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Health care of people in homelessness: a comparative study of mobile units in Portugal, United States and Brazil

Igor da Costa Borysow [1]
Eleonor Minho Conill [2]
Juarez Pereira Furtado [3]

Abstract *This paper describes and analyzes the legal and normative framework guiding the use of mobile units in Portugal, United States and Brazil, which seek to improve access and continuity of care for people in homelessness. We used a comparative analysis through literature and documentary review relating three categories: context (demographic, socio-economic and epidemiological), services system (access, coverage, organization, management and financing) and, specifically, mobile units (design, care and financing model). The analysis was based on the theory of convergence/divergence between health systems from the perspective of equity in health. Improving access, addressing psychoactive substances abuse, outreach and multidisciplinary work proved to be common to all three countries, with the potential to reduce inequities. Relationships with primary healthcare, use of vehicles and the type of financing are considered differently in the three countries, influencing the greater or lesser extent of equity in the analyzed proposals.*

Key words *People in homelessness, Health, Portugal, United States of America, Brazil*

[1] Departamento de Medicina Preventiva, Universidade de São Paulo. Av. Ana Costa 95/1º andar/ Laboratório de Avaliação de Programas e Serviços de Saúde, Vila Mathias. 11060-001 Santos SP Brasil. igorsow@yahoo.com.br
[2] Departamento de Saúde Pública, Universidade Federal de Santa Catarina. Florianópolis SC Brasil.
[3] Departamento de Políticas Públicas e Saúde Coletiva, Universidade Federal de São Paulo. São Paulo SP Brasil.

Introduction

Ensuring access also to vulnerable groups has become an objective of some contemporary health systems, as evidenced by the development of new care models[1]. This paper describes and analyzes proposals aimed at people in homelessness in Portugal, the United States (USA) and Brazil, respectively called Street Teams, Mobile Outreach Clinics and Clinics on the Street.

Under the category "people in homelessness" (PIH) are individuals who share the condition of extreme poverty, the use of streets and public spaces (or possibly hostels) as a primary place of survival, overnight stay and personal relationships, on a temporary or permanent basis. On the other hand, they evidence heterogeneous reasons for going to the streets and life strategies[2,3]. PIH make up excess population groups that do not keep pace with socio-economic transformations and/or are victims of circumstances – environmental disasters, expropriation, forced migration, etc. The mismatch in relation to the current social model leads to negative discrimination and repressive actions[4], since they are considered by society as "an inconvenient and threatening presence"[5]. The prevalence of mental disorders and alcohol abuse and other drugs use adds to PIH breaking with their social networks and protective groups, increasing their vulnerability[6].

PIH are by the thousands in Brazil, the United States and Portugal[7-9], where problems of access and continuity of health care are identified due to the inadequacy of services to the particularities of this group[3,10,11] and the stigma they suffer, including from workers[12]. Faced with these challenges, some countries have adopted outreach and roaming strategies to overcome limitations of spontaneous demand for this group[13]. Such strategies are characterized by teams moving into the territory in order to reach people who are refractory or unsuitable for health networks[14], overcoming hurdles to access to conventional services[2,5,15].

Countless political, technical and institutional issues emerge from the itinerant care proposals. In Brazil, the Clinic on the Street initiative totals 129 facilities[16] and, despite its numerical expansion and complex actions, the number of studies on the subject is still limited[17-20]. This research seeks to contrast what is common and diverse between the standards geared to PIH itinerant health care, relating national socioeconomic and institutional contexts. It also aims to highlight the contributions and limitations of health equity initiatives for its target population, that is, to analyze the investment and organization of systems and services in the differential and fair treatment of a population that experiences inequalities[21], such as PIH. Given the lack of comparative studies on this subject, we will place the Brazilian proposal under a comparative international perspective, so that the experience of other countries represents an analytical mirror[22] and provides useful elements for the transfer of knowledge in this field[23] and subsidies for future studies.

