






## IS THE ACCESS OF THE STREET POPULATION A DENIED RIGHT?

O ACESSO DA POPULAÇÃO EM SITUAÇÃO DE RUA É UM DIREITO NEGADO?

¿EL ACCESO DE LA POBLACIÓN EN SITUACIÓN DE CALLE ES UN DERECHO NEGADO?

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### ABSTRACT

**Objective:** to analyze the access of the street population to health services. **Methods:** this was a qualitative study in which 29 interviews were conducted with health workers, distributed among professionals in family health teams, urgency and emergency care units, and a general emergency hospital. **Results:** the access of the street population occurs preferentially through emergency services, through the requirement of identity and Unified Health System cards, and the continuity of health service is not guarantee; there is a transfer of responsibility for care among the health care network institutions; standardization of forms and assistance; difficulties of access materialized in: bureaucratic issues, reduced number of professionals, insufficient structure and inputs, absence of residence address, and social devaluation of this population. **Conclusion:** the understanding of access that permeates health services is restricted to the first care, thus becoming a denial of constitutional right to the street people. Although this population is present in neoliberal society, it is invisible to the health service, being recognized through stereotypes historically constructed by capitalist society that has a defined standard of the way to lead a life. Therefore, the access of the street population to health service is a challenge for managers, workers, social movements, and educational institutions, because it questions the Unified Health System as a conquest of society and a public policy of social inclusion.

**Keywords:** Unified Health System; Homeless Persons; Health Services Accessibility.

### RESUMO

**Objetivo:** analisar o acesso da população em situação de rua (PSR) aos serviços de saúde. **Métodos:** trata-se de pesquisa qualitativa na qual foram realizadas 29 entrevistas com trabalhadores de saúde distribuídos entre profissionais de equipes de saúde da família, de unidades de pronto-atendimento e de hospital geral de urgência e emergência. **Resultados:** o acesso da PSR ocorre preferencialmente nos serviços de urgência e emergência, mediante a exigência de documentos de identificação pessoal e cartão do Sistema Único de Saúde (SUS), embora estes não assegurem a continuidade do atendimento; transferência de responsabilidade pelo atendimento entre as instituições que compõem a rede de atenção à saúde; padronização dos formulários e da assistência; dificuldades de acesso materializadas em: questões burocráticas, número reduzido de profissionais, estrutura e insumos insuficientes, ausência de residência fixa e desvalorização social dessa população. **Conclusão:** a compreensão de acesso que permeia os serviços de saúde é restrita à entrada para o primeiro atendimento, constituindo-se em direito constitucional negado à população em situação de rua. Essa população, embora esteja presente na sociedade neoliberal, é invisível ao serviço de saúde, sendo reconhecida por estereótipos historicamente construídos pela sociedade capitalista, que tem um padrão definido do que sejam os modos de andar a vida. Desse modo, constitui-se em desafio para a gestão, trabalhadores, movimentos sociais e instituições formadoras, uma vez que questiona o SUS como uma conquista da sociedade e uma política pública de inclusão social.

**Palavras-chave:** Sistema Único de Saúde; Pessoas em Situação de Rua; Acesso aos Serviços de Saúde.

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## RESUMEN

**Objetivo:** analizar el acceso de la población en situación de calle (PSR) a los servicios de salud. **Método:** Investigación cualitativa con 29 entrevistas a trabajadores de la salud, entre ellos profesionales de equipos de salud de la familia, de guardias y de urgencias y emergencias. **Resultados:** la PSR acude principalmente a los servicios de urgencias y emergencias, es obligada a presentar un documento de identificación y la tarjeta del SUS (Sistema único de salud), aún cuando no se le garantice la continuidad de la atención; transferencia de responsabilidad entre las instituciones del sistema de atención de la salud; estandarización de los formularios y de la atención; dificultades de acceso concreto en: asuntos burocráticos, poca cantidad de profesionales, estructura e insumos insuficientes, ausencia de domicilio fijo y desvalorización social. **Conclusión:** la idea de acceso a los servicios de salud se restringe a la primera consulta/ atención y con ello se le niega un derecho constitucional a la población en situación de calle. A pesar de estar presente en la sociedad neoliberal, dicha población es invisible a los servicios de salud y es reconocida por los estereotipos históricamente contruidos por la sociedad capitalista que tiene un modelo definido de cómo debe llevarse la vida. Por ello, es un reto para la gestión, los trabajadores, los movimientos sociales y las instituciones formadoras, que cuestionan cómo el SUS puede considerarse como una conquista de la sociedad y una política pública de inclusión social ante semejante realidad.

