Revista ARACÊ
ISSN: 2358-2472

HEALTH POLICIES AND INEQUALITY – SOCIAL DETERMINANTS AND BARRIERS IN ACCESS TO SERVICES OF THE UNIFIED HEALTH SYSTEM (SUS)

https://doi.org/10.56238/arev7n4-082

Submitted on: 08/03/2025 **Publication date:** 08/04/2025

Antonio Nacílio Sousa dos Santos[1], Carlos Lopatiuk[2], Titiano Magalhães Dantas[3], Alan Judson Zaidan de Sousa[4], Andréia Ferreira de Souza[5], Paulo Honorato de Souza[6], Lindemberg da Silva Maia[7], Marcela Deyse Castro Lima[8], Aparecida Heliane Cavalcante Oliveira[9], Natália de Paula Bessa Alencar[10],

---

[1] PhD student in Social Sciences
Federal University of Espírito Santo (UFES)
Horizonte, Ceará – Brazil.
E-mail: naciliosantos@gmail.com
[2] PhD in Social Sciences
State University of Ponta Grosa (UEPG)
Curitiba, Paraná – Brazil.
E-mail: carloslopatiuk@yahoo.com.br
[3] Master in Family Health/RENASF
Regional University of Cariri (URCA)
Crato, Ceará – Brazil.
E-mail: ticiano.mdantas@upe.br
[4] Graduating in Medicine
Pythagoras Health Sciences Faculty
Codó, Maranhão – Brazil.
E-mail: alanjudson_zaidan@outlook.com
[5] Specialist and Public Health
Estácio de Sá University (UNESA)
Parnamirim, Rio Grande do Norte – Brazil.
E-mail: andreia_renier@hotmail.com
[6] Master in Social Work and Regional Development (PPGSSDR)
Fluminense Federal University (UFF)
Niterói, Rio de Janeiro – Brazil.
E-mail: honoratopaulo.as@gmail.com
[7] Master's student in Family Health
University of International Integration of Afro-Brazilian Lusophony (Unilab)
Russas, Ceará – Brazil.
Email: lindembergmaiapsy@gmail.com
[8] Master's student in Family Health
University of International Integration of Afro-Brazilian Lusophony (Unilab)
Redenção, Ceará – Brazil.
Email; marcelalimapsic@gmail.com
[9] Master's student in Family Health
University of International Integration of Afro-Brazilian Lusophony (Unilab)
Boa Viagem, Ceará – Brazil.
Email: helianecavalcante347@gmail.com
[10] Master's student in Family Health
University of International Integration of Afro-Brazilian Lusophony (Unilab)
Itapipoca, Ceará – Brazil.
E-mail: nataliapbalencar@hotmail.com

Revista ARACÊ
ISSN: 2358-2472

Victoria Caroline da Silva[11], Cláudio Luiz da Costa Rebello[12], Ana Lara Silva de Oliveira[13], Ericina Cimare de Oliveira Lima Martins[14], Brenda dos Reis Nascimento[15], Cynthya Taynara Bezerra Gomes[16].

ABSTRACT

This article proposes a critical reflection on public health policies in Brazil, considering, above all, the social determinants and inequalities that hinder the population's effective access to the services of the Unified Health System (SUS). Although the SUS represents a civilizational milestone in guaranteeing the right to health as a duty of the State and a right of all, in practice, this access has been marked by profound asymmetries. This is because, in addition to economic conditions, factors such as race/color, territory, gender, and education continue to structure invisible but concrete barriers in the path of the most vulnerable population. In this context, we ask: How do the social determinants of health – notably socioeconomic, racial, territorial, gender and educational inequalities – operate as structural barriers to the Brazilian population's equal access to the public services offered by the Unified Health System (SUS)? For this, the works of McKeown (1980), Starfield (2002), Arouca (2003), Funasa (2004), Paim (2006; 2008; 2009), Merhy (2007), Farmer (2003), Scheper-Hughes (1993), Fassin (2012), Adams (2016), Giovanella (2012), Anderson (2023), Machado, Lima and Baptista (2017), Vilaça Mendes (2011), Freeman (2018), Wilkinson and Marmot (2003), Padula, Anderson and Rodrigues (2022), among others, and official documents from national and international organizations on the object of research. This scientific enterprise is configured as qualitative (Minayo, 2007), descriptive and bibliographic (Gil, 2008) and with analysis from a comprehensive perspective (Weber, 1949). The analysis revealed that access to health care in Brazil remains deeply unequal, even under the normative framework of the SUS. Factors such as institutional racism, poverty, geographic location and low education constitute structural and symbolic barriers to care. Public policies, although they advance in regulations, face operational challenges,

---

[11] Specialist in Endodontics
Catholic University Center of Quixadá (Unicatólica)
Fortaleza, Ceará – Brazil.
E-mail: vicctoriacsilva@outlook.com

[12] Master's student in Rehabilitation Sciences
Augusto Motta University Center (UNISUAM)
Campinho, Rio de Janeiro – Brazil.
E-mail: clrebelloiz@gmail.com

