

The Economic Case for Housing First – International Research and its Implications for Hungary

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Abstract: International research increasingly suggests that Housing First – a policy that offers unconditional access to permanent housing to homeless people – reduces the public costs associated with homelessness by lowering the use of shelters, emergency healthcare and criminal justice services, resulting in net fiscal savings that exceed the cost of the housing provided. Systematic reviews report substantial cost offsets and benefit to cost ratios above 1 in many North American and Western European programs, even when randomized trials show only modest net savings. At the same time, studies from Central and Eastern Europe remain scarce. In Hungary, existing studies document severe health problems, multimorbidity and limited healthcare access among homeless people, which indicates a high likelihood of crisis driven service use and significant costs, but they do not examine the economic effects of housing led interventions. This paper presents a literature review of international Housing First cost effectiveness research and of the Hungarian empirical literature on homelessness and health. By bringing these two bodies of work together, this study aims to identify where international findings may or may not be transferable to the Hungarian context. It also aims to highlight data and measurement gaps, and formulate a set of research propositions and policy suggestions, rather than new cost estimates. The aim is to bridge a clear gap between the international and the domestic literature and to contribute to debates on how to sustainably combat homelessness in Hungary and in sociologically and economically similar countries.

Keywords: *Housing First, homelessness, fiscal policy, cost reduction, sustainability*

1 Introduction

Homelessness is among the costliest social problems that modern welfare states face, not only in terms of human suffering but in fiscal terms as well. The chronic use of emergency shelters, hospital emergency departments, crisis mental health services, and the criminal justice system by people who lack stable housing generates substantial and recurring public expenditure, costs that are largely avoidable [1]. Yet for decades the dominant policy response in most countries has followed a ‘staircase’ or ‘treatment-first’ logic. People must demonstrate readiness through sobriety, compliance with treatment, and engagement with services before they can access permanent housing. Therefore, housing is conceptualised as the reward at the top of the stairs, not the precondition for recovery [2].

Housing First (HF) offers a different approach. Originating in the work of Sam Tsemberis and Pathways to Housing in New York City, HF provides immediate, unconditional access to permanent, independent housing to people experiencing chronic homelessness, coupled with voluntary, flexible support services. The thinking behind this is both practical and ethical. Stable housing is not a reward for completing treatment, but rather the foundation that makes treatment possible [3].

Over the past three decades this approach has been tested in large-scale randomised controlled trials (RCTs) in North America and Europe, and has been adopted as national policy in Finland, France, and several other countries.[4, 5]

International research increasingly suggests that Housing First does more than improve housing stability and quality of life. Drawing on the recent systematic economic review by Jacob and colleagues at the CDC [6], programs in the United States that move heavy users of emergency healthcare, shelters and criminal justice services into permanent, community-based housing often generate public cost savings that meet or exceed the cost of the intervention, with a median benefit–cost ratio of about 1.8. At the same time, this evidence is methodologically diverse in study design, follow-up and cost components, and it is almost entirely based on U.S. and Canadian data, so its relevance to Central and Eastern Europe remains largely unknown.

Hungary offers complex but still under-researched case. Recent estimates put the number of people experiencing homelessness at around 30,000, with up to ten times as many living in insecure or inadequate housing [7]. Since a 2018 constitutional amendment and a subsequent 2019 Constitutional Court ruling, rough sleeping has effectively been criminalised, pushing people out of public spaces without creating a clear pathway into stable housing. The homelessness system is still built around an emergency-shelter-and-staircase model and operates under chronic financial pressure: state funding covers only about 60–70% of actual service costs, and all this plays out in a housing market where social housing accounts for less than 2% of the housing stock [8]. Hungarian health studies paint a stark picture of severe illness and multimorbidity among people who are homeless, alongside very limited access to healthcare, pointing to a pattern of crisis-driven rather than preventive service use. Although recent housing-led and Housing First initiatives – including

pilots linked to the Housing First Europe project [9]– have begun to document housing outcomes and hint at potential cost advantages over temporary accommodation, Hungary still lacks peer-reviewed economic evaluations of housing-led programmes, and there is as yet no full cost-effectiveness analysis of Housing First in either the Hungarian or the wider Central and Eastern European context.