**Palabras clave:** Sistema Unico de Salud; Personas sin Hogar; Accesibilidad a los Servicios de Salud.

## INTRODUCTION

The universality defended by the Brazilian Sanitary Reform presupposes that all people have the right to access, actions and health services. It reinforces the understanding of health as a citizenship right, understood as the right of all and the duty of the State, guaranteed by social and economic policies of social protection.<sup>1</sup>

Access is, therefore, characterized by accessibility, acceptability, and availability of health services. The following aspects are indispensable: quantity and quality of services consistent with the needs of the population; organization, physical structure, and human resources in quantity and quality consistent with the demand; working hours, embracement and capacity to adapt to the different needs of users; concern with the establishment of equity, routines and protocols aimed at inclusion; valorization of light technologies (listening, bonding, etc.); and legitimization and acceptance by the population according to their previous cultural experiences.<sup>2</sup>

One of the major challenges of social policies, including health policies, is to ensure that large numbers of people excluded from the world of work be included and actively participate in social life. It is in this context that the historically excluded street population (SP) emerges, experiencing the stereotype of renegades, without documented, dirty, and without dignity.<sup>3</sup>

They live on the margins of inclusion processes and suffer varying degrees of vulnerability and marginality in access to goods and services, such as work, education, housing, transportation, leisure and health.

When the people and families who live on the streets are organized, they prefer to be called “street people”. This name aims to characterize the principle of transitoriness of this process of absolute social exclusion, although in the end, many people know that leaving the streets is not simple.<sup>4</sup>

They represent a little recognized population, but very often seen in the streets, under bridges, in the lighthouses and alleys of the city, in the “favelas”, in public places, next to commercial centers, urban spaces, shelters. They are characterized as an itinerant population. Some of these people uses places close to highways and roads, as well as areas of imminent risk.<sup>5</sup>

The scenario of the street people is tangential to the phenomenon of poverty. They are people who have less than they need to meet their needs.<sup>4</sup> They live along the lines of indigence or absolute poverty, whose physical survival is, for the most part, compromised by the lack of resources to meet nutritional needs. The SP, therefore, goes through innumerable situations of deprivation, violence, misery, and social futility associated, according to common sense, with alcoholism, crime and vagrancy.

Supported on the principle of universality, the Unified Health System (SUS) legally guarantees equal, integral and equitable access to health for the entire Brazilian population. However, in the practice, the extension of this right to the street population is not seen. This population in fact has access to services (they can have consultations) only in situations of urgency and emergency, and they are received by professionals who do not have the proper preparation to identify and understand their real health needs: “*in practice, there is still a selective, focused and exclusive access*”<sup>6</sup>, in particular with regard to the SP.

Thus, the problem described raises the following question: how does the access of the SP to health services take place? In order to reflect on this theme, the present study aimed to analyze the access of the street population to health services. This problem has as assumption the fact that the SP has access to health services that are selective, focused on groups, and exclusive, opposing to the idea that health is a citizenship right.

## MATERIAL AND METHOD

For a better understanding of the object of the study, the methodological course was guided by the challenge of visualizing it in its specificities, from its determinations throughout history, as well as the institutional and organizational relationships that permeate the chances of valuing it, interpreting it, and rebuilding it.

These prerogatives have brought us closer to the understanding of the object of study, and also guide its analysis. It is also recognized here the dynamicity of the relationships established in society, the contradictions, conflicts, continuities and transformations. Thus, it is understood that there are no institutions or ideas that are finished, complete in themselves, and the provisional character is susceptible of knowledge and facts.<sup>7</sup>

With this understanding, the study developed was of a qualitative nature, since it enabled a process of reflection and analysis of phenomena in all its aspects, contextualizing/articulating the events to the historical period and to the singularities of the field of study.<sup>8</sup> In order to reach the proposed objective, the study sought to grasp the object in its essence, considering its specificity, its articulations and concrete historical determinations.