Methodology

Comparison is the analytical resource[24] of this multiple case study[25]. We outline the focus on the PIH itinerant initiatives in Portugal, the United States of America and Brazil. We chose the U.S. based on the pioneering provision of this type of service and the volume of indexed publications on the subject; Portugal was chosen for its cultural proximity and similarities between the principles and organizational design of the Portuguese National Health System (SNS) and the Brazilian Unified Health System (SUS).

We define as units of analysis proposals by the federal governments regarding mobile services, considering the national socio-political situation and national health systems[26]. We define three descriptive categories: context, characteristics of the service system and facilities. The first uses a set of indicators that act as approaches (proxy variable) to locate the main factors that influence the health situation – demographic, socioeconomic and epidemiological indicators. We include in this item indicators of health problems with a higher prevalence among PIH, such as alcohol abuse and other drugs use[3,9,27], mental disorders[28-30], HIV/AIDS[3,31] and tuberculosis[32-36] – considering the low amount of specific PIH health data in Portugal and Brazil. We also consider PIH estimates, however, it is necessary to consider the limits of its validity due to the difficult operationalization and use of different methodologies[7-9].

The context description summarizes the history of health systems, placing the political-institutional option against the social protection in health prevalent in each country. The operationalization of the systems' characteristics prioritized access, coverage, organization and management of services and the financing method, as expressed in the normative and legal frame-

work[25,37]. Mobile units were described according to their design, care model and financing.

This paper is based on bibliographical and documentary review, considering laws, governmental ordinances and health sector booklets, among others. Scientific papers were identified through SciELO, PubMed and Google Scholar databases, with the following combinations of terms: in English, "*mobile outreach services*" and "*homeless*", "*mobile health*" and "*homeless*", "*mobile unit health service*" and "*homeless*", and in Portuguese "*saúde*" (health) and "*morador de rua*" (homeless). The analysis systematizes similarities and differences between the proposals of mobile units, based on the theory of convergence / divergence between contemporary systems[25,38].

Results - context, health systems and structuring of mobile teams in the three countries

Portugal and Street Teams

In 2013, the estimated population for Portugal was over 10 million inhabitants, with a demographic profile marked by low fertility and aging population[39]. In that same year, there were approximately 5,000 PIH, 0.04% of the total population[8]. In Lisbon, the 2015 survey identified a majority of single, divorced or widowed Portuguese men with low schooling and no vocational training[40].

The per capita Gross Domestic Product (GDP) is US$ 22,080 with a very high Human Development Index (HDI), and a Gini Index of 36,0[41,42]. When Portugal joined the European Union in 1986, there was a period of improvement in socioeconomic indicators, but they started to recede by mid-2009 with the worsening of the financial crisis in this geopolitical space, together with austerity social policies[43].

The SNS was created in 1979, based on ensured universal access, tax-derived financing and partial decentralization of responsibilities in the provision of care to Regional Health Administrations (ARS); but the SNS started with low funding, little development of own services and access problems. Since 1990, the private sector increased its participation in the SNS in an international context of strengthening the neoliberal model[44].

There was a gradual favoring of the primary healthcare model, but in spite of its good performance[44,45], its implementation was reduced with the recent economic crisis. By 2013, spending remained predominantly public (66% of the total), with an increase in private expenditure (out-of-pocket and insurance)[46]. Thus, there are now three health subsystems in Portugal: SNS, insurance of some professional categories and private insurance.

Some Portuguese health indicators are close to the average of the other countries of the Organization for Economic Cooperation and Development (OECD), while others – such as cerebrovascular disease mortality, mental health care and, mainly, HIV/AIDS prevalence – show an unfavorable situation in all European countries[45,47]. In addition, in 2012, 2.7% of the population reported having used some type of drug in the last 12 months, excluding alcohol and tobacco[48], and in 2013, a high rate of alcohol consumption per person per year was observed[49]. Few cases of tuberculosis were estimated in 2014[50], and neuropsychiatric disorders contributed to 25.6% of the global burden of disease.

HIV/AIDS and psychoactive substance use indices have been the argument for the implementation of mobile health teams since 2001, such as Street Teams (ER), aimed at drug users[45,51,52]. However, increased PIH in the country led to the establishment, in 2006, of an interinstitutional group that elaborated the "National Strategy for the Integration of Homeless People" (ENIPSA)[11]. ENIPSA considered the ER as the main means of addressing, monitoring and referring PIH to other points in the network to receive basic care.