[13] Undergraduate student in Psychology
Luciano Feijão College (FLF)
Itarema, Ceará – Brazil.
E-mail: lara-oliveira10@hotmail.com

[14] Master in Maternal and Child Health
Fluminense Federal University (UFF)
Rio de Janeiro, Rio de Janeiro – Brazil.
E-mail: ericinacimare@id.uff.br

[15] Undergraduate student in Dentistry
Faculty of Sciences of Tocantins (FACIT)
Araguaína, Tocantins – Brazil.
Email: Brendareiss2015@gmail.com

[16] Microbiology Specialist
CEUMA University
Imperatriz, Maranhão – Brazil.
E-mail: gomestaynara739@gmail.com

such as underfunding and fragmentation of care. The biomedical and homogeneous model still predominates, making subjectivities and diverse social contexts invisible. Therefore, the urgency of intersectoral actions and a management committed to real equity is evident.

Keywords: Social determinants. Health inequalities. Unified Health System. Institutional racism.

INTRODUCTION

RIGHT TO HEALTH, INEQUALITIES AND DETERMINANTS: STRESSING THE UNIVERSALITY OF THE SUS IN CONTEMPORARY BRAZIL

Health, in Brazil, has been recognized as a social and universal right since the promulgation of the Federal Constitution of 1988, which in its article 196 establishes: "[...] health is everyone's right and the duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other health problems and universal and equal access" (Giovanella, 2012, p. 214). This legal framework consolidated the ideals of the Health Reform[17] and gave rise to the Unified Health System (SUS), which became the main institutional expression of social security in the field of health. As Paim (2006, p. 37) reaffirms, "[...] this political and social achievement can be attributed to various struggles and efforts undertaken by the Health Reform movement between 1976 and 1988".

> Originally an idea and an idea of a group of intellectuals, the proposal was developed in the democratic transition, bringing together entities representing managers, health professionals and social movements that, articulated in the National Plenary of Health Entities, managed to influence the constituent process and enshrine in the Brazilian Constitution of 1988 (CF/88) the text approved at the 8th National Health Conference that guarantees that 'health is a right of all and a duty of the State'. In other words, health became part of the social rights of citizenship (Paim, 2008, p. 155).

The SUS represents a universal and equitable public policy that aims to ensure comprehensive health care for the Brazilian population. Not only does it organize the provision of services, but it also seeks to promote social justice in the health field. However, as Machado et. al. (2017, p. S144), "[...] the expansion of public services occurred concomitantly with the strengthening of private segments, configuring dynamic health

---

[17] The Brazilian Health Reform was one of the most significant milestones in the struggle for social justice and equity in the country, representing a historic inflection in the conception and management of public health. Far from being just a technical-administrative process, the Reform was, above all, a social and political movement, driven by intellectuals, health professionals, workers and users of the system, who aimed at a structural change in the bases of health care. As Paim (2008) points out, the Reform "[...] did not propose only to improve the current system, but to radically transform it, breaking with the authoritarian, exclusionary and welfare model" (Paim, 2008, p. 33). Its apex occurred with the promulgation of the Federal Constitution of 1988, which enshrined the right to health as a duty of the State and instituted the Unified Health System (SUS), based on the principles of universality, integrality and equity. The Reform, therefore, not only reconfigured the care model, but also redefined the role of the State in guaranteeing health as a right of citizenship. See: PAIM, Jairnilson Silva. *Brazilian Health Reform: contribution to understanding and criticism*. Salvador: EDUFBA; Rio de Janeiro: Fiocruz, 2008.

markets". And, as the report of the National Commission on Social Determinants of Health reinforces[18]: "[...] the health sector can already make an important contribution if it manages to manage the factors that are within its control" (2011, p. 27).

Despite the advances, historical social inequalities continue to have repercussions on the health of the Brazilian population. In other words, the formal universality of the SUS still coexists with structural barriers that perpetuate inequities. According to Starfield (2002, p. 34): "[...] socially less privileged groups have a higher risk of getting sick and dying than socially more privileged groups". And as Paim (2008, p. 143) points out: "[...] the low number of signatures of the popular health amendment [...] indicates the narrow basis of political and social support for the Brazilian Health Reform".

> Not only are the poor more likely to suffer and die early, but they are also systematically deprived of access to advances in modern medicine. Their illnesses are at best treated with indifference; at worst, they are considered the result of their own imprudence. This double standard, which quietly governs the delivery of health care around the world, ensures that millions perish needlessly[19] (Farmer, 2003, p. 50).

