisation of public sector services as a means to reduce costs and reduce welfare states is undermining rights**. The drive to privatise and liberalize services is driven by EU macroeconomic and internal market policies prioritizing efficiency concerns to reduce public deficits, through austerity and increased competition in the internal market, rather than effectiveness and equity. This is a factor in increasing poverty and inequality.

▽ **Reliance on the market alone to increase the supply of housing has spectacularly failed to provide affordable housing for all**. This has been exacerbated by increased de-regulation of rents and cuts to investment and supply of social housing.

▽ **Access to affordable quality housing is an essential pre-requisite in preventing as well as tackling social inclusion**, together with adequate income and income support. Investing in the right to quality affordable housing, including public social housing, should be seen as a priority intervention policy to prevent homelessness and tackle housing exclusion as well as reduce poverty and social exclusion. It should be a foundation to the right to a dignified life.

▽ **Provision of affordable quality public health services is vital to ensure a longer and a healthier life for all, but also to promote more inclusive and sustainable growth**. The social and economic costs of reduced access, directly impact on employment, as well as social inclusion, and impact negatively on growth. Reduced access to key public services and social protection are a key social determinant in increasing inequalities in health, and generating poverty and social exclusion.

▽ The **European Pillar of Social Rights linked** could play an important role in defending social standards, as long as it is mainstreamed to ensure that macroeconomic and internal market policies and EU funds actively contribute to guaranteeing these rights, rather than undermining them. The link to the **UN Sustainable Development Goals** as an overarching rights-based agenda is also crucial.

▽ **The voices of the poor are essential: as a fundamental right to participation** and to understand the decline in rights to services and their impact on people in poverty, and to inform more effective policy solutions.

POLICY RECOMMENDATIONS – NATIONAL LEVEL

Housing

▽ **More investment for accessible social housing: (BE, HR, CY, EE, FI, FR, DE, IE, IT, NO, PL, PT, RO, RS, SE).** Increased national social house-building should be an initiative to address the current fall in the supply and promote an adequate supply of affordable housing, thus avoiding long waiting lists (FI, IE, IT, RO, SK, UK). They should meet the people's needs in terms of quality (heat, electricity etc.) and personal and community safety (IS). It is also necessary to promote rehabilitation measures of the most deprived urban areas and the eradication of precarious accommodation (PT). It would be important to have an adequate social protection system (IT, PT, RO) that could cover all the needs of people – especially vulnerable people - such as increases in housing benefits for low income families and individuals in order to reduce their burden of housing costs (IS, NO) and contribute to an equal access to all the basic needs and services. In addition, there is also a need to keep the public informed about the existence of such reimbursement at municipality level (LV). Using ESF and other EU funds for building social and municipal houses is key (EE). Investing in quality affordable social housing should be seen as an intervention policy to prevent homelessness (IE), as well as tackling poverty and social exclusion (PT, RO). In the areas where there is a lack of affordable housing, government should give land to not-for-profit associations to build social housing (HR, IS, NL, UK).

▽ **Promote a more sustainable, inclusive 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 (IE, IT). There is also a need to make renting, in quality accommodation at affordable prices, a more viable option than it is currently by limiting conditions that exclude people from being accepted as tenants (IS, IE, IT, PL, SE). A level of rent control is necessary to prevent rents in the private market from becoming unaffordable. This should be benchmarked against the cost of living with changes linked to inflation or deflation. MS need to make sure that all different types of housing are accessible and affordable – thinking also of old age, disability - and linked to financial support for people who cannot afford it (HR, IS, NL, UK). Support should be given to subsidise loans and to help avoid over-indebtedness (EE, FI, FR, NO, SK). A key recommendation would be the setting of a benchmark of acceptable housing cost for people on low income.

▽ **Developing national campaigns for tackling stereotypes and inequalities and for sharing good practices:** There is a need to avoid large segregated social housing developments which reproduce social exclusion and disadvantage for the residents (IE, IT, PT, RO). National policies on social housing should be designed to halt and reverse social housing stigmatisation and include allocations to low-income families as well as those with acute social need. Establishment of agencies dealing with specific housing issues for key vulnerable groups on governmental level is essential (e.g. Travellers, Roma, migrants (including undocumented), homeless people).

Health Services

▽ **Increase investments/expenditure in public health services taking account of growing needs.** Investments should be made in prevention, as well as primary, specialist and mental health/therapeutic care. The healthcare budget should be supported by increased tax revenue through tax justice.

▽ **Promote accessibility to quality health** (access, affordability, coverage, quality). Healthcare should be not just affordable but free at the point of entry, for all aspects – i.e. optical and dental treatment, but also mental health care (BE, HR, HU, IS, IE, LV, NL, UK). In terms of coverage every essential service should be included, including the link to long-term health care. The quality of care must be considered in terms of reducing waiting times and increasing geographical accessibility and proximity of services. Further privatization should be considered carefully due to increasing costs and decreasing quality, and its role in increasing inequality.

▽ **Avoid stigmatization**: In many countries with insurance-based schemes, there is 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. However, people have to ask for this themselves, which is stigmatizing and some doctors refuse. The right should be generalized and destigmatized. Higher health compensation is part of our social protection system, and makes it possible for people with low incomes to have access to affordable health care.

▽ **Tackle the social determinants of health**: Growing inequality in health and in access to health services is a major challenge. Poverty and social exclusion is a major social determinant of health outcomes and cause of growing health inequalities. Key factors include the quality of employment, social protection and services. Investment in these areas is crucial to ensure better and more equal health for all as well as reduce poverty and inequality.

POLICY RECOMMENDATIONS: EU LEVEL

Housing

▽ **The EU should pursue a housing rights agenda**. The right to a decent and affordable home should be seen as key EU aquis[3], drawing on a growing EU and international jurisprudence in relation to housing rights[4]. The right to housing should be enforced regardless of residence status, to ensure access to rights for migrants, homeless people and other excluded groups.

▽ **EU minimum quality standards for housing should be agreed and monitored**, taking the indicators from the EU SILC as a minimum. Such absolute standards should also be benchmarked in relative terms in relation to country norms. A composite housing exclusion indicator should be developed linking existing EU SILC indicators (e.g. on housing cost, rent arrears, overcrowding etc.).

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[3] Community *acquis* or *acquis communautaire* sometimes called the *EU acquis*, is the combined legislation, legal acts, and court decisions which constitute the body of *European* Union law. They are also the pre-requisite conditions by candidate countries in order to join the EU

[4] FEANTSA (2016) 5 Key principles for implementing the housing priority in the European Pillar of Social Rights.

▽ **EU minimum energy efficiency standards should be established and refurbishment supported** including through EU funds (e.g. ESIF) prioritizing social housing and houses of people on low incomes to ensure that the cost is not passed on to them in the form of increased rents.

▽ **Increased social investment in housing and innovative housing solutions in the EU must be supported, including through EU funds.** Increased investment in social housing is crucial in order to increase access to affordable housing for low income groups. Recognition of the benefits from such social investment should be discounted in the deficit calculations and a revision of the Growth and Stability Pact proposed. More priority to such investments should be made through the European Fund for Strategic Investment (ESIF) and other funds (e.g. EaSi and SFs) in scaling up innovative housing solutions, e.g. Housing First.[5]

▽ **The EU should support regulation of housing rents in areas of housing market failure,** in order to promote affordable homes for low income households. Guidance should be given to ensure that housing benefit and income support schemes adequately compensate low income households who are not able to access affordable rents.

▽ **A road map should be established to implement the European Commission's proposals for tackling homelessness and housing exclusion** in the Social Investment Package and to develop integrated, cross-sectoral strategies including Housing First, working to eliminate legislation that criminalizes homelessness.[6]

▽ **Europe 2020 and the European Semester should make Country-Specific Recommendations** (CSRs) to support the increase of adequate and affordable housing for low income groups, including through investment in social housing, support to targeted regulation and adequate housing and income support, promotion of cross-sectoral strategies to tackle homelessness and a stop to criminalization.

Health Services

▽ **The EU should create an adequate framework to guarantee the right to affordable universal, quality health and care services for all,** covering all essential health and care services (including prevention, primary, hospital and specialist care, dental, mental health, long-term care and the cost of medicines).

▽ **Equal access for all groups and in all areas must be ensured**, in terms of disability but also geographical coverage, including regional inequalities particularly rural areas.

▽ **A specific commitment should be made to public health** and an independent assessment of the impact of privatisation and liberalisation on access to affordable, quality health care for all carried out.

▽ **EU macroeconomic policy must visibly move away from an austerity focus** on only cost-effectiveness and efficiency in health services, giving a new priority to effectiveness, equity and access. MS with good health care systems should be warned against reducing health care access and coverage. This should be reflected in the European Semester and the CSRs.

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[5] FEANTSA, as above.
[6] FEANTSA, as above.

- ▽ **EU mobility and transferability of rights to affordable health services must be clarified** and guaranteed as part of the support to EU people mobility, ensuring that all groups can access rights, including undocumented migrants.

- ▽ **Transparent monitoring of EU funds spending on health (ESIF and EFSI) should be carried out with the involvement of civil society** to ensure that funding supports affordable access to quality health for all.

- ▽ **Higher transparency must be required of the pharmaceutical industry** on the EU level, with better negotiation of prices for medicines for costly treatments.

- ▽ **Poverty and social exclusion must be recognised** as major social determinants of health inequality which lead to long-term social and economic costs.

- ▽ **The users (patients and those currently unable to access health services) must be made key actors** in diagnosis, monitoring and delivery.

OVERARCHING RECOMMENDATIONS ON ACCESS TO KEY SERVICES

Nobody left behind: Guarantee the right of access to adequate, affordable quality services to all

- ▽ The EU must guarantee people's rights to access all essential services for a dignified life. Social rights should not be subordinate to the internal market in services.

- ▽ Access to services must cover accessible as well as affordable, quality services i.e. geographical coverage, disability access, as well as access to waiting lists and for all groups.

- ▽ It must also be environmentally sustainable i.e. support the circular economy.

- ▽ The European Pillar of Social Rights should provide an operational roadmap for implementing these rights at EU and national level.

- ▽ The EU has signed up to the SDG[7] agenda. This includes several key rights related to the eradication of poverty and access to key services including health and housing. These must be mainstreamed, supported and concretized at EU and global level with the support of civil society (SDGs 1, 3 and 11).

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[7] UN Sustainable Development Agenda and 17 Sustainable Development Goals (SDGs) adopted in 2015.
SDG 1: Eradicating poverty in all its forms; SDG 3:Ensuring healthy lives and promote well-being for all ages;
SDG 11: Making cities and human settlements inclusive, safe, resilient and sustainable

Stop austerity and promote social investment in access to housing and health, including through EU funds

▽ The EU must stop its austerity approach and prevent further cuts to public investment in these essential Services of General Interest.

▽ Social investment in key services such as housing and health should be seen as a key redistribution instrument and an essential requisite to inclusive growth as well as contributing to the reduction of poverty.

▽ Investment in social spending in services and social protection must be measured as a benefit, not a cost, in public deficits and should be a key priority in the European Semester, starting with the Annual Growth Survey (AGS) and reflected Country-Specific Recommendations (CSRs).

▽ Give new priority in EU European Structural and Investment Funds (ESIF) to investing in affordable, quality housing and health services, particularly social housing, and quality public health services and in ensuring affordable access for all, particularly for excluded groups.