Proposals for Portuguese ERs were reorganized in 2013 through the establishment of the General-Directorate for Intervention on Addictive Behaviors and Dependencies (SICAD), responsible for health programs related to this theme[53,54]. ERs' financing would be of federal public origin, complemented by funds from social institutions performing the service[54].

Disseminating information, tools and programs to reduce harm and risks, interacting with consumers, conducting referrals as needed and providing first aid are ERs' planned actions[52]. These teams may or may not use vehicles, consisting of contracted professionals and volunteers[52]. Presently, ERs receive funding from the federal government through public tenders launched by municipalities for focal activities.

The US and the Mobile Outreach Clinics

A country with a large territorial area and a population estimated at more than 320 million

inhabitants[55], the U.S. accounted for 610,042 PIH in 2013[7], which meant 0.20% of the population. A significant increase in this figure was observed in the 1970s with the de-hospitalization of psychiatric patients, and a new increase occurred following social programs cuts in the 1980s[56]. What happened in 2013 was that a large majority of men over 25 years of age, and 42.17% of people had severe mental disorders and/or disorders related to the use of psychoactive substances[7].

The country has a high GDP per capita, an HDI of 0.915 and a Gini of 41.1. By 2013, per capita health expenditure was twice the average of OECD countries and predominantly private (around 52%). Both child mortality and potential years of life lost are greater than those estimated for Portugal[41,42,46,57].

Throughout the twentieth century, the U.S. health system was structured by a business and philanthropic model with a predominance of financing and private service provision. While U.S. states have autonomy in coordinating the sector[58], the U.S. Department of Health and Human Services (HHS) manages the entire network of care, regulating private plans and services. In 1965, two subsystems, Medicaid, and Medicare were established. The first is care-oriented, aimed at low-income people, with federal subsidies; the second is social insurance financed by fiscal sources and wage contributions to cover people over 65 or who have specific morbidities. HHS also runs programs for other specific groups, such as war veterans and low- and middle-income children[58].

In 2010, 49% of Americans were covered by employer-sponsored insurance, 17% had Medicaid, 12% had Medicare and 16% of individuals had no social protection in health[59], including PIH. Access difficulties and rising expenditures contributed to the approval of the Patient Protection and Affordable Care Act (ACA), starting the reform known as Obamacare[60]. ACA is based on expanded coverage due to mandatory private insurance, increased regulation, Medicare and Medicaid expanded coverage, reforms in the care model, among other actions[25]. Despite criticisms to the business model with private insurance intermediation, this reform has increased access of PIH to services[25,61].

Health indicators identified a high HIV infection rate, similar to Portugal in 2009[47]. Average alcohol consumption was 8.8 liters per capita in 2013[49]. Regarding other drugs, 9.2% of the population reported having used some kind of substance in the last month, in 2012[62], and a small number of tuberculosis cases was recorded in 2014[50]. Neuropsychiatric disorders contributed with 30.9%[63] of the global burden of diseases.

The use of PIH-oriented mobile outreach clinics began in the 1970s.[64] Given the serious situation of PIH in the United States, several social movements pressured the federal government to ensure rights to this public, which led to the establishment of a specific section for PIH in the Anti-Drug Abuse Act[65]. In 1987, under intense pressure from institutions and movements linked to the issue, and from the mobilization of Congressmen Stewart McKinney and Bruce Vento, Congress enacted the McKinney Homeless Assistance Act (later renamed the McKinney-Vento Homeless Assistance Act), which created amendments to the Public Health Service Act for the implementation of PIH services, including outreach strategies[66,67]. The McKinney-Vento Act does not address the organization of mobile teams; it only mentions that they are primary healthcare services that can be complemented by specific teams geared to the treatment of drug addiction and mental disorders.