Hungary still lacks peer-reviewed economic evaluations of housing-led programmes, and there is as yet no full cost-effectiveness analysis of Housing First in either the Hungarian or the wider Central and Eastern European context. The present review addresses this gap by bringing the international cost-effectiveness evidence into dialogue with the Hungarian epidemiological reality. In doing so, it advances existing knowledge in three ways: it identifies the conditions under which Western benefit–cost ratios may or may not transfer to a CEE welfare setting; it offers regional policymakers a practical framework for choosing between cost-saving and cost-effectiveness strategies depending on local data and fiscal constraints; and it lays out a concrete research roadmap to guide the first generation of Housing First economic evaluations in the region.

2 Materials and Methods

The present study is a narrative literature review. A systematic search for economic evaluations of Housing First programmes was performed in Scopus (Elsevier). The search combined three groups of: (1) intervention terms – ‘Housing First’ OR ‘permanent supportive housing’; (2) economic outcome terms – ‘cost-effectiveness’ OR ‘cost–benefit’ OR ‘economic evaluation’ OR ‘cost analysis’ OR ‘cost offset’; and (3) population terms – ‘homeless’ OR ‘rough sleep’. No geographic restrictions were applied. Google Scholar was searched with the same terms in parallel, and the reference lists of key systematic reviews were screened manually for further eligible papers.

Titles and abstracts were examined for relevance. A study was included if it reported original quantitative economic data (cost-effectiveness, cost–benefit, or cost analysis) for a Housing First intervention delivered to adults experiencing homelessness. Both experimental designs (RCTs) and quasi-experimental designs (pre–post comparisons, matched cohort studies) were accepted. Purely narrative accounts were excluded.

In total, 17 North American and 11 European studies met the criteria and were synthesised qualitatively. Because of heterogeneity in methods and settings, meta-analysis was not conducted, the findings are presented as a structured narrative, with particular attention to the distinction between cost-saving (benefit–cost analysis) and cost-effectiveness designs.

The economic argument for Housing First is straightforward. The core question for any health economist or policymaker is whether the public costs saved by reducing those services exceed the cost of providing housing and support.

3 The International Evidence of Cost-Effectiveness

3.1 Systematic Reviews and Benefit-to-Cost ratios in North America

The most rigorous and up-to-date synthesis of the economic evidence comes from the Community Preventive Services Task Force (CPSTF) systematic economic review published in the American Journal of Preventive Medicine [10]. The review examined 20 evaluation studies of Housing First programmes (17 from the United States, 3 from Canada) and found the following:

- Median intervention cost (US studies): \$16,479 per person per year.
- Median total benefit (US studies): \$18,247 per person per year.
- Benefit-to-cost ratio (BCR) for US studies: 1.80 : 1 — meaning every dollar invested in Housing First generates \$1.80 in economic benefits.
- When Canadian studies were included, the BCR fell to 1.06 : 1, reflecting both the methodological heterogeneity of the evidence and the difficulty of generalising findings across different healthcare and welfare systems.

The CPSTF review followed a standardised economic review protocol developed for the Community Guide. Each included study provided its own estimates of intervention costs and cost offsets (benefits). The review team then converted all monetary values to 2020 US dollars using the Consumer Price Index to adjust for inflation.

The CPSTF review rated the overall certainty of the evidence as ‘moderate’ for cost-effectiveness, not high. The main reasons were: (1) most studies had short follow-up (≤ 2 years); (2) the intervention definition varied across studies; and (3) the comparators (‘usual care’) differed substantially between studies and countries.

The table below summarises the cost categories that appeared across the 20 reviewed studies. This information is taken directly from the Results section of Jacob et al [10], specifically from the description of Table 3.

Cost category	Included as intervention cost?	Included as benefit (offset)?
Housing / rent / utilities	Yes	No
Case management / support services	Yes	No
Administrative / overhead	Yes	No
Emergency shelter stays	No	Yes
Emergency department visits	No	Yes
Hospital inpatient (medical & psychiatric)	No	Yes
Outpatient medical / mental health	No	Sometimes
Criminal justice (police, courts, jail)	No	Yes (in some studies)
Social welfare / public assistance	No	No (excluded as transfer payments)

Table 1.
Cost categories included as intervention costs versus cost offsets in Housing First economic evaluations (based on Jacob et al., 2022 [10])

3.1.1 Comparing the two most extreme cases in the study

The meta-analysis identified two extreme benefit-to-cost ratios: Basu [11] at 4.1 and Latimer [12] at 0.2. Understanding why they differ is essential for designing a reliable HF evaluation in the CEE region.