Benchmark and effectively monitor social standards on adequacy and affordability

▽ Concrete EU benchmarks for social standards in quality housing and health must be developed as part of the European Pillar of Social Rights. This should include common definitions and improved common indicators to monitor access by all groups to affordable, quality housing and public health services.

▽ Monitoring must be transparent and democratically accountable, and result in impact on policy. Key social inclusion indicators must be considered on an equal basis with economic and employment indicators and trigger policy change.

▽ The EPSCO, EMCO and SPC have a key role to ensure this implementation with the involvement of NGOs including people experiencing poverty.

Provide effective regulation and mainstream social impact assessment

▽ EU Macroeconomic and internal market policies should be regulated to ensure people's rights to access quality public services (Services of General Interest) is guaranteed, honouring public service obligations.

▽ An independent study should be carried out to assess the distributional and social impact of privatisation and deregulation policies in the health and housing sectors.

▽ More transparent ex-ante and ex-post social impact assessment must be put in place, involving civil society and other stakeholders, for example the new Regulatory Scrutiny Board, and debated in the European Parliament.

Make equity and effectiveness core goals for macroeconomic policies

∇ More curbs and balances are insufficient without a new vision for macroeconomic policies – **beyond efficiency and fiscal sustainability.**

∇ A new narrative must be built around the **role of macroeconomic policies to ensure 'effective public policy' in support of fundamental social rights and promoting 'equity'** including equal access to services of general interest.

Promote an integrated, rights-based strategy for a dignified life

∇ **Access to housing and health is vital, but not enough to provide a dignified life**. This needs to be combined with access to adequate income through the life cycle – through quality jobs and social protection, and the right to participation and non-discrimination. Integrated active inclusion remains a key concept if applied across the life cycle.

∇ **The EU needs urgently to develop an integrated, rights-based strategy to prevent and tackle poverty** and social exclusion, ensuring access to rights, resources and services.

Put the user at the heart of services and engage NGOs as equal partners

∇ The user must be given a clear role in the development of quality services.

∇ The voice of civil society, and particularly people impacted by the attacks on their rights is essential at all stages of the policy process – design, delivery and monitoring.

∇ Obligatory guidelines and indicators for quality civil society engagement in EU processes, including the European Semester but also EU Funds need urgently to be enacted. Increased financial resources to support participation of excluded groups in such processes is essential if citizens' voices and equal participation is to be promoted.

3. OVERVIEW OF THE CURRENT STATE OF PLAY IN THE FIELD OF HOUSING AND PUBLIC HEALTH SERVICES IN THE EU

INTRODUCTION

Services of General Interest can be defined as "*the basic services that are essential to the lives of the majority of the general public and where the state has an obligation to ensure public standards*". At EU level, these have been further divided into **Services of General Economic Interest** (SGEI) and **Services of General Interest** (SGI). SGEIs are defined as "*essential services where state regulation is deemed necessary to ensure adequate delivery, but which are considered to have an economic nature (most are linked to the existence of a market such as electricity, gas, telecommunication)*".

Social Services of General Interest (SSGI) are further defined as "*essential basic services which are provided in the public interest, but are essentially social in their character, and are often linked to national social welfare and social protection rights*". The European Commission has distinguished two types of social SSGIs: 1) statutory social security schemes linked to main life risks (ageing, health, unemployment, retirement, disability), and 2) personal services such as social assistance, employment and training services, social housing, long-term care. A Social Service of General Interest can be considered to be economic in nature or not, depending on whether they are supplied through the market.

HOUSING: CURRENT STATE OF PLAY

What definitions do we use? Quality Housing Services

One of the issues when discussing access to affordable quality services is to clarify what it means and how it can be defined. Setting out a framework on access to affordable quality services will serve as a reference for defining, assuring, evaluating and improving the quality of these services.
The EU differentiates between the services considered as serving the general interest and other services.

Eurostat defines accessibility to affordable quality housing in terms of:

∇   Housing costs measured by the overburden rate, which is the percentage of the population living in households where the total housing costs ('net' of housing allowances) represent more than 40 % of disposable income ('net' of housing allowances);

∇   Availability of sufficient space in a dwelling (overcrowding rate);

∇   Housing deprivation such as lack of certain basic sanitary facilities in the dwelling (such as a bath or shower or indoor flushing toilet); problems in the general condition of the dwelling (leaking roof or dwelling being too dark); and

∇   Problems in the residential area (noise, crime, pollution, access to other services etc.)

Legal framework: what international agreements say about the right to housing

The right to housing is the economic, social and cultural right to adequate housing and shelter. Many national constitutions and International commitments recognize the right to adequate housing to promote an adequate standard of living, as a matter of respect for human dignity, and as a way to combat social exclusion and poverty, although a formal EU right to decent housing, currently does not exist.

United Nations: Universal Declaration on Human Rights 1948 confirmed at the 1966 International Covenant of Economic, Social and Cultural Rights: Article 25 states that *"**Everyone has the right to** a standard of living adequate for the health and well-being of himself and his family, including adequate food, clothing, **housing** and medical care"*.

United Nations: 2030 Agenda for Sustainable Development (21 October 2015)

This UN agenda is a global plan of action for 'people, planet and prosperity' adopted by all countries in the UN, and delivered through 17 Sustainable Development Goals (SDGs) and 169 targets. Three goals refer to housing.

> *Goal 1: End Poverty in all its forms everywhere (including 1.4: Ensure.. equal rights to economic resources, as well as access to basic services, ownership and control of land and other forms of property).*
> *Goal 3: Ensure healthy lives and promote well-being for all at all ages.*
> *And more specifically **Goal 11**: Make cities and human settlements inclusive, resilient and sustainable (including 11.1: **By 2030, ensure access to all to adequate safe and affordable housing and basic services and upgrade slums**.*

The Council of Europe's European Social Charter (revised version, 1996) article 31 states that "*With a view to ensuring the effective exercise of the right to housing, the Parties undertake to take measures designed: to promote access to housing of an adequate standard; to prevent and reduce homelessness with a view to its gradual elimination; to make the price of housing accessible to those without adequate resources.*"

The Charter of Fundamental Rights of the EU (2010) does not provide a specific right to housing but to housing assistance in article 34 (3): "*In order to combat social exclusion and poverty, the Union recognises and respects the right to social and **housing assistance** so as to ensure a decent existence for all those who lack sufficient resources, in accordance with the rules laid down by Community law and national laws and practices.*"

For more information see the Housing Rights Watch leaflet here. See also FEANTSA's 5 principles for implementing the housing priority of the European Pillar of Social Rights here.

A snapshot of the housing situation across Europe

According to Eurostat data 2014, at EU-28 level **27.1% of the population lived in an owner-occupied home for which there was an outstanding loan or mortgage**, while 43% were owners without a loan or a mortgage. 19.1% were tenants with a market price rent, while 10.8% were tenants in reduced rent or free accommodation. **69.1% lived in owner-occupied dwellings**, ranging from 52.4% in Germany to 96.1% in Romania. The highest rates of population that were owners with loans or mortgage were recorded in Sweden (61.3%) and the Netherlands (59.2%), but also in Norway (56.6%) and Iceland (62.9%).

In the framework of accessing quality housing services, **affordability is an increasingly important obstacle** faced by people in Europe. Increases in housing costs (rent, utilities etc.) have been referenced by many countries as being a substantial cause for limited access to housing.

Housing affordability refers to the percentage of income that a household is spending on housing costs. According to Eurostat's definition "a household is considered 'overburdened' when the total housing costs ('net' of housing allowances) represent more than 40 % of disposable income ('net' of housing allowances)".[8]

The most recent data available (2014), shows that **11.4 % of the EU-28 population lives in households that spent more than 40 % of their disposable income on housing**[9]. This rate was a little bit lower in Iceland and Norway being around 8%. However, there exists a variation across different groups of society: overall, women were found to be more vulnerable to housing cost overburden than men (12.1% and 10.7% respectively)[10]. This percentage was 10.7 % for people below the age of 18, 11.9 % for people in the age of 18-64 and 10.6 % for people over the age of 65. The overburden rate was higher for owners with a loan or mortgage (7.4%) compared to those without a mortgage or loan (6.8%), whereas for tenants with market price rents this rate accounted for 27.1%.

Furthermore, lack of affordability to quality housing is a key reason for **over-indebtedness and people being trapped in bad credit risk**. This situation has led many private owners' tenants to lose their right to stay and thus has **worsened the house crises and increased the number of evictions**. According to Plataforma de Afectados por la Hipoteca *"Since the start of the 2008 economic crisis, in Spain there have been 500,000 foreclosures and 184 evictions per day, and the situation of hundreds of thousands of families is critical. Many lives are at stake."* An additional consequence coming from the inability to afford high rents is the fact that many people are **forced to move geographically**, away from city centres, and are facing additional cost such as travelling costs to reach work, school, hospital etc.

Lack of affordable, quality housing has forced many people (particularly families with children) to live in **bad quality conditions,** such as: insufficient space to live, lack of certain basic sanitary facilities in the dwelling (such as a bath or shower or indoor flushing toilet), problems in the general condition of the dwelling (heating and cooling issues, lack of electricity, humidity, leaking roof, dwelling being too dark etc.), as well as problems in the residential area (noise, pollution, crime, access to other services etc.).

2014 data shows that the **average rate of overcrowding**[11] at EU-28 level was 16.9 %, whereas in Iceland and Norway this rate was at a lower level, with 8.0% and 4.6% respectively. In the EU-28, the highest

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[8] http://ec.europa.eu/eurostat/statistics-explained/index.php/Glossary:Housing_cost_overburden_rate
[9] http://appsso.eurostat.ec.europa.eu/nui/show.do
[10]
http://ec.europa.eu/eurostat/tgm/refreshTableAction.do?tab=table&plugin=1&pcode=tessi160&language=en
[11] Overcrowding rate is the indicator used by Eurostat to describe space problems, which assesses the proportion of people living in an overcrowded dwelling, as defined by the number of rooms available to the household, the household's size, as well as its members' ages and family situation.

rates were observed in Romania (52.3 %), Poland (44.2 %), Bulgaria (43.3%) and Hungary (41.9 %). This EU-28 percentage gets higher (17.9%) if single person households are excluded from the calculation of the indicator and much worse if we consider people at risk of poverty (30.1%).

Another housing problem at the EU-28 level was found to be a **'leaking roof'** (i.e. leaking roof, damp walls, floors or foundation, or rot in window frames or floor') (15.7 %)[12], followed by '**darkness of the dwelling**' (5.8 %)[13] while around 2.6 % [14] of the EU population lacked basic sanitary facilities (i.e. lack of bath/shower or indoor flushing toilet). Overall, people at-risk-of poverty suffered more than the total population from these specific housing problems or were deprived to a greater extent.

An additional obstacle closely related to access to affordable quality is the rise of energy/fuel costs for heating and cooking. This has led many people to experience **Energy Poverty**, which means not being able to afford to keep yourself and your family warm. According to EU SILC statistics, 10 % of EU citizens had arrears on utility bills in 2015 (37 % in the Member State most affected) whereas 12 % of EU citizens were unable to keep their home adequately warm in 2014 (60 % in the Member State most affected). The result of living in cold homes can have direct implications on health (such as contributing to more winter deaths, respiratory diseases and mental problems). This situation is more serious when we take into account the most vulnerable groups such as older people, people with disabilities, children etc.

