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Healthcare for those who (live) in the shadows

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Abstract *This study aimed to analyze the implementation of Street Clinic teams, co-financed by the Ministry of Health, in the national territory from 2018 to 2023, focusing on the perspective of equity and the scope of healthcare provided to Brazilian people living on the streets. This quantitative, exploratory study employed spatial distribution techniques based on secondary data from implemented Street Clinic teams. The data analysis on the implementation of eCR showed significant developments toward democratizing access to health services. An increase of 21,73% in the number of teams co-financed by the Ministry of Health was observed from 2018 to 2023.*
Key words *Primary Health Care, Homelessness, Health Services Accessibility, Health Vulnerability*

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Introduction

In Brazil, the Street Clinic teams (eCR) initiative was conceived to reach individuals experiencing homelessness, social vulnerability, and disconnected from health services, aiming to comply with legislative safeguards protecting the right to health in the country, as established by the Federal Constitution of 1988 and regulated by Organic Health Laws, specifically Laws No. 8,080/1990 and No. 8,142/1990, which strengthened the Unified Health System (SUS) in the country[1].

This movement was also influenced by discussions surrounding the National Policy for the Homeless Population (PNPSR), instituted by Decree No. 7,053/2009, with the objective of ensuring access to health services and programs related to social policies, including those in the health sector. According to Dias and Amarante[2], the promotion of proposals such as eCR was fostered through the strengthening of popular movements and the election of center-left governments in Brazil.

From a historical perspective, in 2011, Brazil made significant strides towards democratizing access to health services, following the psychiatric reform, aiming to enhance mental health promotion and health care for the homeless. Among the key initiatives were the publication of Ordinance No. 3,088/2011, which established the Psychosocial Care Network (Raps), and Ordinance No. 2,488/2011, which revised the National Primary Care Policy (PNAB), including eCR as teams within Primary Health Care (PHC) for specific populations. Subsequently, Ordinances No. 122/2012 and No. 123/2012 were instituted, establishing guidelines for the organization and functioning of street clinic teams.

In 2012, eCR could be composed of professionals from the following categories: nursing at medium and higher levels, psychology, social work, occupational therapy, medicine, social agents, oral health professionals. In 2014, Ordinances No.1,238/2014 and No.1,029/2014 were published. The first established a fixed funding amount for eCR, and the second added higher-level oral health professionals, physical education professionals, and those trained in arts and education to these teams. The recommended membership modalities were Modality I, with four professionals, two of whom were mid-level professionals and two of whom were college graduates; Modality II, with six professionals, three of whom were mid-level professionals and three of whom were college graduates; and Modality III, with the arrangement of Modality II, plus a medical professional. As guiding materials for the services, the "Street Population Care Manual" and the "Guidelines, Methodologies, and Devices for the Street Population" were published in 2012 and 2014, respectively[3].

Starting in 2016, Brazil experienced setbacks regarding the promotion of social welfare policies, such as the enactment of Constitutional Amendment No. 95/2016, which limited primary government expenditures without considering economic and demographic growth rates [4]. Additionally, the revision of PNAB in 2017 brough the flexibilization of the concept of universal coverage of PHC, without a commitment to expanding services according to critics of the national scientific literature[5-7].

In 2019, PHC underwent changes in its funding structure with the *Previne Brasil* Program, instituted by Ordinance No. 2,979/2019, replacing the Fixed and Variable Basic Care Floors (PAB) with Weighted Capitation, which required greater efforts from municipal managers in managing team arrangements in territories[8].

Still within this context, the Ministry of Health published Ordinance No. 1,255/2021, establishing regulations for the operation of eCR and adopting criteria for calculating the maximum number of teams that municipalities and the Federal District could adhere to, considering data records in the Health Information System for Primary Care (Sisab) and the Single Registry for Social Programs (CadÚnico). Furthermore, territories with an estimated total population of over 100.000 inhabitants gained the right to have at least one eCR co-financed by the Ministry of Health. Regarding changes in the allowed modalities, Community Health Agents (ACS) became part of the composition possibilities for these teams.

