Homeless population's health: reflections from the social determination of health

Saúde da população em situação de rua: reflexões a partir da determinação social da saúde

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Abstract

This article aims to present reflections about the homeless people's health, using the social determination of health-disease process concept as an analysis key. This article in essay format was organized in two sections: the first one presents the discussion about this population's health, indicating to the organization of health services that assist these people, its advances and obstacles; the next section performs an analysis of the health-disease process of the homeless population using the theoretical reference of Collective Health based on the social determination of health concept. The article argues that the biomedical model has been insufficient to think about the health of the homeless population, once it disregards the complexity of this social reality. Understanding the health-disease process as socially determined approaches health as a result of the material conditions of existence of this population, which are conditioned by the form of social production organization in the capitalist production mode. Thus, social determination operates as an important tool to analyze the homeless people's health from a perspective of totality.

Keywords: Homeless people; Collective health; Social determination of health.

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Resumo

Este artigo tem como objetivo apresentar reflexões sobre a saúde da população em situação de rua, utilizando o conceito da determinação social do processo saúde-doença como método de análise. O artigo está estruturado em formato ensaístico, sendo organizado em duas seções: a primeira, que apresenta a discussão sobre a saúde dessa população, discorrendo sobre a organização dos serviços de saúde para dar assistência a essas pessoas, seus avanços e entraves. A segunda seção realiza uma análise do processo saúde-doença da população em situação de rua, utilizando o referencial teórico da Saúde Coletiva a partir do conceito da determinação social da saúde. O artigo argumenta que o modelo biomédico tem sido insuficiente para pensar na saúde da população em situação de rua, uma vez que desconsidera a complexidade dessa realidade social. A compreensão do processo saúde-doença como socialmente determinado localiza a saúde como resultando das condições materiais de existência dessa população, as quais são condicionadas pela forma de organização social no modo de produção capitalista. Assim, a determinação social opera como uma importante ferramenta de análise da saúde da população em situação de rua em uma perspectiva de totalidade.
Palavras-chave: População em situação de rua; Saúde coletiva; Determinação social da saúde.

Introduction

This paper stems from the deliberations initiated in 2019 during the defense of a Multi-professional Family Health Residency Final Project. The debate among the authors continued over the following years, and in November 2021, during the conclusion of the manuscript revisions, we experienced the passing of our colleague Marco Aurélio da Ros. For this reason, we would like to begin with a tribute to the memory of our dear Marcão, a public health physician, professor, and researcher of utmost importance for Brazilian Collective Health. A prominent activist of the Brazilian Sanitary Reform Movement, Marco influenced different generations of healthcare workers, building a collective of critical thinking in the field of health and leaving his mark on our lives. In this sense, we are certain that this paper is yet another product of his powerful analytical capacity, and that his ideas will undoubtedly continue to resonate within all of us. Marcão, present!

Amidst structural crises and attempts at restructuring, the capitalist production mode has imposed, throughout history, organization forms on various productive sectors. Contemporary capitalist development takes on its most perverse form – neoliberalism – in which, under the premise of maximum possible freedom, capital seeks to dismantle any sociopolitical barriers. The neoliberal rhetoric advocates for a reduction in the State economic intervention, but during a crisis, the monopolistic capital also relies on it. In practice, it is a case of a minimal capitalist state for workers and a maximum capitalist state for the capital. We perceive the attack of big capital on the democratic institutions of the State in the intense deregulation of labor relations, as well as the devastation of education and social security systems (Netto; Braz, 2006; Vita, 2000).

In Brazil, the specificity of capitalist development has marginalized an entire layer of the population from the productive process. The Brazilian social structuring, marked by slavery, land and income concentration, has historically subjected a significant segment of the population to an immense social exclusion. As a mode of production structured on the

exploitation of labor, the centralization of capitalist accumulation generates a population surplus that cannot be incorporated into the productive process, functioning as a lever for capitalist accumulation itself. It is within this context that the population experiencing homelessness (PEH) emerges as a social issue, given that these individuals, deriving from an unequal organization of wealth production and distribution, find no alternative but to live on the streets of urban centers (Escorel, 1999).

In this context, the PEH faces barriers in meeting their most basic material needs, such as food, sleep, and personal hygiene. This hardship is frequently reinforced by the State itself, whose hygienist actions often bear the mark of disposal, in which the central objective is to remove these individuals from urban spaces (Varanda e Adorno, 2004).

