

Health equity for homelessness: a critical review

Equidade em saúde para a população em situação de rua: uma revisão crítica

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DOI: 10.1590/0103-11042023139171

ABSTRACT The notion of equity in health manifests itself in modern societies through different ideas and operational proposals. Concerning homeless persons, equity dialogues with equality and justice to mobilize several applications in health: while the liberal conception of equity in health seeks to favor the health conditions of this population without breaking with the current mode of production, the critical conception aims to expand health conditions and needs in the struggle for an emancipated society. With the aim of characterizing the conceptions of equity in health expressed in the scientific literature on this population, this study carried out a critical review of the articles available on online search portals databases. 1,716 publications were identified in the initial sample and 35 articles were included in the review after application of methodological procedures. The articles were characterized in relation to the ideas and applications of equity in health for the homeless population, discussing methodology, justice and equality, distinction between conceptions, health-disease process, public policies and the COVID-19 pandemic. It points to the dominance of the liberal conception in the literature on this population and the need for investigations from the critical conception.

KEYWORDS Health equity. Ill-housed persons. Review. Thinking. Health care economics and organizations.

RESUMO A noção de equidade em saúde se manifesta nas sociedades modernas por meio de diferentes ideias e propostas operacionais. No que diz respeito às pessoas em situação de rua, a equidade dialoga com a igualdade e a justiça para mobilizar diversas aplicações na saúde: enquanto a concepção liberal de equidade em saúde busca favorecer as condições de saúde dessa população sem romper com o modo de produção vigente, a concepção crítica almeja ampliar as condições e as necessidades de saúde na luta por uma sociedade emancipada. Com o objetivo de caracterizar as concepções de equidade em saúde expressas na literatura científica sobre essa população, este estudo realizou uma revisão crítica dos artigos disponíveis em portais de busca on-line. 1.716 publicações foram identificadas na amostragem inicial e 35 artigos foram incluídos na revisão após aplicação de procedimentos metodológicos. Os artigos foram caracterizados com relação às ideias e aplicações da equidade em saúde para a população em situação de rua, discutindo-se a respeito de metodologia, justiça e igualdade, distinção entre as concepções, processo saúde-doença, políticas públicas e pandemia da Covid-19. Aponta-se para a dominância da concepção liberal na literatura sobre essa população e a necessidade de investigações a partir da concepção crítica.

PALAVRAS-CHAVE Equidade em saúde. Pessoas mal alojadas. Revisão. Pensamento. Economia e organizações de saúde.

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Introduction

The ideas of justice and equality manifest themselves synthetically in the notion of equity, an emerging concept in modern societies. In an economic sense, equity means establishing criteria so that the distribution of existing resources occurs disproportionately in a given historical period.

The rapprochement between equity and health was introduced by social medicine in the 19th century, a debate that advanced over time, being marked by theoretical, methodological and conceptual disputes¹. Equity was incorporated by economic thinking in health as a “principle according to which the allocation of resources is made according to the needs of a given population”²⁽³⁷⁾, giving rise to the term ‘health equity’.

Using this term is an activity that necessarily expresses a political-economic positioning – in other words, addressing equity in health represents assuming a perspective on the relationship between the health-disease process and the dynamics of production, distribution and consumption of goods and services. Unlike the equality-inequality dyad, in which concepts can unfold into quantifiable measurements³ that easily hide structural determinations, equity and its negation, inequity, are concepts that always declare a position on social relations. It is no coincidence that the concept of health inequity is being replaced by others that are apparently more neutral, such as ‘health inequalities’ and ‘health disparities’¹, as their use manifests a “meaning in the political dimension of sharing wealth in society”⁴⁽¹⁴⁰⁾.

Knowing that language is “a set of determined notions and concepts and not simply words that are grammatically empty of content”⁵⁽¹¹⁾, every manifestation of intellectual activity is supported by a social form of consciousness, that is, by a conception of the world. Each conception of the world expresses an analysis of the relationship between man, nature and society, necessarily endorsing a

specific economic and sociopolitical project. In this sense, the theoretical-conceptual dispute on the issue of health equity is marked by the competition of two antagonistic conceptions: the liberal, linked to the project of maintaining the current mode of production; and the critical, linked to the forces that fight to overcome capitalist society.

The liberal conception of equity in health is based on the theory of justice formulated by John Rawls, a liberal egalitarian thinker who sought to level the notion of equity with the concept of justice. Based on neoclassical economic thought, Rawls⁶⁽³³³⁾ theory states that economic and social inequalities must, concomitantly, bring “the greatest possible benefit to the least favored, obeying the restrictions of the principle of fair savings” and be “linked to posts and positions open to all under conditions of fair equality of opportunity.” This neo-contractualist idea of social justice, called the theory of justice as equity, has been incorporated since the 1990s into policies aligned with social counter-reforms developed in several countries, taking effect in the health area through targeting strategies.

In contrast to these ideas, the critical conception of health equity introduces the discussion in broader socioeconomic contexts, positioning itself in the face of contradictions about how human beings distribute the wealth produced by global social practice. Based on the assumption that society is divided into fundamental classes whose interests are irreconcilable, this conception points out the limits of actions focused on health as a means of responding to social inequalities, since the organization of health goods and services is also part of production relations dominated by the interests of capital. In this way, the notion of equity in health can only be fully implemented by overcoming current society, achieving a dynamic of health production and distribution that comes close to the following principle: “from each one according to their capabilities, to each one according to their needs”⁷⁽³²⁾.

As investigations into social problems and their intersections in the health area expand, the notion of health equity is increasingly expressed to present projects, justify assumptions and validate practices aimed at the health-disease process of certain population groups. The problem of the homeless population raises a growing debate on how to develop and implement public policies that meet the health needs of those who live in public spaces, culminating in operational proposals arising from different conceptions of health equity.

Societies' responses to this population changed as the dominant modes of production changed. Analyzed from historical materialism, the process of streetification reveals itself as a social process, "a condition that is shaped by multiple conditions, in a *continuum*"⁸⁽¹⁹⁴⁾ inseparable from the material basis of the production of life – an expression resulting, therefore, of conflicts between fundamental classes in each historical period. In slavery, the valorization of leisure over work encouraged charity for people who lived on the streets of the polis, like the cynics in Ancient Greece; in the decline of the feudal mode of production and the rise of commercial capitalism, people capable of working were punished for begging in incipient cities, a practice acceptable only when carried out by orphans, widows and those unable to work; finally, in the present time of dominance of financial capital, solutions are sought that are sometimes specific and sometimes prolonged to deal with a homeless population made up mainly of "people involved in informal jobs, which are their main survival strategy"⁹⁽³⁶³⁾. Modern societies almost always seek to react to the demands of this population through specific actions that do not interrogate the reasons for the current 'homelessness' nor seek solutions that challenge its roots, often resulting in fragmented and incoherent processes.

The imbroglio faced by the Brazilian State in responding to the demands of the homeless population exemplifies the impossibility of trying to reconcile the notion of equity with the

opposing interests of social classes. Although the right to housing is constitutionally guaranteed in the country, priority attention to the speculative interests of the restricted group of real estate owners prevents the housing deficit from being immediately addressed. One of the partial solutions found by the State was the institution of the National Policy for the Homeless Population, which emerged in the midst of Latin American policies aligned with social counter-reforms formulated by international organizations such as the World Bank and the Economic Commission for Latin America and the Caribbean (ECLAC)¹⁰, resulting in focal, cost-efficient and supposedly equitable interventions.

Considering the issues related to the notion of health equity, as well as its dispute between different traditions of economic thought, it is considered relevant to investigate the concepts of health equity for the homeless population, specifically with regard to its main applications, its relationship with the health-disease process and its position on the socioeconomic structure, aiming to produce more comprehensive answers on the notion of equity in this population. There are vast questions about health equity, therefore, the following guiding question was formulated to conduct the present study: what does the scientific literature present about health equity for the homeless population? The general objective is to characterize the concepts of health equity that appear in the scientific literature about this population, with the following specific objectives: a) identify the applications of these ideas of health equity for the homeless population; and b) analyze the foundations of applications based on currents of economic thought.