A study carried out between 2006 and 2007[10] showed that most of the investigated teams used their own vehicle and financing derived from federal, municipal and corporate funds. They consisted of several professional categories, including a doctor in just over half of them[10]. Currently, several elements point out a synergy of policies to overcome PIH's difficult access to health services. ACA's implementation expanded the criteria for inclusion in Medicaid and facilitated the funding of innovative experiences. These actions have led to a decreased number of PIH as from 2010, despite national recession[61]. National institutional networks coordinated with the federal government, such as the National Coalition for the Homeless and the National Alliance to End Homelessness[68,69], which are mobilizers of political actions and train several public and private institutions executing PIH-oriented services nationwide.

Brazil and the Clinic on the Street

With a population estimated at 200 million inhabitants[70], PIH count totaled approximately 50,000 people in 2008, or 0.02% of the Brazilian population of that year[9]. Most were men of African descent with low schooling, who associated going to the streets to alcohol abuse and/or other drugs use and to unemployment, added to family disagreement[9].

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In 2013, Brazil's GDP per capita was well below the US and Portugal. Its Gini Index was well above the OECD countries average[41], but its HDI ranked it 75th in the 2015 Human Development Report[42]. Per capita health expenditure in that year was well below the countries under study, and the potential years of life lost were much higher than those found in Portugal and the United States[46] (Table 1).

With the enactment of the Constitution in 1988, in Brazil, health became a citizenship right ensured by the SUS[71], whose objective is to provide universal, comprehensive and equitable coverage through organized networks of services under shared management between federal, state and municipal governments[72]. However, low public funding resulting from the 1990s neoliberal agenda fostered a significant expansion of private health plans. From the standpoint of financing and service delivery, the Brazilian health system can be considered a hybrid system consisting of three subsystems: the SUS financed with state resources and universal access with emphasis on primary health care; a private subsystem, whether for profit or not, maintained with public and private funds; and the supplementary subsystem composed of several types of private plans, which also receives tax subsidies[71,73].

In 2009, 0.31% of the population lived with HIV/AIDS[47]. In 2013, less liters of alcohol were consumed per person than in the other two countries[49], but in 2005, 10.3% of the population reported having consumed some type of drugs, excluding alcohol and tobacco, in the last 12 months[74]. The high incidence of tuberculosis cases in 2014[50] placed the country on the World Health Organization's watch list. Neuropsychiatric disorders contributed to 20.3% of the global burden of diseases[63].

PIH health strategies emerged from municipal experiences between 1980 and 2000, some related to primary healthcare and others aimed at homeless users of psychoactive substances[77-79]. Since 2007, the Ministry of Social Development has teamed up with other ministries (Ministry of Cities, Education, Health, Justice, Labor and Employment, the Special Secretariat for Human Rights and the Federal Government Public Defender), with workers in this area and movements, which resulted in the production of the National Policy for the Social Inclusion of People in Homelessness[80].

Table 1. Demographic, socioeconomic and health indicators: Portugal, United States of America and Brazil.

Indicators/countries	Portugal	United States	Brazil
Population, census 2010	10,562,178	308,745,538	190,732,694
Population estimated, 2015	10,427,301 (2013)	321,865,400	204,881,900
Population in homelessness Percentage in relation to the total population estimated for the referred year	Approx. 5,000 (2013) 0.04%	610,042 (2013) 0.20%	Approx. 50,000 (2008) 0.026%
Gross Domestic Product per capita, 2013 (US$)	22,080.90	54,629.50	11,384.60
Human Development Index, 2014	0.830	0.915	0.755
Gini Index	36.0 (2012)	41.1 (2013)	52.9 (2013)
Fertility rate, 2013	1.21	1.86	1.8
Potential years of life lost per 100,000 inhabitants – PYLL, 2010	3,492	4,629	7,576
PYLL defined by women / men 2010	2,230 / 4,841	3,447 / 5,814	5,037 / 10,216
Contribution rate of neuropsychiatric disorders in the global burden of disease in 2008	25.6%	30.9%	20.3%
Annual alcohol consumption per person in 2011	10.3 liters	8.8 liters	7.3 liters
Rate of people who consumed any drugs (except alcohol and tobacco) in the last year, in 2012 (Brazil in 2005)	2.7%	9.2% (last month)	10.3% (2005)
Rate of people infected by HIV / AIDS, 2009	0.40%	0.39%	0.31%
Incidence of tuberculosis cases per 100,000 population in 2014	25	3	44

Sources: IBGE[75]; United States Census Bureau[55]; INE[76]; OECD[46,47,57]; Meta[9]; United States of America[7]; Pereira e Oliveira[8], PNUD[42], DATASUS[70], SICAD[48], WHO[50,63], Substance Abuse and Mental Health Services Administration[62], Duarte et al.[74].