On the other hand, the Federal Constitution assures health as a social right, and the Unified Health System (SUS) has the universality of access as one of its principles. However, the healthcare system is driven by professionals whose training process sometimes takes part in isolation from the material reality of this population, which reflects the unpreparedness to embrace the demands brought by individuals living on the streets. The lack of sensitization regarding the social context experienced by the PEH has led to situations of discrimination within healthcare services themselves (Barata et al., 2015; Wijk; Mângia, 2017). Thus, when seeking health services, the accumulation of discriminations promotes an internalization of suffering and, as Varanda and Adorno point out (2004, p. 67):

> Internalizing this process generates a certain resignation that interferes with the way health issues are dealt with and hampers the relationship with healthcare professionals. A large number of people living on the streets rarely seek healthcare services, enduring the presence of disease symptoms and only turning to outpatient network as a last resort, often with the accumulation of multiple health problems (our translation).

This mismatch highlights the difficulty in recognizing that the health-disease process cannot be explained through a homogenizing approach, since different social realities involve different forms of illness. Nonetheless, the dominant ideology in the field of health, known as the biomedical model, took form throughout the 20th century based on a positivist teaching model, resulting in a school of thought organized around the paradigm of the unicausality of the health-disease process. This has led to technocratic health practices, with an individualistic and biologicist perspective (Pagliosa; Da Ros, 2008; Da Ros, 2000).

Although it remains a hegemonic force, this way of thinking about health has not been immune to questioning over the years. The study by Da Ros (2000) demonstrated that different schools of thought have approached health from alternative perspectives, proposing displacements and epistemological connections. Here, we approach the health of PEH from the perspective of Collective Health, specifically focusing on the school of thought that employs the concept of social determination of health. Therefore, we aim at discussing the health of the PEH, utilizing the social determination of health as a method of analysis. To achieve this, we present the debate in an essay format, divided into two sections: the first one provides a discussion on the PEH and their relationship with healthcare services; and the second one proposes an analysis of the health of PEH based on the concept of the social determination of the health-disease process.

The population experiencing homelessness and the health services

The debate on issues related to the PEH has advanced in recent years. Although it seems a recent social phenomenon, the existence of people who live on the streets is not a contemporary process. Understanding this movement of occupying urban spaces as a historical phenomenon requires, above all, analyzing it within the context of the capitalist production mode.

In his discussion on the rise and development of capitalism in the 15th and 16th century Europe, Marx (2017) already pointed out the existence of a population segment that, in the face of massive land expropriation processes, began to live in itinerancy,

unfit for the emerging manufacturing sector. The speed at with which they were forcedly removed from their lands did not match the possibility of incorporation into the still emerging manufacturing sector, and as the author aptly wrote: "the parents of the present working class were initially punished for their metamorphosis, which had been imposed on them, into vagabonds and *paupers*" (Marx, 2017, p. 806). The term "vagabond" used in that context does not carry the current pejorative connotation, since, as Frangella (2004) explains, the term derived from the French and English word *"vagabond"*, which refers to the act of wandering, of people living an itinerant lifestyle.

Brazil's social formation is also marked by the existence of people who, in the face of a production model based on colonial domination and slavery, could not find means of incorporating themselves into the productive process. In that historical context of limited production diversification, resulting from the slave-based latifundia, a crowd of "free" workers arose between landowners and slaves. This population layer, in addition to the millions of freed slaves, lived in poverty and constant mobility, seeking the possibility of producing at least for their own subsistence (Franco, 1997).

Thereby, it is important to understand that, although more prominent in contemporary times, the PEH is a social product of the capitalist mode of production, representing a historically marginalized population. The social exclusion of this population segment comes to light when we consider their inclusion in the field of public policies in Brazil. Over the years, the Brazilian State has chosen to address the PEH through the logic of social hygiene, employing the public security device to forcibly remove these individuals from where they reside. The movement of acknowledging the need to safeguard social rights for this population is very recent. It aims at overcoming the traditional hygienist and medicalizing assistance actions that have reinforced those people's invisibility (Paiva et al., 2016; Varanda; Adorno, 2004).