Material and methods

This study consists of a critical review of the literature, guided by the key processes of critical interpretative synthesis¹¹, a literature review method that seeks to bring together

the evidence from the articles included in a synthetic argument through the dynamics between research, sampling, criticism and analysis. Although this methodology guides reviews that focus on access to the healthcare system by vulnerable groups in the United Kingdom, its procedures were considered relevant to conduct this critical review of the literature, mainly when underlining that “there is a need for constant reflexivity to inform emerging theoretical notions, as they guide other processes”¹¹.

Search strategy and data sources

The first methodological moment of this review consisted of planning the orderly and systematic search strategy in data sources, guided by the recommendations for systematic reviews focused on equity present in the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA-E 2012)¹². Initially, the research question helped to delimit the key items ‘health equity’ and ‘homeless population’. From these key items, controlled and corresponding words were chosen by searching for descriptors in the following virtual thesauruses: a) Medical Subject Headings (MeSH), made available by The United States National Library of Medicine (NLM); and b) Health Sciences Descriptors (DeCS), 2021 edition, developed by the Virtual Health Library (BVS) of the Brazilian Ministry of Health. Five descriptors were derived from the key item ‘health equity’, selected from the MeSH and DeCS portals: “Equity”, “Health equity”, “Equity in access to health services”, “Strategies for universal health coverage” and “Vertical equity”; and two descriptors of the key item ‘homeless population’: “People living on the streets” and “Young people living on the streets”.

The descriptors were combined with Boolean addition (AND) and opposition (OR) operators to create reproducible search

syntaxes in Portuguese, Spanish and English. The following online search portals were selected as data sources, taking into account the vast number of publications indexed in these languages in their databases, as well as public recognition in the areas related to this study and territorial coverage: a) VHL Regional Portal, b) PubMed®, c) Scientific Electronic Library Online (SciELO) and d) Scopus®.

Between January and February 2022, exploratory searches were carried out on these portals through the operation of preliminary syntaxes in the advanced search form, intending to improve the selection of descriptors and the construction of definitive syntaxes, so that the results converge to answer the guiding question. The following search syntax was established in Portuguese: (“*Equidade*” OR “*Equidade em Saúde*” OR “*Equidade no Acesso aos Serviços de Saúde*” OR “*Estratégias para Cobertura Universal de Saúde*” OR “*Equidade vertical*”) AND (“*Pessoas em Situação de Rua*” OR “*Jovens em Situação de Rua*”); with the corresponding syntax in Spanish: (“*Equidad*” OR “*Equidad en Salud*” OR “*Equidad en el Acceso a los Servicios de Salud*” OR “*Estrategias para Cobertura Universal de Salud*” OR “*Equidad Vertical*”) AND (“*Personas sin Hogar*” OR “*Jóvenes sin Hogar*”); and in English: (“*Equity*” OR “*Health Equity*” OR “*Equity in Access to Health Services*” OR “*Strategies for Universal Health Coverage*” OR “*Vertical Equity*”) AND (“*Homeless Persons*” OR “*Homeless Youth*”).

The search was carried out on online search portals on March 7, 2022, using previously tested and defined syntaxes. 1,716 publications indexed in the databases were identified, 239 in the BVS, 149 in PubMed®, 22 in SciELO and 1,306 in Scopus®. Table 1 shows the number of publications resulting from searches carried out on portals with these syntaxes. Each search result was exported to a reference collection file and then imported into the Zotero® reference manager software to group the results and continue the review methodology.

Table 1. Number of publications resulting from searches carried out on the portals, distributed by language and search syntax

Language	Search syntax	Online search portal	Number of publications
Portuguese	("Equidade" OR "Equidade em Saúde" OR "Equidade no Acesso aos Serviços de Saúde" OR "Estratégias para Cobertura Universal de Saúde" OR "Equidade vertical") AND ("Pessoas em Situação de Rua" OR "Jovens em Situação de Rua")	BVS	80
		PubMed®	0
		SciELO	15
		Scopus®	15
Spanish	("Equidad" OR "Equidad en Salud" OR "Equidad en el Acceso a los Servicios de Salud" OR "Estrategias para Cobertura Universal de Salud" OR "Equidad Vertical") AND ("Personas sin Hogar" OR "Jóvenes sin Hogar")	BVS	73
		PubMed®	0
		SciELO	3
		Scopus®	7
English	("Equity" OR "Health Equity" OR "Equity in Access to Health Services" OR "Strategies for Universal Health Coverage" OR "Vertical Equity") AND ("Homeless Persons" OR "Homeless Youth")	BVS	86
		PubMed®	149
		SciELO	4
		Scopus®	1.284
Total			1.716

Source: Own elaboration.

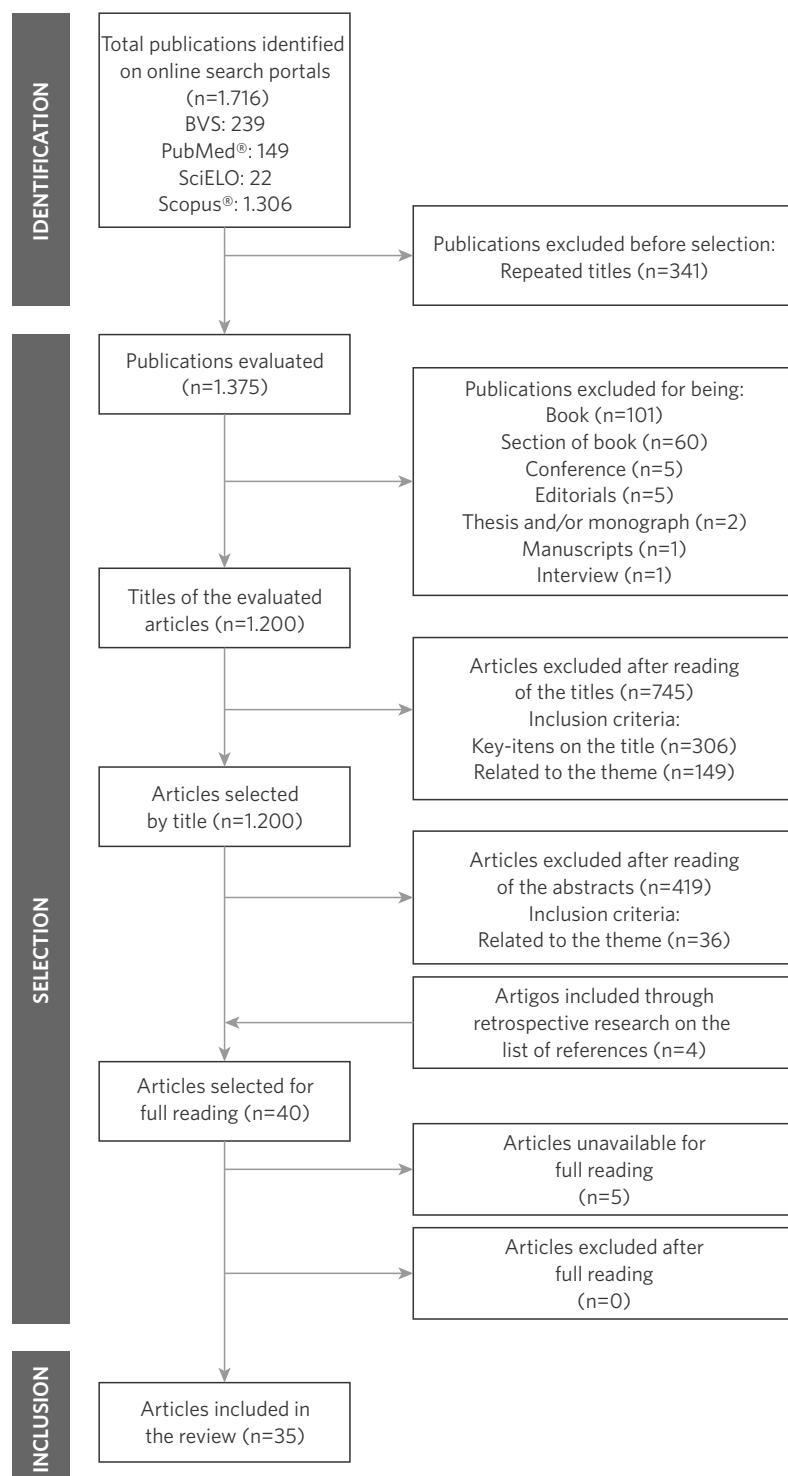
Process for including articles in the review

The second methodological moment of this study consisted of the identification, selection and inclusion of publications, according to the flowchart in *figure 1*. The publications resulting from searches on the portals were evaluated using the Zotero® software to exclude duplicate titles (n = 341) and publications that are not articles (n = 175).