Changes in the historical landscape and in the operational, compositional, and financial aspects of Primary Health Care have influenced municipalities' adherence. Therefore, conducting studies to assess the advancements and profiles of territories that have adopted eCR becomes an ethical imperative. In this perspective, this study aimed to analyze the implementation of Street Clinic teams co-financed by the Ministry of Health in Brazil from 2018 to 2023, focusing on the perspective of health equity and the scope of care for the homeless population.

Methods

This is an exploratory study with a quantitative approach using spatial distribution techniques, utilizing secondary data from Street Clinic teams implemented nationwide. Data were obtained from the Health Information System for Primary Care website, specifically from the public report under the "PHC Financing" tab, covering the period from 2018 to 2023. The choice of this time interval stems from the absence of data in previous years. The information is organized monthly on the website and was collected in February 2024.

The variables studied include the number of Street Clinic teams with federal funding, those accredited and approved, as well as their respective Modalities I, II, and III. Spatial distribution analysis was based on area data to identify possible geographical concentrations of Street Clinic teams in certain regions of the country.

Given the limitation of data sources on the homeless population, information was sought from the Social Assistance databases and the Single Registry website to identify the number of homeless families. To address various situations pointing to exclusion and social vulnerability in Brazil, the Social Vulnerability Index (SVI) was employed. This index covers three analytical dimensions: Urban Infrastructure SVI, Human Capital SVI, and Income and Labor SVI. The purpose of using the SVI is to capture a more comprehensive perspective, encompassing multiple dimensions that reflect the complexity and diversity of unfavorable social conditions, thus providing a bigger view of social issues in the country.

Results

From 2018 to 2023, it was observed that the number of eCR co-financed by the Ministry of Health showed an increase of 45.34% (n=73). However, there was a slight reduction in co-financing of these teams between 2019 and 2020, corresponding to -6.45% (n=10) (Graph 1).

Among the 264 teams included in federal co-financing in 2024, 35.89% (n=84) were registered under modality I, 12.82% (n=30) under modality II, and 51.28% (n=120) under modality III. When observing this distribution by Major Region and Federative Unit (FU), it is evident that all FU have eCR, with modality III teams predominating (51.28%, n=120), particularly in the Southeast Region (53.41%, n=125), with São Paulo state standing out, hosting nearly half of the total teams in this region (48%, n=60). The Midwest Region concentrates the lowest number of eCR (7.26%, n=17) compared to other regions of the country. Conversely, states in the Northern Region, such as Acre and Rondônia, present the fewest teams relative to other FU (Table 1).

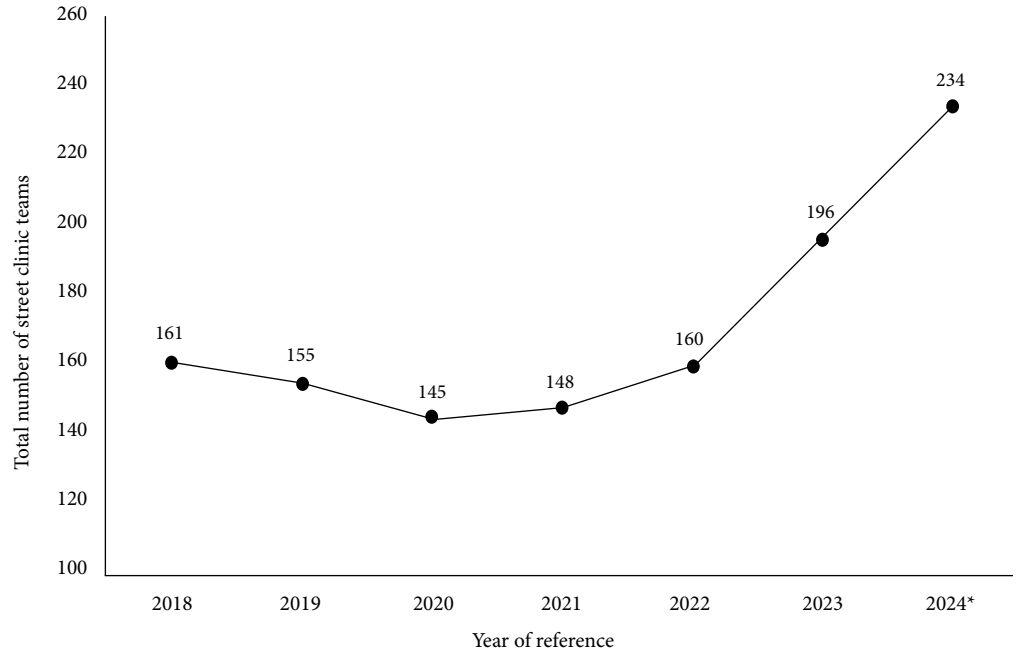
The country has 169 municipalities with eCR (Figure 1a), showing a heterogeneous distribution across territories, with a higher concentration in the eastern parts of states in the Southeast and South Major Regions (Figure 1b).