The National Policy for the Population Experiencing Homelessness (PNPSR) was established in 2009, following the organization of the PEH National Movement. It was proposed with the aim of recognizing the rights of this population and ensuring access to public policies related to health, social assistance, education, social security, housing, security, culture, leisure, sports, work, and income (Brazil, 2009). Regarding the health policy, considering the specificities of the PEH, the National Policy of Primary Care (PNAB) of 2011 established the Street Clinics, facilities composed of multidisciplinary teams responsible for working directly with the PEH (Brazil, 2011).

Although late, the establishment of a policy aimed at the PEH demonstrates an important advancement in the discussion regarding the lives of this population. The creation of healthcare teams focused on the PEH marks the recognition of the need to consider the health of this population. The review by Andrade et al. (2022) identified a scarcity of scientific publications addressing the access of the PEH to healthcare services, and among those that addressed the topic, the majority focused on primary care and the Street Clinics. In this regard, the inclusion of Street Clinic teams (eCR) as an integral part of the PNAB signaled the accountability of this level of care in providing healthcare to the PEH. Thus, eCR teams play a central role in organizing a healthcare network for this population, facilitating the coordination between the PEH and various healthcare services (Andrade et al., 2022).

Therefore, the inclusion of the PEH in the PNAB represented the recognition of the need to reorganize the healthcare network to meet the specific needs of this population. The eCR certainly have a central role in working with the PEH, with potentialities such as the use of light/relational technologies, the establishment of welcoming and bonding relationships, and inter-sector coordination. Even though these teams are not solely responsible for the assistance to the PEH, there is a lack of understanding among healthcare services regarding their role. It is common to encounter access barriers for the PEH in different services without the follow-up of eCR professionals (Ferreira; Rozendo; Melo, 2016).

When it comes to the health conditions of the PEH, there is a predominance of certain clinical conditions, including infectious diseases, skin and foot problems, oral health issues, mental illness, alcohol and substance use, among others (Aguiar;

Iriart, 2012; Brazil, 2012). Despite the importance of knowing the epidemiological profile of PEH, the identification of the most common clinical conditions is not enough to guarantee care production in health services. In order to do so, understanding the meanings attributed by these individuals to different processes of illness is crucial. As Aguiar and Iriart (2012) identified, the meanings of the health-disease process on the streets are influenced by the struggle to secure basic material conditions of existence. In the words of the authors, the PEH presents:

> [...] a conception of health that is associated with the ability to be alive and to resist the daily hardships of living on the streets. On the other hand, illness was associated with a state of weakness to the point of being unable to work, the impossibility of fighting and earning money, the inability to perform simple tasks, or in extreme cases, an organism being unable to withstand suffering, end up weakening, and succumbing (Aguiar and Iriart, 2012, p. 120, our translation).

It is noticeable that the health-disease process on the streets is connected to the reproduction of material conditions of existence, going beyond the purely biological dimension. As Paiva et al. (2016) point out, the biomedical model has generated an insufficient way of thinking and acting within healthcare services to deal with the issues inherent to the health-disease process of the PEH. By limiting the understanding of the processes of illness to the biological/pathological dimensions, the hegemonic thinking disregards the social and political dimensions that intersect with the health-disease process among the PEH, resulting in simplistic solutions that often blame this population for their conditions (Paiva et al., 2016).

Therefore, the biomedical model that attempts to explain the processes of illness based on a unicausal and biologistic approach clashes with the multiplicity of life conditions. Additionally, by ignoring the social determinants of health affecting different population groups, it fails to consider the daily struggles of the PEH. It is crucial for healthcare professionals to understand that living on the streets entails daily exposure to precarious material conditions, as well as multiple forms of violence (physical, symbolic, and state-sanctioned), discrimination, deprivations (such as lack of sleep and adequate food), and denial of rights (e.g, housing, employment, and healthcare) (Barata et al., 2015; Escorel, 1999).

For example, we can think about a common condition among the PEH: injuries or infections on their feet due to excessive walking, lack of footwear, or wearing wet shoes. In a simplified analysis, one might assume that this condition could be solved by addressing the cause directly: wearing proper shoes or even ceasing the nomadic lifestyle. However, it is essential to understand the motivations behind this constant displacement, i.e., the concrete living conditions of these individuals.