In view of this, the present research is justified by the urgency of understanding how the social determinants of health (SDH) influence access to and quality of services offered by the SUS. Investigating these variables is essential to unveil the mechanisms that produce exclusion and selectivity in the system. According to the World Health Organization, "[...] inequalities [...] are politically, economically and socially unacceptable – as well as unjust and, to a large extent, avoidable" (Who, 2011, p. 1). And, as stated in the Final Report of the 8th National Health Conference[20]: "[...] the necessary changes to the

---

[18] The final report of the National Commission on Social Determinants of Health (CNDSS) represented a fundamental milestone in the consolidation of the understanding that health is strongly conditioned by social, economic, cultural and environmental factors. The document highlights that health inequities are not natural, but historically constructed and, therefore, can be addressed through intersectoral, participatory public policies committed to social justice. As the report emphasizes, "[...] health is a public good that must be built with the solidarity participation of all sectors of Brazilian society" (Brasil, 2008, p. 7). The CNDSS proposes a new paradigm for health care, centered on acting on social determinants as an essential path to promote equity and strengthen the Unified Health System (SUS). See: BRAZIL. Ministry of Health. *The social causes of health inequities in Brazil: final report of the National Commission on Social Determinants of Health – CNDSS*. Brasília: Ministry of Health, 2008.

[19] Our translation.

[20] The Final Report of the 8th National Health Conference, held in 1986, represented a watershed in the formulation of the guidelines that would underpin the Unified Health System (SUS). The conference was historic in that it brought together health workers, managers, users and researchers in a democratic process of collective construction of public policies in the sector. In the final document, it was stated that "[...] health must be conceived as resulting from the conditions of food, housing, education, income, environment, work, transportation, employment, leisure, freedom, access to and possession of land and access to health services" (Brasil, 1986, p. 3). The 8th Conference consolidated the understanding of health as a universal right and duty

health sector transcend the limits of an administrative and financial reform" (Paim, 2008, p. 155).

The discussion about equity in the SUS has not only social relevance, but also scientific and political importance, especially because it involves the struggle for the right to full citizenship. Therefore, to understand how inequality in the health system is structured is also to understand how exclusions operate in the Brazilian social fabric. According to Giovanella (2012, p. 308), "[...] equity in access to and use of health services depends fundamentally on health systems organized in order to reduce barriers". And as the article "The Brazilian health system: history, advances and challenges" warns, "[...] the implementation of a universal health system in Brazil began in an unfavorable political and economic context" (Machado et. al., 2017, p. 144).

> The SUS proposal is linked to a central idea: all people have the right to health. This right is linked to the condition of citizenship. It does not depend on the 'merit' of paying social security (meritocratic social insurance), nor on proving poverty (assistance from the protection system), nor on purchasing power (capitalist market), much less on charity (philanthropy). Based on the concept of social security, the SUS supposes a solidary and democratic society, driven by values of equality and equity, without discrimination or privileges (Paim, 2021, p. 50).

Thus, the questions that structure the problematization of this article arise: if the SUS is universal, why are there still barriers to access to health services? How do factors such as race, class, gender, and territory interfere with the right to health? As the CMDSS report points out, "[...] it is necessary to define specific interventions, based on the analysis of how barriers to access can be reduced" (2011, p. 28). And, as evidenced by Giovanella, Oliveira and Carvalho (2012, p. 244), "[...] The distance from the hospital does not constitute an access barrier for people who can assume the financial costs of travel".

To understand the barriers that persist even in a universal system such as the SUS, it is essential to recognize the complexity of the social determinants of health. These factors go beyond the biomedical sphere and are linked to income, education, race, housing, sanitation, territory, work, and political power. According to Wilkinson and Marmot (2003, p. 10), "[...] social factors play a determining role in the health and well-being of populations, as much as genetic or behavioral factors". In addition, according to Barbara

---

of the State, establishing the principles of universality, comprehensiveness, equity and social participation as pillars of the new system. See: BRAZIL. Ministry of Health. *8th National Health Conference: final report*. Brasília: Ministry of Health, 1986.

Starfield (2002, p. 27), "[...] primary care will only be able to generate equitable results when it is articulated with broad social policies that focus on SDH".

In this context, race and social class continue to be central markers of inequality. Whether due to the structural heritage of racism[21] or the historical organization of public policies, black and peripheral populations have less access to quality services. As Farmer (2003, p. 8) reinforces: "[...] human rights violations occur more frequently where people are already deprived of other basic rights." And according to Scheper-Hughes (1993, p. 276), "[...] vulnerability to disease and death, in poor communities, is more than biological: it is political". For Paul Farmer (2003, p. 45):

> The idea of 'race', which most anthropologists and demographers consider to be a biologically insignificant term, carries enormous social weight. Racial classifications have been used to deprive many groups of basic rights and thus occupy an important place in reflections on human inequality and suffering. [...] In South Africa, one of the most glaring examples of the long-term effects of racism, epidemiologists report that the infant mortality rate among blacks can be up to ten times higher than among whites. [...] Poverty remains the leading cause of the prevalence of many diseases, as well as widespread hunger and malnutrition among black South Africans[22].

Therefore, the analysis of the social determinants of health needs to be articulated with a debate on social justice and redistribution. Because, sometimes inequality is reproduced in policies, sometimes it is contested by them. According to Fassin (2012, p. 54), "[...] social suffering has become the starting point for a humanitarian morality that operates selectively." And as Merhy (2007, p. 97) points out, "[...] the logic of live work in action in health care requires attentive listening to the ways of life that produce suffering".