Next, the titles of 1,200 articles were evaluated using the Rayyan online application, adopting as inclusion criteria the presence

of key items in the title (n = 306) and the relationship with the research topic (n = 149), 455 articles being selected for reading the abstracts. Finally, 36 articles were included after reading the abstracts due to the summary's relationship with the topic, and 4 were included through a retrospective search in the list of references, resulting in 40 articles to be read in full. 5 articles were unavailable or restricted for reading and were excluded from the research, as they would harm the reproducibility of the study. Among the 35 articles, all were included in the literature review.

Figure 1. Flowchart of the process of identification, selection and inclusion of articles in the review on health equity for the homeless population



Source: Own elaboration, based on PRISMA¹².

Data analysis

After fully reading the articles included in the review, a characterization and synthesis matrix (synthesis table) was created that includes the main characteristics of each text (authorship, year of publication, methodology and place of analysis) along with the conception of equity in health and its main application.

The elaboration of the summary table began the third methodological moment of this study, allowing the comparison of information based on data synthesized into categorical-nominal qualitative variables. The criticality criteria set out in the introduction were taken as a method of analysis and distinction between variables, proceeding, in parallel, to the discussion of the results obtained.

Results and discussion

The central regions of contemporary capitalism are the most prevalent locations of the articles analysis, with emphasis on North America, where 12 examine the homeless population in the United States of America (USA), and also 12 in Canada; in addition to Oceanian ($n = 6$) and European ($n = 11$) countries, mainly the United Kingdom ($n = 6$). Among the peripheral regions, Brazil is present in 9 articles, and there is only 1 article that covers the African continent, coming from Kenya.

The majority were published in the 2010s ($n = 19$), in addition to 15 articles dated from the 2020s and 1 from the 2000s. The most prevalent journal was the 'International Journal for Equity in Health' ($n = 5$). 26 articles were first published in English, 9 in Portuguese, and no articles in Spanish were included.

Box 1. Summary table of the literature review on health equity for the homeless population: synthesis matrix and characterization of the articles included in the review

N	Authorship	Publication year	Methodology	Analysis location	Concept of equity in health and its main application
1	Aguiar MM, Iriart JAB ¹³	2012	Qualitative study	Brazil	Liberal conception of health equity: equity in access to health services
2	Andrade R, Costa AAS, Sousa ET, <i>et al.</i> ¹⁴	2022	Integrative literature review	Brazil	Liberal conception of health equity: equity in access to health services
3	Baggio S, Jacquierioz F, Salamun J, <i>et al.</i> ¹⁵	2021	Transversal study	Switzerland	Liberal conception of health equity: equity in resource allocation
4	Baum F, Newman L, Biedrzycki K, <i>et al.</i> ¹⁶	2010	Qualitative study	Australia	Liberal conception of health equity: equity in resource allocation
5	Borysow IC, Furtado JP ¹⁷	2014	Case Study	Brazil	Liberal conception of health equity: equity in access to health services
6	Borysow IC, Conill EM, Furtado JP ¹⁸	2017	Comparative data analysis	Portugal, USA and Brazil	Liberal conception of health equity: equity in access to health services
7	Carneiro Júnior N, Jesus CH, Crevelim MA ¹⁹	2010	Experience report	Brazil	Liberal conception of health equity: equity in access to health services
8	Cernadas A, Fernández A ²⁰	2021	Qualitative study	Spain	Liberal conception of health equity: equity in access to health services
9	Clifford B, Wilson A, Harris P ²¹	2019	Systematic literature review	USA, Australia, Canada and France	Liberal conception of health equity: social determinants of health

Box 1. Summary table of the literature review on health equity for the homeless population: synthesis matrix and characterization of the articles included in the review

N	Authorship	Publication year	Methodology	Analysis location	Concept of equity in health and its main application
10	Cruz JR, Taquette SR ²²	2020	Qualitative study	Brazil	Liberal conception of health equity: equity-based interventions
11	Dunn JR, van der Meulen E, O'Campo P, et al. ²³	2013	Theory-based assessment	North America, Venezuela e New Zealand	Liberal conception of health equity: equity in resource allocation
12	Embleton L, Shah P, Gayapersad A, et al. ²⁴	2020	Qualitative study	Kenia	Liberal conception of health equity: social determinants of health
13	Farina M, Lavazza A ²⁵	2021	Cases study	USA and United Kingdom	Liberal conception of health equity: equity in resource allocation
14	Field H, Hudson B, Hewett N, et al. ²⁶	2019	Exploratory data analysis	United Kingdom	Liberal conception of health equity: equity in resource allocation
15	Gallaher C, Herrmann S, Hunter L, et al. ²⁷	2020	Project analysis	England	Liberal conception of health equity: equity in health care
16	Horvitz-Lennon M, Zhou D, Normand SLT, et al. ²⁸	2011	Exploratory data analysis	USA	Liberal conception of health equity: equity in health care
17	Kazevman G, Mercado M, Hulme J, et al. ²⁹	2021	Experience report	Canada	Liberal conception of health equity: eHealth strategies
18	Lazarus JV, Baker L, Cascio M, et al. ³⁰	2020	Collaborative project report	Europa	Liberal conception of health equity: equity in access to health services
19	MacKenzie M, Purkey E ³¹	2019	Qualitative study	Canada	Liberal conception of health equity: equity in health care
20	Magwood O, Hane-maayer A, Saad A, et al. ³²	2020	Project analysis	Canada	Liberal conception of health equity: equity in health care
21	McNeil R, Guirguis-Younger M, Dilley LB ³³	2012	Qualitative study	Canada	Liberal conception of health equity: equity in access to health services
22	Mercer T, Khurshid A ³⁴	2021	Project analysis	USA	Liberal conception of health equity: equity in access to health services
23	Moledina A, Magwood O, Agbata E, et al. ³⁵	2021	Systematic literature review	USA, Canada, United Kingdom, Netherlands and Australia	Liberal conception of health equity: equity in resource allocation
24	Orciari EA, Permanent Howe PR, Foxcroft DR ³⁶	2022	Systematic literature review	USA	Liberal conception of health equity: equity-based interventions
25	Paiva IKS, Lira CDG, Justino JMR et al. ³⁷	2016	Integrative literature review	Brazil	Liberal conception of health equity: equity in access to health services
26	Patterson ML, Markey MA, Somers JM ³⁸	2012	Qualitative study	Canada	Liberal conception of health equity: social determinants of health
27	Pinto AH, Fermo VC, Peiter CC, et al. ³⁹	2018	Experience report	Brazil	Liberal conception of health equity: social determinants of health
28	Purkey E, MacKenzie M ⁴⁰	2019	Qualitative study	Canada	Liberal conception of health equity: equity in health care
29	Robards F, Kang M, Steinbeck K, et al. ⁴¹	2019	Qualitative study	Australia	Liberal conception of health equity: equity in access to health services
30	Seaman A, King CA, Kaser T, et al. ⁴²	2021	Experimental study	USA	Liberal conception of health equity: equity in resource allocation

