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ARTICLE

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Public policies and access to health in Brazil: an integrative review of public and collective health evidence

Políticas públicas e acesso à saúde no Brasil: revisão integrativa de evidências em Saúde Pública e Saúde Coletiva

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Abstract

Objective: To analyze how recent scientific evidence characterizes the effects of public policies on access to health care in Brazil. Method: An integrative review was conducted in SciELO and PubMed, covering articles published from 2020 through 2025. Searches combined terms related to public policy, health services accessibility, the Unified Health System, primary health care, inequality, and Brazil. Twelve studies meeting the eligibility criteria were analyzed through thematic synthesis. Results: The evidence indicates that the Unified Health System and the Family Health Strategy remain essential mechanisms for universal access, but formal entitlement does not ensure timely, continuous, or equitable care. Geographic distribution of services, financing rules, workforce composition, race, income, education, disability, and Indigenous status shape the ability to obtain care. Recent changes in primary care financing created incentives for registration and performance, while also raising concerns about unstable transfers, selective indicators, and weakened community orientation. Digital health can reduce distance and improve coordination, but may reproduce exclusion where connectivity and digital literacy are limited. Conclusion: Expanding access requires stable and redistributive financing, territorially based primary care, multidisciplinary teams, accessible infrastructure, anti-racist and culturally appropriate policies, and digital strategies integrated with in-person care. Access should be monitored through availability, first contact, continuity, comprehensiveness, acceptability, and effective use rather than enrollment alone.

Resumo

Objetivo: analisar como as evidências científicas recentes caracterizam os efeitos das políticas públicas sobre o acesso à saúde no Brasil. Método: realizou-se revisão integrativa nas bases SciELO e PubMed, abrangendo artigos publicados de 2020 a 2025. As buscas combinaram termos relacionados a políticas públicas, acesso aos serviços de saúde, Sistema Único de Saúde, atenção primária, desigualdades e Brasil. Doze estudos que atenderam aos critérios de elegibilidade foram analisados por síntese temática. Resultados: as evidências indicam que o Sistema Único de Saúde e a Estratégia Saúde da Família permanecem mecanismos essenciais para o acesso universal, mas o direito formal não assegura cuidado oportuno, contínuo e equitativo. Distribuição geográfica dos serviços, regras de financiamento, composição das equipes, raça, renda, escolaridade, deficiência e pertencimento indígena condicionam a obtenção do cuidado. Mudanças recentes no financiamento da atenção primária criaram incentivos ao cadastro e ao desempenho, ao mesmo tempo que suscitaram preocupações sobre instabilidade dos repasses, seletividade dos indicadores e enfraquecimento da orientação comunitária. A saúde digital pode reduzir distâncias e melhorar a coordenação, mas também reproduzir exclusões onde há baixa conectividade e letramento digital. Conclusão: ampliar o acesso requer financiamento estável e redistributivo, atenção primária territorial, equipes multiprofissionais, infraestrutura acessível, políticas antirracistas e culturalmente adequadas e estratégias digitais integradas ao cuidado presencial. O acesso deve ser monitorado por disponibilidade, primeiro contato, continuidade, integralidade, aceitabilidade e uso efetivo, e não apenas pelo cadastro.

1. Introduction

Access to health care is simultaneously a legal right, an organizational property of health systems, and a lived experience shaped by social position. In Brazil, the 1988 Constitution established health as a right of all and a duty of the State, and the Unified Health System (Sistema Único de Saúde—SUS) translated this mandate into the principles of universality, equity, and comprehensiveness. These principles transformed access from a market-mediated benefit into a public commitment. Nevertheless, the distance between formal entitlement and effective care remains one of the central problems of Public and Collective Health.