Based on these elements, the general objective of this article is to analyze how the social determinants of health contribute to the reproduction of inequalities in access to and quality of services provided by the SUS. The proposal is based on the recognition that

---

[21] The structural heritage of racism in Brazil manifests itself as a historical process rooted in institutions, norms, and social practices that systematically relegate the black population to positions of vulnerability and exclusion. This racialized logic of social organization crosses the fields of health, education, housing, and work, profoundly impacting access to fundamental rights. As Cida Bento points out, "[...] whiteness has been constituted as a place of historical privilege, sustained by a tacit pact that naturalizes inequalities and makes the concrete effects of racism invisible" (Bento, 2022, p. 27). Thus, racism is not restricted to individual attitudes, but is configured as a structuring axis of social inequalities, perpetuating hierarchies of value between black and white lives in the Brazilian social fabric. See: BENTO, Maria Aparecida Silva. *The pact of whiteness*. 2. ed. São Paulo: Companhia das Letras, 2022.

[22] Our translation. This quote reinforces how race and social class, although historical and social constructions, produce material effects on the body and life of vulnerable populations not only in Brazil, but in various parts of the world.

health is crossed by multiple dimensions of social life. As McKeown (1980, p. 35) points out, "[...] most of the improvement in health conditions in the nineteenth and twentieth centuries was due to changes in social and environmental conditions, rather than to medical advances." And Paim (2009, p. 91) reaffirms: "[...] Confronting inequalities requires transformations that go beyond the biomedical and commercial model[23]".

> The hegemonic model of health care is centered on disease and specialized medical knowledge, reducing care to technical prescription and the production of procedures. [...] This way of producing health reinforces inequalities, as it neglects the social, cultural and subjective aspects of human suffering. Change requires rethinking the clinic as a space for listening, bonding and accountability, which values the uniqueness of the subjects and their life contexts (Merhy, 2007, p. 89).

That said, the specific objectives consist of: (1) identifying the main socioeconomic and territorial barriers that hinder universal access; (2) discuss public policies implemented with a focus on equity; and (3) point out structural challenges and possibilities for transformation. As Anderson (2023, p. 12) points out, "[...] Family and Community Medicine can contribute to person-centered care, but it needs to be inserted in an equitable system". And, as Vilaça Mendes (2011, p. 246) emphasizes, "[...] Health care networks will only be successful if they overcome fragmentation and recognize the complexity of the territories".

Thus, this research also seeks to contribute to the field of Collective Health, as a political and scientific project committed to the transformation of the population's living conditions. Therefore, resuming the critical foundations of the Health Reform is essential. As Padula Anderson and Rodrigues (2022, p. 7) state, "[...] the Flexner Reform[24]

---

[23] The biomedical and commercial model of health care has been shown to be limited in the face of the social, cultural, and subjective complexities that cross the health-disease process. Centered on disease and technicist specialization, this model reduces care to standardized procedures, disregarding social determinants and the integrality of the subjects' needs. In addition, its link with the mercantile logic promotes the privatization of services and the medicalization of daily life, transforming suffering into a commodity and the user into a consumer. As Merhy warns, "[...] the dominant biomedical model expropriates the knowledge of the subjects and is organized under the logic of industrial production, in which living care is suffocated by norms and protocols" (Merhy, 2007, p. 115). Such a configuration compromises the right to health as a public good and challenges the consolidation of emancipatory practices within the scope of the SUS. See: MERHY, Emerson Elias. *In search of lost time: the micropolitics of living work in health*. São Paulo: Hucitec, 2007.

[24] The Flexner Reform, implemented at the beginning of the twentieth century, consolidated a biomedical model of medical education based on scientific rationality, specialization, and the centrality of disease as an object of intervention. Inspired by Abraham Flexner's report, published in 1910 in the United States, the reform promoted profound changes in the curricula of medical schools, prioritizing laboratories, teaching hospitals, and natural science disciplines. However, this reform also contributed to the distance between health professionals and the social and cultural realities of patients, consolidating a technocratic, hospital-centric and fragmented education. As stated by Garcia et. al., "[...] the Flexner Report enshrined a medical model centered on biology, disregarding social determinants and the relational dimension of care" (Garcia et. al., 2019, p. 42). This legacy still impacts contemporary health systems, especially in countries marked by deep inequalities such as Brazil. See:

crystallized a technocratic medical education, centered on disease, and still in force in many health systems". And, as the Declaration of Alma-Ata[25] (1978, p. 2) reinforces, "[...] the existing inequality in the state of health of peoples [...] is the object of common concern of all countries".

CRITICAL QUALITATIVE METHODOLOGY: DOCUMENTARY AND BIBLIOGRAPHIC ANALYSIS ON SOCIAL DETERMINANTS AND INEQUALITIES IN THE SUS

The research was developed from a qualitative approach of a critical-reflective nature, as proposed by Minayo (2007), who considers that "[...] qualitative research works with the universe of meanings, motivations, aspirations, beliefs, values and attitudes" (Minayo, 2007, p. 21). In this sense, we opted for a methodology that does not seek statistical generalizations, but rather an in-depth understanding of social processes that structure inequalities in health. Also according to the author, "[...] it is not just about capturing what is being said, but about interpreting meanings, contradictions and contexts" (2007, p. 30).

