Special report

Contributions of Street Outreach teams to primary health care and management*

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ABSTRACT *As part of the Unified Health System (SUS) in Brazil, a Street Outreach Program was created with the goals of delivering primary health care (PHC) and guaranteeing access to health initiatives for homeless populations in the street environment itself, connecting these populations to other services beyond urgent care and emergency facilities. The Program's scope of action involves, in addition to health care, protecting this population against the risks to which they are exposed, combined with an effort to guarantee their rights. In this sense, the Street Outreach Clinics (*Consultórios na Rua*) strive to ensure equity and access for people with no fixed address, within a system that essentially relies on geographical catchment areas to provide health care. Thus, the establishment of Street Outreach Clinics has introduced new modes of providing health care, and consequently new modes of managing work processes. Based on this coordination between care and management, the present article discusses three levels of intervention for the work of Street Outreach Clinics and teams (the street itself, health care units, and institutional networks), as well as the relationship between this program and other PHC services and the program's contribution to reconciling PHC with its essential attributes, beyond catchment areas.*

Keywords Health management; universal access to health care services; primary health care; homeless persons; Brazil.

Since the Alma-Ata Declaration in 1978 (1), primary health care (PHC) has become established as the gateway to health systems and the preferred mode of service delivery. The structure of this level of care highlights the importance of PHC within a health context historically characterized by high-tech interventions and the treatment of well-established diseases.

In Brazil, Street Outreach Clinics (*Consultório na Rua*) were instituted with the second edition of the National Basic Care Policy (*Política Nacional de Atenção Básica*, PNAB), in 2011. Street Outreach teams are itinerant teams of health care workers who operate in areas with a high concentration of homeless persons. The actions of these teams are diverse and depend on the health needs they identify, from isolated instances to chronic diseases, many of which ultimately require longitudinal follow-up.

The priority role of Street Outreach teams is to provide primary care, with particular emphasis on the diseases most prevalent among people living on the streets; distributing health supplies and guidance and ensuring access to interventions and services directly in the street environment; and connecting this population to health services beyond urgent care and emergency facilities (2). In addition, their scope of action includes

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providing protection against the particular risks to which this population is exposed, combined with an effort to guarantee their rights.

The Street Outreach Clinics program emerged in a context of expanding social rights in Brazil: public policies were being extended to populations that previously lacked access to the basic rights enshrined in the Brazilian Constitution, and the focus was on impacting the drivers of social inequality. Other factors that contributed to its emergence were the decision by the Ministry of Health to focus on PHC as the overarching strategy of the national health system and to prioritize health care networks; the controversial and questionable crackdown on crack-cocaine plan that emerged in the wake of two mass events held in the 2010s in Rio de Janeiro, namely, the FIFA World Cup and the Summer Olympics (3); and the growing organization and involvement of the national homeless people's movement in the politics of major Brazilian cities.

The rationale for establishing the Street Outreach teams was the great vulnerability faced by the homeless population, compounded by the limited intake capacity of the existing network of basic care (as PHC is known in Brazil). This fact reflects a multitude of difficulties related to the PHC model adopted in Brazil, which, in broad strokes, relies on users having fixed addresses to define catchment areas. This model precludes follow-up of populations with no fixed abode and has historically constituted a barrier to access to health services by the homeless.

The living spaces of homeless populations pose a series of challenges to the Brazilian Unified Health System (SUS) in terms of the effective realization of its principles, which include the provision of comprehensive care – i.e., the practice and delivery of care from a more integrative and less "specialist" perspective. There are two issues here: one concerning the way that "territory" is generally considered, i.e., merely as a geographic demarcation of one's place of abode, so that only those who officially live in a given territory are part of that territory; and the other concerning the way in which the different skillsets of a multidisciplinary team come together into a single practice so that the biopsychological dimensions of care are not broken up (4). When it comes to the homeless population, all of the organizing concepts of PHC are challenged: not all those who live in a given territory have a fixed address; the biological, subjective, and social processes of the health-disease continuum are connected and they mutually support one another.