At first, the managers of the 2<sup>nd</sup> Health Region of Rio Grande do Norte and the Municipal Health Department of Mossoró/RN were contacted for request of authorization. After approval by the Ethics Committee, the access to health services under their responsibilities, i.e. the Regional Hospital, Basic Family Health Units (BFHUs) and Emergency Care Units (ECUs) was allowed to the researchers.

These institutions were chosen as a *locus* of research because they are historically recognized as a gateway to the health services of Mossoró-RN. It is important to clarify that, at the time of the research, the municipality did not have a specific health care network for the street population. In this sense, the regional hospital was chosen as the gateway to urgent and emergent care; the three EUCs were chosen for being the gateway to the emergency services; and the six BFHUs were chosen because they are a reference in the Municipality for the SP and/or because of their geographical location, they are close to public squares and/or streets where street people live and work.

To this end, 29 semi-structured interviews were conducted with health workers, distributed as follows: 16 professionals from family health teams, nine professionals from emergency care units, and four professionals from the emergency room of the Regional Hospital.

The subjects of the research were selected respecting the inclusion and exclusion criteria. The inclusion criteria were: to work in the service for at least one year; be over 18 years old; be a permanent employee of the team. The exclusion criteria were: being on vacation, on leave or absent through justification by medical certificate at the time of field survey.

The workers who met the above criteria were individually approached in the health services and asked about their interest in participating in the research. In this moment, the objective and purpose of the study were presented. In the case of those who were willing to participate and who had availability, the researchers started the interviews in that very moment; in some cases, there was a need for scheduling.

It is also worth noting that the interviews took place in the work place, but in a private room. Only the researchers and the interviewees were present. In this moment, an Informed Consent Form (ICF) was read and signed by the participant, and doubts about research were clarified. The interviews were recorded in a cellular phone and later transcribed into written text in order to guarantee the completeness and reliability of the information provided. The participants authorized the recording before the interviews were started. The interviews lasted around 25 minutes.

For the conduction of the interviews, a guiding script was prepared with the following questions: does the street population seek this service? If so, what are the most frequent injuries? If they do not seek this service, then why?; what procedure(s) is(are) necessary for the street population to have access to health services?; how did the health services receive/assist the street population?; are there specific strategies/actions to make the access possible for the street population?; what are the difficulties/challenges (link, registered, reference and counter-reference, authorization for hospital admission-AHA, etc.) to allow the access to the street population?; what actions/strategies could be developed for the street population to have access?

The participants were named interviewees and enumerated according to the order of the interview (1, 2, 3, etc.). This care was necessary to guarantee the confidentiality of the subjects who collaborated with this research.

The closure of the interviews was decided when the demands of the study were met. For this, there was the understanding of the distinction between volume and richness of data, as well as that the construction of knowledge in qualitative research happens when there is proximity with reality. In this sense, there is a prevalence of *"the researcher's certainty that, although provisionally, he found the internal logic of its object of study – which is also subject – in all its connections and interconnections"*.<sup>9</sup>

The analysis of the data was guided by the prerogatives mentioned above, being organized in three movements. In the first one, in-depth readings of the theoretical framework and the transcription of the interviews were carried out in order to identify the more general concepts.

In the second movement, the empirical material was explored with the intention of constructing categories, in order to interpret the object of study, which were: the reality of access to health services of the street population and difficulties faced by the street population to access health services. Finally, in the third movement, the data was interpreted, identifying its contradictions and determinations, based on the theoretical framework adopted for study.

Initially, this study had the goal to analyze documentary records/registers/medical records so as to contribute to the

characterization of the street population and identify their reported and/or diagnosed diseases.

However, this analysis was not possible, despite the numerous visits to the health services *locus* of this research because in general, there are no records and/or criteria for the organization of the documents in these institutions that allowed the identification/selection of those that concerned the street population. This situation, in turn, did not result in sample loss, but rather reinforced the argument of invisibility and a pretended equality, for it homogenized social inequalities and annihilated individualities.

In order to ensure that the ethical aspects of research involving human beings were respected, this research was submitted to the *Comitê de Ética em Pesquisa* (CEP) of the *Universidade Estadual do Rio Grande do Norte* (UERN) and approved under Opinion N° 807,659. Therefore, the study respects the *Guia de Normas e Regulamentos de Pesquisa*, supported by Resolution N° 466 of December 12, 2012, of the *Conselho Nacional de Saúde*.