Although all co-financed eCR are in urban areas, they exhibit different Social Vulnerability Index (SVI) classifications. SVI values between 0.000 and 0.200 are classified as very low; values between 0.201 and 0.300 fall into the low category; values between 0.301 and 0.400 are considered medium, while those between 0.401 and 0.500 are deemed high. Values between 0.501 and 1.000 indicate municipalities in very high social vulnerability situations. Among the 169 municipalities hosting eCR, the majority exhibit SVI classifications categorized as very low (13.01%, n=22) and low (42.60%, n=72), indicating low social vulnerability. Following these, there are medium (34.91%, n=59), high (6.50%, n=11), and very high (2.95%, n=05) SVI classifications. The overall median SVI of these municipalities is 0.288, with an interquartile range of 0.116, a minimum of 0.130, and a maximum of 0.727. No atypical SVI values were identified among the classification groups, except in municipalities classified as 'very high', where one municipality presented an SVI of 0.727 (Graph 2).

Discussion

Studies demonstrate that individuals experiencing homelessness have higher rates of morbidity and mortality compared to the general population, representing a serious public health issue. Within the homeless population, females exhibit a higher mortality rate (11.9) compared to males (7.9)[9]. In this context, it is essential to coordinate public policies and other sectoral policies to ensure broad access to social and health services for the homeless population[10].

The issue of access to adequate housing in Brazil is also experienced in other countries around the world and has been gradually increasing year by year, as seen in the United States, England, and Australia. Circumstances leading



Graph 1. Distribution of total Street Clinic teams co-financed by the Ministry of Health, Brazil, 2018-2024.

Note: *In 2024, references for the total number of teams are from data recorded in February 2024. For other years, references for information from July were used, as a representative time frame of the 12-month scenario.

Source: e-Gestor AB, 2024. Authors.

individuals to live on the streets may be related to various factors such as unemployment, lack of affordable housing and income support, physical and mental health problems, substance use, domestic and family violence, among others[11].

Considering these issues, homelessness is directly related to health problems, including poorer physical and mental health outcomes and premature death. For the elderly homeless population, these issues are exacerbated by inadequate access to and treatment within the healthcare system. This situation contributes to increased emergency room admissions and hospitalization rates[12].

Social Vulnerability

The Social Vulnerability Index provides a comprehensive perspective on inequalities present in Brazilian metropolises, incorporating assessments of indicators related to urban infrastructure (sanitation, garbage collection, per capita income), human capital (infant mortality, education, illiteracy, among others), and income and work (unemployment, informal employment, substance dependence, for example)[13].

Beyond the results presented regarding low social vulnerability, in this scenario, there is also low territorial dispersion of teams in their respective territories, as well as the absence and fragmentation of estimates of the homeless population at disaggregated municipality levels, hindering the conduct of more robust situational diagnostics. This situation highlights the urgent need for effective coordination of tripartite management to promote visibility of this population and meet their health needs.

Implementation of Street Clinic Teams in Brazil

Street Clinic teams were established with the aim of expanding access to and quality of comprehensive care for marginalized individuals. In addition to providing healthcare, these teams also facilitate access to basic social rights, con-

Table 1. Distribution of Street Clinic teams co-financed by the Ministry of Health, by Greater Region and Federative Unit, Brazil, 2024 (n=234).