Affordable access to quality housing is of particular concern: the lack of investment in social housing is forcing people into inadequate housing as well as homelessness as they cannot afford to pay increasing rents in the private market. The European Commission estimates that approximately 4 million people experience homelessness every year, amongst which 1/4 are children in most Member States[15]. The situation is even worse for Roma and Traveller communities and increasingly for the growing numbers of refugee and migrants. These groups may prefer to live in larger family groupings in line with the type of accommodation that best suits their traditions but they should still be provided with quality support services, in the areas in which they live.

> State of Housing in the EU 2015/Housing Europe - excerpts from the Executive Summary
> *The overall state of housing in the EU remains unstable. Two alarming issues emerge: there are more people without a home today than six years ago and there are not enough affordable homes available in most European Countries to meet the increasing demand. There is a sort of 'housing trap' in many EU countries: the rental sector is expensive, home ownership is not an option due to even higher cost, social homes are not enough with waiting lists growing in a number of countries including Italy, UK, France and Ireland… A large number of households are overburdened by housing costs and the quality of housing is a big challenge particularly in Central and Eastern European Countries. Europe also builds less, except in Germany. Homelessness is on the rise – highlighting the crucial role of the social housing sector, at a time when the state retreats from the social housing sector and hands over a big share of responsibility to private initiatives.*
> *"Housing is the foundation of people's lives and their priority among their needs. We should make sure that it becomes a priority for policy makers too" (Marc Calon, President of Housing Europe).*
> See here

Homelessness is also increasing at an alarming rate in some countries. There is still no comparable, robust EU indicator or data on homelessness, but improvements are being made in data collection in different Member States. In 2014, the European Observatory on Homelessness (EOH) published a

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[12] http://appsso.eurostat.ec.europa.eu/nui/show.do

[13] http://appsso.eurostat.ec.europa.eu/nui/show.do

[14] http://appsso.eurostat.ec.europa.eu/nui/show.do

[15] FEANTSA: http://www.feantsa.org/spip.php?article5152

detailed look at available data on homelessness in most EU Member States. It highlighted worrying trends such as a sharp rise in many countries and increasing numbers of young people becoming homeless, including a higher representation of women among young homeless people. In countries where reliable data are available (still with some caveats), the rise in homelessness numbers has reached double digit increases (16% in Denmark, 50% in France, 21% in Germany, 17% in the Netherlands, 29% in Sweden, 44% in Brno, Czech Republic) in recent years.[16]

Access to housing in the European Semester and Europe 2020

EU Policy has increasingly focused on the need to improve the access to housing as a key challenge. However, the primary focus has been to support the housing market as an instrument to drive growth. In this section, we assess how far equal and affordable access, and tackling exclusion from quality housing is being promoted through the Europe 2020 Strategy and in the European Semester, with particular reference to the National Reform Programmes 2016 and the Country-Specific Recommendations 2016.

The Annual Growth Survey 2016 (AGS) contained encouraging references to access to housing, quoting measures in a number of countries to build more housing, including social housing and to improve accessibility, particularly for the most vulnerable. It also mentions better support and protection against over indebtedness and evictions, and fighting energy poverty. However, access for low income households is not mentioned, nor the quality and affordability of new housing, and homelessness is not comprehensively addressed. Moreover, the continuing focus on austerity measures or limits to spending, explicitly undermines social investment, especially when no allowance is made for governments to be able to justify it off the balance sheet. It is also disappointing to see social investment limited to supporting 'return to the labour market and to adapt', rather than investing in enabling and social protection services that can guarantee access to quality services for all.

In the framework of services, access to housing and homelessness are flagged up by most **Country Reports 2016** reviewed by our members (FI, IE, LU, SK, ES, SE, UK) as being an urgent and very critical issue in Member States. The most prominent issues that the Reports pick up on are lack of housing supply (FI, IE, UK), as well as increases in homelessness (CZ, IE, UK), decrease in housing benefits (CZ), the impact of foreclosures and evictions (ES), rise in housing costs (SK) and energy costs (ES). While these aspects are mentioned in many countries, they are not mentioned at all in others (CZ, HU, IT, MT, PL, PT, RO, UK). Also, what is strikingly missing is a comprehensive analysis of the reasons that led to a housing crisis and increase in homelessness in many countries, such as inadequate government policies (IE), privatisation on the housing market, leading to over-indebtedness (PT, SE), or the impact of cuts to social housing budgets (FR). Please find the EAPN Assessment of the 2016 CSRs here.

Whilst investment in housing is given some priority in the **National Reform Programmes 2016** (NRPs), the solutions are primarily market-driven and without assessment of the social impact (LT, MT, ES). Members highlight that deregulation is too often seen as the main solution, which in reality weakens the position of low income households on the housing market and makes them vulnerable to unaffordable rents. In several countries, the NRPs fail to mention important positive developments in tackling access to housing and homelessness (HR, PL, PT). Although some mention is made of specific measures and strategies to deal with the growing number of homeless people in Europe (BE, HR, CZ, IE, LV, MT, ES, SE), the budget, implementation and impact is not always clear (BE, CZ, ES). A major concern for most of EAPN members is the diminishing supply of affordable homes and social housing

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[16] FEANTSA : http://www.feantsa.org/spip.php?article2565&lang=en

across the EU, particularly for low income households (CZ, FR, HU, IE, LV, LT, MT, NL, SK, SE). Please find EAPN's Assessment of NRPs 2016 here.[17]

Despite the AGS priorities, austerity is the main priority for 4/5 MS in their **Country-Specific Recommendations 2016** (CSRs), with cost-cutting (CZ, FI, FR, IT) and increasing market potential for key public services the focus (particularly health and housing) rather than ensuring affordable access (AT, BE, CY, DK, IT, NL). The Macroeconomic CSR for Ireland called for increased capital expenditure in public infrastructure, including housing. Three other countries got CSRs on housing investment (LU, SE, UK). However, this is mainly through private investment in increasing supply, i.e. removing 'bottlenecks', particularly to building housing for sale or rent, but without priority to increasing access for low income families to affordable rented properties including introducing rent control. The Recommendation for the UK to boost housing supply could benefit people in poverty if investment is made in affordable, particularly social housing. The CSR on housing for Sweden suggested fostering competition and revising rent-setting mechanisms to allow more 'market-orientated' rents. But the demands for more liberalization on the housing market will affect the vulnerable and poor groups negatively. More focus is given to increasing housing supply as a boost to growth, but not to ensuring affordable access for low income households, including through social housing. Nor is growing homelessness addressed and recognition of positive housing first strategies that have been put in place in some countries. Please find EAPN's Assessment of the 2016 CSRs here.

PUBLIC HEALTH SERVICES: CURRENT STATE OF PLAY

What definitions do we use? – Quality Health services

Council of Europe (1998)

Quality of care is the degree to which the treatment dispensed increases the patient's chances of achieving the desired results and diminishes the chances of undesirable results, having regard to the current state of knowledge.

WHO (2006)

Quality of care is the level of attainment of health systems' intrinsic goals for health improvement and responsiveness to legitimate expectations of the population.

A health system should seek to make improvements in six areas or dimensions of quality, which are named and described below. These dimensions require that health care be:

▽ effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;

▽ efficient, delivering health care in a manner which maximizes resource use and avoids waste;

▽ accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;

▽ acceptable/patient-centred, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;

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[17] EAPN (October 2016) 2016 NRP Assessment: What progress for Social Europe?

∇ equitable, delivering health care which does not vary in quality because of personal character-istics such as gender, race, ethnicity, geographical location, or socioeconomic status;

∇ safe, delivering health care which minimizes risks and harm to service users.

According to **the Institute of Medicine** quality health care is easily defined as doing the right thing (getting the health care services you need), at the right time (when you need it), in the right way (using the appropriate test or procedure), to achieve the best possible results.

Health care quality is defined by six attributes:

∇ Safety - patients should not be harmed by the care that is intended to help them

∇ Patient-Centred - care should be based on individual needs

∇ Timely - waits and delays in care should be reduced

∇ Effective - care should be evidence-based

∇ Efficient - reduce waste

∇ Equitable - care should be equal for all people

However, none of the above definitions deal directly with the issue of affordability.

Legal framework: what international agreements say about the right to health

The right to health is the economic, social and cultural right to a universal minimum standard of health to which all individuals are entitled. Many international agreements have recognized the right to health as a way to promote a decent standard of living.

United Nations: Universal Declaration on Human Rights 1948 article 25 states that "*Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including adequate food, clothing, housing and medical care*".

United Nations: 2030 Agenda for Sustainable Development (October 2015).

Goal 3 is to ensure healthy lives and promote well-being for all at all ages. 3.8 states "*by 2030 ensure universal health coverage, including financial risk protection, access to quality, essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all*"**.**

The Council of Europe's European Social Charter (revised version 1996): article 11 states "*With a view to **ensuring the effective exercise of the right to protection of health**, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia: to remove as far as possible the causes of ill-health; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; to prevent as far as possible epidemic, endemic and other diseases, as well as accidents*".

The Charter of Fundamental Rights of the EU (2010) states in article 35 that "*Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities*".

The ILO Social Protection Floors Recommendation (2012) says that a social protection floor should include *"access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality… persons in need of health care should not face hardship and an increased risk of poverty due to the financial consequences of accessing essential health care".*

A snapshot of health services situation across Europe

According to Eurostat, life expectancy in the EU-28 increased by 2.5 years, from 77.7 (in 2002) to 80.2 years (in 2014), ranging from 74.5 years in Bulgaria and Latvia to 83.2 years in Italy. While **life expectancy has risen in all European Member States** we cannot say the same about the health of the EU's ageing population, where the average healthy life at EU-28 level is calculated to be 61.6 years, from 53.4 years in Latvia to 74.6 in Sweden. There are also widening gaps in terms of inequality in access to health across and within MS. At the EU-28 level 39.5% of the population in the first quintile perceived themselves as being in fair or bad health situation. This percentage reached the highest level in Latvia (69.0%) and the lowest in Ireland (24.0%).

According to Eurostat data[18], in 2014 6.7% of the population aged 16 years and older in the European Union experienced unmet need for health care, ranging from 2% in Malta to 13% in Estonia. **2.4% of people experienced unmet need due to cost, at EU-28 level**, which was a particular problem among older inactive people (5.8%), unemployed people (5.2%), retired people, the poorest, people aged over 75, people with lower educational status and women and girls. 10.4% of people experienced unmet need due to cost in Latvia, while only 0.1% in the UK. This rate was 3.4% in Iceland and 0.2% in Norway. **0.3% of the EU population reported they were facing unmet need due to travelling costs** and **1.1% due to waiting time** (from 0.0% in Belgium to 10.1% in Estonia). These long waiting times delay diagnosis and treatment and perpetuate the steep social gradient of the health inequalities.

Dental care was the sector facing the biggest regression with 10.4 % of the population aged 16 and over in the EU-28 facing unmet need for a dental examination or treatment. The main reasons reported were the service being too expensive (10%), fear of treatments / dentists and lack of time. In most countries dental care for adults is not free or highly subsidised.

Access to healthcare services is considered to be a multi-dimensional issue.[19] European people face individual barriers (such as age, gender, race, religion, communication skills etc.) as well as barriers at the level of health service providers (discrimination, poor management, poor training of the staff, lack of staff etc.) and the health system (insufficient coverage, poor access to services, high costs etc.). Access is also affected by public policy such as fiscal policy i.e. cuts in health services, transport system, education and cultural aspects. These cuts and lack of investments have led to unequal distribution of healthcare services, being mostly concentrated in the main urban areas as well as lack of healthcare services offered, lack of GPs and specialists etc.