Box 1. Summary table of the literature review on health equity for the homeless population: synthesis matrix and characterization of the articles included in the review

N	Authorship	Publication year	Methodology	Analysis location	Concept of equity in health and its main application
31	Smithman MA, Descô-teaux S, Dionne E, et al. ⁴³	2020	Literature scoping review	USA, Canada, Australia, United Kingdom, New Zealand, Israel, Italy, Mexico e Deutschland	Liberal conception of health equity: equity in access to health services
32	Stajduhar KI, Mollison A, Giesbrecht M, et al. ⁴⁴	2019	Qualitative study	Canada	Liberal conception of health equity: equity in access to health services
33	Varanda W, Adorno RC ⁴⁵	2004	Qualitative study	Brazil	Liberal conception of health equity: equity in access to health services
34	Wang JZ, Mott S, Magwood O, et al. ⁴⁶	2019	Systematic literature review	USA, Canada, South Korea and Netherlands	Liberal conception of health equity: equity-based interventions
35	White BM, Newman SD ⁴⁷	2014	Systematic literature review	USA	Liberal conception of health equity: equity in access to health services

Source: Own elaboration.

The summary table on screen (*box 1*) reveals that all 35 articles included in this literature review are based on the liberal conception of health equity, and none on the critical conception.

The included articles presented six central applications of health equity for the homeless

population, guided by the liberal conception of this notion: social determinants of health, equity in resource allocation, equity in health care, equity in access to health services, eHealth strategies and equity-based interventions. The distribution of these applications in the articles is shown in *table 2*.

Table 2. Distribution of articles included in this review regarding the concept of health equity and the main application of this notion to the homeless population

Concept of health equity	Main application of health equity for the homeless population	Number of articles (n = 35)	Number of article(s) in Box 1
Liberal conception of health equity	Social determinants of health	4	9, 12, 26, 27
	Equity in resource allocation	7	3, 4, 11, 13, 14, 23, 30
	Equity in healthcare	5	15, 16, 19, 20, 28
	Equity in access to health services	15	1, 2, 5, 6, 7, 8, 18, 21, 22, 25, 29, 31, 32, 33, 35
	eHealth Strategies	1	17
	Equity-Based Interventions	3	10, 24, 34

Source: Own elaboration.

In light of the results obtained, the following topics were defined to guide the discussion: 1) methodological characteristics of the articles; 2) justice and equality in the conceptions of health equity; 3) applications of the liberal conception of health equity for the homeless population; 4) critical conception of health equity and the homeless population; 5) equity and the health-disease process of the homeless population; 6) equity and public policies aimed at the homeless population in Brazil; 7) health equity for the homeless population during the Coronavirus disease 2019 (COVID-19) pandemic.

Methodological characteristics of the articles

The majority of articles ($n = 31$) present the results of studies with a predominantly qualitative approach, using procedures such as unstructured and semi-structured interviews, focus groups, ethnography and document analysis. Of these articles, those that specifically carried out experience reports^{19,29,39}, project analysis^{27,32,34}, case studies^{17,25}, comparative data analysis¹⁸, collaborative project reports³⁰ and theory-based evaluation²³ stand out.

Eight literature reviews were included, these being systematic^{21,35,36,46,47}, integrative^{14,37} and scope⁴³. None of these reviews focused specifically on health equity for the homeless population.

In some articles, quantitative approaches combined with qualitative analyzes were used, such as exploratory data analysis studies^{26,28} and a cross-sectional analytical observational study¹⁵. Only one article resulted from research with an experimental design⁴².

It is worth noting that several articles analyze population groups in addition to the homeless population, despite this being present in all articles included in the review. Users of illicit substances, people with mental disorders^{13,14,17,19,23,28,35,38}, undocumented immigrants^{15,20,25,30}, aborigines or indigenous people^{16,35,38,40,41,43}, refugees or asylum

seekers^{25,31,41,43} and people in situations of sexual exploitation^{20,23,30} are also some of the groups highlighted, often intersecting with the homeless population.

Justice and equality in conceptions of health equity

The conceptual inaccuracies regarding health equity are highlighted by several authors^{3,4,48,49}. Campos⁴⁸ presents two opposing meanings of equity that are useful to distinguish what we call in this study conceptions of equity in health: the generic and predominant meaning in the area of health, for which equity is synonymous or correlated with the concepts of equality and justice and indicates certain rules for social organization, approaching the concept referred to here as the liberal conception of health equity; and the specific meaning, which correlates the notion of equity with other concepts and values historically apprehended to indicate "a situational judgment and intervention, that is, in accordance with the singularity of each case"⁴⁸⁽²⁶⁾, a convergent meaning to what is called in this study a critical conception of health equity.

In more depth, it is considered that each notion of health equity is linked to a constitutive idea of justice. For the liberal conception, the principle 'to each according to his merit' only applies in practice in association with the distributive principle 'to each the same thing', translating into the spheres of distribution and consumption of societies stratified through the following regulatory idea of justice: 'to each according to his position'⁵⁰⁽⁵¹⁾. Because they are based on the legal right to property, modern societies establish proportionality norms to apply this restricted idea of distributive justice, resulting in social policies that seek to direct spending to a defined population and achieve an egalitarian society. For the critical conception, the fundamental principle 'to each according to their needs' does not represent an idea of justice, as it presupposes real equality

as a starting point, going beyond justice and advocating for absolute freedom to be achieved in the construction of a self-determined and emancipated society, where ‘radical needs’ are met through the activity of freely associated individuals. The regulatory ideas of justice and the modern notion of justice itself are irrelevant to this societal project⁵⁰⁽¹⁵²⁾, as they are only required in societies in which social relations of production based on exploitation, divided into classes and structurally unequal and unfair, predominate.

The ideas of justice are articulated in the articles through a general discussion about this concept^{14,21,23,24,37-39,44} or in a way linked to health^{18,20,25,27,44}; as is the case with the use of its antonym, injustice^{22,24,36,38,44,45}. Arguments about equality follow the same path and arise alongside health^{20,25,31,38,41} or other approaches¹⁴. The problem of inequality generally manifests itself in the concept of ‘social inequality’^{16,17,22,24,32,35-37,39}, although some articles apply this notion in the area of health^{15,20,23,25,30}. The concepts of justice and equality, as well as their opposing concepts, do not always appear together in the debate on equity.

In recent decades, health systems have presented some operational proposals that seek to equalize the health conditions of poor populations, often presented as ‘health equity policies’. Broadly speaking, equitable health policies have been implemented based on the ‘principles for action’ formulated by Margaret Whitehead in the early 1990s, ideas that have had a major influence on interventions concerned with creating “equal opportunities for health and with bringing health differentials down to the lowest level possible”⁵¹⁽²²⁰⁾. These practical recommendations for health policies are derived from the economic thinking of John Rawls³ and, therefore, integrate the liberal conception of equity in health. Added to this conception is the concept of equity developed by the International Society for Equity in Health (ISEqH) and supported

by Macinko and Starfield⁵², which, despite helping to identify inequities that may be subject to intervention,

does not distinguish equity from equality by defining it as ‘absence of differences’. Also, by refusing to enter the debate on health justice, this position does not address controversial issues regarding access and supply of services, financing and forms of organization and control of health systems that constitute concrete political dilemmas. And, finally, by not explaining the meaning attributed to the concept of ‘equal needs’, it implies some conceptual and operational problems^{49(s218)}.