The Street Outreach program was established in an attempt to increase equity in the system. The vulnerability of this population highlights the vulnerabilities of SUS care practices, but also shows that the work of Street Outreach teams introduces a series of innovations to the practice of PHC, as well as to the management of the care process.

Within this context, the present text is built on a series of experiences with the Street Outreach program, in different fields: the experience of working in the early stages of development of a Street Outreach Clinic team in the city of Rio de Janeiro; the experience of conducting doctoral research on the care practices of this team, which resulted in a technical paper on the matter; and the experience of developing educational materials for a course designed to train providers for the Street Outreach program (5).

Addressing issues raised by the implementation of these teams in the Brazilian PHC model, this article outlines how the guidelines and mandates of the Street Outreach program reconcile with other PHC services. This analysis focuses specifically on how management of the work of Street Outreach teams is extremely closely coordinated with care practices—in other words, there is no separation between management and care. This close linkage can shed light on some issues faced by other PHC services, such as Family Health Strategy teams.

MANAGEMENT AND HEALTH CARE: THE WORK PROCESS

Management, a concept originating in the field of administration, is defined as the activity of exercising a mandate over work and enhancing the quality of work processes. During the modern age, management gained a central role in industrial production; in the examples of Taylor and Ford, it is characterized by rationalization, division, and mechanization of work processes, which are subject to central control down to their smallest aspects. The field of public health has come to view Taylorist management as a problem (6), and that changing the models of care requires changing management models as well: i.e., developing a new rationale for management processes other than the administrative or private logic.

Thus, management in the health field has a unique feature: work process management and care practices, although distinct dimensions, are inseparable (7). Care practices are produced jointly with management practices. In every management practice, there is a care dimension, and in every care practice, there is a management dimension. The unique nature of health management processes lies in that they must be integrated with the delivery of care. To deliver care is to construct a practice based on the unique features of the object of care: unique people and territories. However, the delivery of care involves a certain way of performing management. In other words, managing the work process in health means managing care.

Management in health is concerned with the coordination of work, involving the various actors involved in its scope of practice – workers, users, the community; hence, co-management (7). Within the framework of co-management, managing does not mean placing oneself above the work and the territory in order to regulate it (which is the classical management perspective); rather, it means positioning oneself alongside the work and the territory, and acting from there. In this sense of "management", care is not regarded as an action upon another actor– the hierarchical, vertical, centralized, Taylorist concept. By eschewing the stewardship function classically attributed to care, the provision of care no longer depends solely on a worker's technical expertise or core functions, but rather involves the various actors, resources, and dynamics of the territory in which the action is to take place. Territory, here, is used in the sense of a category that defines complex relationships across different vectors and that involves objective and subjective dimensions (4). It is in this relationship—with, within, and from the territory itself, not upon or against it—that care is delivered as a collective, democratic, and inclusive practice, within the framework of the expanded clinic (4, 6, 7).

In a vertical, procedure-centered care model, health and user become universal categories—not situation-specific ones—and care takes on a dangerous role of

calculated life-management (8). Care and management of the care process take place through encounters with subjects and territories; these encounters are among the most unique moments of the work process in the field of health (9). Management of this work must be approached from the same perspective: that of co-management. Co-management is a guideline. It permeates all processes in the field of health to a greater or lesser degree but is always present. Management is not limited to the actions of managers; it is present in clinical interventions and in every scope of every service and of the work process.

From the perspective of co-management, care and politics are also inseparable (4, 10): management takes on and creates the conditions for care. It is necessarily political, in that it is always situated in a field of dispute, of power relations, and can produce practices both of domination and of liberation and empowerment. There is always the risk of producing constraints and standardization of ways of living as subjective effects. This issue arises especially in PHC, where services operate in close proximity to the everyday life of users.

Thus, care management in PHC has unique features that call for a shift away from the management practices carried over from private business administration. In the practice of Street Outreach teams, it is especially important that both care and management build and manage the work process, with the relationship between the program/team and the territory as the fulcrum of support.