> The qualitative study is interpretative. It focuses on the meanings of human relations from different points of view. Researchers are comfortable with multiple meanings. They respect intuition. Observers in the field remain receptive to recognizing unexpected developments. This type of study recognizes that the findings and reports are the result of interactions between the researcher and the subjects (Stake, 2011, p. 25).

Thus, the investigation is characterized as a documentary and bibliographic research, developed based on academic sources, legislation and institutional reports in the field of public health. According to Gil (2008), "[...] bibliographic research is developed based on material already prepared, consisting mainly of books and scientific articles" (p. 50). In the same way, documentary research is based on the analysis of official and

---

GARCIA, Lígia; LUZ, Roseni; NASCIMENTO, Rosana. *Medical education and collective health: rethinking education from the SUS.* São Paulo: Hucitec, 2019.

[25] The Declaration of Alma-Ata, adopted in 1978 during the International Conference on Primary Health Care, held in Kazakhstan (then part of the USSR), represented a historic milestone by affirming health as a fundamental human right and primary care as an essential strategy to achieve it. The document emphasized that "[...] health, which is a state of complete physical, mental and social well-being, and not just the absence of disease, is a fundamental human right, and the attainment of the highest attainable standard of health is an extremely important social goal" (WHO, 1978, p. 1). The Declaration also established the need for intersectoral actions, community participation, and equity as pillars for building fair and sustainable health systems, directly influencing the principles of the Unified Health System (SUS) in Brazil. See: WORLD HEALTH ORGANIZATION (WHO). *Declaration of Alma-Ata: International Conference on Primary Health Care*. Alma-Ata, USSR, September 6-12, 1978. Geneva: WHO, 1978.

normative records, and "[...] written documents, although not produced for the purpose of research, can reveal valuable elements of social reality" (Gil, 2008, p. 147).

> For the purposes of scientific research, documents are considered not only the writings used to clarify a certain thing, but any object that can contribute to the investigation of a certain fact or phenomenon. [...] But many studies use episodic and private records, consisting mainly of personal documents and visual images produced by the mass media. And research that makes use of the so-called found data, which is made up not only of material objects, but also of physical traces produced by erosion or accumulation in the environment can also be identified (Gil, 2008, p. 148).

That said, the analytical corpus of the research was built from the reading of classic and contemporary works, such as McKeown's "The Role of Medicine", Paul Farmer's "Pathologies of Power", and Scheper-Hughes' "Death Without Weeping", as well as official documents such as the PNPS, the Declaration of Alma-Ata, and the CNDSS reports. According to Stake (2011), "[...] qualitative research is anchored in contextual descriptions that allow us to see how things work in a given reality" (p. 25). Flick (2009) adds that "[...] the documents and texts reveal the dominant and marginalized discourses of a society" (p. 134).

The criteria for selecting the sources prioritized their scientific, political, and historical relevance to the field of public health. Authors and documents that discuss social inequalities, social determinants of health, structural racism, social participation and criticism of the biomedical model were especially chosen. For Minayo (2007), "[...] the choice of sources must be guided by the problem and the objectives of the research" (p. 51). According to Gil (2008), "[...] the relevance of the selected material lies in its ability to answer the questions asked" (p. 73).

That said, the analytical procedures adopted were guided by content analysis, which seeks to unveil the social and political meanings hidden in the discourses and norms. According to Minayo, "[...] content analysis aims to interpret empirical material through the decomposition and recomposition of meaningful categories" (2007, p. 77). And Flick (2009) states that "[...] critical hermeneutics combines empathetic understanding and ideological analysis of texts" (p. 112).

The categorization of the sources was structured in five thematic axes: (1) social determinants and inequities; (2) institutional racism and cultural barriers; (3) underfunding and unequal access to the SUS; (4) social participation and democratic radicalism; and (5) public policies and intersectoral perspectives. For Stake (2011), "[...] the categories are constructions of the researcher that organize the complexity of reality" (p. 38). And Minayo reinforces that "[...] the categories must emerge from repeated readings and dialogue with the theoretical framework" (2007, p. 90).

Based on the categories identified, the relationships between public health policies, social determinants and inequalities in access to the SUS were interpreted, especially with regard to vulnerable populations. According to Minayo (2007), "[...] qualitative research allows us to make explicit the connections between the structure and the lived experience" (p. 34). And Stake adds that "[...] understanding how programs work for different groups is central to interpretive research" (2011, p. 23).

The focus fell on black, indigenous, peripheral, riverside populations, women, users of the countryside and the forest, evidencing how social segmentation is articulated with institutional mechanisms of exclusion. For Flick (2009), "[...] marginalized groups reveal the fissures and contradictions of universalist policies" (p. 143). And Minayo observes that "[...] it is necessary to make visible the subjects whose voices have been historically silenced" (2007, p. 62).

> Participant research, according to Fals Borda (1983, p. 43), is research '[...] that responds especially to the needs of populations that comprise workers, peasants, farmers and Indians — the most needy classes in contemporary social structures — taking into account their aspirations and potentialities to know and act. It is the methodology that seeks to encourage autonomous (self-confident) development from the grassroots and relative independence from the outside' (Gil, 2008, p. 31).