## RESULTS

### THE REALITY OF ACCESS TO HEALTH SERVICES OF THE STREET POPULATION

Access of the SP to health services is preferably provided by urgency and emergency services. The following statements are representative of this statement:

*They prefer more this type of service: fast, practical and without bond* (Interviewee 21).

*[...] the street population seeks this service, in fact, because there is no basic unit reference, when they need it, they come, either voluntarily or brought by the SAMU* (Interviewee 26).

Although these services ensure the first care measures, they are not responsible for the continuity of the monitoring, disregarding the health care network, as recommended by the SUS. Thus, the services share the responsibility of providing care to the ST.

*No, not the ECU [Emergency Care Unit], because this is too much for basic health units. This is a service to be provided by of the units really. The ECU already works in another way, there is no way of working with that specific public, at all* (Interviewee 26).

*[...] we are here for urgent and emergent care. Thus, we do not work with the follow-up of these people. So,*

*what is it for us to do, we do it, which is this consultations [...]* (Interviewee 4).

Access to health services sometimes requires the presentation of personal identification documents and the SUS card, as it is possible to see in the following statements:

*[...] the necessary documents are the SUS card; with it we generate the medical records of both the BHU, the ECU and hospitals [...] documents are the personal ID and "CPF". If the person does not have any of these documents, we usually take care of them and the file will have some spaces missing information* (Interviewee 2).

*[...] we prepare the medical record as "itinerant" and we receive the person, and depending on the need, we refer him to another service, but only if it is necessary. And it is in this the place to which we refer the patient that the thing gets complicated because documents are necessary, the SUS card is required, in order to enter the information in the system and to schedule consultations* (Interviewee 6).

Moreover, the institutional forms that guide the first consultation, as well as the assistance provided by the health professionals follow previously established standards, not ensuring the specificities of the SP. The following excerpt is representative of this statement.

*As there is no differentiated care or differentiated records, all who seek care in the hospital's PS, [all] have the same medical record, the same forms, so it is the same care* (Interviewee 7).

In view of the above, the study made it possible to infer a conception and practice of access to health services for the SP restricted to the first care, in a punctual way and not ensuring the particularities of this population, producing difficulties that will be presented below.

### DIFFICULTIES FACED BY THE STREET POPULATION TO ACCESS HEALTH SERVICES

Among the difficulties related to access to health services, there is a bureaucratization of care due to the absence of SUS card and of residence address of the SP, as can be seen in the following testimony.

*Sometimes they have no documents... Sometimes, for example, the person has certain disease, right? That needs follow-up, then because this person does not have*

*residence, sometimes this makes it difficult because, otherwise we could keep in contact through that nearest unit. [...] Follow-up is necessary, then this is a difficulty, because since the person does not have a address of residence, it is more difficult to locate him, because one day he is here, another day he is in another place (Interviewee 27).*

*Difficulty with the homeless people, usually with the documents. There are some of them that do not have the SUS card, they don't anything. Then to make an appointment with the specialties, the requirement is the SUS card. If they do not even have identity, they do not have anything, not even the date of birth, you know? (Interviewee 3).*

Besides this difficulty, the study also made it possible to identify the low number of health professionals in the institutions investigated.

*The major difficulty is the amount of professionals to take care of the demand of the unit, they are many families for just a few health professionals. How are we going to have time to look for these people on the streets? [...] (Interviewee 9).*

*The biggest difficulty is the number of professionals; there is only one nursing technician to do the dressings and he has to stay in the unit, you can not go to go to the area (Interviewee 5).*

Another difficulty is related to the social devaluation attributed to the SP by health professionals, as it can be noticed in the following speech: *"Sometimes it is also like the professionals do not value this street person" (Interviewee 9).*

There was also mention of the absence of a service specifically organized for SP's demand, based on their way of living and working on the streets, passing on the idea that those people alone are responsible for seeking access to health services:

*"these people are certainly very difficult users, because the CHAs can find them on a street today and tomorrow they don't know where they are, they don't care" (Interviewee 12).*

Thus, this form of access produces another difficulty, which is the construction of bond between users and the health service