Based on this document, the Ministry of Health (MS) developed an emergency plan to strengthen and expand the so-called Clinic of Street, mobile itinerant services based on harm reduction strategies and drug addiction treatment[81]. Two years later, the MS reorganized the Psychosocial Care Network[82], in coordination with the primary healthcare services, and remodeled the former Clinic of Street to the new Clinic on the Street (CnR), which became part of primary healthcare[82]. In 2012, parameters were established for the implementation of CnRs and criteria for the number of teams based on the population of municipalities[83,84], and subsequently, the incentive values and the role of professional categories that would be part of the teams were redefined[85,86].

The CnR is a PIH-exclusive PHC multiprofessional service. It includes care for alcohol abuse and use of other drugs through outreach and sharing of actions with other points in the network and other sectors. Its implementation is mandatory according to the number of HIP identified in municipalities. Three types of teams were defined and only modality III provides for the inclusion of doctors[85].

Table 1 and the Charts 1 and 2 summarize the main elements found in the comparison between the contexts, the characteristics of the systems and the mobile units in the analyzed countries.

Discussion

Convergences for reducing inequity: objectives, outreach, multiprofessionality and harm reduction

Despite the structural differences in the health policies of the countries surveyed, all three recognize as main problem the barriers in the access of PIH to the services, implanting strategies and similar resources of approach and care[52,66,83] (Table 3). Outreach, followed by referral to the other points of the network proves to be an essential strategy in the linkage and continued care to people in homelessness, with potential to facilitate the access of services by the population[13,20]. The approach and provision of care before issues related to alcohol abuse and use of other drugs was also a convergent action[52,66,83], which is consistent with the high prevalence of psychoactive substances among PIH (as highlighted by PIH censuses of the US and Brazil) and among the general population of the three countries studied (Table 1).

We identified as a convergent resource the establishment of the teams through the integration of professionals of different graduations. The actual multidisciplinary character seems to face the complexity of its object, enabling articulation of different perspectives on the issues[87,88].

Therefore, outreach and harm reduction strategies associated with multiprofessional teams' resources would favor the promotion of equity by adapting mobility and broadening coverage, range of actions and team composition to people's essential needs, and alleviating barriers imposed by social inequality, often reproduced by the health network itself[21].

Divergent actions among the proposals: care models and intersectorality

In the United States and Brazil, mobile services originated in the care of alcohol and other drug users[52,65,77], but were later directed and integrated with primary healthcare[66,83]. Thus, Portuguese ERs focused on the strategy of care to users of psychoactive substances in response to the high levels of HIV/AIDS and substance abuse in the country[89], a restriction reinforced by the last decree-law[54], even with the proposed expanded functions of ERs by ENIPSA[11]. Working through primary healthcare, Brazilian and U.S. services enhance comprehensive health care for PIH, considering their complexity and the identified barriers to access. They provide assistance to the most common problems of the population, such as tuberculosis, avoiding excessive referrals to specialties[90]. A broader approach enables a better linkage and continuity to treatments, and care for comorbidities[19,20,91]. In all three countries, but especially Brazil, primary healthcare could contribute to reducing morbidities among men, which are predominant among PIH, who have the highest rates of potential years of life lost (see Table 1) and are less seeking health services in the country[92].

Otherwise, services proposed by the last Portuguese legislation do not serve PIH in general, and they need to seek comprehensive care elsewhere in the network[77,94]. Restricting the care modality focused here may result in limited and stigmatizing actions vis-à-vis the target population, with the risk of providing assistance only to urgent issues, not promoting processes to improve the overall quality of health[95] and not favoring the overcoming of inequity[21]. Moreover, the lack of a more organized axis of health actions can lead to segmented and/or overlapping strategies by ERs[96].