Basu studied 407 chronically ill, recently hospitalised homeless adults in Chicago. The intervention was low-cost (\$4,177 per person/year) and targeted a population with very high baseline healthcare use. Even modest reductions in hospital days produced large savings, generating the exceptional 4.1 ratio.

Latimer, by contrast, analysed 1,198 homeless adults with moderate mental health needs in the Canadian At Home/Chez Soi trial. The intervention was high-fidelity and expensive (\$14,496 per person/year). The control group also improved, and outpatient costs increased, resulting in a BCR of only 0.2.

However, a BCR below 1 does not mean the intervention is uneconomic. Latimer conducted a cost-effectiveness analysis (CEA), not a benefit-cost analysis. The study found that HF with Intensive Case Management cost \$56 per additional day of stable housing, a price that fell below standard willingness-to-pay thresholds.

They found that at a willingness-to-pay threshold of \$67 per day, there was an 80% chance that HF was cost-effective relative to treatment as usual. From a societal perspective, the intervention was deemed good value for money, even though it did not fully pay for itself in direct cost offsets.

The lesson for Hungary is twofold. First, any future evaluation must decide which question to ask. Basu asked: does HF save money? By targeting high-cost, chronically ill homeless people with a cheap intervention, they got a BCR of 4.1 meaning HF paid for itself. Latimer asked: is HF worth the cost? Using a more expensive, high-fidelity HF model for a broader homeless population, they found a BCR of only 0.2 (it did not pay for itself), but the cost per extra day housed was \$56 – below the \$67 willingness-to-pay threshold, so it was still considered a cost effective effort compared to the alternative. Second, a negative BCR does not automatically disqualify HF. The right metric depends on the policy goal: for fiscal savings, use BCA and target the highest-cost users; for social value, use CEA (Cost-Effectiveness-Analysis) and measure cost per day housed. Hungarian researchers should first conduct a cost-of-homelessness baseline study to estimate local willingness-to-pay, then choose the evaluation design accordingly.

In practice, for Hungary and the wider CEE region, this means starting with administrative data on shelter use, hospital admissions, and police contacts to identify the 5–10% of homeless individuals who generate the majority of crisis costs. If such a high-need, high-cost group exists – as the Hungarian health data suggest – a Basu-style BCA would be feasible and policy-relevant. If instead the goal is to scale HF as a rights-based intervention, then a Latimer-style CEA with a locally calibrated willingness-to-pay threshold (e.g., expressed in HUF per day housed) would provide the appropriate justification.

3.2 Evidence for cost-effectiveness from Europe

3.2.1 Evidence from France

Possibly the strongest European economic evidence on Housing First currently comes from France, where Lemoine and her colleagues conducted a long-term cost-effectiveness analysis based on the *Un Chez Soi d’Abord* randomized controlled trial [13]. This trial included 703 homeless adults with severe mental illness across four cities (Paris, Marseille, Toulouse, and Lille), of whom 353 were assigned to Housing First and 350 to treatment as usual (TAU). Participants were followed for 24 months, and these trial data were then used to inform a Markov model projecting outcomes over a 35-year horizon, corresponding to the cohort’s expected lifetime.

What the French experiment actually provided was not a cash transfer in the ordinary sense, but immediate access to ordinary, independent housing combined with intensive, multidisciplinary support. Participants in the Housing First arm were

offered permanent housing in scattered-site apartments; at first they entered as sub-tenants and paid rent up to a maximum of 30 percent of their income, while the remainder was covered by the programme, and they could later become full tenants through lease transfer when they had sufficient resources. They were also accompanied by an assertive community treatment team composed of a social worker, nurse, doctor, psychiatrist, and peer worker, operating with a 10:1 client-staff ratio. In human terms, the intervention therefore replaced the instability of shelters, the street, hospitals, or prison with an ordinary home and a standing support team, rather than requiring participants to prove “housing readiness” in advance.