*"[...] It is very difficult to create a bond with these users" (Interviewee 12); "The issue of registration, of the bond*

*also, because they do not have a fixed residence, then this hinders the creation as well as the continuity of that bond" (Interviewee 6).*

Another difficulty concerns the lack of knowledge that the SP has about the organization of health services, as shown in the following speech:

*"the greatest difficulty is the lack of knowledge of the population about the service itself. They think that it is only for urgency and emergency care here" (Interviewee 25).*

This disinformation is not restricted to users, but also to the network's own professionals, when they say:

*"But in general terms, we do not have policies for this street population, they don't exist, and if they exist they don't work" (Interviewee 6).*

## DISCUSSION

Reflecting on the reality of access to health services, especially in the case of the street population, call attention to the fact that this is a principle of the SUS, regulated by the State.<sup>10</sup> Although legally defined, universal access is a complex concept, often used in a confusing way and without much clarity in its relation to the use of health services. It is also a concept that varies among authors and changes throughout of time and according to the social context in which people are inserted.<sup>11</sup>

Regarding the use of health services, the universal access assumed in this study is understood in its relation to the organization of services. Therefore, it concerns the entry into the service and the continuity of health care, considering the meeting of social needs.<sup>12</sup>

That being so, it is not just a matter of having services available. The use of health services may be a measure of access, but not only explained by it. Although access is an important determinant of use, effective use of health services is defined, considering issues related to the context, by the geographical area, the quality of service provided, and the response to social needs.<sup>13</sup> Likewise, the continuity of this care is sometimes determined by situations other than those that define the entry into the health care network, which implies the analysis of the demands in their particularities.

The access of the SP actually occurs preferentially through urgency and emergency services, because these services are more accessible than primary care, which historically has been the main gateway to SUS health services. Thus, this data point to the fragility of primary care in identifying this population and recognizing it as user of all the services that compose the



health care network, regardless of housing and attached area. Consequently, the SP identifies the urgency and emergency units as the immediate response to its needs.

Similarity, a study in Joinville-SC found that units are more often sought by the SP as a result of the difficulty of access to primary care.<sup>14</sup>

This reality calls for the need to overcome the chaotic, atomized, standardized logic and rush in interventions that have historically ruled the urgency and emergency services,<sup>15</sup> because these are the spaces considered by this population as the main gateway to the health care network.

On the other hand, this form of service organization homogenizes people and unifies service. The initiative to reorganize them requires constant analysis, given the complexity that surrounds the SP, as well as interventions aimed at problems and determinants of the health-disease process.<sup>16</sup> Such an initiative must take into account that the needs are different and, therefore, require different resources/methods.

Structuring public services, particularly health services, requires policies and a set of practices that meet the needs of these various groups and an ability to reflect on the condition of the various social segments. In this context, the processes of exclusion and social inclusion must be considered and, from this point, practices within the public services can be organized in the different social areas, with the creation of new forms of networking, transforming technical and administrative organizations as to incorporate these population segments into their needs and demands.<sup>17</sup>

While these services are part of a network that should ensure universal access, responsibilities are generally not shared but transferred from one institution to another. Therefore, the role of urgency and emergency units in the health care network needs to be reviewed so that the street population has the right to access duly respected.

The organization of network services presupposes a horizontal design of health care in which all services are equally responsible for meeting the users' demands.

Thus, there is no hierarchy between the different points of health care, but rather a structure of distinct technological densities and support systems, without order and without degree of relevance between them.<sup>8</sup> The SP's access requires that the health care network create new flows, expand the sense of citizenship and the understanding of the relationship between the ways of living/working and the health-disease process.<sup>18</sup>

With regard to the SP, the ways of living and working of these people have peculiarities that require new arrangements as a means of ensuring their access to the health care network. The absence of formal residence and the itinerant behavior typical of the SP represent specific characteristics not always

contemplated in health work, thus restricting the access of populations that are organized in a manner where there is no permanent residence.<sup>19</sup>

The requirement of proof of residence address to define the territorial base of care ends up becoming an additional barrier for street people, and should be relativized. Does the logic of the home matrix disregard the ways of living/working that do not fit into general patterns and lead to questioning the place of the streets in health services? Because the SP do not belong to a defined territory, they easily end up belonging to nobody.<sup>20</sup>

Moreover, the need for identification documents such as the SUS card, as a bureaucratic requirement of institutions, sometimes hinders the access to health services in the case of the SP.<sup>4</sup> However, the absence of such documents does not prevent the provision of care.