Chart 1. Synthesis of the characterization of health systems.

	Characterization of health systems		
	Type of system/ coverage	**Service organization and management**	**Funding (2013)**
Portugal	National health system - SNS Universal and comprehensive care as a citizenship right Insurance for certain professional categories and private insurance	Public services offered at the three levels of care through own services, public-private partnerships and private entities. SNS oversees public and private services 5 ARS responsible for the operationalization and transfer of resources, including for the Family Health Units. Private sector offers specialized, hospital services and some high technological density procedure. There is no specific health policy for PIH, only proposals for adaptation suggested by ENIPSA	Tax sources Total expenditure per capita: US$ 2,514 Public: 66.56% Private: 33.44%
EUA	Permissive or pluralistic corporate Compulsory private insurance to ensure care, with federal subsidies Retirees, people with certain chronic diseases, low-income population covered by Medicare (public insurance) and Medicaid (care); Public subsystems for indigenous people, children, military and civil servants	Fragmented provision of services through private insurance or public subsystems. Network more focused on specialties, hospital care and, with high technological incorporation. Federal government (DHHS) administers public insurance (Medicare) and regulates private insurance, state government administers Medicaid and private insurance manage the provision of managed care services they ensure. PIH-specific health policies are included in the McKinney-Vento Act	Tax sources, employer and worker contributions, direct family budget Total expenditure per capita: US$ 8,713 Public: 48.17% Private: 51.83%
Brasil	Unified Health System-SUS, public system of universal, comprehensive and free access, as a right of citizenship. Private subsystem consisting of regulated private services and insurance subsidized by the federal government.	Primary healthcare services offered mainly by the municipalities, States ensure hospital care and some specialized services and the Federal Government provides high complexity services. Organization at three levels of care: basic care, medium and high complexity. Establishment of coordinated networks of care in the areas of obstetrics and priority specialties. Shared management between levels of government, encouraging regionalization through Regional Inter-managerial Commissions (CIRs) Private network offers supplementary services focused on specialties, complementary examinations and hospital care, with high technological incorporation There are specific health policies for PIH, especially in PHC documents.	Tax sources, private insurance with employer and worker financing, and direct from families with federal subsidies (fiscal renunciation) Expenditure per capita: US$ 1,471 Public: 48.20% Private: 51,80%

Source: Brasil[72]; Bahia[71]; Paim et al.[73]; United States of America[7,60]; Costa[58]; Portugal[53]; Santos[44], Conill[25].

Intersectoral action received greater investment from the U.S. federal government, which articulated intersectoral and interinstitutional partnerships to care for PIH, setting an organized network that promoted a reduced number of this population group, considering its multiple

Chart 2. Synthesis of the characterization of mobile health units for people in homelessness.

	Characterization of mobile health units for PIH		
	Design	Service Organization and management	Funding
Portugal – Street Teams	Harm reduction in psychoactive substances abuse, acting as mediator between users in the places of consumption and the health network Coordination provided with other sectors through the Planning and Intervention Center.	- Services offered: information, tools and harm- and risk-reduction programs, interaction with consumers, conducting referrals as needed, offering first aid in case of emergency and negligence. - No professional modalities were defined to work in - Members can be hired or volunteers	Public and private. Federal government defines the percentage of public fund financing, to be complemented by the institution that will perform the service.
USA – Mobile Outreach Clinics	Primary care including care for psychoactive substances users. It coordinates access to other health network points, and services of other sectors, when necessary.	- Services offered may vary according to teams' composition - There is no definition for the professional categories, but they must respect the model of primary healthcare and of drug abuse treatment.	Public financing, and may be complemented with private funds via corporations. Federal government evaluates payment percentage, but local government needs to finance at least 25% of the total cost of the service.
Brazil – Clinic on the Street	Design focused on primary healthcare and harm reduction. It coordinates access to other health network points and services of other sectors, when necessary.	- Services offered: basic healthcare actions, first aid, rapid tests, qualified listening, psychological support, active outreach, educational and cultural activities, dispensing supplies. - Professional categories envisaged are nurses, psychologists, social workers, social agent, nursing technician or assistant, oral health technician, dental surgeon, professional / physical education teacher, professional with graduation in art and education, community health workers and physicians.	Public financing. The federal government defrays service expenses, except the supply of vehicles, whose responsibility lies with the municipal management.