Affordable access to health is of particular concern: unmet need for health services is rising, because of restrictions to access and increased prices and out of pocket payments. This burden falls most heavily on patients who are least able to bear it, both in terms of their health and in terms of their income, and increases with the increasing number of chronic condition such as cancer, high blood pressure, diabetes and depression etc. 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

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[18] Unmet health care needs statistics – Eurostat
http://ec.europa.eu/eurostat/statisticsexplained/index.php/Unmet_health_care_needs_statistics
[19] European Commission (2015) Access to Health Services in the European Union

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.

Access to health in the European Semester and Europe 2020

In this chapter we analyse how far access to a quality public health service is equal and affordable, and tackling exclusion, promoted through the Europe 2020 Strategy and the European Semester, with particular reference to the National Reform Programmes 2016 and the Country-Specific Recommendations 2016.

Although **cost effectiveness for health care is the main focus in the AGS 2016**, adequate access is mentioned with the recognition that investment in health is needed, but primarily through an economic rather than a social rights lens i.e. that it improves labour market participation and productivity, but also encourages investment in prevention and early detection. The Joint Employment Report (JER) recognises growing unmet health needs (most visible in BG, EL, IT and LV), and the significant gap between rich and poor, highlighting that low-income households face severe difficulties in accessing adequate healthcare. Measures to improve accessibility and coverage are mentioned, but nothing is said about affordability and quality of health services, while, for instance, it is mentioned that 30% of people with disabilities experience poverty and social exclusion.

Health inequalities and unmet health needs are recognized as a major issue in the **2016 Country Reports** 2016 in a number of countries (FI, IE, LV, LT, PT, SK, SE) as well as concerns regarding the quality of healthcare (IE) and unaffordability (PT, SK). What is also missing is the reform of the disability policy (PL) and the impact of limiting sickness benefits (DK). The full EAPN Report on the CRs 2016 can be found here.

In many **2016 NRPs,** explicit recommendations are made to reduce health expenditure and to make it more efficient (CY, FI, IE, LV, ES), with little visible concern about 'effectiveness' or with an assessment of the social impact. Major concerns are raised by members around the erosion of universal health care (IE, LV). This is partly due to the impact of cuts and efficiency, but also the lack of investment in a comprehensive public healthcare system which can benefit all.[20] Please find EAPN's Assessment of NRPs 2016 here.

In terms of the 2016 Country-Specific Recommendations, 12 Member States received CSRs on health reform (AT, BG, CY, CZ, FI, IE, LV, LT, PT, RO, SK, SI), with the main focus on reducing costs – e.g., ensuring financial sustainability (AT, CZ, PT, SI) and increasing cost effectiveness (FI, IE, LV, SK). Austria, Slovenia and Spain received CSRs on long-term care clearly focused on financial sustainability. Among them only 5 countries received positive CSRs on healthcare reform (BG, CY, LV, LT, RO). Improvement in accessibility is of important concern in Bulgaria and Latvia (in Bulgaria the funding of health system is also highlighted), while in Cyprus there is a support to ensure effective implementation of universal healthcare. In Lithuania and Romania positive recommendations are made around tackling informal payment and outpatient care, but nothing is mentioned in terms of improving quality and accessibility of health services at all. However, the overall tone within other CSRs is giving priority to sustainability with an emphasis on efficiency and cost effectiveness, rather than guaranteeing universal and affordable access to quality health and care services. The full EAPN Report on the 2016 CSRs can be found here.

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[20] EAPN (2016) Assessment of 2016 NRPs: What progress for Social Europe?

CRISIS

Politicians can... a positive change... be ready to assu... their responsibilit...
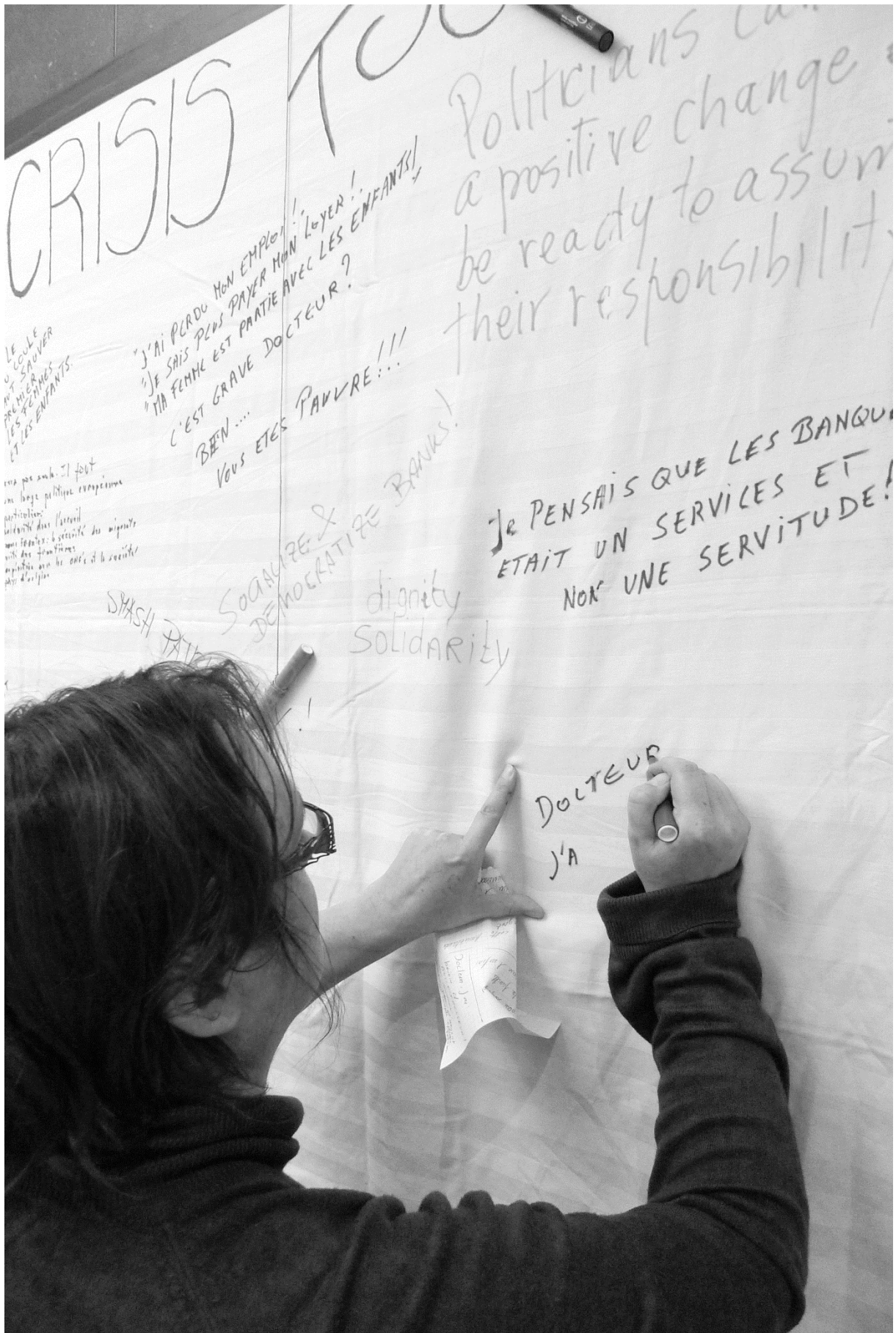
"J'AI PERDU MON EMPLOI!!"
"JE SAIS PLUS PAYER MON LOYER!"
"MA FEMME EST PARTIE AVEC LES ENFANTS!

C'EST GRAVE DOCTEUR?

BEN ...
VOUS ÊTES PAUVRE!!!

LE ... ÉCOLE
... SAUVER
... PREMIER ...
... LES FEMMES
ET LES ENFANTS.

... pas souh. Il faut
... large politique européenne
... particulier:
... solidarité dans l'accueil
... femmes: la sécurité des migrants
... avec des femmes
... migration avec les chefs et la société
... pays d'origine

SMASH PATR...

SOCIALIZE &
DÉMOCRATIZE BANKS!

dignity
SOLIDARITY

JE PENSAIS QUE LES BANQU...
ÉTAIT UN SERVICES ET...
NON UNE SERVITUDE!

DOCTEUR
J'A

4. EAPN MEMBERS ASSESSMENT: ACCESS TO HOUSING AND HEALTH

In this section we provide a synthesis of the main responses of EAPN members to a questionnaire regarding their assessment of the reality and main challenges in access to housing.

OBSTACLES IN ACCESSIBILITY TO QUALITY HOUSING AND HEALTH

Housing

The main obstacle identified by EAPN members was **the lack of affordable and appropriate housing** (AT, BE, CY, CZ, EE, FI, FR, DE, IS, IE, IT, LV, MK, NL, NO, PL, PT, RO, SE, UK). Many households, especially low income ones, do not have access to good quality housing at an affordable price. In many countries the housing demand is rising due to population increase, coming as a consequence of net migration, changes in household structure and demographic ageing (HR, CY, IE, PT, SE, UK). On the other hand, there exists an inadequate supply of affordable, quality and accessible housing due to a fall in housebuilding of any tenure including for purchase, although the population is rising, but also the cut or removal of rent regulation. This phenomenon creates competition and pushes prices up, especially in urban centres, which is seen as one of the biggest reasons for poverty in bigger cities. People spend so much on housing that they often don't have money for the rest of their basic needs. Furthermore, **many available houses are of bad quality**, very inefficient in terms of energy consumption (many households face difficulties in maintaining the temperature of housing) and many poor households live in damp conditions (BE, IE, IT, NO, PL, PT, RO, UK) impacting also on their health.

Lack of social housing (AT, HR, CY, CZ, EE, FI, FR, DE, IT, LV, MK, NO, PL, PT, RO, RS, SK, SE and UK) creates an additional obstacle, particularly where rents in the private sector are very high and unregulated, and household incomes too low to afford owner occupation. Many people are forced to remain in temporary accommodation, overcrowded places and sometimes also in very poor living conditions. A further issue faced in many countries, is **the privatization** of social housing, which has reduced the amount of social housing at affordable rents and in many cases has pushed the prices up and made it almost impossible for people on low incomes to afford adequate social housing.

In Estonia public housing has also been privatized during ownership reform. Only 4% of housing is owned by state or municipalities. The lack of municipal and social housing is the most acute problem of social welfare in cities and settlements, which are the only places that it is possible to find a job. The private sector does not build houses for rent, but is trying to sell the flats. The rental market of flats is mainly "grey", commercial rents are high and tenants' rights are not protected. Because of the high rents and low salaries and wages the subsistence allowance system causes a poverty trap. Housing policy focusing on buying of dwelling and financing it with housing loans will cause indebtedness, when real estate bubbles occur and burst.

In Ireland the state has reduced its stock of public housing and over the past number of years has been increasingly 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 incomes, out of the market. This coupled with a decrease in supply in the private rented sector has led to growing numbers ending up homeless.

In June 2016, the Government introduced a national increase of 15% in Rent Supplement with increases of almost 30% in Dublin. There will also be increases in the Housing Assistance Payment. This is a positive move which should help make rental costs more affordable. However, without measures to slow the increase of rents which are not above their pre-crisis peak of 2007 the issue of rent affordability will be an ongoing problem. In July 2016 the Government also published Rebuilding Ireland, an Action Plan for Housing and Homelessness in which it committed to provide an extra 47,000 social houses by 2021.