The study also showed that the social devaluation of this population is reproduced by the health service through stereotypes such as "extra", "itinerant" and "desultory" people, among others, as a way of adapting it to the established order. These stereotypes reinforce their invisibility and give the wrong impression of guaranteeing the right to access, becoming a major challenge for the reorganization of the network discussed earlier, as well as for the work and training of health professionals.

With regard to work, the meeting of these professionals with the stories of life in the context of the street provokes a destabilization of their knowledge and crystallized practices, considering that this removes the identity places of each profession, reconfiguring them in act. The challenge is to produce a health service that goes beyond what is expected, what is scheduled, what is prescribed.<sup>15</sup>

Likewise, the way of living/working of the SP requires a re-orientation of the health training process, historically based on the disciplinary mode, and individual, biological and centered procedures, given the complexity of the health/disease process of these people.

There are also those who blame the street people themselves for the difficulty of accessing the health care network, without realizing that health care does not depend solely on the user, but on the entire socioeconomic and political system in which health care services are embedded.

Therefore, it is the service that needs to reorganize based on the living and working conditions of the SP and on their demands, and not the other way around. This will make it possible to build a link with such users. The link between professionals and users encourages autonomy and citizenship, and promotes their participation during the provision of care.<sup>21</sup>

Furthermore, the access to health services by the SP is sometimes hampered by the lack of knowledge of some health professionals about the existence of the National Policy for the Street Population, regulated since 2009. It should be empha-

sized that the lack of awareness of such policy should not constitute a barrier for the access of the RSP, because universal access is ensured in the Constitution of 1988.

In general, the speeches in this study are related to the difficulty of accessing health services by the SP, either due to bureaucratic issues of the service itself, documentation requirements, reduced number of professionals, insufficient supply in terms of structure and inputs, lack of permanent residence address, and social devaluation. Similar difficulties have been found in other researches, such as: technical-administrative organization of services, the requirement of documentation, bureaucracy for scheduling consultations, service restricted to spontaneous demand, limits on intersectorial action, and prejudice.<sup>13,22</sup>

Comparison of studies in Brazil, Portugal and the United States analyzing the health systems regarding universal access to health care for the SP highlights the active search, followed by referral to other points of the network, as an essential strategy for the construction of bond and continuous care, with the potential to facilitate the access to services in the case of this population.<sup>23</sup>

In view of the above, it can be understood that access as an entry and continuity of care in health services, a legally assured right, is generally denied to the SP. This is because the entry is ensured, but the continuity of care, considering the actual social needs of this population, is denied.

In this sense, the study makes explicit the need to inscribe in the public agenda policies that take into account the complexity of the SP and the construction of full citizenship, which is constantly being threatened by the neoliberal capitalist project, expressed in absolute hygiene. Above all, it is necessary to attain the hard core of social inequality reigning in the capitalist society, with need of articulation with the most structural and political, indeed universal, issues.<sup>24</sup>

## FINAL CONSIDERATIONS

The study made it possible to perceive that although the SP is present in society, it is invisible to the health service and, consequently, to society itself. These people are recognized through stereotypes and stigmas built by capitalist society, which has a definite pattern of what the ways of life are. It should be stressed that the homeless population is a product of the neoliberal state, but at the same time it is a threat to this state because it lives outside social policies and puts in check a certain pattern of sociability and social production.

In view of this invisibility, the access, understood as entry in health services and continuity of care, is generally denied to the SP. These people have their entry guaranteed, but the continuation of care to meet the original demand, as well as their real social needs, is not.

This inconsistency deepens at a time when, although services are part of a network that should ensure universal, equitable and integral access, they are not organized to do so, in particular capable of responding to the demands of the PSR in all its specificities. Thus, it constitutes a challenge for management, workers, social movements and training institutions, as it questions the SUS as a conquest of society and public policy of social inclusion.