LEVELS OF INTERVENTION BY STREET OUTREACH TEAMS

The practice of Street Outreach teams, which is heavily reliant on proximity to and action within the territory and based on its unique features, shows that the work process takes place through subdivisions, based on the various levels of intervention of the Street Outreach program. These levels, in turn, require management of more specific work processes.

The Street Outreach program has three fundamental levels of action: the street; the referral center/health facility; and institutional (health and intersectoral) networks. All management and delivery of care goes through these three levels. The notion of "levels" goes beyond the idea of space as a fixed, immutable, Euclidean physical space, with clearly demarcated, visible, well-defined borders. We understand that these levels are present within each another, making it possible to identify influences and ways of acting that one level exercises over the others. Thus, each level reaffirms the dependence between the different spaces of work, as these are not established as stable units.

From the transdisciplinary perspective (11), spaces of work are understood as porous to the myriad flows that cross them. As they are composed of objective and subjective aspects, these plans interpenetrate and intermingle. There is a little bit of street in a health facility and a little bit of health facility in the street, for instance. Regarding the street as a level denotes not only its objective sense of a physical demarcation, but also, in a subjective sense, certain "street" qualities in the setting of the health facility.

The "street"—as a level of intervention—is the territory in which care recipients live. This territory is very different from the usual living arrangements in a city. It is the territory in which this population resides and lives but it is not a home. Not only from a physical and geographical standpoint, but also in terms of organization and subjective functioning, it is characterized by both visible and invisible aspects.

The visible aspects of the street can be mapped and systematized: number of people, territorial boundaries, epidemiological data to support evaluation and monitoring of care practices, concrete situations of violence, resources, size, and movement, among many others. Thus, the assigned territory or "catchment area" of a Street Outreach team is composed of several types of homeless populations (some more fixed, others more itinerant), various other actors (the homeless themselves, local storeowners, police, other law enforcement agents, passers-by, drug dealers, death squads, religious institutions, etc.), resources that the territory offers to the homeless population (sources of food and money, places to sleep, other care services), and the most prevalent types of health problems, among other aspects.

The invisible aspects of the street level involve relational dynamics that users or groups establish in a given territory. This subjective dimension of the street refers to the relations that are established within it – to the place it occupies in the life of its subjects (affective and symbolic places). Although these aspects are not palpable, they do exist, and when it comes to organizing the work process, they must be taken into account. This creates the need to rethink and reconsider health strategies and concepts, as well as engagement with the territory. One must understand the territory, feel it, see it, and breathe it.

The "health facility" is traditionally understood as the venue where care practices are organized and delivered. As a level of intervention of the Street Outreach program, this facility is also present in the street and in the network, going beyond the usual practices performed and planned in the health facility itself. The main factor that defines a care space is the relational aspect (12): the manner in which processes and workflows are organized and implemented in the context of the territory, its actors, and their ways of living. Thus, a care space is manifested through a way of entering into relationships beyond the structure and limits of the facility in which providers work, and even beyond the traditional procedures usually classified as care. Just like health facilities or network clinics, care spaces established in the streets may have a mandate to provide care, but fail to effectively deliver it.

The relational aspect of the care space is perceived when the Street Outreach "clinic" thus becomes a "referral unit" within its territory, whether on the street, at a health facility, or in the network. In one way or another, the facility is present in the street and the street is present at the facility. The facility must be organized as a welcoming space for users, and its flows must fit the dynamics of street living in numerous aspects: from its (flexible and non-standard) working hours and the paperwork required to receive care to the ways in which providers listen, speak, and provide guidance – in short, in how users are received. In our experience, this required, for instance, always having a Street Outreach caseworker at the facility, so as to facilitate relations between Street Outreach users and the providers and users of other programs; and having a waiting room that considered as "urgent" not only biological issues affecting the body, but also subjective and social events—such as someone who urgently needed to go to a job interview, someone who had been

missing for a long time, or someone who was in the throes of drug withdrawal.