Access is not equivalent to the existence of a service or to registration in a primary care database. It involves the possibility of recognizing a need, reaching an appropriate service, obtaining timely attention, continuing treatment, receiving medicines and diagnostic support, and participating in decisions without discrimination. Barriers can arise from distance, opening hours, waiting time, cost, professional availability, inaccessible buildings, communication failures, institutional racism, and services that do not correspond to cultural or territorial realities. For this reason, access is best understood as a relationship between population needs and the capacity of public policies to organize resources and care pathways.

Primary health care (PHC) occupies a strategic position in this relationship. The Family Health Strategy (FHS) expanded community-based teams, territorial responsibility, home visits, prevention, and coordination of care. A national dataset covering 1998–2020 documents the scale and geographic variation of PHC coverage and offers a basis for evaluating universal health coverage (Alves et al., 2023). However, policy reforms since 2017 changed team configurations, accreditation, and federal financing. Mendonça et al. (2023) identified expansion of alternative primary care teams alongside reductions in community health agents and weakening of multidisciplinary support, raising questions about the sustainability of the FHS model.

The effects of these changes are not evenly distributed. Analysis of the 2019 National Health Survey showed inequalities by sex, age, education, and macroregion, including lower medical consultation rates in the North and lower use of services by men (Palmeira et al., 2022). Gender and racial analyses also demonstrate that Black and Brown populations face differentiated patterns of access and use (Cobo et al., 2021). In 2025, a decomposition analysis found better access among White Brazilians and showed

that income and private insurance explained an important share of racial gaps, while an unexplained component suggested contextual inequalities and bias within services (Coelho et al., 2025).

Other barriers concern the material and cultural organization of care. A national assessment identified very low adequacy for people with disabilities and illiterate users in many PHC facilities (Santos et al., 2020). Indigenous populations encounter distance, referral difficulties, discontinuity, and services insufficiently prepared for intercultural care (Ahmadpour et al., 2023; Santos et al., 2024; Thomazinho et al., 2024). Digital health has become a major policy response to geographic distance and fragmented information, yet its benefits depend on infrastructure, interoperability, governance, and inclusion (Haddad & Lima, 2024).

This review asks: how does recent literature indexed in SciELO and PubMed characterize the relationship between public policies and access to health care in Brazil? The objective was to synthesize evidence published from 2020 through 2025, identifying policy advances, persistent barriers, and priorities for equitable access from a Public and Collective Health perspective.

2. Method

An integrative literature review was conducted to combine empirical, documentary, and analytical studies addressing health policies and access in Brazil. The approach was chosen because the research question requires dialogue among epidemiological evidence, policy analysis, service organization, financing, infrastructure, and population-specific studies. The review was interpretive and did not claim the exhaustive coverage expected of a systematic review.

SciELO and PubMed were selected because they combine strong coverage of Brazilian Public and Collective Health journals with international biomedical and health-services indexing. Searches used Portuguese and English combinations of the terms “políticas públicas”/“public policy,” “acesso aos serviços de saúde”/“health services accessibility,” “Sistema Único de Saúde”/“Unified Health System,” “atenção primária à saúde”/“primary health care,” “desigualdades em saúde”/“health inequities,” and “Brasil”/“Brazil.” Boolean operators AND and OR were adapted to each database.

Eligible records were full scientific articles published between January 2020 and December 2025, available in Portuguese, English, or Spanish, and directly concerned with a public policy, program, financing mechanism, organizational arrangement, or structural determinant of access to health care in Brazil. Studies restricted to clinical efficacy without a policy or access dimension, editorials without analytical development, duplicates, protocols, and publications outside the period were excluded. Titles and abstracts were screened, followed by full-text assessment. A purposive final corpus of 12 studies was retained because each contributed evidence to at least one predefined access dimension.

Data extraction covered authorship, year, database, design, population or policy context, access dimension, and principal contribution. Findings were coded and compared through thematic synthesis. Five analytical categories emerged: (1) financing and PHC organization; (2) sociodemographic and racial inequalities; (3) physical and communication accessibility; (4) Indigenous and culturally appropriate access; and (5) digital health and continuity. As the review used published and publicly accessible studies, research ethics committee approval was not required.