## REFERENCES

1. Vasconcelos CM, Pasche DF. O Sistema Único de Saúde. In: Campos GWS, Bonfim JRA, Minayo MCS, Akerman M, Drummond Junior M, Carvalho YM. Tratado de saúde coletiva. São Paulo: Hucitec; 2006.
2. Carnut L. Desafios das políticas sociais no Brasil: caso da universalidade da Atenção Primária à Saúde – primeiras notas. *J Monag Prim Health*. 2011[cited 2017 Oct 12]; 200:25-9. Available from: <http://www.jmphc.com.br/jmphc/article/download/96/97/>
3. Cohn A. O estudo das políticas de saúde: implicações e fatos. In: Campos GWS, Bonfim JRA, Minayo MCS, Akerman M, Drummond Junior M, de Carvalho YM. Tratado de saúde coletiva. São Paulo: Hucitec; 2006.
4. Brêtas ACP, Cavicchioli MGS, Rosa AS. O processo saúde-doença-cuidado e a população em situação de rua. *Rev Latino-Am Enferm*. 2005[cited 2017 Sept 23];13(4):576-82. Available from: <http://www.scielo.br/pdf/rlae/v13n4/v13n4a17.pdf>
5. Botti NCL, Castro C, Ferreira M, Silva AK, Oliveira L, Castro AC, et al. Condições de saúde da população de rua na cidade de Belo Horizonte. *Cad Bras Saúde Mental*. 2009[cited 2017 Sept 23];1(2):162-76. Available from: <http://incubadora.periodicos.ufsc.br/index.php/cbsm/article/view/1141/1383>.
6. Assis MMA, Villa TCS, Nascimento MAA. Acesso aos serviços de saúde: uma possibilidade a ser construída na prática. *Ciênc Saúde Coletiva*. 2003[cited 2017 Sept 23];8(3):815-23. Available from: [https://www.scielo.org/article/ssm/content/raw/?resource\\_ssm\\_path=/media/assets/csc/v8n3/17462.pdf](https://www.scielo.org/article/ssm/content/raw/?resource_ssm_path=/media/assets/csc/v8n3/17462.pdf).
7. Minayo MCS, Souza ER. É possível prevenir a violência? Reflexões a partir do campo da saúde pública. *Ciênc Saúde Coletiva*. 1999[cited 2017 Sept 23];4(1):7-32. Available from: [https://www.scielo.org/scielo.php?pid=S1413-81231999000100002&script=sci\\_arttext&tlng=](https://www.scielo.org/scielo.php?pid=S1413-81231999000100002&script=sci_arttext&tlng=)
8. Oliveira EXG, Carvalho MS, Travassos C. Territórios do Sistema Único de Saúde: mapeamento das redes de atenção hospitalar. *Cad Saúde Pública*. 2004[cited 2017 Sept 23];20(2):386-402. Available from: [http://www.scielo.br/scielo.php?pid=S0102-311X2004000200006&script=sci\\_abstract&tlng=pt](http://www.scielo.br/scielo.php?pid=S0102-311X2004000200006&script=sci_abstract&tlng=pt).
9. Minayo MCS. Amostragem e saturação em pesquisa qualitativa: consensos e controvérsias. *Rev Pesq Qualitativa*. 2017[cited 2017 Sept 23];5(7):1-12. Available from: <http://rpq.revista.sepq.org.br/index.php/rpq/article/view/82/59>.
10. Ministério da Saúde (BR). Coletânea de normas para o controle social no Sistema Único de Saúde. Conselho Nacional de Saúde. 2ª ed. Brasília (DF); 2006.
11. Andersen RM, Newman JF. Societal and individual determinants of medical care utilization in the United States. *Milbank Mem Fund Q*. 1973[cited 2017 Sept 23];51:95-124. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690261/>
12. Malta DC, Duarte EC, Escalante JJC, Almeida MF, Sardinha LMV, Macário EM, et al. Mortes evitáveis em menores de um ano, Brasil, 1997 a 2006: contribuições para a avaliação de desempenho do Sistema Único de Saúde. *Cad Saúde Pública*. 2010[cited 2017 Sept 23];26(3):481-91. Available from: <http://www.scielo.br/pdf/csp/v26n3/06.pdf>