Within the context of a health policy aimed at a population that has historically been on the fringe of the health services, it is important to consider that the countless serious situations experienced by this population, compounded by the current fragmentation of health care networks and the lack of secondary and tertiary care surge capacity, mean that the Street Outreach program must have facility space to address very specific issues, such as dressing wounds and performing cervical smears. Despite its itinerant nature, the team must have its headquarters at a physical facility, which, in turn, must provide walk-in services to the homeless population; its doors must be open with no restrictions and no need for any form of authorization. It must be a space which homeless persons are entitled to access, and this right must be guaranteed. The level of the facility must be created within at street level: an itinerant space for patient encounters, close to where users live. The "headquarters", with its resources and flows, is thus not restricted to the walls of the health facility; it operates in and crosses the levels of the street and the network, and, consequently, its mode of functioning.

The "network" level of intervention refers to the physical spaces (services) and organizational logics of health facilities, other public policies, and civil society as they relate to the work of the Street Outreach program. The network level is made up of its points (specific health services and actions, as well as those of other sectors) as well as by the ways in which these services, workers, and users relate to one another.

The recent establishment of health care networks (*redes de atenção à saúde*) (13) highlights the unique work carried out by PHC, which is responsible for coordinating care and organizing the different networks within its territory. These networks must have a shared mission and objectives, operating in a cooperative and interdependent manner and exchanging resources. No hierarchies should be established between their various components. All points at which health care is provided are equally important and are horizontally interrelated. All should focus on the full cycle of care for any given health condition and take unequivocal responsibility for the health and economy of their population (14). Despite the importance of its internal organization, the Brazilian Unified Health System (SUS) cannot be the sole agent responsible for meeting the complex demands of homeless populations. Thus, intersectoral networks are also part of this level of intervention of the Street Outreach program.

Networks are present at street level, for instance, when a local merchant helps treat a patient; when the emergency medical services are called; or when the need arises to establish a dialogue with the police, local drug dealers, or local residents. One example of how the network is present at the headquarters level would be the creation of a project to integrate treatment with another service. The role of the Street Outreach program is to weave and strengthen this network, creating relationships, negotiating, understanding the logic and role of each service, accepting its difficulties, but also focusing on welcoming the homeless population and its unique features. Intrinsic to the construction of this level of intervention is the whole perspective of care and organization of the work process of the Street Outreach teams, which stresses the urgency of devising practices and policies that meet the needs of the streets—in particular, how to build an intersectoral network.

To organize a network is to ensure that services flow in its internal and external dynamics. Organization is not the sole responsibility of managers, but rather of the management function – that is, all workers and even users themselves are responsible. To "ensure that services flow" is to establish flows that help work consolidate, allow follow-up to take place, and tear down obstacles and barriers to communication, ensuring that the more work is shared, the more it helps solve users' problems.

Networks are arrangements between the different health services operating in a given territory to deconstruct the fragmentation of health practices based on the logic of providing incidental care for health problems and conditions, usually centered on an organic and biological logic. Experience shows that the systemic integration provided for in health care networks responds more effectively both to the internal organization of the health system and to the challenges of the socioeconomic, demographic, epidemiological, and health panorama of each territory. Networks are built on the notion that PHC must solve the most common health problems and coordinate the provision of care to users at all other levels of care (13). As such, building the network is a task inseparable from the delivery of care, and Street Outreach workers must set aside the time to build it and keep it strong.

FINAL CONSIDERATIONS

The issues and aspects briefly discussed in the present article are highlighted by real-world experiences with the Street Outreach program, but do not concern only the work of these teams. Considering the broader reality of PHC services, we see many points in common, especially regarding the relationship between care practices, work process management, and territory. The Street Outreach program is becoming less and less of a specialized service. It also serves to analyze health practices.

Beyond a structure focused on primary care, prevention, and health promotion, with a high capacity for capillary action, PHC is characterized by its nature as a territorially constrained service. This does not mean catchment areas alone, which would ultimately restrict the full potential of this level of care. In Brazil, it is not uncommon for PHC services to become confined to the limited catchment area of the referral unit or facility and thus be oblivious to the surrounding territorial dynamics. This, in turn, encourages a focus on the "complaint-management" dyad, rather than on actual care. The relationship between team and territory presented here can provide elements that are essential both for care practices and for care management practices.