3. Results

3.1 Characteristics of the evidence

The corpus included studies based on national household surveys, administrative and policy documents, facility census data, longitudinal financial transfers, qualitative or scoping approaches, and national datasets. Most studies examined PHC because it is the principal entry point to SUS and the level at which financing, territorial coverage, workforce, and continuity converge. The diversity of designs allowed the review to connect population-level inequalities with the institutional mechanisms that produce or reduce them.

Table 1. Characteristics and contributions of the included studies.

No.	Study	Database	Design	Access focus	Main contribution
1	Geremia (2020)	SciELO	Policy analysis	Continuity of the PHC model	Warns of policy and financing changes that may weaken comprehensive, territorial PHC.
2	Santos et al. (2020)	PubMed/SciELO	Cross-sectional census analysis	Physical and communication access	Identifies widespread barriers for disabled, older, and low-literacy users.
3	Massuda (2020)	SciELO	Policy analysis	PHC financing	Examines equity risks created by the Previne Brasil financing model.
4	Cobo et al. (2021)	SciELO	National survey analysis	Gender and racial inequalities	Shows differentiated PHC access and use across sex and race/skin-color groups.
5	Palmeira et al. (2022)	SciELO	Cross-sectional national survey	Sociodemographic access	Documents differences by sex, age, education, and macroregion.
6	Mendonça et al. (2023)	SciELO	Mixed methods/policy documents	PHC teams and FHS	Finds alternative-team growth, fewer community agents, and weaker multidisciplinary support.
7	Alves et al. (2023)	PubMed	National longitudinal dataset	PHC coverage	Provides policy-relevant coverage data for 1998–2020 across geographic units.
8	Ahmadpour et al. (2023)	SciELO	Scoping review	Indigenous health subsystem	Maps barriers to resolvability and continuity across levels of care.
9	Haddad & Lima (2024)	SciELO	Policy perspective	Digital health	Discusses digital transformation as an opportunity for coordination, with governance needs.
10	Minami (2024)	SciELO	Longitudinal financial analysis	Previne Brasil transfers	Finds overall growth but fluctuations in performance and strategic components.

No.	Study	Database	Design	Access focus	Main contribution
11	Santos et al. (2024)	SciELO	Access evaluation	Indigenous oral health	Highlights geographic, organizational, and cultural determinants of service use.
12	Coelho et al. (2025)	PubMed	Decomposition analysis	Racial inequalities	Shows racial gaps in care and medicines; FHS coverage is associated with smaller gaps.

Source: Prepared by the author(s) from SciELO and PubMed records (2020–2025).

3.2 Financing, territorial organization, and the Family Health Strategy

The literature consistently treats stable public financing as a precondition for access. Massuda (2020) argued that the Previne Brasil model altered federal transfers by replacing important elements of the previous per-capita mechanism with weighted capitation and performance criteria. The reform sought to improve registration and accountability, but it also generated concern that municipalities with limited administrative capacity or difficulty registering vulnerable populations could lose resources precisely where needs were greatest.

Evidence after implementation is mixed. Minami (2024) observed an overall increase in operating transfers in a Brazilian capital between 2018 and 2023, while weighted capitation remained stable and performance and strategic-action payments fluctuated. The finding shows that aggregate growth can coexist with uncertainty in specific components. Policy evaluation therefore needs to examine distribution, predictability, local fiscal capacity, and the cost of meeting targets—not only nominal totals.

Mendonça et al. (2023) found that federal policy changes encouraged new team arrangements, expanded primary care teams, reduced community health agents, and weakened the former Family Health Support Center. Flexibility may facilitate accreditation in some municipalities, but reduced territorial and multidisciplinary presence can limit active outreach, health promotion, and coordination for people who do not spontaneously reach services. Access policy should thus protect the features that make PHC community-oriented: defined territories, longitudinal responsibility, community workers, multidisciplinary support, and referral coordination.