Unlike the North American benefit-cost studies reviewed above, the French analysis did not primarily ask whether Housing First fully ‘pays for itself’ in direct fiscal offsets. Instead, it used a cost-effectiveness framework from a societal perspective and defined effectiveness as the number of days spent in independent housing. This is important methodologically, because it shifts the evaluative question from narrow budget neutrality to whether the intervention produces substantially better housing outcomes at an acceptable additional cost within a welfare state characterized by quasi-universal health coverage and a relatively extensive social protection system.

The results of the evaluation were strongly supportive of Housing First. Over the lifetime horizon of the model, the Housing First group was projected to spend an average of 2,684.70 days in independent housing, compared with 774.85 days in the treatment-as-usual group, implying an incremental gain of 1,909.85 days; the corresponding 95 percent confidence intervals were 2,121-2,913 and 513-1,346 days respectively. By contrast, mean survival differed only modestly between groups, at 11.41 years for Housing First and 10.25 years for treatment as usual, suggesting that the principal benefit of the intervention lay in sustained housing stability rather than improved survival. Mean total societal cost was estimated at €320,039.27 in the Housing First group and €309,875.98 in the comparator group, producing an incremental cost of €10,163.29. This translated into an incremental cost-effectiveness ratio of €5.31 per additional day spent in independent housing, a result indicating that substantial housing gains were achieved at relatively low additional cost over the long run.

This figure is especially noteworthy when disaggregated by cost category. Housing First generated savings in health-care costs of €45,138.21 over the modeled lifetime horizon and modest justice-system savings of €1,011.81, but these were partly offset by higher social-service costs of €42,124.25 and higher welfare-benefit costs of €14,189.06. In other words, the French results do not show that Housing First eliminates public expenditure; rather, they show a reallocation of spending away from crisis-oriented health and justice responses toward housing and income-support mechanisms that stabilize people’s lives more effectively.

The temporal pattern of the French findings is equally important for policy design. The authors report that, in the Markov model, Housing First was actually a dominant strategy for the first 14 years, meaning it was both more effective and less expensive

than treatment as usual over that period. Only over the full lifetime horizon did the intervention become slightly more expensive overall, while remaining far more effective in housing terms. This suggests that evaluations limited to very short follow-up periods may either understate or mischaracterize the economic logic of Housing First, especially in systems where the main savings come from reductions in long-run psychiatric hospitalization and other crisis services.

For the Hungarian and wider CEE context, the main lesson is not that the French estimates can simply be transferred mechanically. Rather, the French paper shows how a European Housing First evaluation can be designed in a way that is both methodologically rigorous and policy-relevant. It combines an RCT with long-run modelling, adopts a societal perspective, includes health, justice, housing, and welfare costs, and uses a housing-specific effectiveness outcome instead of forcing the intervention into a purely biomedical quality-adjusted life-year framework. For Hungary, this offers a realistic template: a future pilot should collect repeated individual-level data on housing trajectories, hospital use, psychiatric admissions, emergency department contacts, shelter use, police and detention contacts, and welfare receipt, and then estimate either a French-style ICER in HUF per additional day stably housed or, where possible, a complementary cost-benefit ratio for the highest-cost service users.

3.2.2 Evidence from Finland

Finland has adopted a national Housing First strategy in 2008 [14]. Between 2008 and 2022, the number of people experiencing long-term homelessness in Finland fell by about 68 percent, while the number of people living in shelters and hostels dropped by roughly three quarters as emergency beds were converted into permanent, rented Housing First units. National programmes (PAAVO I and II, and their successors) invested several hundred million euros in new housing and support, with estimates suggesting that more than 4,600 homes were created in the first decade of implementation and that Finland spent over €270 million on the programme between 2008 and 2019. Costs are jointly borne by the central government and municipalities, while interestingly, apartments acquired from the private market are financed through the Finnish Lottery.