needs[7,61]. Both the Brazilian and Portuguese governments proposed the coordination of several sectors in their national strategies[11,80]. However, only Brazilian ordinances in the health sector covered this principle[82,83], and both countries have not displayed concrete results on this action so far. Intersectorality for PIH care is an essential strategy in face of the complexity of its demands, avoiding inadequate services to its users and promoting equity[97].

Diverse resources and limitations to the fight against inequity

The existence or not of a vehicle available to the teams seems to be an indicator of the actual capacity to monitor people in their respective territories, since this resource enables transport of professionals along with their equipment and supplies, besides the transfer of patients to other services[19,64]. By omitting the requirement of a car in ERs' proposals, the Portuguese initiative compromises one of the pillars of this strategy, particularly based on the mobility of its team, not contributing to reduced inequity before the difficult access of PIH to services.

With regard to financing, Portugal and the U.S. operate with a public-private resource sharing scheme. However, such legislation differs from one another because of the fact that Portuguese ERs are outsourced, while U.S. law allows both the public and third parties to perform the

service, even under a system heavily influenced by private initiative[52,54,66]. In the case of the Brazilian proposal, the federal government and municipalities bear the costs and perform the CnRs[83].

Direct contracting by a public body ensures stability and favors the maintenance of bonds between them and users. However, hiring through private institutions allows greater agility in the recruitment of professionals, but carries the risk of precariousness of labor ties and workers' dissatisfaction, which may affect the quality of care[98]. However, even with the advantage of continued care provided by a public service, maintaining a fully functioning and adequate team when inserted in an underfunded health system is quite a challenge, as we have seen in Brazil[73].

Conclusion

In addition to a product of technical and institutional decisions, health policies are the result of successive mediations between different agents, until their operational expression in terms of services or programs occurs. Thus, the legal and normative framework we described and compared in this study represents only part of this picture. Each of the countries surveyed organized mobile service according to their respective economic and political context, their health systems and the way in which the issue of PIH has been shaped in each of these societies. However, the comparative perspective allowed us to point out the main elements that underpin interventions of this nature.

The objective of improving access, establishing multiprofessional teams, outreach and care in addressing substance abuse are common to all three initiatives, suggesting an essential axis in PIH care. However, we identified a divergence between care strategies and resources – on the one hand, primary healthcare and compulsory use of a vehicle, and on the other, care limited to harm reduction actions with optional vehicle use. There is greater potential to reduce access time and ensure continuity of care if itinerant teams can provide primary healthcare actions combined with *in situ* harm reduction actions, as proposed by Brazilian and U.S. strategies, resulting in greater equity. However, offering all the care possible on the street or specifying services only for PIH may lead to lower attendance of this group in the traditional units, generating a segregating care circuit[99]. Moreover, the excess of team assignments associated with the fragile working conditions resulting from the situations found in the streets can lead to the simplification of tasks by the workers, and reduction of what could be offered to service users, mechanizing care in PHC[100,101].

The U.S. health system surprisingly presented proposals for PIH care with greater integration into primary healthcare, when compared to the Portuguese initiative, which is inserted in a system guided by the primary model. The U.S. also indicated a better introduction of health actions in the intersectoral framework[61] in synergy with measures to improve access through the ACA[60].

The main aspects of each country studied stem from a bibliographical review and analysis of the legal and normative framework. However, new methodological approaches and further evaluations would be necessary to identify how the aspects identified materialize in the daily practice.

Collaborations

IC Borysow and JP Furtado worked on the theme design. The three authors, namely, IC Borysow, JP Furtado and EM Conill worked on the survey, methodology and final writing.

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