The management of work processes proposed in this paper is carried out strictly in response to demands arising from the relationship between team dynamics and territorial dynamics. Building work management on these foundations can help reconciliate the PHC model with its mission to provide care for 80% of all health problems, based on a territorial logic that works from the inside, ultimately serving as a means of expanding access. However,

relating with the territory in these ways allows not only an increase in scope, but also increase the capacity to deal with complex concurrent situations. This is expansion in a dual sense: both broadening access and increasing the capacity for care, and expanding the capacity to consider and tackle the various constituent vectors of complex situations involving individuals, groups, or communities. This reconciliation between PHC and territory, through the construction of new care practices, has direct implications for new work process management practices within the Unified Health System.

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RESUMEN

Contribuciones de los equipos de Consultorio en la Calle para el cuidado y la gestión de la atención básica

Como parte del Sistema Único de Salud en Brasil, los Consultorios en la Calle y sus equipos fueron creados teniendo como función prioritaria prestar cuidados primarios y garantizar el acceso a las acciones y servicios de salud para poblaciones en situación de calle, en el propio ambiente de la calle, creando vínculos en esa población con otros servicios que no sean solamente los de urgencia o emergencia. Su alcance involucra, además de la atención, la protección contra los riesgos a que está expuesta esa población, combinada con la búsqueda de la garantía de sus derechos. En ese sentido, los Consultorios en la Calle buscan hacer efectiva la equidad y el acceso a las acciones y servicios de salud para una población sin domicilio fijo dentro de un sistema basado esencialmente en la adscripción territorial de la población. Así, la creación del Consultorio en la Calle inaugura nuevos modos de cuidados de la salud y, en consecuencia, nuevos modos de gestionar el proceso de trabajo. A partir de esa articulación entre cuidado y gestión, el presente artículo discute tres planos de intervención donde se da la práctica de los equipos de Consultorio en la Calle (la propia calle, la sede o unidad de referencia y las redes institucionales), su relación con los demás servicios de atención primaria de salud y su contribución para reconciliar la atención primaria de la salud con sus atributos fundamentales, además de la adscripción del territorio geográfico.

Palabras clave Gestión en salud; acceso universal a los servicios de salud; atención primaria de salud; personas sin hogar; Brasil.

RESUMO

Contribuições das equipes de Consultório na Rua para o cuidado e a gestão da atenção básica

Como parte do Sistema Único de Saúde (SUS) no Brasil, os Consultórios na Rua e suas equipes foram criados tendo como função prioritária o desenvolvimento de cuidados primários e a garantia de acesso às ações e serviços de saúde para populações em situação de rua no próprio ambiente da rua, criando vínculos dessa população com outros serviços que não sejam somente de urgência e emergência. Seu escopo de atividades envolve, além da atenção, a proteção contra os riscos a que essa população está exposta, combinada com a busca da garantia de seus direitos. Nesse sentido, os Consultórios na Rua buscam efetivar a equidade e o acesso a ações e serviços de saúde para uma população sem domicílio fixo dentro de um sistema baseado essencialmente na adscrição territorial da população. Assim, a criação do Consultório na Rua inaugura novos modos de cuidar em saúde e, consequentemente, novos modos de fazer a gestão do processo de trabalho. A partir dessa articulação entre cuidado e gestão, o presente artigo discute três planos de intervenção onde se dá a prática das equipes de Consultório na Rua – a própria rua, a sede/unidade de referência e as redes institucionais –, sua relação com os demais serviços de atenção primária à saúde (APS) e a sua contribuição para reconciliar a APS com os seus atributos fundamentais, para além da adscrição do território geográfico.

Palavras-chave Gestão em saúde; acesso universal aos serviços de saúde; atenção primária à saúde; pessoas em situação de rua; Brasil.