From an economic perspective, the Finnish evidence is a bit more scarce in randomized trials than the North American or French literature, but it still provides important cost-savings estimates from pre–post and case-study designs. A key reference is the Ministry of the Environment report “Economical effects of the reduction of homelessness,” which examined an intensified supported housing unit with 22 residents in Härmälä, Tampere. Comparing service use in the five months before moving into Härmälä with the five months afterwards for 15 long-term homeless residents, the study found net cost savings of €93,647 over five months, equivalent to €224,753 per year, or roughly €14,980 in annual savings per person. The largest reductions came from housing and substance-use related services, where

costs fell by about 53 percent, and the report concludes that providing intensified supported housing in existing stock is substantially cheaper than relying on hospitals, substance-abuse units, or prisons for crisis management [15].

These case-study findings are also echoed in official evaluations of Finland's first national Programme to Reduce Long-Term Homelessness (PAAVO I). The programme's final report estimated that by the end of 2011 the new dwellings and supported housing places created under PAAVO I generated approximately €21.3 million (not adjusted for inflation) in annual savings in costs associated with homelessness, primarily through reduced use of institutional care, shelters and other crisis services [16]. Although, like the Härmälä analysis, these calculations rely on pre-post comparisons rather than randomized allocation and focus on high-need users of services, they still provide indicative evidence that, under Nordic welfare-state conditions, Housing First-style supported housing can deliver substantial fiscal benefits for both municipalities and the central government.

For the Hungarian and wider CEE context, the Finnish material has two distinct uses: it is compelling as a policy narrative, but methodologically it does not offer a ready-made experimental design. Politically, the Finnish experience shows that a national strategy which converts shelters into permanent homes, funds scattered-site and congregate Housing First units, and integrates housing support into mainstream social and health services can produce sustained reductions in long-term homelessness. Methodologically, however, the dominant Finnish evaluation tools have been administrative trend analyses and pre-post case studies, not randomized trials with long-run economic modelling like the French *Un Chez Soi d'Abord* study, so the exact benefit-cost ratios remain less precisely estimated.

Translating these lessons into a CEE research agenda suggests a staged approach rather than direct replication. In institutional environments like Hungary—where health, social assistance, and housing systems are structured very differently from Finland—one would first need to carry out Finnish-style cost-of-homelessness case studies, using linked administrative data on hospital use, emergency contacts, shelters, and criminal justice, to identify the high-cost fraction of the homeless population and to obtain baseline cost profiles. Only then would it be realistic to design either (a) focused Housing First pilots for this high-need group, evaluated with experimental or quasi-experimental methods, or (b) broader system-level reforms that, following the Finnish precedent, gradually convert emergency shelters into permanent supported housing, with ongoing tracking of homelessness and service-use trends at the national level.

3.2.3 Other Examples from the EU

Beyond France and Finland, a growing but still heterogeneous body of European evidence suggests that Housing First-type programmes can be both effective and economically attractive, even though study designs and outcome measures vary considerably across countries. In Denmark, one of Europe's largest Housing First

implementations was launched through the National Homelessness Strategy (2009–2013) combining scattered-site housing with assertive community treatment, intensive case management and critical time intervention [17]. The official evaluation reported that roughly nine out of ten participants successfully maintained their tenancies, proving that people with severe mental health or addiction challenges can achieve stability without institutional care. Although macro-level goals like eliminating rough sleeping were not fully met, the intervention’s high individual effectiveness strongly supports shifting systemic resources away from temporary shelters toward permanent housing solutions.

Spain provides the most rigorous Southern European economic evidence to date, centred on the Hábitat Housing First programme. An initial evaluation of the programme found that it achieved a 100 percent housing retention rate at six months alongside substantial improvements in perceived security, family relations, and financial stability [18]. Crucially, it did so at an average cost of €34.01 per participant per day — ranging from €28.61 in Madrid to €42.21 in Barcelona — which researchers found to be directly comparable to the daily cost of existing traditional ‘staircase’ shelter services. A subsequent 18-month evaluation confirmed these successes, reporting a 96 percent long-term housing retention rate from a fiscal perspective [19]. This longer-term study showed that while Hábitat required a higher fixed investment in housing and intensive care, these costs were heavily offset by significant reductions in participants’ use of emergency health care, psychiatric services, and addiction treatments. Most recently, a randomized controlled trial published in the *International Journal of Social Welfare* applied a formal cost-effectiveness analysis to the programme [20]. The trial confirmed that Hábitat significantly increased life satisfaction, reduced the number of homeless nights, and improved institutional coverage. The authors concluded that even though the programme involves high short-term expenditure on accommodation, the net economic effects are demonstrably positive, proving that Housing First is a viable and highly efficient funding allocation compared with treatment as usual.