13. Carneiro Junior N, Jesus CH, Crevelim MA. A Estratégia Saúde da Família para a equidade de acesso dirigida à população em situação de rua em grandes centros urbanos. *Saúde Soc.* 2010[cited 2017 Sept 23];19(3):709-16. Available from: [http://www.scielo.br/scielo.php?pid=S0104-12902010000300021&script=sci\\_abstract&tlng=pt](http://www.scielo.br/scielo.php?pid=S0104-12902010000300021&script=sci_abstract&tlng=pt)
14. Schimith MD, Lima MAD. Acolhimento e vínculo em uma equipe do Programa Saúde da Família. *Cad Saúde Pública.* 2004[cited 2017 Sept 23];20(6):1487-94. Available from: <http://www.scielo.br/pdf/csp/v20n6/05.pdf>
15. Londero MFP, Ceccim RB, Bilibio LFS. Consultório de/na rua: desafios para um cuidado em verso na saúde. *Interface (Botucatu).* 2014[cited 2017 Feb 15];18(49):251-60. Available from: [http://www.scielo.br/scielo.php?pid=S1414-32832014000200251&script=sci\\_abstract&tlng=pt](http://www.scielo.br/scielo.php?pid=S1414-32832014000200251&script=sci_abstract&tlng=pt)
16. Paiva IKS. População em situação de rua: desafios e perspectivas para formação do enfermeiro [dissertação]. Mossoró: Universidade do Estado do Rio Grande do Norte; 2015.
17. Barata RB, Carneiro Junior N, Ribeiro MCSA, Silveira C. Desigualdade social em saúde na população em situação de rua na cidade de São Paulo. *Saúde Soc.* 2015[cited 2017 Sept 23];24(1):219-32. Available from: <http://www.scielo.br/pdf/sausoc/v24s1/0104-1290-sausoc-24-s1-00219.pdf>
18. Macerata IA. Experiência POP RUA: implementação do "Saúde em Movimento nas ruas" no Rio de Janeiro, um dispositivo clínico/político na rede de saúde do Rio de Janeiro. *Rev Polis Psique.* 2013[cited 2017 Sept 23];3(2):207-19. Available from: <http://www.seer.ufrgs.br/PolisePsique/article/view/46178>
19. Silva CC, Cruz MM, Vargas EP. Práticas de cuidado e população em situação de rua: o caso do Consultório na Rua. *Saúde Debate.* 2015[cited 2017 Mar 18];39:246-56. Available from: [http://www.scielo.br/scielo.php?pid=S0103-11042015000500246&script=sci\\_abstract&tlng=pt](http://www.scielo.br/scielo.php?pid=S0103-11042015000500246&script=sci_abstract&tlng=pt)
20. Pagot AM. O louco, a rua, a comunidade: as relações da cidade com a loucura em situação e rua. Rio de Janeiro: Fiocruz; 2012
21. Campos GWS. Considerações sobre a arte e a ciência da mudança: revolução das coisas e reforma das pessoas. O caso da saúde. In: Cecílio LCO. *Inventando a mudança na saúde.* 2ª ed. São Paulo: Hucitec; 1997. p.29-87.
22. Aguiar MM, Iriart JAB. Significados e práticas de saúde e doença entre a população em situação de rua em Salvador, Bahia, Brasil. *Cad Saúde Pública.* 2012[cited 2017 Sept 23];28(1):115-24. Available from: <https://www.scielosp.org/pdf/sdeb/2015.v39nspe/246-256/pt>
23. Borysow IC, Conill EM, Furtado JP. Atenção à saúde de pessoas em situação de rua: estudo comparado de unidades móveis em Portugal, Estados Unidos e Brasil. *Ciênc Saúde Coletiva.* 2017[cited 2017 Sept 23];22(3):879-90. Available from: <https://www.scielosp.org/pdf/csc/2017.v22n3/879-890/pt>.
24. Paiva IKS, Lira CDG, Justino JMR, Miranda MGO, Saraiva AKM. Direito à saúde da população em situação de rua: reflexões sobre a problemática. *Ciênc Saúde Coletiva.* 2016[cited 2017 Sept 23];21(8):2595-606. Available from: [http://www.scielo.br/scielo.php?pid=S1413-81232016000802595&script=sci\\_abstract&tlng=pt](http://www.scielo.br/scielo.php?pid=S1413-81232016000802595&script=sci_abstract&tlng=pt)