In Italy, cities have not been investing in social housing for a long time. The real estate market is totally in the hands of private business that continues to build despite the crisis in the construction industry. This sector has slowed down considerably with the outbreak of the crisis, causing a high rate of unemployment. The cities, that are undergoing strong cuts by the state (mostly due to the Stability Pact and the large public debt), are forced to "make money" in the only way that is left to them, i.e. granting building permits for new dwellings, which, at any rate, few will be able to afford. The real estate sector in Italy is mainly based on ownership since over 80% of Italians are homeowners and, of course, many are in debt with the banks. Rentals are few, expensive, especially in the cities and contracts often insecure. There is a mutual distrust between landlords and tenants, the former are afraid of not being paid regularly, the latter of being evicted with a very short notice.

In Macedonia, there is a lack of investment in social housing and procedures take a long time. The state tries to provide and build social apartments, by 2013 they awarded 599 social flats to people at risk. However, there was a lot of disputes about the allocation policy, with a lack of control and transparency. There is a need for a local strategy for social housing.

In the Netherlands, there is a lack of social housing. During the last decade even social housing corporations were building houses to sell or asking a rent above the rent supply ruling (710€ per month). This means that more and more people had and have to accept not just a higher rent, but also to pay 100%.

In Norway, public housing has to a large extent been privatized by the municipalities during the last 15 years leading to an increase of public housing rents as much as in the private tenant market. In the big cities the provision of social housing is too low for what is needed. There are 5.000 homeless people in Norway and the figures are stable.

In the UK, a key aspect of inadequate social rental housing is the rapid fall in the number of social houses at subsidised rent available from local authorities. 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. 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.

Strong concerns are raised by most of EAPN respondents regarding the **lack of potential to access housing[21]** (BE, CY, EE, FR, DE, IS, IT, LV, PT, RO, SK, SE, UK). Not only unemployed households, but also low income/salaried families find themselves in serious difficulties to pay their daily expenses, housing included. This has led many people to a situation of over indebtedness. High levels of **unemployment and indebtedness make it even more difficult to afford housing costs** (CY, CZ, FI, FR, IS, IE, NL, PT, RS). On the other hand, banks put more restrictions on lending, which lead to a considerable increase in people looking for houses to rent (CY, IS, PT, RO).

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[21] EAPN (2010) : Active Inclusion – Making it happen

"To get a house, I need a job - But I don't have a job."
"There are not enough houses, and the cost of rent can force people into homelessness."
"Rents are really too high and there isn't enough social housing."
"We have often to choose between heating and eating." (Quotes from EAPN Active Inclusion booklet)

In addition to their monetary deprived situation, **some groups face further obstacles such as discrimination.** This is highly visible among **Roma and Traveller** communities, as well as migrants, asylum seekers and homeless people (BE, CZ, FR, IE, IT, MK, PT, RO, RS, SE, UK). These groups have limited resources and struggle to obtain proper housing conditions. Although the procedure and criteria for allocating public or social housing are regulated by law[22], the allocation process can nevertheless lead to discrimination, whether intentional or not, such as the requirement to be based locally or to speak a certain language. These obstacles increase the likelihood of residential segregation (HR, CZ, IE, IT, PT, UK), which reproduces social exclusion and further disadvantages for poorer people.

In Croatia, in the capital city, a new settlement was built in which most of the residents were Roma people. Nowadays other social groups refuse to live in the same neighbourhood.
In Italy there is strong discrimination against Roma people who live in segregated camps, some spontaneous and some "legal". The assisted housing system, especially in the big cities like Rome, is practically inexistent and the little there is, is designed and implemented in such a way as to condemn thousands of Roma purely on ethnic grounds to live in segregated, substandard accommodation in camps far from services and residential neighbourhoods. Furthermore, the lack of affordable housing foments frictions between natives and immigrants, that may become tough local revolts or, in any case, put social cohesion in danger.
In Latvia there is limited access to housing for people experiencing poverty, although there are many empty houses in cities and rural areas.
In Macedonia, the most at risk group is Roma. There are enormous problems housing Roma, as many of them have had to improvise houses with no heating and without sanitary system.
In Portugal discrimination is an obstacle to Roma communities and immigrants and sometimes forces them into houses with higher rents, or are they forced into overcrowded houses with poor living conditions. 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 drinkable 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 cause 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 maintains them in vulnerability and exclusion."

"It is impossible for me to invite the friends of my children at home, because my home is so small. So my children in turn are not invited any more. Thus they become also excluded. We are obliged to lead a hidden life."
"When you have no address, you're pushed around, you're like a stranger. You do not have access to your rights. You do not receive your mail. You cannot participate in civic life, or vote. You are ashamed to tell an employer that you are domiciled or without an address."[23]

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[22] http://ec.europa.eu/justice/discrimination/files/la_discrimination_dans_le_logement_final_en.pdf
[23] EAPN (2014) Explainer on poverty and inequality

> *"I work in a hotel and sometimes, when I pick up my children from school, some other mother offers me a ride home. They don't know that we live in a camp, I'm ashamed and always refuse."*[24]

Lack of information creates a further obstacle in some countries (IS, LV). Some people don't know of or utilize the services that are available such as housing benefits that you can apply for with the municipalities.

> *"The system is too complicated; I don't know where to get what."*
> *"I have slept in cardboard boxes. I had the choice to die on the street or to take back my life in my own hands. I went to social services to get help to find a house. I was confronted with an enormous bureaucracy. I had to tell my story several times, each time again and it took years before I got a house."*[25]

Health Services

The main obstacle faced by people experiencing poverty regarding access to quality public health service is **affordability** (BE, EE, FR, DE, IS, IE, LV, PT, RS). One of the main reasons is seen to be due to the privatisation of the sector, most visible in **dental care** (CZ, FR, IS, NL, NO, RS, SE). In many countries increase in costs have also come as a consequence of austerity measures (BE, CZ, FI, IE, IT, NL, PT, RS, UK). This has a direct impact on the disposable income of those on the lowest incomes and has meant that some people are choosing to postpone their medical care or to go without health care or their medication.

> *In Cyprus there is a lack of a National Health System and the deterioration of the public health sector due to austerity measures – having to pay 10 euros to see a doctor, no matter for what, providing less medicines than before, cutting back on "overtime" thus having big waiting lists for surgeries or specialized examinations etc.*
> *In Iceland ambulatory resources are being used more frequently, but it costs more for the patient than admission.*
> *In Ireland as part of austerity measures a new prescription charge was introduced in 2010 on each item that is dispensed under the medical card scheme. The monthly cap on the total charges a family has to pay also rose from 10€ in 2010 to 25€ in 2014, reduced to 20€ in Budget 2017. 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.*
> *In Italy, the national health care system is run by the 20 Regions. Access to hospitals is free, while for medical analysis or specialized visits there is a ticket to be paid depending on the region where you live. The tickets are higher in the Southern regions because of their high public health debt. Many people who can afford it use the private sector because the national health system has been undergoing many cuts and much money has been wasted over the years due to corruption, disorganisation, and politicization. Waiting lists are terribly long so that the private sector becomes mandatory for those who can afford it. It is unfortunately true that today, in Italy, "to be sick is a luxury". With the outbreak of the crisis, many people have stopped going to the doctor or buying; the statistics of the National Health Observatory tell us that for the first time since the end of WWII, life expectancy has decreased, mostly due to the continuous health care cuts. Investment in this sector fell from 112.5 billion euro in 2010 to 110.5 billion in 2014. These cuts have helped to overcome*

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[24] Quote supplied by EAPN Italy.
[25] EAPN (2014) Explainer on poverty and inequality

> *the health deficit but the citizens have paid a very high price, poor people first. This has increased the inequalities between the population and the territories, especially between North and South, between cities and suburbs, all determinants that impact on the population's health status.*
> ***In Portugal*** *in 2011, the country faced a high increase in 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 has risen from the 6th country with higher out-of-pocket health expenditure, in 2007, to the 4th position in 2012.*

> *"Last night I was very sad, my little sister was very sick, but mother had no money to buy medicine. There are still 3 days until the child benefit payment, I am really worried."*
> *"Services have to be accessible, not just childcare, but also wider such as health services, so that people can work."*
> *"Health care costs a fortune. Poverty makes people ill." "There are great hospitals in towns, but you have to pay the doctor cash to get treated."*

Furthermore, public health services increasingly involve **long waiting times** for often explicitly rationed and cut services (HR, CY, EE, FI, FR, DE, IE, IT, LV, PL, RS). These long waiting times delay diagnosis and treatment and perpetuate the steep social gradient of the health inequalities. In Croatia, there are cases where people have had a diagnosis of a cancer and a specialized medical examination is done in two years.

Lack of documentation and administrative barriers constitutes a further barrier in accessing health services (BE, CY, FR, IE, PT, RO, RS). 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 who don't have an ID card any more, for several reasons, amongst which is the price of a new ID card). The access of the homeless people to health services is often made in emergency situations. In Ireland 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 additional obstacle highlighted by EAPN members is **unequal geographical distribution of healthcare services**[26] (HR, CY, FR, DE, IS, IT, PT, RO, RS, SK, SE), being mostly concentrated in the main urban areas or in the rural central villages. This growing inequality has been exacerbated by austerity measures that resulted in increased centralization. This has resulted in reduced healthcare services in rural areas and in some cases cuts in transportation coverage for medical appointments or treatment. This means that people experiencing poverty and social exclusion now need to bear extra travelling costs, but they cannot afford them. Furthermore, the access to health services in rural areas is hindered by a weak public transport system, which doesn't meet people's needs. An overriding 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 on costs to ordinary people.

Dental care is a key health sector with highly deficient access (CY, EE, FR, IT, NL, NO, PT, RS). In Italy dental care is practically 100% in the hands of the private sector, especially in the Centre and South of the country. In the Netherlands, dental insurance is very expensive. It is free for children only if parents are insured. In Portugal the almost nonexistence of dentists in the public health services led to the creation of a dentist-cheque programme. But this programme does not allow for a widespread access

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[26] EAPN (2010) Active Inclusion – making it happen

to this kind of health service. The social groups that can access this programme are children (under 18), pregnant women, elderly and HIV/AIDS patients. In many countries (e.g. CY, EE, DE, NO, RS, UK, etc.), dental care is not covered by the public health system, and has to be paid for out of pocket, with no repayment of costs.

Lack of general practitioners (GPs) and restrictions of specialisms covered by the public health system (FR, IS, LV, NO, PT). In France, there are some places called "deserts", where you cannot easily find a doctor. One has to travel for many kilometres and this increases travelling costs too. The main cause is that most doctors do not want to live in small cities, where there are no services, transportation system and so on, and there are no state measures undertaken to change this situation. **Mental health services are particularly at risk.** In Iceland, psychologists are not a part of the public health care system, so their services are very expensive. In Norway you have to belong to special groups with special diagnoses to get some reimbursement from the Norwegian Health Economics Administration (HELFO). According to the Portuguese Observatory of Health Systems, Portugal has one of the highest prevalence of mental disorder. Despite this 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. In Cyprus, there is a lack of adequate mental services and therapy units, and lack of a preventive mental health programme for children and young people. In Italy as well the rate of mental illness is very high, particularly among young people, and these are the services that suffer the biggest cuts. Along with prevention and treatment services against addiction, mental health, despite the presence of new legislation introduced in 1980, has suffered the biggest cuts, especially in community-based services.