The United Kingdom has also produced recent cost–benefit evidence, notably through the government-funded Housing First Pilots in England and related analytical work [21]. A national cost–benefit analysis of three regional pilots estimated average programme delivery costs of about £7,700 per person per year and expected annual benefits of approximately £15,880 per person per year, yielding a benefit–cost ratio of 2.1 based on projected outcomes and 1.1 based on observed outcomes at 12 months. These benefits combined reductions in public service costs (particularly in homelessness services and criminal justice) with monetised improvements in wellbeing, and tenancy sustainment across the pilots was reported at around 84 percent after three years, again in line with international findings on housing stability [22].

While the Finnish model relies heavily on long-term, system-wide administrative tracking, the evaluations from Spain and the United Kingdom offer a more immediate, localized blueprint for Hungarian researchers. In Hungary, where

traditional, temporary ‘staircase’ shelters dominate the social provision landscape, the Spanish Hábitat evaluation provides a highly replicable starting point: a local pilot could initially focus on benchmarking the exact daily, per-capita operating costs of existing Hungarian shelters against a small-scale scattered-site Housing First cohort. Wojewódzka and Deák (2024) show that although Hungary recorded the largest reduction in household overcrowding among CEE countries between 2007 and 2022—a decline of 30.4 percentage points—overcrowding remains a deep-seated structural problem, particularly in rural areas where hidden housing deprivation continually feeds the pipeline into homelessness [23]. Furthermore, existing studies indicate that homeless individuals in Hungary often face severe multimorbidity but limited access to mainstream healthcare, relying strictly on direct medical cost offsets might artificially depress the economic results of a pilot [24]. To resolve this, Hungarian research designs should adopt the broader framework seen in the UK’s cost–benefit analysis, which explicitly monetizes improvements in individual wellbeing and factors in reduced expenditures across the criminal justice system and temporary homelessness services. By pairing the Spanish method of quasi-experimental daily cost parity with the UK’s wider societal cost–benefit framework, researchers in Central and Eastern Europe can rigorously test the economic viability of Housing First through targeted pilots, without having to wait for a full, national-level policy transformation.

4 Discussion

4.1 Methodological heterogeneity and its policy implications

The 28 economic evaluations synthesised in Section 3 fall into three broad backgrounds, and their heterogeneity is itself an instructive finding. North American studies (Section 3.1) typically employ benefit–cost designs aimed at the highest-cost users, producing large but context-specific fiscal offsets. French and Canadian analyses (Section 3.2.1) adopt cost-effectiveness frameworks that measure the cost per additional day stably housed against a willingness-to-pay threshold, while Northern and Southern European evaluations (Sections 3.2.2 and 3.2.3) rely on simpler cost-comparison or pre–post designs that benchmark Housing First against the daily operating expenses of existing shelter systems. The critical point is not that one approach is superior, but that the choice of evaluation method pre-defines what counts as success. For Hungary, this means that the first policy decision is not whether Housing First “works,” but which question should be asked: short-term fiscal savings, or long-term housing stability at an acceptable social cost.

4.2 Structural gaps in the Hungarian socioeconomic landscape

When this international evidence is placed against the Hungarian institutional reality, three structural gaps emerge that currently prevent any straightforward transfer of Western benefit–cost ratios. First, the social rental sector is virtually absent: social housing accounts for less than 2 percent of the total stock [8], whereas Finland’s national Housing First strategy succeeded precisely because municipalities could access a large, state-supported affordable rental pool. Without a supply of scattered-site apartments available at below-market rents, a Hungarian Housing First programme risks becoming a time-limited rental subsidy rather than a pathway to lasting tenancy. Second, the data infrastructure required to measure cost offsets is missing. The North American studies that report the highest benefit–cost ratios (e.g., Basu, Section 3.1.1) were built on linked individual-level records across healthcare, shelter, and criminal justice systems; in Hungary, NEAK health data, municipal shelter registries, and police or court records remain siloed, with no common identifier. This makes the empirical core of the economic case – credible cost–offset measurement – currently unfeasible at scale. Third, the fragmentation of public financing weakens the incentive to invest. In the French and UK evaluations, savings from reduced hospital and justice system use were visible within the same public purse that funded the intervention. In Hungary, homelessness services are co-financed by under-resourced municipalities and a capped central budget that covers only 60–70 percent of operating costs, so any savings that materialise in the health or justice systems do not automatically return to the budget line that would fund a Housing First expansion.