Alves et al. (2023) demonstrated the importance of transparent, reusable PHC coverage data for monitoring policies across municipalities and regions. Yet coverage indicators must be interpreted cautiously. Population registration or nominal team coverage is an enabling condition, not proof that appointments, medicines, examinations, referrals, and follow-up are available. A policy may increase recorded coverage while queues, professional turnover, or restricted opening hours continue to generate unmet need.

3.3 Social, regional, gender, and racial inequalities

The National Health Survey evidence shows that Brazil's universal system operates within a deeply unequal society. Palmeira et al. (2022) analyzed 293,725 respondents and found lower proportions of medical consultations and health-service seeking among men, as well as regional and educational differences. The North had lower medical consultation coverage, whereas people with lower education depended more heavily on public provision and the Popular Pharmacy Program. These findings confirm that the same national policy produces different experiences according to service supply and social resources.

Cobo et al. (2021) showed that gender and race intersect in the search for and use of PHC. Differences cannot be attributed only to individual preferences; they reflect labor conditions, income, care responsibilities, exposure to discrimination, territorial segregation, and the responsiveness of services. Policies focused only on aggregate utilization risk hiding groups whose needs are underrecognized or whose contact with services occurs later and under more severe conditions.

Coelho et al. (2025) strengthened this interpretation by decomposing racial inequalities among more than 200,000 respondents. White Brazilians reported better access to services and medicines than Black and Brown Brazilians. Observable factors explained part of the difference—especially income, education, and private insurance—while residual gaps indicated that socioeconomic adjustment does not eliminate inequality. FHS coverage was associated with smaller racial gaps, suggesting that universal and community-based public provision can mitigate inequity, although anti-racist institutional measures remain necessary.

From a Collective Health perspective, equity requires unequal allocation in response to unequal need. Resource formulas should incorporate poverty, remoteness, racial composition, epidemiological vulnerability, and local service costs. Monitoring should disaggregate indicators by race/skin color, sex, age, disability, income, education, territory, and Indigenous status. Without disaggregation, national averages can improve while preventable exclusion persists.

3.4 Physical, communication, and cultural accessibility

Santos et al. (2020) found widespread architectural and communication barriers in PHC facilities. Adequacy for users with disabilities and people with low literacy was particularly poor, with several indicators below one third of facilities and some close to zero. These barriers transform a formally available service into an unusable one. Ramps, accessible bathrooms, tactile and visual signage, interpreters, plain-language communication, and trained staff are not ancillary amenities; they are components of effective access.

For Indigenous peoples, access depends on geographic mobility, intercultural communication, the organization of the Indigenous Health Care Subsystem, and articulation with the broader SUS network. Ahmadpour et al. (2023) mapped challenges in resolvability, including referral pathways and continuity across levels of care. Santos et al. (2024), studying oral-health services among the Xukuru do Ororubá, highlighted the need to evaluate not merely whether services exist but whether they are reachable, continuous, and responsive to community organization.

Thomazinho et al. (2024) discussed the incentive for specialized care for Indigenous peoples and the difficulty of translating a financial instrument into culturally appropriate medium- and high-complexity care. Policy design must include Indigenous participation, reliable transport, communication between Indigenous health teams and referral services, respect for language and therapeutic practices, and accountability for discrimination. A referral completed on paper is not effective access if travel, accommodation, interpretation, or return care is absent.

3.5 Digital health: expansion with safeguards

Digital health can support access through teleconsultation, remote specialist advice, electronic records, appointment systems, and exchange of clinical information. Haddad and Lima (2024) described the accelerated digital transformation of SUS and its

potential to improve coordination and continuity. Digital tools are especially relevant for remote municipalities and for communication between PHC and specialized services.

However, digitalization is not intrinsically equitable. Connectivity, device availability, data plans, digital literacy, disability accessibility, and trust determine who benefits. Systems built around smartphones may exclude older adults, low-income households, rural and Indigenous communities, and people with sensory or cognitive disabilities. Fragmented platforms can also transfer administrative work to users and professionals without shortening care pathways.