The methodology allowed for a critical discussion of the structural and symbolic barriers that limit the effectiveness of the principles of the SUS – universality, equity and integrality. According to Stake (2011), "[...] public policies must be analyzed based on their concrete effects on populations, and not only on their intentions" (p. 31). And Minayo emphasizes that "[...] the principles of the SUS are only fully realized when confronted with the social reality in which they operate" (2007, p. 49).

Despite its analytical depth, the research has methodological limitations inherent to the exclusive use of secondary data. This is because, as Gil (2008) points out, "[...] bibliographic research does not allow for empirical generalizations, but rather reasoned interpretations" (p. 74). Minayo adds that "[...] the knowledge produced does not intend to be universalizing, but rather contextual, situated and critical" (2007, p. 84).

However, the empirical limits are compensated by a broad capacity for theoretical problematization and articulation with broader social processes. According to Flick (2009), "[...] the interpretative depth of qualitative research lies in its ability to describe and explain complex social contexts" (p. 118). And for Minayo, "[...] social criticism is one of the central objectives of qualitative research in collective health" (2007, p. 56).

Thus, it is reaffirmed that the present investigation aimed to contribute to the critical debate on the social production of health inequalities and the challenges faced by the SUS. According to Stake (2011), "[...] research is also an ethical and political act that aims at social transformation" (p. 26). And Minayo concludes that "[...] Critically knowing reality is the first step to transform it" (2007, p. 11).

SOCIAL DETERMINANTS AND BARRIERS TO ACCESS TO SERVICES OF THE UNIFIED HEALTH SYSTEM (SUS)

The conception of health as a socially determined phenomenon has been widely recognized by international organizations such as the World Health Organization (WHO). According to the WHO, "[...] inequalities within and between countries are politically, economically, and socially unacceptable – as well as unjust and, to a large extent, avoidable" (Giovanella, 2012, p. 214). And, as the National Commission on Social Determinants of Health points out, "[...] health is a public good that must be built with the solidarity participation of all sectors of Brazilian society" (Brasil, 2008, p. 7).

In this sense, the model of Dahlgren and Whitehead (1991) has become one of the most widespread references to explain SDH. Such a model highlights multiple layers of determination, from genetic and behavioral factors to socioeconomic, cultural, and environmental contexts. According to this model, "[...] behaviors and lifestyles depend not only on people's free will, but also on determinants such as access to information, peer pressure, and social infrastructure" (Mendes, 2011, p. 248). As the CNDSS also explains, "[...] SDH are arranged in different layers, according to their level of coverage, from individual determinants to macro-determinants" (Brasil, 2008, p. 9).

> The Dahlgren and Whitehead model includes the social determinants of health arranged in different concentric layers, according to their level of coverage, from a layer closest to the individual determinants to a distal layer where the macro determinants are located. The model emphasizes interactions: individual lifestyles are wrapped up in social and community networks and living and working conditions, which in turn relate to the broader economic, cultural, and economic environment. [...] Behaviors and lifestyles depend not only on people's free will, but also on other determinants, such as access to information, influence of propaganda, peer pressure, possibilities of access to healthy food and leisure spaces (PAHO/WHO, 2011, p. 248-249).

The WHO Commission on Social Determinants of Health has emphasized the need to intervene on these factors to ensure equity. To this end, it proposed recommendations based on three fronts: "[...] improving living conditions; to combat the unequal distribution of power, money and resources; and measure the magnitude of the problem" (Giovanella, 2012, p. 216). And, as the CNDSS adds: "[...] actions aimed at combating inequities must be based, on the one hand, on scientific evidence and, on the other, on social mobilization and participation" (Brasil, 2008, p. 28).

The debate on SDH also requires the recognition of the structural inequalities that cross Brazilian society. These inequities are expressed in multiple dimensions: income, education, race/color, gender, housing, work and territory. The CNDSS points out that "[...] income and schooling are strongly associated with health outcomes" (Brasil, 2008, p. 47). In addition, as stated in the Commission's technical report, "[...] structural determinants are the deepest cause of health inequalities" (2011, p. 32).

> Not all determinants are equally important. The most important are those that generate social stratification – the 'structural' determinants – such as income distribution; gender, ethnic, or prejudice against people with disabilities; and political and governance structures that feed – rather than reduce – inequalities related to economic power. [...] These structural mechanisms – which alter the social positioning of individuals – are the deepest cause of health inequalities (Brasil, 2011, p. 32).

Among the concrete data, marked inequalities in access to preventive exams and obstetric care are observed. However, among women without education, only 1.2% had seven or more prenatal consultations, while among those with higher education, this rate is 20% (Brasil, 2008, p. 50). And, as the same report reinforces, "[...] the level of education is manifested in the most different ways: in the ability to understand health information and in adherence to therapeutic procedures" (2008, p. 44).