EAPN France, Germany and Portugal identifies further obstacles such as **communication and literacy barriers** between 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; **cultural aspects** also have an impact in the access to health services. Inside Roma communities, for example, the importance of accessing preventive health is not perceived and the access to health services is made mostly in emergency situations. In France, communication and literacy barriers are a problem among people who cannot speak French well. EAPN France highlights that patients are asked to fill in some papers at the hospital, such as a preregistration for healthcare services, but many people do not understand them and find it complicated to answer in French so they just don't do it, and thus skip the medical services/ treatments. In Germany, cultural aspects are an increasing issue due to growing numbers of refugees.

CAUSES OF LIMITED ACCESS AND EXCLUSION

Housing

Most EAPN respondents point to the most important cause for limited access to housing as the **lack of social housing** (BE, HR, CY, EE, FI, FR, DE, IS, IE, IT, LV, MK, PL, RO, RS, UK). Since many local governments have prioritized budgetary considerations over social services consideration there is a lack of funds and as a consequence lack of investment in social housing. Growing waiting lists is a key indicator of unmet housing need.

> *In Croatia, an application to the list for social housing requires a large amount of documentation and housing provision is very low. In small cities, there is no available social housing.*
> *In France, there are 1.8 million people waiting in the list. Construction of social housing is not in line with the growing population. The majority wait for 10 years to get an answer, so most people have to find alternative solutions for their situation.*
> *Recently in Ireland 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 social houses without these being replaced. 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 over 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[27].*
> *In the UK there was a 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.*

Alongside the lack of social housing there is also a **shortage of housing** generally (BE, FI, FR, IS, IE, IT, NL, PT, SK). 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, Rome, Naples, Milan and in other urban centres but is now beginning to spread to other areas of countries. In Slovakia, the lack of rented accommodation has led to long waiting times or living in overcrowded private rented housing.

Another important cause is that **housing policies are focused more on supporting house owners rather than tenants** (BE, EE, IT, NO, PL, UK). In Norway, housing policies have been weak. The total number of municipally-accessible dwellings are less than 5 percent. In the UK there have been two big ideological changes in housing policy, identified as causes for limited access from housing: 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; and 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**.** In Macedonia, there is a problem **of legalization** – as many people live in non-legal properties, and face gaps in the legal system to get legal documentation for their homes. They can then be put at risk of eviction.

Increases in housing costs/prices (rents or mortgages) has been referenced by many countries (EE, FI, FR, DE, IE, IT, MK, NL, SE, UK) as being a substantial cause for limited access to housing, particularly in relation **to rising rents and inadequate housing benefit** or other types of income support to cope with these increases. In France, rents have increased by 50% compared to 10 years ago. From the late 1990s until 2007 in Ireland, house prices rose dramatically with many people borrowing very heavily from

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[27] Summary of Housing Needs Assessment 2013 Housing Agency www.housingagency.ie

financial institutions to pay for these, with some getting mortgages in excess of 100% of the value of their homes. In Macedonia, many people can't afford to buy, but rents in the private market are very high and most are not legally controlled. This means there is no **protection for the tenant to enforce their rights.** No information is given that the owner is taking money for rent, or about the person renting the apartment. Many landlords hide this information to avoid paying taxes. In the Netherlands, high rents are a real problem for a growing part of the population. The city of Amsterdam started a new programme that is aimed at giving low incomes an extra rent support, recognizing that if people can no longer pay the rent in time or at all, the long-term costs will be much higher. The problem may be that the official rent will be raised once it is known that Amsterdam Local Authority is helping with the rent. In the UK, housing affordability has worsened significantly, with knock-on effects on government social budgets that subsidise incomes and rents. The introduction of a housing cap on benefits paid in support of rent in the private sector means that many people will not be able to afford the rents in certain areas and may be evicted.

Financial crises and austerity measures in general contributed to the deterioration of people's living conditions (BE, CY, IE, IT, PT, RO, RS, UK). According to the report Social Housing in the EU[28] 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". In Ireland and Italy house prices plummeted as did people's incomes, with many people also losing their jobs. This meant that people were left with unsustainable mortgages. Last year in Italy, nearly one hundred families each day suffered an eviction, often for arrears due to the effects of the economic crisis. Most of these people go back to their parents' homes and, once again, the extended family prove to be the real and only Italian welfare. In the UK 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.

> "*We are having a very major issue at the moment which is the lack of accommodation and the Rent Allowance. We have many people coming in who are desperate because they are about to be made homeless through mortgage repossessions and all of that. It's even more upsetting for them because they don't know where they are going. They now know that there is nowhere to rent in Portloise or the surrounding areas at the moment. And we know that from the auctioneers. So where do they go?*" Money Advice and Budgeting Service (MABS) staff member (EAPN Ireland)

High conditionality for accessing the rental market (BE, CZ, EE, FR, IS, IT, NL, PT, SE, UK). With the increases in unemployment and indebtedness levels, the impact of increased conditionality and requirements is quite high. In Belgium, landlords refuse to accept people who depend on social benefits (or even only accept couples with 2 full-time wages). In France, tenants have to pay a deposit of 3 months in advance and they have to prove that the rent accounts for a maximum of 1/3 of their salaries. This is a huge problem in Paris but also in other big cities, because many people cannot afford to pay money in advance. In Iceland, one has to pay a deposit equivalent of three months´ rent and people don´t have that money. Many don´t pass the bank´s credit rating for loans, so their position is hopeless. In the Netherlands, you have to earn at least four times the rent per month, and have to pay 2-3 months' rent as deposit; you must have a valid ID and proof of your income. This is a way to exclude many groups and make renting a house very difficult for them. In Portugal and Italy, poverty and social exclusion increased at national level. The same is true for the unemployment rate. Both situations contributed to greater difficulty for families in paying their housing loans. Banks put more restrictions on lending, which lead to a considerable increase in those looking for houses to rent. In Sweden, there

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[28] European Parliament, *Social Housing in the EU*, January, 2013, p. 14.

are problems of being accepted as tenant due to debts or other economic reasons. In addition to these issues, the UK also identifies the problem of rapid fall in the proportion of young adults able to buy housing and therefore putting additional pressure on the rental market.

Individual social situation may create further obstacles in accessing affordable and quality housing (EE, FR, IE, PL, SE). Many people who are homeless face a wide range of complex problems. Some of these relate to addiction and mental health, family conflict etc., insufficient income or income support although a large number are homeless because they simply cannot find suitable and affordable accommodation. In Ireland this situation 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. 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, a large percentage of it goes unspent.

"I met a Traveller woman in April 2014 who was homeless. She just got a home two weeks ago (February 2015). The issues that she experienced in the intervening time have had a detrimental effect on her and will probably take a long, long time for her to get over. Her mental and her physical health were impacted as well as our own organisation. Our own mental health was affected by meeting with this woman on a continuous basis and seeing the deterioration in her health".
Community Worker with Traveller organisation in Ireland (EAPN Ireland)

Health Services

The main cause for increasingly limited access identified by most of the members were **cuts in health expenditure** due to austerity measures and public deficit restrictions (BE, CY, FI, IS, IE, IT, PT, RO, RS). Many local authorities had not enough resources so budgetary considerations were often prioritized over health/welfare considerations. Public health services have also been a specific target for cost-cutting efficiency measures. In Ireland 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 costs 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. In Italy access to public services (social services, school canteens, transport) is subject to a means test, through the presentation of a model that includes family income and expenses. Each municipality sets an income threshold above which people cannot access services free of change, but only by paying a fee – the level of which is decided according to income. Only social services to children who are victims of abuse are free, everything else, including home care, is subject to the economic conditions of the applicant, although there is a national and regional law that should ensure essential services for all and for free.

Access to affordable medication is a problem (CY, EE, DE, IS, PT, RO, RS, SK, SE). There have been increased costs for individuals in the public health care system making services inaccessible due to **lack of affordability**. Among others, one of the main reasons is due to **privatisation** of the sector. Many have to choose between buying medicine or buying food.

Exclusion of Dental Care from public health provision. Dental care is another sector with highly deficient access (CY, IS, IT, NL, NO, PT, RS, SE). In Iceland, people cannot afford to go to the dentist, whose service must be paid in full, with only a small part refunded (for people with disabilities). In only a few regions in Italy is it possible to access dental care using the public health system, it being for

most parts a private business. In recent years, many dental centres in franchise were opened and prices are much lower than in a private practice but it is too early to access the quality of the care they give. Another phenomenon is the so-called "dental tourism" and many people now go to East European countries, such as Romania or Croatia, to take care of their dental problems. In Norway, dental health in general has been seen as a private responsibility from the perspective of politicians. It's generally not a part of the public health system once you are over 18. Whereas in Sweden, dental care is not included in public health care. Subsidies are lower for this sector leaving many vulnerable groups without possibilities to access dental care.

Unequal distribution of health services (HR, CY, FR, DE, IS, IT, PT, RO, RS, SK, SE) being mostly concentrated in urban areas.

> *In Croatia, there exists a deficit in the geographical coverage of emergency medical services due to the last health care reform. In addition, there is a weak medical service in rural areas.*
> *In Iceland 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.*
> *In Italy, the so-called "health tourism" from the South towards the North and Rome is still very high. Despite the approval of a set of national welfare basic levels, the inequalities between economically stronger and weaker regions are still persistent.*
> *In Portugal there exists a deficit in the geographical coverage of National Health System, mainly in the rural areas. In addition, there is a weak public transport system, especially outside the urban areas.*
> *In Sweden there is more access in well-established and urban areas due to privatisation. The localisation of health care centres is connected to how profitable the area is.*

Some countries have identified additional causes for limited access and exclusion from health-care services such as **lack of general practitioners** (FR, IS), **inequalities** (FR, IE), **stigma and lack of knowledge** (CZ, FR, PT). 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 health inequalities. In Italy, the health system for children includes psychologists, psychiatrist, speech therapists, physiotherapists. The shortage of staff prevents the services supporting all the children in need and, again, the families who can afford it turn to the private sector while the poor are forced to undergo long waiting lists at the risk of their physical and mental health.

ASPECTS OF HOUSING AND HEALTH SERVICES FACING THE BIGGEST REGRESSION

Housing

Social housing faced the biggest regression both in terms of accessibility and affordability (AT, HR, EE, FI, FR, DE, IT, LV, NO, PL, PT, SK, SE, UK). There is a lack of social housing in general forcing a lot a people to remain in temporary accommodation while waiting for access to a social house, and forcing others to live in overcrowded places. Furthermore, in many cases the existing stock of social houses is of a bad quality and in need of renovation. An additional obstacle is the **privatization of the sector**, which has pushed prices up making renting unaffordable for people with low income/salaries. In many countries homelessness is increasing.