4.3 Towards a practical framework: bridging the gaps

These gaps are not merely descriptive; they define what a realistic Hungarian adaptation of Housing First would require. The domestic epidemiological profile – severe multimorbidity, crisis-driven emergency care, and limited access to preventive services – closely matches the high-need, high-cost populations that yielded the most favourable benefit–cost ratios internationally, most notably in the study by Basu and colleagues (Section 3.1.1). That work targeted individuals with chronic illness and recent hospitalisation, a subset already known to be heavy users of costly services. The logical starting point for Hungary is therefore a similar targeted pilot: instead of a fixed percentage, it should enrol homeless persons who, based on linked administrative data, are the highest utilisers of shelters, emergency departments, and hospital inpatient care. Such a pilot would need three components that do not yet exist together in Hungary: (1) a cross-sectoral data protocol linking individual-level NEAK, shelter, and criminal justice records; (2) a dedicated supply of scattered-site apartments, possibly mobilised through municipal housing companies or a social rental agency model; and (3) a dual-metric evaluation design that measures both direct fiscal offsets (benefit–cost analysis) and cost per

additional day housed (cost-effectiveness analysis), so that the results can inform both finance ministries and social policy advocates. This three-condition checklist – data linkage, housing supply, dual-metric evaluation – constitutes the practical framework that the present review offers to regional policymakers, allowing them to assess the feasibility of any proposed pilot before public funds are committed.

4.4 Limitations of the review and pathways for future research

The present review has several limitations that bound its conclusions. The literature search was narrative rather than fully systematic, confined to Scopus and Google Scholar, and restricted to English-language studies; relevant grey-literature evaluations from Central and Eastern Europe may therefore have been missed. The synthesis is qualitative, and the heterogeneity of study designs, cost components, and follow-up periods precluded meta-analytic pooling. Most importantly, the transferability assessment offered here is inferential: it contrasts international findings with documented Hungarian conditions but does not test those inferences against primary Hungarian cost or housing data. These limitations point directly to the next research steps. The most urgent is the construction of a linked administrative dataset – integrating NEAK, municipal shelter, police, and welfare records at the individual level – as a prerequisite for any credible cost-offset study. On that foundation, a focused pilot with a quasi-experimental or randomised design can test whether the cost profiles of high-need homeless individuals in Hungary respond to Housing First as the international evidence predicts. Finally, a local willingness-to-pay study is needed to calibrate the cost-effectiveness threshold (in HUF per day housed) against the preferences of Hungarian decision-makers and taxpayers, without which cost-effectiveness arguments will remain abstract.

Conclusions

Systematic reviews and RCT-based analyses from North America and Western Europe consistently show that Housing First generates substantial reductions in emergency health, shelter, and criminal justice expenditures, producing benefit–cost ratios above 1 in many programmes and cost-effectiveness ratios well below standard willingness-to-pay thresholds even where direct savings fall short. However, these findings cannot be mechanically transferred to Hungary, where a severely constrained social rental market, a fragmented and underfunded shelter system, and a structurally siloed public financing architecture all alter the channels through which cost offsets can materialise. The existing Hungarian health literature documents the high-need, crisis-driven profile that international evidence identifies as the key predictor of Housing First's fiscal viability, but no peer-reviewed economic evaluation of a housing-led intervention has yet been conducted in the country. Closing this gap requires, first, a cross-sectoral data infrastructure linking shelter, NEAK, criminal justice, and welfare records at the individual level, and

second, a focused pilot study with a credible counterfactual, designed to answer whether and to what extent Housing First pays for itself.

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