Greater Region/ Federative Unit	Street Clinic Teams (Modality I)	Street Clinic Teams (Modality II)	Street Clinic Teams (Modality III)	Total
North	13	03	04	20
Acre	01	0	0	01
Amazonas	01	0	01	02
Amapá	02	01	01	04
Pará	05	02	01	08
Rondônia	0	0	01	01
Roraima	02	0	0	02
Tocantins	02	0	0	02
Northeast	14	04	31	49
Alagoas	01	0	05	06
Bahia	01	0	08	09
Ceará	02	0	05	07
Maranhão	01	01	04	06
Paraíba	04	01	02	07
Pernambuco	02	01	04	07
Piauí	0	01	01	02
Rio Grande do Norte	03	0	0	03
Sergipe	0	0	02	02
Southeast	40	17	68	125
Espírito Santo	02	03	0	05
Minas Gerais	13	02	11	26
Rio de Janeiro	08	04	22	34
São Paulo	17	08	35	60
South	12	04	07	23
Paraná	04	01	02	07
Rio Grande do Sul	05	03	04	12
Santa Catarina	03	0	01	04
Midwest	05	02	10	17
Distrito Federal	03	0	03	06
Goiás	01	0	03	04
Mato Grosso do Sul	0	02	02	04
Mato Grosso	01	0	02	03
Brazil	84	30	120	234

Source: e-Gestor AB, 2024. Authors.

currently recognizing the dignity of these individuals as citizens. The creation of the Unified Registry is a tool that, in addition to facilitating access to healthcare services, promotes the recognition of citizenship in an environment where these rights are often denied.

In 2023, the Ministry of Health focused efforts on expanding Primary Health Care teams, especially those with pending accreditation and approval requests from the Department of Primary Health Care, including street clinic teams. Variations in the number of teams over this period indicate an increase in the accreditation of new teams, along with the discreditation of old teams due to non-compliance with financial transfer criteria established by Consolidation Ordinance GM/MS No. 2/2017.

In this context, it is evident that the Ministry of Health has been committed to addressing the crisis exacerbated by the pandemic, which has amplified pre-existing vulnerabilities. The response to this crisis includes the implementation

a) Identification of municipalities with adherence to the Street Clinic teams (n=169).

b) Total number of Street Clinic teams by municipality (n=234).

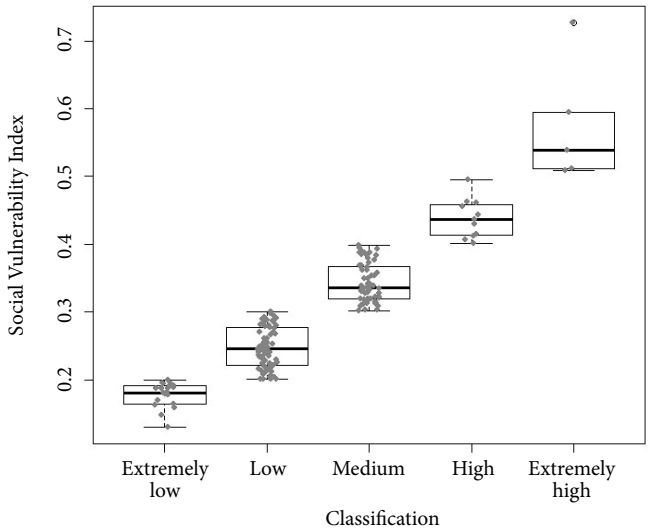
Figure 1. Identification of municipalities with adherence and total number of Street Clinic teams co-financed by the Ministry of Health, Brazil, 2024.

Source: e-Gestor AB, 2024. Authors.

of specific initiatives targeting this population with the gradual expansion of street clinic teams.

Conclusion

The expansion of Street Clinic teams in Brazil is essential to improve access to health services for socially vulnerable populations, especially those experiencing homelessness or living in hard-to-reach areas. As part of its planning, the Ministry of Health aims to reach 660 teams by the year 2027, marking a 312,5% increase from July 2022. This strategy is crucial to ensure that more vulnerable individuals have access to primary health care, thereby promoting greater equity within the Unified Health System[14].



Graph 2. Summary measures of the SVI of municipalities with eCR co-financed by the Ministry of Health, by boxplot, Brazil, July 2023 (n=169).

Source: Ipea, 2010; e-Gestor AB, 2023. Authors.

Collaborations

AG Pereira worked on the conception and writing of the article. TB Oliveira worked on the methodology and research of the article. ALFR Caldas worked on the editing and review of the article. JEB Vieira worked on the review of the article.

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