> *In Croatia, only in the capital city is there a list of 3.235 residents for a social housing. In addition, most of the people and families remain on the lists for a long time, since there is a lot of corruption in access to a social house.*
>
> *In Italy, the lack of a public housing policy has given rise to rather big squatting movements. Abandoned buildings, especially those in big cities, such as schools, offices, old barracks or even hospitals, are occupied and remain so for many years. In these buildings live people and families with or without children; on low or no income.*
>
> *In Portugal the reduction of social protection benefits, like social insertion income (reduction in terms of amounts and stricter rules) has had significant impact on the lives of the most vulnerable. Even where people benefiting from Social Insertion Income are able to receive an additional support for housing, this support is not enough for all the expenses. For homeless people the situation is worse, because the support given consists of placing people into hostels. "Without this support these people would still live in the street. However, this only allows them to sleep and does not allow them to cook, wash clothes, and so on".*

Lack of affordable quality housing, has forced several people (also families with children) to live in **overcrowded places with poor living conditions** (BE, CZ, EE, FR, IT, MK, NO, PL, PT, RO). This also affects their general situation: health problems, children without good conditions to study having more difficulty in succeeding in school; adults that don't have adequate conditions at home for washing and maintaining proper hygiene having more difficulties when applying for a job. In this way, it's clear that having good housing conditions is a step towards the social inclusion of people living in poverty and social exclusion. With more restrictions to lending and over-indebtedness of families, one of the things noticed in Portugal was that several families returned to their parents' home, or bring back their elderly family member, who was in a nursing home, in order to have his/her pension to strengthen the family budget. The Portuguese Association for Victim Support highlighted that this situation, together with unemployment, led to an increase of elder abuse. Whereas Norway identifies that the lack of affordable quality houses has led many people into **in-work poverty.** In Macedonia, bad housing conditions are exacerbated by poor heating systems, with central heating only in some parts of Skopje, the capital city. There is a great need for energy efficiency programmes and measurement. Pollution is also increasing, as people cut wood, use coal and even burn plastic to keep warm.

> *"You may be a bit shy to invite your friends over because when they come in they'll be freezing and they might want to leave early."[29]*
>
> *"My room, the roofs damp and then, if I just look right from the bed the whole entire walls covered in damp, and I'm there in bed freezing cold."*

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[29] EAPN (2013) Explainer on Child poverty and well-being.

> *"All children need a warm bed, a roof and to eat healthily to be well."*
> *"The children have no heating in winter, they live in unhealthy conditions."[30]*

Increase in homelessness is an urgent and very serious issue for many countries (BE, FR, DE, IE, IT, PT, RO). The main concern for those who cannot afford to rent on the private market is ending up living on the streets or "staying with friends". The situation is even worse for Roma Communities. Living in tents or in slums where there are poor housing conditions, without running water, without electricity, has a clear impact on health, in the labour market and even in school.

> *In France, homeless people can call 115 to ask for help, but more than 50% of those who call get as an answer 'we are not able to propose a solution for your problem'.*
> *In Ireland, between January and August 2016 the number of homeless families grew by almost 30% from 884 to 1151 families. In August 2016 there were 6,611 people in homeless accommodation, including 2,363 children.*
> *In Italy, the number of homeless is around 50,000. They can have a fictitious residence so that they can have identity documents, receive social assistance, have access to health services, receive essential care such as their retirement or disability cheque.*
> *In Portugal homeless people sometimes have to use the address of the hostel where they live or of the social services in order to receive social benefits, like social insertion income. In both cases people have to expose their private lives.*

As highlighted above, there is an urgent **need for investment in new social housing** but, due to the financial crisis and austerity measures, local authorities lack the necessary budget. In the UK 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 was common before. 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.

Alongside the lack of social housing there is also a **shortage of housing in general** (BE, HR, FR, IS, IE, IT, LV, NL, PL, SK, SE). Due to the financial crisis many people were unemployed and there were less sufficient benefits. Furthermore, the collapse of the housing market resulted in fewer house completions and an increased dependency on the private rental market. Disequilibrium between a very high demand in housing and lack of affordable supply, has encouraged landlords to drive up prices. Due to these conditions, many people are forced to live in poor situations or in some cases end up on the street.

> *In Iceland new housing laws were passed recently, aiming at lower housing costs and to secure housing to low income households. The authorities plan to increase the availability of smaller, cheaper apartments, as there is a severe shortage of rental housing. The city of Reykjavik, NGOs and the state (police and hospital) have joined hands in addressing the issues of the homeless. Sheds have been built for these people, "city guards" assist in finding shelters for the homeless and in obtaining other help as needed, and the project "Harm Reduction Unit Mrs. Ragnheidur" makes it easier for these people to gain access to wound treatment and clean syringes and needles.*
> *In Portugal in 2012 the new Tenancy Law (Law nº 31/2012, 12th November) was published as an answer to the growing demand for rental supply and the absence of an adequate response, with accessible market prices"[31]. The goal was to create a rental market, which together with boost to urban rehabilitation, can offer the Portuguese people more housing solutions adjusted to their needs; less consuming of their resources and therefore also promoting savings and their mobility in*

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[30] EAPN (2010) Active Inclusion Handbook – making it happen.
[31] In http://www.portaldahabitacao.pt/pt/nrau/home/apresentacao_nnrau.html

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 carrying out works in rented buildings; 5. special procedure to evict (made easier). For the items nº 2 and 3 the new law indicates that people living in poverty needed to be protected. For item 3 it must be the social security institute that finds an answer to the situations of economic disadvantage. One of the things that was noticed was that these new orientations affected in particular the elderly with low income, because they couldn't afford the new rents. There is little 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[32] (Balcão Nacional do Arrendamento) issued, until June of 2015, 929 evictions (in 2014 it was 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 to the non-payment of the rent (even realising that rents are the last expense that people fail to pay)[33].

In the scope of the National Emergency Plan, the Social Rental Market (SRM)[34]was implemented. This SRM is a partnership between the State, Local Authorities and Banking entities (that decided to take part) and is aimed at social classes, with incomes higher than those that allow access to 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 the UK** there is an **increasing poverty of home-owners**. 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.*

Health Services

Austerity measures and funding cuts had bad impact on accessibility to health services (CY, FI, IS, IE, IT, PT, RO, RS), especially in rural areas (IS, NO, PT, RO, RS, SE). Cuts to health services have led to a reduction in services and in an understaffing in many public health services. There is a lack of nursing homes for the elderly (CY, IS, RO, RS) and the closing down of maternity hospitals in Portugal has resulted in increasing number of children being delivered in ambulances. The general medicine insurance increasingly reduces its scope, with less and less services covered. Now for a lot of health related problems people need an extra (private) hospitalization insurance (BE, CY) or you have to belong to certain small patient group to receive public coverage regarding dental health (NO). Long-term cuts of public hospitals result in long waiting lists (CY, FR, DE, IS, IE, LV, RO, RS) for operations and many of the devices are old and obsolete (IS, RO, RS).

Low spending and funding cuts in health care has resulted in an under-resourced care sector in terms of the coverage of medical specialities leading to **unmet needs of communities** (FR, IS, IE, IT, RO, RS),

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[32] https://bna.mj.pt/Entrada.aspx

[33] *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

[34] http://www.mercadosocialarrendamento.msss.pt/mercado_social_arrendamento.jsp

mainly for those who live in rural areas, because specialization functions in hospitals are centralized (DE, NO, RO, RS). 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** (IE). Furthermore, the closing down of health care services (PT, RO) and local satellite services resulted in higher unemployment. In the medium term, it leads to a desertification of these areas, unequal opportunities and risk to health for these populations. The increase in medical costs and the cuts to social benefits also increased the risk of deprivation bringing increasing risk of ill health, poverty and social exclusion with it.

There have been **increased costs in public health care systems** (FR, IS, IT) and these **expenses were increasingly passed on to patients** (FR, DE, IS, IT, PT) making services inaccessible. Many low income families and individuals were forced to **postpone or even avoid going to the hospital** due to the lack of financial resources and as a consequence their **health situation has deteriorated** (BE, CY, FI, FR, DE, IE, IT, RO). Additionally, lack of affordability to maintain their health makes the **way back to the labour market harder to achieve** (NO, PT).

Increased privatization of health care is identified as a further obstacle (DE, IS, IT, SK, SE). Private or commercial services are not accessible for people who are in the situation of poverty and social exclusion. The private sector is affected by the conditions of support (decision) of the health insurance (institutions) which are themselves private and profit-making (IT, SK). The Health Insurance institutions receive their money from employed people and from the state (state insurance for the people who are in a bad social situation and who meet conditions). These contributions are mandatory.

GROUPS OF PEOPLE THAT FACE THE BIGGEST PROBLEMS

Housing

Roma and Traveller communities, immigrants and homeless people are groups facing the biggest problems in accessing quality housing (BE, CZ, FR, DE, IE, IT, PL, PT, RO, RS, SE, UK). People who are homeless are trapped in emergency accommodation far longer than is needed as they have no accommodation to move to. In Ireland and Italy, this is due to the lack of supply in social housing but also the lack of properties available to rent within Rent Supplement and Housing Assistance Payment limits. This is coupled with landlords not willing to accept people on Rent Supplement.

> *In Ireland Travellers are facing an ongoing problem of inadequate and inappropriate accommodation. 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.*
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> *In the UK homeless people 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: 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. Most Roma live in inadequate living conditions and 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 association to their situation of monetary deprivation Roma people face additional obstacles like discrimination.*

Undocumented migrants and asylum seeker face the same problems.

> *In Ireland, asylum seekers 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 €15.60 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.*
>
> *In Italy, asylum seekers, until their status as refugees is recognized, are hosted in facilities financed by the state and managed by non-profit organisations. For daily expenses the state pays €35.00 per day, which includes €2.5 as pocket money. The rest has to cover the cost of meals, lodging, clothing, etc. Access to the education system is free. The reception facilities are not always adequate and when this situation becomes known, thanks to intervention by the police or journalists, the organisation loses its contract and the guests are moved to other centres.*

People on benefits or excluded from the system (BE, CZ, FR, NO, SK, SE, UK) are other groups facing greater difficulties with housing access and housing security, particularly due to the severe cuts.

> *In the UK 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 on social housing waiting lists face particular problems in accessing appropriate accommodation and remain for years in temporary accommodation while waiting for access to a social house. The situation for **social housing tenants** meanwhile, 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 with a disability (IS, IE, LV, PL, PT, SE, UK) are more likely to be poor and to live in unsuitable housing. There is an ongoing issue of accessible accommodation for people with disabilities, particularly those who use wheelchairs.

> *In France, recent reforms have slightly improved the situation of people with disabilities in accessing social housing. But the problem is that most of the social houses are not adequate for this group of people (e.g. toilets are not adequate for them, and many other things do not work). So many are not able to live in such situations and financial support doesn't help either.*
>
> *In Iceland, as the disabled and elderly receive pension and social insurance amounts lower than minimum wage, they bear increased costs of health services. Although recent changes have been made in the system aimed to redistribute direct costs of the public, lifting the cost of those who use the health care system the most and letting those who use it seldom pay more, no money has been added to the system. Total yearly costs of an individual are limited to a fixed sum. There are still high costs to be paid by individuals, especially for people with disabilities and long term illnesses who have no other income than the disability benefits from the state.*
>
> *In Ireland, 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.*
>
> *In the UK, 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. 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.*

Young people in general, and in particular those leaving care institutions (HR, CY, FR, IS, IE, NL, NO, PL, RS, SE, UK) also face difficulties in accessing quality housing. Young people are living longer with their parents due to extension of studies, unemployment or difficulties to have sufficient money (financial independence) to afford buying or renting a house. In France, young people leaving care institutions at age 18 do not have a place to go. To have a house you need a guarantee, but they have no families to support them. The state provides guarantees only for young people in difficulties, but there is a lot of discrimination. There are solutions, but are they are not working well. In the UK younger people - up to age 35 - are not entitled to have rent subsidy for the rent of a one-bedroom flat in any sector. They are subsidised only for a room in a shared house, which inhibits family formation. In Ireland, 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.