Applications of the liberal conception of health equity for the homeless population

The population groups that occupy the most vulnerable layers of the working class, including the homeless population, appear distinguished in the articles as marginalized, vulnerable, stigmatized, disadvantaged, needy, deprived, underprivileged, forgotten, invisible, discriminated against, rejected, among other denominations. Social exclusion emerges in most articles ($n = 18$) as an apparently self-explanatory theoretical-conceptual instrument on why, after all, these groups can be classified as such. Thus, these characterizations stand out from the exclusionary and discriminatory social processes that produced them. Social inclusion is indicated in several articles^{16,17,21,22,25,37,38} as an objective of the proposals made throughout the argument, even though they take into account the precariousness of these groups included in the world of work. In the meantime, the emerging approach of ‘inclusive health’ stands out, understood as “service, research and political agenda that aims to prevent and correct social and health inequalities among the most vulnerable and excluded populations”⁵³⁽²⁶⁶⁾ (our translation) and used by articles²⁵⁻²⁷ to evaluate the effectiveness of focused interventions.

Articles that apply equity to resource allocation vary in their approach to both how allocation should occur and what resources should be allocated. Aiming to favor the health conditions of the homeless population, there are more immediate proposals such as prioritizing this population in testing¹⁵ and vaccination²⁵ during the COVID-19 pandemic, as well as broader proposals that aim to improve the allocation of assistance resources in health^{26,42} and resources resulting from cost-effective³⁵, housing²³ and social inclusion¹⁶ policies. With regard to equity-based interventions, there are articles that evaluate the impact of interventions carried out⁴⁶ and also suggest intervening in meeting the demands of this population²² and changing behaviors regarding substance use³⁶.

Access to health services consists of the majority application of the notion of equity in the articles. In the case of Brazil, the principle of the Unified Health System (SUS) is mentioned to recommend the implementation of flexible health actions and services¹³, with better resources¹⁷ and new approaches³⁷, meeting the health needs^{14,18,19,45} of the population in a street situation. Articles that analyze other locations highlight the various obstacles in access to health services^{20,34,40,41,47} for this population, with emphasis on palliative care services^{31,33,44}, proposing overcoming these barriers through the construction of checklist³⁰ and typology of organizational innovation components⁴³. Equity in health care is investigated based on local and operational issues, such as hospital care^{26,27,40} and the effects of implementing guidelines³² and treatments²⁸, aiming for egalitarian³¹, fair and equitable²⁷ care for this population.

Critical conception of health equity and the homeless population

Only part of the articles touch on socioeconomic processes, either to contextualize a certain argument or to vaguely indicate its influence on health conditions. In four articles,

there is reference to capital^{13,37} and capitalism^{22,37,39}, however, none of them delve into the relationship between this mode of production and the health of the homeless population; furthermore, nowhere is the notion of equity critically articulated to the fundamental economic processes of current society.

Also, in four articles^{21,24,38,44} the structural dimension of health equity prevails, improving the debate on the dynamics between the health of the homeless population and the underlying economic problems, however, they all present important limitations. None of the articles uses historical materialism as an analysis paradigm, resorting to phenomenology to guide the discussion on the results found. It is no coincidence that the theory of Social Determinants of Health appears in all these articles as explanatory support for the health inequities that affect the homeless population. None of these articles indicate the capitalist mode of production as central in the contemporary streetification movement, secondaryizing the impact of social relations of production on the health-disease process of this population group. Thus, these articles were also categorized as forming part of the liberal conception of health equity, given the established criticality criteria.

Even though the critical conception of health equity is heterogeneous, presenting theoretical-conceptual and operational disputes, there is an indispensable premise in its argument: capitalism produces social inequalities – and, consequently, health inequities – in a structural and irremediable way. It is known that the systematic denial of the human right to housing is inseparable from the interests of the dominant classes, therefore, the current process of streetification and its effects on the health of the homeless population can only be fully understood through the analysis of the dominated mode of production by capital. Regarding the proposals of the liberal conception, which autonomizes health problems in relation to the structural dimension, it is worth highlighting that

[...] as long as the capitalist mode of production exists, it would be madness to try to resolve the issue of housing or any other social issue that affects the fate of workers in isolation. The solution lies rather in the abolition of the capitalist mode of production, in the appropriation of all means of life and work by the working class itself⁵⁴⁽¹⁰⁸⁾.

Equity and the health-disease process of the homeless population

The theory of Social Determinants of Health is present in 19 articles included in the review, either directly^{16,21,23,24,32,38,39,44}, referencing publications and definitions that support this theory; or indirectly^{19,20,29,30,34-37,40,41,47}, mobilizing these ideas in the discussion about the health of the homeless population. The components of social life are understood in an isolated and fragmented way in this theory, formed into factors or determinants that ‘influence’ risk factors and health problems in populations, intentionally distancing the health debate from the economic debate.

For the theory of social determination of the health-disease process, the sphere of production establishes inequalities that are impossible to be resolved only in the spheres of distribution and consumption⁴⁽¹⁴²⁾, the latter shaping the determinants of health into commodities. In other words, by considering social relations of production as essential for human beings to produce the social world in all its dimensions, this theory assumes an ontological position on health that encompasses all spheres of social life⁵⁵. Starting from the definition of health as the “maximum development of man’s potential, according to the degree of advancement achieved by society in a given historical period”⁵⁶⁽¹⁰³⁾, the dynamics between protective and destructive processes that affect individuals and communities is understood in a totalizing way and belonging to the material production of life, this determines the relationship between health and

disease. From this perspective, interventions aimed at the broader needs of population groups that exist in the worst living conditions under capitalism, such as the homeless population, only produce health to the extent that they contribute to altering the quality of insertion of these groups and individuals into the appropriation-objectification dialectic on social practice, which essentially concerns the sphere of production and goes beyond access to health goods and services, including in relation to health care practice.

Equity and public policies aimed at the homeless population in Brazil

The historical formation of Brazil was marked by inequalities and injustices, expressions of a society divided into antagonistic classes since its origin. The organization of health care in the country has made efforts since the beginning of the 20th century to deal with groups that inhabit urban public spaces, initially carried out through charitable and philanthropic actions⁵⁷. In contemporary Brazilian society, the reproduction of population groups devoid of regular conventional housing is linked to the “process of capital accumulation, in the context of the continuous production of a relative overpopulation, exceeding the absorption capacity of capitalism”⁵⁸⁽⁹⁷⁾. These heterogeneous groups make up the so-called homeless population, whose main survival strategy is informal work activities⁹.

SUS regulations indirectly incorporated the notion of equity in the formulation and implementation of public policies, endorsing a conceptual distinction that helps in decision-making: while vertical equity (inequality between unequals) is generally used in analyzes of economic resources, financing and budget management, horizontal equity (equality between equals) appears in regulations relating to access and use of health goods and services³. The latter has been guiding public health policies for the homeless population, correlated with the ideal of ‘social inclusion’ present in some articles^{17,18,37}.

Equity appears as one of the principles of the National Policy for the Homeless Population, established in 2009 to favor this population's access to social rights in Brazil, at the same time that it also contributed to reaffirming the denial of their access to the constitutional right to housing. This policy emerged in the midst of the financial crisis that originated in the real estate market in 2008, therefore, it converged with the interests of the Brazilian State in applying the recommendations expressed by the World Bank¹⁰ and accelerating the allocation of resources to meet some needs of the homeless population, adopting focused measures that postponed the resolution of this problem and did not disturb the interests of the ruling classes, especially in the real estate sector.

One of the objectives of the National Policy is "to ensure broad, simplified and safe access to services and programs that are part of public health policies"⁵⁹. It is noted that this social policy meant a reaction to inequity in access to health services by the homeless population, seeking to reaffirm equity as an ethical-doctrinal principle of the SUS. Currently, the main form of access and health care for this population occurs on-site through the Street Clinic teams, established in 2011⁶⁰ in support of this National Policy. Some articles correctly value the work carried out by these teams^{14,17,18,39}, however, they only touch on the obstacles inherent to the work process carried out by itinerant care teams¹⁸ for this population: ultimately, health is produced together with homeless population within the limits imposed by the interests of capital, helping to reinforce restrictions on their health needs.