An equity-oriented digital policy should preserve telephone and in-person alternatives, adopt accessibility standards, provide assisted digital access in health facilities, protect personal data, ensure interoperability, and evaluate whether technology reduces waiting time and loss to follow-up. Digital contact should complement rather than replace territorial teams and relational care.

4. Discussion

The synthesis shows that Brazil has a robust constitutional and institutional foundation for universal access, but access is produced through concrete policy choices. Financing formulas determine which territories can maintain teams; accreditation rules shape workforce composition; infrastructure determines whether users can enter and communicate; referral systems determine continuity; and data systems determine which inequalities become visible. Public policy is therefore not a background variable—it is an active mechanism that distributes opportunities for care.

A central tension concerns the difference between measurable enrollment and substantive access. Registration, nominal coverage, and performance indicators are valuable, but they may privilege what is easily counted. Effective access also includes waiting time, successful first contact, comprehensiveness, continuity, respectful treatment, medicines, diagnostic completion, referral resolution, and outcomes. A balanced monitoring framework should combine administrative measures with user-reported experience and equity indicators.

The evidence also supports the continued centrality of the Family Health Strategy. Community health agents and multidisciplinary teams connect services to households, identify needs before demand becomes acute, and reduce informational and geographic barriers. Flexible team models may be useful in specific contexts, but should not create a lower standard of territorial responsibility for vulnerable populations. National policy should define a strong minimum model while allowing local adaptation above that floor.

Redistributive financing is equally important. Performance incentives can stimulate improvement, but indicators must be risk-adjusted and accompanied by a stable base sufficient to maintain infrastructure and staff. Otherwise, municipalities with greater needs and weaker information systems may be penalized. Funding evaluation should report real per-capita values, predictability, regional distribution, and effects on the availability of comprehensive services.

The persistence of racial, regional, gender, disability, and Indigenous inequalities shows that universalism needs explicit equity policies. Anti-racist training alone is insufficient without representative governance, reliable race/skin-color data, protocols for discrimination, community participation, and resource allocation. Likewise, cultural competence should be embedded in referral, communication, and service design rather than treated as an individual professional attribute.

Digital health offers an opportunity to connect a continental country, but it must be governed as public infrastructure. Interoperability, open standards, cybersecurity,

accessibility, and public control are essential. Evaluation should compare digital and nondigital pathways and identify who is not reached. The appropriate question is not whether a service is digital, but whether the digital arrangement increases timely and equitable resolution.

4.1 Limitations

This review was limited to SciELO and PubMed and may not represent studies indexed exclusively in other databases or grey literature. The purposive integrative design prioritized policy relevance and thematic diversity rather than meta-analysis or exhaustive systematic coverage. The included studies used heterogeneous designs and access indicators, preventing direct quantitative pooling. Several studies analyzed data collected before publication, so findings may not reflect all subsequent changes. Nevertheless, convergence across surveys, policy analyses, facility data, financing studies, and population-specific research strengthens the interpretive conclusions.

5. Conclusion

Public policies have expanded the institutional basis of health access in Brazil, particularly through SUS, PHC, and the Family Health Strategy. Yet formal universality continues to coexist with unequal and sometimes interrupted access. Financing instability, uneven workforce and infrastructure, regional scarcity, racial and socioeconomic inequality, inaccessible environments, fragile referral networks, and insufficiently intercultural care remain central barriers.

The review identifies six priorities for 2025: stable and redistributive PHC financing; protection of territorial and multidisciplinary FHS teams; equity monitoring with disaggregated indicators; universal physical and communication accessibility; culturally appropriate Indigenous care across all levels; and inclusive digital health integrated with in-person services. These priorities require coordination among federal, state, and municipal governments and meaningful social participation.