Another vulnerable group is **elderly people living alone** in houses with poor accessibility that contributes for their isolation and exclusion (IS, IT, LV, PL, PT, RO, RS, UK). In the UK, 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.

Among different households, **young families, single parent families and families with low income** were the ones facing the biggest problems in accessing and retaining quality housing (HR, CY, FR, IS, IE, LV, RO, UK). People have no savings. Therefore they can´t buy their own homes, because they don´t have enough money for the down payment, even though the instalment of the loan may be lower than the rental price they are paying. On the rental market, they often have to pay a deposit equivalent to three months´ rent and people don´t have that money. Many don´t pass the bank´s credit rating for loans, so their position is hopeless. The same holds for **distressed mortgage holders** (CY, IE, RO, SE). Those who can no longer afford to pay their mortgages face great difficulties. This includes people who are both working and who have lost their jobs. EAPN Members underline the unfairness that people have paid the price of bailing-out banks after the financial crisis, including through increased taxes and cuts to services and benefits, but the banks have not been prepared to reciprocate by supporting people in access to low interest mortgages.

Health Services

Undocumented migrants (BE, FR, DE, IT, NO, PT, SE), homeless (FR, DE, IE, IT, PT) as well as Roma (BE, FR, DE, IT, PT, RO, RS) and Travellers (IE) are the groups that face the biggest problems in accessing quality healthcare services, not only in terms of affordability but in some cases also due to the lack of information or low literacy skills (IE, SE). 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. **In Germany,** refugees in general do not enjoy the same status as ordinary citizens concerning public health care**. In Italy**, undocumented immigrants, quickly become "invisible" and if found out they risk expulsion. They can access emergency health services but not the health system.

Populations living in rural areas (FR, DE, IT, PT, RO, RS) face more problems in accessing quality health services. The distance from the primary health services and hospital is greater, and in some cases road conditions and the public transport system makes travel longer or more expensive. Additionally, the number of physicians per inhabitants is much lower than in urban areas, and is more likely to lack some specialties because the most innovative specialities are concentrated in the big cities.

Other critical groups are **people depending on benefits or excluded from the system** (BE, FR, DE, IE, SK), **people with disabilities and long term illnesses** who have no other income except their disability benefits (IS, IE, IT, LV, SE). 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 who cannot pay, wait. These delays can lead to very

negative and ultimately costly outcomes if treatment is not accessed in the appropriate timeframe Other groups include the **elderly** (FI, LV, PT) and the **young** (LV).

People suffering from addiction and drug dependency are another key at-risk group, particularly amongst the most marginalised communities (CZ, EE, IE). This is often a direct effect of poverty and exclusion in these communities and must involve a holistic response to the needs of marginalised communities.

GOOD PRACTICES

Housing

EAPN Finland: There are positive examples of the 'Housing First' principle being implemented, so that housing is the first thing and other support and services (for example to solve alcohol/drug problems) comes only after that. ESF has been used to finance a Housing First project in Finland. 'Housing Help' is also funded, so that people got support when they have questions or problems with housing, so they don't get kicked out of their homes.

EAPN France: The 'Housing First' principle has brought a lot of positive results in France as well. Homelessness is a key issue in public policies. Putting housing first ameliorates access to other services, labour market and reduces discrimination. This is a national programme implemented in 4 regions in France.

EAPN Iceland: Special housing benefits are a good practice. 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** 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 Italy: The fictional residence is a good practice example since it allows the homeless to own documents and therefore access social and health services. Thanks to a certificate of residence, they can also receive their disability or social pension guaranteeing them an income. Together with the SF Financial Programming 2014-2020, a national Operational Programme for social inclusion was set up and, together with FEAD can help access to goods and services, although we do not know if it will help reduce the number of people in poverty. A campaign called "homelesszero" was launched with the aim to raise funds in a 'Housing First' perspective (the actor Richard Gere is behind the campaign).

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 as eligible operations in the EU 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 Fair Water in some districts of the country and 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 good practices at local level and local authorities are being identified that can receive a symbol for their commitment in these areas. Housing and Urban Development is one of the areas of practice that is suggested to be included in local plans (some practices are suggested like: making

discounts on local taxes for families with 3 or more children; support for rehabilitation of degraded houses for families with 3 or more children; and so on).[35]

'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 programme. 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%)".[36]

There are already other experiences of 'Housing First' in other local districts of the country. It's also important to highlight that a National Housing Strategy was defined and implemented this year[37]. 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.

EAPN Slovakia: A possible example is the financial support given to build housing for Roma people, young families, families with disability, and support for municipalities to build rental housing.

EAPN Poland: The support given to the private rental market to provide affordable rents and decent standards by social rental agencies; early prevention of housing indebtedness as a measure for preventing evictions; supported housing as a deinstitutionalization strategy for people with disabilities, homeless etc.

Health Services

EAPN Belgium: Community health centres - These centres are very affordable, accessible, and people experiencing poverty are very positive about the quality of these centres (for more information click here).

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

EAPN Italy: Some regions opened so-called 'health houses' providing care to patients with chronic diseases. These houses supplement the organisation of the national health system.

EAPN Portugal: Access to health services free of user charges for minors was an important measure to spread the access to public health services, especially in a context of economic crises. At the moment that Portugal changed 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 centres are now extinct" (...) "who uses the health centres services after 20H goes to pay only 5€ applied to any medical appointment and not the 10.30€ that they used to pay for using emergency services"[38].

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[35] For more information, (only in Portuguese): http://www.observatorioafr.org/sobre.asp; http://www.observatorioafr.org/documentos/QuadroReferencia2015.pdf

[36] In: http://hf.aeips.pt/wp-content/uploads/2013/10/Jose_Ornelas.pdf

[37] Resolução de Conselho de Ministros nº 48/2015 de 15 de Julho; More informations (in portuguese): https://www.portaldahabitacao.pt/pt/portal/habitacao/EstNacHabitacao

[38] 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)

ROLE OF EAPN MEMBERS IN SUPPORTING GREATER ACCESS AND FIGHTING EXCLUSION

Housing

A large number of EAPN networks and member organisations provide **support and advice services** (BE, FI, FR, DE, IE, LV, NO, PL, PT, RS, SK) as well as **advocacy actions** (BE, FR, DE, IE, IT, LV, NO, PL, PT, RS).

> *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.*
>
> *Many organisations belonging to **EAPN Italy** work with/for Roma communities, the homeless, asylum seekers, migrants (both regular and irregular), elderly, youth, women, drug addicts etc. All of them meet the utmost difficulties whenever housing or temporary shelters are the issue. EAPN Italy does not cooperate with squatters movements.*
>
> *In 2009, **EAPN Portugal** implemented the National and Local Councils of Citizens. These groups are composed of citizens that lived or are living in a situation of poverty and social exclusion and have as main aims to give them a voice in the matters that are directly related to their situation. They also have 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 issues, but also to fight stereotypes, and support some of our documents[39]. In 2013, EAPN Portugal participated in the Project DRIVERS[40] 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 social protection services and health services. Through the debate on social protection services, the area of housing was also analysed. Through our research department it is planned to develop in 2016 a national research project on Poverty Impact of People and Mental Health. The aim of the research is understanding the relation between poverty and social exclusion and mental health problems in vulnerable groups[41]. Although the National Strategy for the Inclusion of Homeless People has no developments, EAPN with other NGOs are lobbying for its reinforcement and evaluation once it ends in 2015.*

EAPN Finland, Norway and Slovakia highlight particularly their **support for the direct participation of users** in these services. EAPN Finland provides **direct services**.

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[39] Participation web page - http://participacao.eapn.pt/apresentacao/; EAPN Portugal web page: http://www.eapn.pt/index.php

[40] http://www.eapn.pt/projectos_visualizar.php?ID=151; http://health-gradient.eu

[41] 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

Health Services

Some of the EAPN members provide **support and advice services** (BE, FI, FR, DE, LV, NO, PL, SK), followed up by **advocacy actions** (BE, FR, DE, LV, NO, PL, RS) and **support on the direct participation of users** in these services (FI, DE, IS, NO). In EAPN Ireland the issue of increasing mental health issues has been raised in their reports on the impact of the crisis on marginalised groups and communities. EAPN Finland has a specific focus on providing direct services for supporting greater access and fighting exclusion from public health services.

EAPN Iceland 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 needs.

5. KEY SOURCES OF INFORMATION AND DATA

Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on a Commission Recommendation on the active inclusion of people excluded from the labour market (2008): http://ec.europa.eu/social/BlobServlet?docId=613&langId=en

Council of Europe (1998) Quality of Care

European Commission (2015) Access to Health Services in the European Union: http://ec.europa.eu/health/expert_panel/opinions/docs/010_access_healthcare_en.pdf

Institute of Medicine: http://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/sixdomains.html

The Charter of Fundamental Rights of the EU (2000), article 34 (3) and article 35

The Council of Europe's European Social Charter (revised version, 1996), article 11 and 31

United Nations: Universal Declaration on Human Rights (1948), article 25.

United Nations: 2030 Agenda for Sustainable Development and Goals. UN Sustainable Development Goals: http://www.un.org/sustainabledevelopment/sustainable-development-goals/

WHO (2006) Quality of Care: http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf

EUROSTAT AND EU-SILC

Eurostat (2014) Unmet Health Care Needs Statistics: http://ec.europa.eu/eurostat/statistics-explained/index.php/Unmet_health_care_needs_statistics

Eurostat (2014) Housing Statistics: http://ec.europa.eu/eurostat/statistics-explained/index.php/Housing_statistics

Eurostat (2014) Housing Conditions: http://ec.europa.eu/eurostat/statistics-explained/index.php/Housing_conditions

Eurostat (2015) Quality of Life: facts and views: http://ec.europa.eu/eurostat/documents/3217494/6856423/KS-05-14-073-EN-N/742aee45-4085-4dac-9e2e-9ed7e9501f23

EAPN

EAPN Assessment of the Country Reports and Proposals for Country-Specific Recommendations 2016: http://www.eapn.eu/wp-content/uploads/2016/05/2016-EAPN-CountryReports-CSRs-assessment.pdf

EAPN Assessment of the 2016 Country-Specific Recommendations: http://www.eapn.eu/wp-content/uploads/2016/06/EAPN-2016-CSR-Response-Main-Messages-75.pdf

EAPN's response to the annual Growth Survey & Joint Employment Report 2016: http://www.eapn.eu/images/stories/docs/EAPN-position-papers-and-reports/2015-EAPN-response-to-the-AGS-JER-16-12-2015.pdf

EAPN Assessment of the NRPs 2016: What progress on Social Europe?: http://www.eapn.eu/15775-2/

European Organisations

Feantsa: 5 Key principles for implementing the housing priority in the European Pillar of Social Rights: www.feantsa.org

Housing Rights Watch: http://www.housingrightswatch.org/

Housing Europe: Social Housing in Europe: http://www.housingeurope.eu/section-14/research?topic=&type=country-profile&order=datedesc

PEP quotes from EAPN publications

Active Inclusion: Making it Happen (2011)

Adequacy of Minimum Income in the EU (2010)

Poverty and Inequality in the EU (2014)

Towards Children's Wellbeing in Europe: Child Poverty in the EU (2013)

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The European Anti-Poverty Network (EAPN) is an independent network of non-governmental organisations (NGOs) and groups involved in the fight against poverty and social exclusion in the Member States of the European Union, established in 1990.

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