Therefore, the focus on SDH requires the adoption of public policies that transcend the health sector. Health must be treated as a collective good, articulated with the other social spheres. For the WHO, "[...] the promotion of equity in health is fundamental to sustainable development and a better quality of life" (Giovanella, 2012, p. 215). And, according to the CNDSS report, "[...] the fight against health inequities must occur by acting on the social determinants that generated them, which, being the product of human action, can and should be modified" (Brasil, 2008, p. 19).

Understanding SDH implies recognizing that the health-disease process is not only biological, but also socially produced. In other words, the patterns of illness and death follow a historically structured axis of inequality. As Wilkinson and Marmot warn, "[...] social determinants are the social and economic factors that determine the health of people and populations" (2003, p. 10). In addition, according to the WHO, "[...] poor living conditions, such as precarious housing, food insecurity and lack of sanitation, create contexts of persistent vulnerability" (Giovanella, 2012, p. 221).

> Inequalities within and between countries are politically, economically, and socially unacceptable – as well as unjust and largely preventable – and that the promotion of health equity is fundamental to sustainable development and a better quality of life and well-being for all. [...] The determination to act on the social determinants of health collectively [...] requires improving living conditions; to combat the unequal distribution of power, money and resources; and to measure the magnitude of the problem, understand it and evaluate the impact of the interventions (Who apud Giovanella, 2012, p. 215).

SDH operate cumulatively and interdependently, as precarious income can limit access to education, which in turn affects employability and access to basic services. As the CNDSS report points out: "[...] the poor get sick more and die earlier than the rich" (Brasil, 2008, p. 30). And, as Starfield reinforces, "[...] low socioeconomic status is associated with poorer health, less access to services and more difficulty in maintaining healthy habits" (2002, p. 52).

Therefore, it is not possible to think of justice in health without intersectoriality. Joint action between the areas of education, housing, social assistance, work and transportation is essential to change the contexts that become ill. According to the Declaration of Alma-Ata, "[...] the promotion and protection of peoples' health is essential for continuous economic and social development and contributes to a better quality of life and world peace" (WHO, 1978, p. 2). And as the CNDSS points out, "[...] intersectoriality is essential to address the structural causes of health inequalities" (Brasil, 2008, p. 23).

The intersectoral approach, however, requires political articulation and recognition that health is not just the absence of disease. As Padula Anderson and Rodrigues state, "[...] Generalist medicine needs to be valued in a health system that understands the complexity of lives and territories" (2022, p. 10). And, according to Fajardo, "[...] public policies must consider the subjects in their singularity and community belonging" (2002, p. 35).

> When seeking to know the life history of the users, it should be privileged not merely a chronological reconstruction, but their history, based on significant facts, contextualized [...] so that dialogue and reflection can be established. [...] Data are collected that are part of the user's life history, family and social ties, occupation, income, education, health, among others, information that supports the construction of the therapeutic project with the user, of his life project (Ministério da Saúde, 2010, p. 103).

Ethnic-racial, gender, and territorial inequalities further aggravate the effects of SDH on vulnerable populations. Therefore, structural racism, for example, becomes a determinant of health. According to Farmer, "[...] diseases reflect not only biomedical conditions, but also political and historical conditions that shape who lives and who dies" (2003, p. 41). And as Scheper-Hughes points out, "[...] extreme poverty does not only produce physical pain, but daily humiliation that sickens the body and the spirit" (1993, p. 27).

Thus, SDH constitutes not only an analytical tool, but also a political agenda for the construction of equity. It is necessary to broaden the view of health, inserting it in a broader conception of social justice. As Fassin states, "[...] social suffering has become a moral indicator that organizes selective actions by the State and NGOs" (2012, p. 62). And as Merhy summarizes, "[...] it is necessary to break with the fragmented and technocratic model of the clinic and recognize the power of the encounter and of living care in action" (2007, p. 143).

> Health is a key factor in these goals. The social determinants approach takes the distribution of health – measured by the degree of health inequality – as an important indicator not only of the level of equality and social justice existing in a society, but also of its functioning as a whole. Therefore, health inequalities function as a clear indicator of the success and level of internal coherence of a society's set of policies for a series of sectors (Brasil, 2011, p. 7).

That said, social inequalities in Brazil profoundly shape access to the Unified Health System. While in the South of the country there are cities with full coverage of the Family Health Strategy, in the North there are locations where the nearest health unit is more than 100 km away by road or river. According to IBGE data, "[...] the population of the North region is the most disadvantaged, receiving 2.2 consultations per year, while the Southeast region is the one with the best coverage, with 2.9 consultations per inhabitant per year" (Giovanella, 2012, p. 342). And, according to Travassos et. al. (2000), "[...] the chance of using services in the North region was almost half of that observed in the South and Southeast regions" (Brasil, 2008, p. 73).

These disparities become more evident in emergency situations. It is common for riverside dwellers in the Amazon to wait days for a health boat to perform a simple blood test. As Paim (2010) points out, "[...] the national average of ICU beds was 6.8 per 100 thousand inhabitants, but Rondônia had only 0.5 and Bahia, 1.3" (2010, p. 33). And according to the IBGE, "[...] the ratio of doctors per thousand inhabitants varies from 1.91 in the North to 4.26 in the Southeast" (Giovanella, 2012, p. 334).