The Street Clinic teams represent a materialization of the focused policies adopted by the Brazilian State to regulate, within the scope of public health, the process of streetification as a 'social issue'⁶¹. In a country where 7 million properties do not fulfill a social function and are capable of being occupied immediately⁶²⁽³⁷⁾, the decision was made to create and expand a health team assigned to the territory

that was designated for the most vulnerable layers of workers: the street. As the national maximum number of these teams follows the massive growth of the homeless population in the country, jumping from 92 teams in 2012 to 892 in 2021⁶³, timid housing policies continue to be relegated to the background, preventing access of this population to the right to housing and, consequently, the right to expand their health horizons.

Health equity for the homeless population during the COVID-19 pandemic

Two articles point to the allocation of resources as a way to achieve health equity for the homeless population in the context of the COVID-19 pandemic. One of them indicates that health disparities can be reduced through equity-based policies, such as the inclusion of marginalized population groups in access to diagnostic tests and essential public services¹⁵. Another article prioritizes the inclusion of these groups in the application of vaccines, with policies and interventions that develop a

more inclusive ethical framework for vaccine allocation, distribution, and inoculation that is capable of taking into account the interests and needs of these disadvantaged/disenfranchised groups²⁵⁽⁴⁻⁵⁾.

In both articles, the socioeconomic inequalities inherent to these groups are addressed, presenting propositions that aim to reduce them instead of solving them.

One of the articles reports on an eHealth strategy carried out among the homeless population, consisting of the free distribution of prepaid cell phones as a way of guaranteeing equity in digital health²⁹. It is curious that such a response to 'digital health inequality' appears as a priority for the health needs of this population during the global health crisis.

These articles highlight specific and emergency measures to deal with inequality in the

allocation of health goods and services that affects marginalized populations, using health equity to defend a focal distribution that favors these groups in the context of the pandemic. It can be stated that none of the practices disseminated in these articles seek to transform the social structures that determine economic and health inequalities, which originated long before COVID-19.

Limitations of this study

A limitation of this review concerns the establishment of criticality criteria to distinguish conceptions of health equity, which can be questioned in the light of other theoretical and strategic formulations. Regarding the methodology adopted, the intrinsic limitations in defining criteria for identifying, selecting and including articles in a literature review stand out, in addition to the option to exclude articles unavailable for reading.

Despite the efforts during the development of this review, the assessment of the risk of bias using the Risk Of Bias In Systematic Reviews (Robis)⁶⁴ instrument allows us to judge that there is a low concern regarding the domains 1) study eligibility criteria and 2) identification and selection of studies, in addition to a high concern about the domains 3) data collection and evaluation of studies and 4) synthesis and results. The evidence found in this study can be classified at level 4, and its recommendations are reasonable and suggestive⁶⁵.

Conclusions

The results obtained in this literature review allow us to conclude that the liberal conception of health equity is dominant in scientific articles on health equity for the homeless population, contributing to the dissemination of neoclassical economic thinking in the health area and striving to naturalize the process of streetification in capitalism. Furthermore, it masks focused interventions as practices

to promote health equity, dissociating them from social counter-reforms and secondaryizing the debate on access to housing and the determination of the health-disease process. Even though targeted public policies contribute to some extent to improving the current living conditions of the homeless population, they are structurally insufficient to meet the maximum needs of this population group, which, ultimately, correspond to the need of the working class to liberate and lead to the emancipation of humanity.

It points to the lack of scientific productions that critically articulate the notion of equity to the socioeconomic processes that determine the health of the homeless population. The critical conception of equity in health contributes to expanding debates on equitable policies and their relationship with the dynamics between health and illness, favoring the collective struggle of workers for the construction of an emancipated society that promotes the full development of human potential. In this sense, the collective organization of all groups and layers that make up the working class is defended with the aim of overcoming capitalism and building a social form in which the idea of justice is no longer necessary, as a society 'beyond of justice'⁵⁰. On the way to this desirable future, it is recommended the implementation of public policies that increase the health of popular sectors by guaranteeing, permanently and unrestrictedly, the right to land, work, food, housing and peace.

Collaborators

Valsechi DF (0000-0001-9975-5881)* contributed to conceptualization, data curation, formal analysis, investigation, methodology, visualization and writing of the article. Marques MCC (0000-0002-7461-3710)* contributed to conceptualization, investigation, methodology, project administration, supervision, validation and writing of the article. All authors approved this final draft of the article. ■

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References

1. Fee E, Gonzalez AR. The history of health equity: concept and vision. *Divers. Equal. Health Care.* 2017 [acesso em 2022 jun 30]; 14(3):148-52. Disponível em: <https://doi.org/10.21767/2049-5471.1000105>.
2. Brasil. Ministério da Saúde. Glossário temático: economia da saúde. 3. ed. Brasília, DF: Ministério da Saúde; 2018.
3. Fundação Oswaldo Cruz. Dicionário da Educação Profissional em Saúde. Escorrel S. Equidade em saúde. [Rio de Janeiro]: Fiocruz; 2009. [acesso em 2022 jun 30]. Disponível em: <http://www.sites.epsjv.fiocruz.br/dicionario/verbetes/equsau.html>.
4. Barata RB. Iniquidade e saúde: a determinação social do processo saúde-doença. *Rev. Usp.* 2001 [acesso em 2022 jun 30]; (51):138-45. Disponível em: <https://doi.org/10.11606/issn.2316-9036.v0i51p138-145>.
5. Gramsci A. Concepção dialética da história. 3. ed. Coutinho CN, tradutor. Rio de Janeiro: Civilização Brasileira; 1978.
6. Rawls J. Uma teoria da justiça. 2. ed. Pisetta A, Esteves LMR, tradutores. São Paulo: Martins Fontes; 2000.
7. Marx K. Crítica do programa de Gotha. Enderle R, tradutor. São Paulo: Boitempo; 2012.
8. Prates JC, Prates FC, Machado S. Populações em situação de rua: os processos de exclusão e inclusão precária vivenciados por esse segmento. *Temporalis.* 2011 [acesso em 2023 jul 13]; 11(22):191-216. Disponível em: <https://doi.org/10.22422/2238-1856.2011v11n22p191-216>.
9. Tiengo VM. Alterações nas expressões da questão social da população em situação de rua. *Lutas sociais.* 2018 [acesso em 2022 jul 7]; 22(41):361-72. Disponível em: <https://revistas.pucsp.br/index.php/ls/article/view/46690>.
10. Lima PRM, Davi J. Aproximações críticas ao conceito de equidade presente nos documentos da CE-PAL e do Banco Mundial. *Temporalis.* 2017 [acesso em 2022 jul 4]; 17(34):127-52. Disponível em: <https://doi.org/10.22422/2238-1856.2017v17n34p127-152>.
11. Dixon-Woods M, Cavers D, Agarwal S, et al. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Med. Res. Methodol.* 2006 [acesso em 2022 jul 1]; 6(1):35. Disponível em: <https://doi.org/10.1186/1471-2288-6-35>.
12. Welch V, Petticrew M, Tugwell P, et al. PRISMA-Equity 2012 Extension: reporting guidelines for systematic reviews with a focus on health equity. *PLoS Med.* 2012 [acesso em 2022 mar 11]; 9(10):e1001333. Disponível em: <https://doi.org/10.1371/journal.pmed.1001333>.
13. 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 [acesso em 2022 mar 12]; 28(1):115-24. Disponível em: <https://doi.org/10.1590/S0102-311X2012000100012>.
14. Andrade R, Costa AAS, Sousa ET, et al. O acesso aos serviços de saúde pela população em situação de rua: uma revisão integrativa. *Saúde debate.* 2022 [acesso em 2022 mar 12]; 46(132):227-39. Disponível em: <https://doi.org/10.1590/0103-1104202213216>.
15. Baggio S, Jacquierioz F, Salamun J, et al. Equity in access to COVID-19 testing for undocumented migrants and homeless persons during the initial phase of the pandemic. *J. Migr. Health.* 2021 [acesso em 2022 mar 12]; (4):100051. Disponível em: <https://doi.org/10.1016/j.jmh.2021.100051>.
16. Baum F, Newman L, Biedrzycki K, et al. Can a regional government's social inclusion initiative contribute to the quest for health equity? *Health Pro. Int.* 2010 [acesso em 2022 mar 12]; 25(4):474-82. Disponível em: <https://doi.org/10.1093/heapro/daq033>.
17. Borysow IC, Furtado JP. Acesso, equidade e coesão social: avaliação de estratégias intersetoriais