The linear reasoning proposed by the biomedical model ignores the social factors that influence the health-disease process. By overlooking the aspects related to material conditions and the possibilities of these individuals, healthcare professionals miss the opportunity to establish a genuine connection and often end up perpetuating violence, prejudice, and discrimination, which the PEH themselves experience when trying to access healthcare services (Barata et al., 2015; Hallais; Barros, 2015). The individualistic and protocol-oriented approach dictated by the biomedical model hinders the perception of the specificities inherent to the street life itself. This leads to interventions that prioritize actions that are disconnected from the real possibilities of the PEH, often restricting the autonomy of these individuals (Brito; Silva, 2022). In this sense, the authors emphasize: "this continuous process can lead to the loss of the most important attribute of all beings: their human condition. Those who are constantly relegated to the position of undesirable lose the right to citizenship and to life." (Brito; Silva, 2022, p. 156).

Consequently, a question emerges: is the existence of the PNPSR and of a health system guided by the principle of universality sufficient to assure the right to health of these individuals? These are undoubtedly essential elements for this assurance, but no policy is a guarantee in itself, as they are executed by individuals whose sensitivity towards differences needs to be mobilized, activated, and encouraged.

In healthcare, the predominant thinking often leads professionals to reproduce a sterile approach, disregarding the interferences from the social field. Regarding the care provided to the PEH, professionals are often unaware of the real conditions concerning this population, leading to paternalistic actions that disregard their realities. (Brito; Silva, 2022).

Likewise, by relating health to the material conditions of existence and the social relationships that determine these conditions, Collective Health presents enormous potential for engagement and collective construction with people living on the streets, since this population materializes in their experiences various factors that reinforce the urgency of understanding health through the lens of social determination. For this reason, we present the following section as a movement towards analyzing the PEH using the social determination of the health-disease process as an interpretive method.

The social determination of health in the PEH context

Despite the evident hegemony of the biomedical model, the field of health in Brazil was not built in a linear manner. Just like any historical process, health has been a stage for dispute between different lines of thought and societal projects. We highlight a trend that emerged around the 1970s and spread throughout Latin America: Social Medicine, whose ideals in Brazil were disseminated and to some extent widely reconfigured by the emerging field of Collective Health. Influenced by critical social theory, the proponents of this school of thought incorporated important categories from political economy into it, which are crucial for understanding the health of populations. These include work as a central axis of human life, social organization and the distribution of production, as well as the development of productive forces in a given historical moment. This led to the expansion of a critical thinking framework in health, which aimed to question the purely biological approach to the health-disease process (Laurell, 1981).

This school of thought became popular because the clinical medicine was unable to fully explain the unequal distribution of health problems within populations. Understanding health as a social process enabled a comprehensive analysis, since it removes health from a purely biological, isolated, and individualistic evaluation, placing it within the capitalist political, social, and economic context. By incorporating historical-dialectical materialism as a method for reflecting on population health worldwide, critical thinking in health allowed for the inclusion of social categories in the debate on populations' health. The guiding principle was the understanding that the division of the capitalist society into classes implies the production of social inequalities and, consequently, an unequal distribution of health burdens (Breilh, 1979; Laurell, 1981). Under this scope, the interaction between health and disease is now understood as a process determined by the way productive forces are organized. As stated by Laurell (1981, p. 10), the health-disease process:

> [...] is determined by the way in which man appropriates nature at any given time, an appropriation is formed through the process of labor based on a certain development of the productive forces and the social relations of production.

Collective Health proposes a shift focusing on emphasizing that people's health cannot be explained solely by biological and individual factors, as individuals are embedded in a society, in a specific historical moment, with a particular social organization of production. Therefore, the position each individual occupies within this organization has an impact on the possibility (or impossibility) of fully developing their material conditions of existence, which are influenced by the dialectical relationship between the individual/collectivity and the biological/social aspects. In this sense, the social determination of health is recognized, since being healthy does not simply mean being free from a pathological state, but it is also the result of the organization of production and the distribution of socially produced goods and services (Laurell, 1981).

Indeed, the concept of social determination provokes a shift in the reasoning model in health, as it leads us to think about it beyond the dichotomy of health and disease, fostering the understanding

of the complexity and dynamism of life, with all its social, economic, and political interconnections. The change lies precisely on the effort to analyze this process in populations from a totality perspective, as the health-disease process is not detached from the way societies are organized (Laurell, 1981).