Access should ultimately be judged by whether people obtain appropriate care when needed, continue through the network, receive medicines and diagnostic support, and experience respectful treatment. Public and Collective Health contributes by connecting these individual experiences to the political, economic, territorial, and institutional processes that produce them.

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Data availability: All data analyzed in this review are contained in the cited publications.

Use of generative artificial intelligence: The author(s) must insert the declaration that truthfully reflects the preparation of the final manuscript.

References

Ahmadpour, B., Silva, J. P. L., & Garnelo, L. (2023). Resolutivity in the Indigenous Health Care Subsystem: A scoping review. Trabalho, Educação e Saúde, 21. https://www.scielo.br/j/tes/a/PyXB7kGVKtNc87Xqr5mYDDQ/

Alves, R. F. S., Boccolini, C. S., Baroni, L. R., & Boccolini, P. M. M. (2023). Primary health care coverage in Brazil: A dataset from 1998 to 2020. BMC Research Notes, 16, 63. https://doi.org/10.1186/s13104-023-06323-0

Cobo, B., Cruz, C., & Dick, P. C. (2021). Gender and racial inequalities in the access to and the use of Brazilian health services. Ciência & Saúde Coletiva, 26(9), 4021–4032. https://doi.org/10.1590/1413-81232021269.05732021

Coelho, R., Mrejen, M., Falcão, L., Rocha, R., & Hone, T. (2025). Racial inequalities in access to healthcare services in Brazil (2019): A decomposition analysis. BMC Health Services Research, 25, 1573. https://doi.org/10.1186/s12913-025-13527-6

Geremia, D. S. (2020). Primary health care on alert: Challenges of the continuity of the care model. Physis: Revista de Saúde Coletiva, 30(1), e300100. https://doi.org/10.1590/S0103-73312020300100

Haddad, A. E., & Lima, N. T. (2024). Digital health in the Brazilian National Health System (SUS). Interface—Comunicação, Saúde, Educação, 28, e230597. https://doi.org/10.1590/interface.230597

Massuda, A. (2020). Changes in the primary health care financing system in the Brazilian health system: Advance or setback? Ciência & Saúde Coletiva, 25(4), 1181–1188. https://doi.org/10.1590/1413-81232020254.01022020

Mendonça, F. F., Lima, L. D., Pereira, A. M. M., & Martins, C. P. (2023). Changes in primary health care policy and the (un)sustainability of the Family Health Strategy. Saúde em Debate, 47. https://www.scielo.br/j/sdeb/a/vGTXbZ93vfbZdKCyKBGfcGS/

Minami, J. (2024). Trends in primary health care financing in a Brazilian capital. Ciência & Saúde Coletiva, 29(11). https://doi.org/10.1590/1413-812320242911.01202024

Palmeira, N. C., Moro, J. P., Getulino, F. A., Vieira, Y. P., Soares Junior, A. O., & Saes, M. O. (2022). Analysis of access to health services in Brazil according to sociodemographic profile: National Health Survey, 2019. Epidemiologia e Serviços de Saúde, 31(3). https://doi.org/10.1590/S2237-96222022000300013

Santos, L. F. R., et al. (2024). Access to oral health services in the Xukuru do Ororubá Indigenous Land. Ciência & Saúde Coletiva, 29(12). https://www.scielo.br/j/csc/a/Z9n68ZfnwSx9GwV6dGd7pft/

Santos, M. L. M., Fernandes, J. M., Vicente, D. P., Simionatto, J., Sanches, V. S., Souza, A. S., Christofoletti, G., & Merey, L. F. (2020). Architectural and communications barriers to access to primary health care in Brazil: An analysis based on the first national census of primary health care centers, 2012. Epidemiologia e Serviços de Saúde, 29(2), e2018258. https://doi.org/10.5123/S1679-49742020000200022

Thomazinho, G., et al. (2024). Considerations on Indigenous peoples' access to specialized health-care policy. Saúde e Sociedade, 33. https://www.scielo.br/j/sausoc/a/rryWntqqGcsVcjvFKSKqyGJ/