- para a população em situação de rua. Rev. Esc. Enferm. USP. 2014 [acesso em 2022 mar 12]; 48(6):1069-76. Disponível em: <https://doi.org/10.1590/S0080-623420140000700015>.
18. 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 [acesso em 2022 mar 12]; 22(3):879-90. Disponível em: <https://doi.org/10.1590/1413-81232017223.25822016>.
19. Carneiro Júnior 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 [acesso em 2022 mar 12]; 19(3):709-16. Disponível em: <https://doi.org/10.1590/S0104-12902010000300021>.
20. Cernadas A, Fernández A. Healthcare inequities and barriers to access for homeless individuals: a qualitative study in Barcelona (Spain). Int. J. Equity Health. 2021 [acesso em 2022 mar 12]; (20):84. Disponível em: <https://doi.org/10.1186/s12939-021-01409-2>
21. Clifford B, Wilson A, Harris P. Homelessness, health and the policy process: a literature review. Health Policy. 2019 [acesso em 2022 mar 12]; 123(11):1125-32. Disponível em: <https://doi.org/10.1016/j.healthpol.2019.08.011>.
22. Cruz JR, Taquette SR. Viver na rua: vulnerações e a bioética da proteção. Rev. Bioét. 2020 [acesso em 2022 mar 12]; 28(4):637-46. Disponível em: <https://doi.org/10.1590/1983-80422020284427>.
23. Dunn JR, van der Meulen E, O'Campo P, et al. Improving health equity through theory-informed evaluations: a look at housing first strategies, cross-sectoral health programs, and prostitution policy. Eval. Program Plan. 2013 [acesso em 2022 mar 12]; 36(1):184-90. Disponível em: <https://doi.org/10.1016/j.evalproplan.2012.03.006>.
24. Embleton L, Shah P, Gayapersad A, et al. Characterizing street-connected children and youths' social and health inequities in Kenya: a qualitative study. Int. J. Equity Health. 2020 [acesso em 2022 mar 12]; (19):147. Disponível em: <https://doi.org/10.1186/s12939-020-01255-8>.
25. Farina M, Lavazza A. Advocating for greater inclusion of marginalized and forgotten populations in COVID19 vaccine rollouts. Int. J. Public Health. 2021 [acesso em 2022 mar 12]; (66):1604036. Disponível em: <https://doi.org/10.3389/ijph.2021.1604036>.
26. Field H, Hudson B, Hewett N, et al. Secondary care usage and characteristics of hospital inpatients referred to a UK homeless health team: a retrospective service evaluation. BMC Health Serv. Res. 2019 [acesso em 2022 mar 12]; (19):857. Disponível em: <https://doi.org/10.1186/s12913-019-4620-1>.
27. Gallaher C, Herrmann S, Hunter L, et al. The St Thomas' Hospital Emergency Department Homeless Health Initiative: improving the quality, safety and equity of healthcare provided for homeless patients attending the ED. BMJ Open Quality. 2020 [acesso em 2022 mar 12]; (9):e000820. Disponível em: <https://doi.org/10.1136/bmjoq-2019-000820>.
28. Horvitz-Lennon M, Zhou D, Normand SLT, et al. Racial and ethnic service use disparities among homeless adults with severe mental illnesses receiving ACT. Psychiatr. Serv. 2011 [acesso em 2022 mar 12]; 62(6):598-604. Disponível em: https://doi.org/10.1176/ps.62.6.pss6206_0598.
29. Kazevman G, Mercado M, Hulme J, et al. Prescribing phones to address health equity needs in the COVID-19 era: the PHONE-CONNECT Program. J. Med. Internet Res. 2021 [acesso em 2022 mar 12]; 23(4):e23914. Disponível em: <https://doi.org/10.2196/23914>.
30. Lazarus JV, Baker L, Cascio M, et al. Novel health systems service design checklist to improve healthcare access for marginalised, underserved communities in Europe. BMJ Open. 2020 [acesso em 2022 mar 12]; 10(4):e035621. Disponível em: <https://doi.org/10.1136/bmjopen-2019-035621>.

31. MacKenzie M, Purkey E. Barriers to end-of-life services for persons experiencing homelessness as perceived by health and social service providers. *J. Am. Board Fam. Med.*. 2019 [acesso em 2022 mar 13]; 32(6):847-57. Disponível em: <https://doi.org/10.3122/jabfm.2019.06.190066>.
32. Magwood O, Hanemaayer A, Saad A, et al. Determinants of implementation of a Clinical Practice Guideline for Homeless Health. *Int. J. Environ. Res. Public Health*. 2020 [acesso em 2022 mar 13]; 17(21):7938. Disponível em: <https://doi.org/10.3390/ijerph17217938>.
33. McNeil R, Guirguis-Younger M, Dilley LB. Recommendations for improving the end-of-life care system for homeless populations: a qualitative study of the views of Canadian health and social services professionals. *BMC Palliat. Care*. 2012 [acesso em 2022 mar 13]; (11):14. Disponível em: <https://doi.org/10.1186/1472-684X-11-14>.
34. Mercer T, Khurshid A. Advancing health equity for people experiencing homelessness using blockchain technology for identity management: a research agenda. *J. Health Care Poor Underserved*. 2021 [acesso em 2022 mar 13]; 32(2):262-77. Disponível em: <https://doi.org/10.1353/hpu.2021.0062>.
35. Moledina A, Magwood O, Agbata E, et al. A comprehensive review of prioritised interventions to improve the health and wellbeing of persons with lived experience of homelessness. *Campbell Syst. Rev.* 2021 [acesso em 2022 mar 13]; 17(2):e1154. Disponível em: <https://doi.org/10.1002/cl2.1154>.
36. Orciari EA, Perman-Howe PR, Foxcroft DR. Motivational Interviewing-based interventions for reducing substance misuse and increasing treatment engagement, retention, and completion in the homeless populations of high-income countries: an equity-focused systematic review and narrative synthesis. *Int. J. Drug Policy*. 2022 [acesso em 2022 mar 13]; (100):103524. Disponível em: <https://doi.org/10.1016/j.drugpo.2021.103524>.
37. Paiva IKS, Lira CDG, Justino JMR, et al. Direito à saúde da população em situação de rua: reflexões sobre a problemática. *Ciênc. saúde coletiva*. 2016 [acesso em 2022 mar 13]; 21(8):2595-2606. Disponível em: <https://doi.org/10.1590/1413-81232015218.06892015>.
38. Patterson ML, Markey MA, Somers JM. Multiple paths to just ends: using narrative interviews and timelines to explore health equity and homelessness. *Int. J. Qual. Methods*. 2012 [acesso em 2022 mar 13]; 11(2):132-51. Disponível em: <https://doi.org/10.1177/160940691201100202>.
39. Pinto AH, Fermo VC, Peiter CC, et al. Determinantes sociais, equidade e Consultório na Rua. *Rev. Enferm. UFPE*. 2018 [acesso em 2022 mar 13]; 12(12):3513-20. Disponível em: <http://dx.doi.org/10.5205/1981-8963-v12i12a236025p3513-3520-2018>.
40. Purkey E, MacKenzie M. Experience of healthcare among the homeless and vulnerably housed a qualitative study: opportunities for equity-oriented health care. *Int. J. Equity Health*. 2019 [acesso em 2022 mar 13]; (18):101. Disponível em: <https://doi.org/10.1186/s12939-019-1004-4>.
41. Robards F, Kang M, Steinbeck K, et al. Health care equity and access for marginalised young people: a longitudinal qualitative study exploring health system navigation in Australia. *Int. J. Equity Health*. 2019 [acesso em 2022 mar 13]; (18):41. Disponível em: <https://doi.org/10.1186/s12939-019-0941-2>.
42. Seaman A, King CA, Kaser T, et al. A hepatitis C elimination model in healthcare for the homeless organization: a novel reflexive laboratory algorithm and equity assessment. *Int. J. Drug Policy*. 2021 [acesso em 2022 mar 13]; (96):103359. Disponível em: <https://doi.org/10.1016/j.drugpo.2021.103359>.
43. Smithman MA, Descôteaux S, Dionne E, et al. Typology of organizational innovation components: building blocks to improve access to primary healthcare for vulnerable populations. *Int. J. Equity Health*. 2020 [acesso em 2022 mar 13]; (19):174. Disponível em: <https://doi.org/10.1186/s12939-020-01263-8>.