With this in mind, we must understand where the PEH is placed in the social organization in order to analyze the health-disease process in their context. Consequently, the discussion about the health in marginalized populations, such as the PEH, must be connected to a debate on the capitalist production mode. As stated above, the existence of people who live on the streets harks back to the period of the rise and development of capitalism, considering that the capitalist production mode marks the historical moment when there were expropriations of the means of production. These means became private property of a social class, delineating the division of society into classes: on one side, those who dominate them, and on the other, a population whose only property is their body and labor force (Marx, 2017).

Comprehending health as being socially determined puts the issue of the productive process organization forth into the debate about health, considering that the production mode determines the material conditions of existence for different social strata. As such, health is linked to the possibility of social production and reproduction, which, in a class-stratified society, occurs unevenly depending where each person is placed within the social organization. Hence, addressing the PEH requires understanding it as a historical phenomenon that marks the development of capitalist societies, a population historically subjected to a marginalized position in the production process. The key to interpreting the social determination of the health-disease process seeks this analysis in a dialectical perspective between the individual and collective dimensions (Breilh, 2013).

With this, it bears recalling that, at the 8th National Health Conference, healthcare was conceptualized as a process crossed by politics, considering that having health is not only a biological and individual factor, but requires access to fundamental resources, such as food, housing, work, income, land, transportation, education and, of course, health services. The concept of health that guides the construction of the SUS is strongly influenced by the framework of thought that understands health as a product of the material conditions of existence of populations, conditions that are prohibited in the context of the PEH (Brasil, 1986).

When we think about health as a result of different dimensions, we comprehend it beyond an individualizing perspective, understanding that it derives from the dialectical relationship between the individual and the social structure. Thus, it is understood that living conditions are not explained solely by individual choices, but conditioned by the social organization of production (Breilh, 2013; Laurell, 1981).

When analyzing the PEH from the totality of the production mode, we point to the socio-historical character of this population phenomenon that throughout capitalist development has been gradually prevented from inserting itself into the productive process. In his studies, Marx (2017) already identified that capitalist accumulation and centralization produced an additional and relatively surplus volume of the working population, which became a lever of capitalist accumulation itself. This population segment was named by the author as the industrial reserve army, which was responsible for providing a significant amount of labor force always ready to be exploited, resulting in the lowering of the value of labor force itself. In the words of Marx:

> The condemnation of one part of the working class to enforced idleness by the overwork of the other part, and the converse, becomes a means of enriching the individual capitalists, and accelerates at the same time the production of the industrial reserve army on a scale corresponding with the advance of social accumulation (Marx, 2017, p. 711-712).

The existence of a population layer that does not find the means to incorporate itself into the productive process is closely linked to the development and structuring of productive forces. In this sense, the PEH has its conditions of social reproduction induced by the unequal distribution of production, and, therefore, are also affected unevenly by the processes

of illness. Consequently, we seek to move beyond the hegemonic biomedical paradigm, which tries to answer health issues in a linear way, fractionating reality and isolating subjects from their social context. Unlike this, critical thinking in health, guided by the social determination of the health-disease process, operates as an analysis tool that understands the centrality of the dynamics of capitalist accumulation in the way different populations live and reproduce their lives (Breilh, 2013).

Final remarks

The existence of people who live on the streets is a historical process that deserves attention, given that the capitalist development in Brazil has pushed more and more people into this situation. The vertiginous increase in the number of PEHs impels us to think about the health conditions of this population, in order to organize and better grant them with access to health services.

Thus, we must debate on health-disease process of the PEH carefully, aiming to surpass the hegemonic biomedical thinking in the health field. This mindset makes an individualizing analysis that disregards the political and social aspects that cross the social context of the PEH, often reproducing attitudes of discrimination and blaming of the individuals. In this sense, critical thinking in healthcare proposes a change in the method of analysis of the health-disease process.

Thereby, we sought to present an analysis of the health-disease process of the PEH, through the concept of social determination of health, which begins in the social organization of the capitalist mode of production to analyze how health problems are distributed in different social strata. This way, we start from the dialectical relationship between the individual and the collective, the biological and the social, understanding that the health of the PEH is the result of its material conditions of existence, which are determined by the form of social organization of production. In this context, the PEH is historically placed on the margins of the production process, facing different barriers in meeting their needs, which is reflected in their health conditions.

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Authors' contribution

Couto conceived the idea for the essay, researched sources, and drafted the manuscript. Abreu, Botazzo, da Ros, Mello and Carcereri collaborated directly in all stages and carried out the critical evaluation of the preliminary content. All authors reviewed the manuscript and approved the final version.

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