44. Stajduhar KI, Mollison A, Giesbrecht M, et al. "Just too busy living in the moment and surviving": barriers to accessing health care for structurally vulnerable populations at end-of-life. *BMC Palliat. Care.* 2019 [acesso em 2022 mar 13]; 18(11). Disponível em: <https://doi.org/10.1186/s12904-019-0396-7>.
45. Varanda W, Adorno RC. Descartáveis urbanos: discutindo a complexidade da população de rua e o desafio para políticas de saúde. *Saúde Soc.* 2004 [acesso em 2022 mar 13]; 13(1):56-69. Disponível em: <https://doi.org/10.1590/S0104-12902004000100007>.
46. Wang JZ, Mott S, Magwood O, et al. The impact of interventions for youth experiencing homelessness on housing, mental health, substance use, and family cohesion: a systematic review. *BMC Publ. Health.* 2019 [acesso em 2022 mar 13]; 19:e1528. Disponível em: <https://doi.org/10.1186/s12889-019-7856-0>.
47. White BM, Newman SD. Access to primary care services among the homeless: a synthesis of the literature using the Equity of Access to Medical Care Framework. *J. Prim. Care Community Health.* 2014 [acesso em 2022 mar 13]; 6(2):77-87. Disponível em: <https://doi.org/10.1177/2150131914556122>.
48. Campos GWS. Reflexões temáticas sobre equidade e saúde: o caso do SUS. *Saúde Soc.* 2006 [acesso em 2022 jul 14]; 15(2):23-33. Disponível em: <https://doi.org/10.1590/S0104-12902006000200004>.
49. Vieira-da-Silva LM, Almeida Filho N. Equidade em saúde: uma análise crítica de conceitos. *Cad. Saúde Pública.* 2009 [acesso em 2022 jun 10]; 25(supl2):s217-s26. Disponível em: <https://doi.org/10.1590/S0102-311X2009001400004>.
50. Heller A. Além da justiça. Hartmann S, tradutor. Rio de Janeiro: Civilização Brasileira; 1998.
51. Whitehead M. The concepts and principles of equity and health. *Health Promot. Int.* 1991 [acesso em 2022 jul 9]; 6(3):217-28. Disponível em: <https://doi.org/10.1093/heapro/6.3.217>.
52. Macinko JA, Starfield B. Annotated bibliography on equity in health, 1980-2001. *Int. J. Equity Health.* 2002 [acesso em 2022 mar 13]; (1):1. Disponível em: <https://doi.org/10.1186/1475-9276-1-1>.
53. Luchenski S, Maguire N, Aldridge RW, et al. What works in inclusion health: overview of effective interventions for marginalised and excluded populations. *The Lancet.* 2017 [acesso em 16 jul 2022]; 391(10117):266-80. Disponível em: [https://doi.org/10.1016/S0140-6736\(17\)31959-1](https://doi.org/10.1016/S0140-6736(17)31959-1).
54. Engels F. Sobre a questão da moradia. Schneider N, tradutor. São Paulo: Boitempo; 2015.
55. Souza DO. O caráter ontológico da determinação social da saúde. *Serv. Soc. Soc.* 2020 [acesso em 2022 jul 10]; (137):174-91. Disponível em: <https://doi.org/10.1590/0101-6628.207>.
56. García JC. A categoria trabalho na medicina. In: Nunes ED, organizador. Juan César García: pensamento social em saúde na América Latina. São Paulo: Cortez; 1989.
57. Sanglard G, Ferreira LO. Caridade & filantropia: elites, estado e assistência à saúde no Brasil. In: Teixeira LA, Pimenta TS, Hochman G, organizadores. História da saúde no Brasil. São Paulo: Hucitec; 2018.
58. Silva MLL. Trabalho e população em situação de rua no Brasil. São Paulo: Cortez; 2009.
59. Brasil. Decreto nº 7.053, de 23 de dezembro de 2009. Institui a Política Nacional para a População em Situação de Rua e seu Comitê Intersetorial de Acompanhamento e Monitoramento, e dá outras provisões. Brasília, DF: Diário Oficial da União. 24 Dez 2009. [acesso em 2021 dez 2]. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2007-2010/2009/decreto/d7053.htm.
60. Brasil. Ministério da Saúde. Portaria nº 122, de 25 de janeiro de 2011. Define as diretrizes de organização e funcionamento das Equipes de Consultório na Rua. Brasília, DF: Diário Oficial da União. 26

- Jan 2011. [acesso em 2021 dez 2]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt0122_25_01_2012.html.
61. Carvalho LFM, Rocha SM. A população em situação de rua enquanto uma expressão da questão social: avanços legais x desafios reais. Praia Vermelha. 2015 [acesso em 2022 jul 9]; 25(2):441-60. Disponível em: <https://revistas.ufrj.br/index.php/praiavermelha/article/view/10163>.
62. Fundação João Pinheiro. Déficit habitacional no Brasil 2015. Belo Horizonte: FJP; 2018. 78 p. [acesso em 2022 jul 7]. Disponível em: <http://www.bibliotecadigital.mg.gov.br/consulta/consultaDetalheDocumento.php?iCodDocumento=76871>.
63. Brasil. Ministério da Saúde. Portaria nº 1255, de 18 de junho de 2021. Dispõe sobre as diretrizes de organização e funcionamento das equipes de Consultório na Rua e os critérios de cálculo do número máximo de equipes de Consultório na Rua, por município e Distrito Federal, por meio da alteração da Portaria de Consolidação GM/MS nº 2, de 28 de setembro de 2017. Diário Oficial da União. 18 Jun 2021. [acesso em 2022 jul 16]. Disponível em: <https://www.in.gov.br/web/dou/-/portaria-n-1.255-de-18-de-junho-de-2021-326852389>.
64. Whiting P, Savović J, Higgins JPT, et al. ROBIS: a new tool to assess risk of bias in systematic reviews was developed. *J. Clin. Epidemiol.* 2016 [acesso em 2022 jul 16]; (69):225-34. Disponível em: <https://doi.org/10.1016/j.jclinepi.2015.06.005>.
65. Stetler CB, Morsi D, Rucki S, et al. Utilization-focused integrative reviews in a nursing service. *Appl. Nurs. Res.* 1998 [acesso em 2022 jul 9]; 11(4):195-206. Disponível em: [https://doi.org/10.1016/s0897-1897\(98\)80329-7](https://doi.org/10.1016/s0897-1897(98)80329-7).

Received on 01/21/2023

Approved on 08/15/202

Conflict of interests: non-existent

Financial support: non-existent