> In the case of ICU beds available for the SUS, the national average was 6.8 beds per 100,000 inhabitants, while most states in the North and Northeast regions had values below the national average, with a negative highlight for Rondônia (0.5) and Bahia (1.3). [...] in 2000 there was a rate of 32.0 per 100,000 inhabitants for the country, although the expected use, according to the Ministry of Health, should be 40.0 per 100,000. The rates of all the states in the South and Southeast regions are close to or above the national average, but the other regions have very low values of this indicator, to the point that the Southeast treats five times more patients than the North (Paim, 2010, p. 34).

However, it is not only geographical distances that determine access: income and schooling also impose significant barriers. For example, a woman with a low level of education in the outskirts of Maceió may fail to undergo gynecological exams because she does not understand the guidelines for care. According to the National Commission on SDH, "[...] illiterate women are 70% less likely to have a Pap smear than those with more than 12 years of schooling" (Brasil, 2008, p. 76). Furthermore, according to data from the PNAD, "[...] among the poorest, only 59% had a medical appointment in the year, against 76% among the richest" (IBGE, 2010a, p. 211).

These inequalities also cross racial dimensions. Black patients often report that their pain is underestimated in public offices and that waiting times are longer when care is outsourced. As Inês Lessa indicates, "[...] the black population has a higher prevalence of chronic diseases and less access to services to control these diseases" (2008, p. 89). And, according to Eduardo Faerstein, "[...] perceived racism directly affects adherence to treatment and the relationship with the health professional" (2008, p. 66).

Gender inequalities are also strongly manifested in health policies. Poor, black and peripheral women face obstacles in carrying out humanized deliveries and in accessing contraception. According to Leal et. al., "[...] women with lower incomes have lower rates of cesarean sections, even when clinically indicated, and less access to adequate anesthesia" (2008, p. 77). And, according to Quadros et. al., "[...] in Pelotas, 70% of illiterate women have not had a Pap smear in the last three years" (2004, p. 59).

> Regarding women's health care, the study by Novaes et al. (2006), based on the national basis, found a gradient of increased access to the Pap smear test corresponding to the increase in income and schooling, with the coverage of this test being higher in women with higher income and schooling, when compared to women with an income of less than one minimum wage and those who were illiterate or had incomplete primary education. [...] in Pelotas, found that 70% of illiterate women had not had a Pap smear in the last three years, while only 11.8% of women with twelve or more years of schooling had not done so. The study [...] also pointed to lower knowledge about the Pap smear test among women with less schooling, with about 30% of these women demonstrating lack of knowledge about this test, while for women with a better educational level this value was less than 5% (Quadros et. al., 2008, p. 74).

Not only do the data show these inequalities; they are experienced daily by millions. Whether it's the mother of a baby with a fever who walks for hours to find a closed post in the interior of Maranhão, or the elderly person in the northeastern hinterland who waits months for an imaging exam. According to Giovanella (2012), "[...] regional inequality affects the entire supply of services – SUS and non-SUS" (p. 292). And according to Ribeiro (2006), "[...] the chance of an individual with up to 3 years of schooling using the SUS is four times greater than that of an individual aged 11 years or older" (Brasil, 2008, p. 68).

Rural populations face even more adverse conditions. In small towns in the semi-arid Northeast, there is often only one community agent for hundreds of families, and sanitary transport depends on improvised vehicles. As the Ministry of Health points out, "[...] remote rural municipalities have worse indicators of primary care coverage and access to preventive exams" (Brasil, 2022, p. 45). And according to Fiocruz, "[...] the distance from services, associated with low population density, limits the right to health in a structural way" (2021, p. 28).

In addition, the effects of inequalities accumulate throughout life. Children from poor families are more likely to be born with low weight, suffer from malnutrition and grow up with limitations in cognitive development. According to IPEA, "[...] in areas with a low Human Development Index, infant mortality is up to three times higher than in higher-income areas" (2020, p. 71). And, as the CNDSS reinforces, "[...] there is a strong correlation between social inequality and child health indicators, such as hospitalizations for diarrhea and pneumonia" (Brasil, 2008, p. 53).

> The results of the review leave no doubt about the presence of marked social inequities in child health and nutrition throughout the country, evidenced in the

> indicators of mortality, morbidity, nutritional status and use of health services. [...] The poor are almost always in a less favorable situation in terms of prenatal care, birth weight (both due to intrauterine growth retardation and preterm delivery), exclusive breastfeeding, vaccination coverage, preventive consultations, morbidity, malnutrition, micronutrient deficiencies, cognitive development and, consequently, mortality (National Commission on Social Determinants of Health [CNDSS], 2008, p. 199).

However, the unequal distribution of health equipment reinforces the idea that access to the SUS is conditioned to the CEP. While upscale neighborhoods have renovated units, with fixed doctors and digital scheduling, favela residents live with a shortage of professionals and long lines. As Giovanella warns, "[...] the regionalization model[26] adopted in Brazil has reproduced inequalities instead of reducing them" (2012, p. 275). And, according to Fausto and Matta, "[...] the absence of equitable criteria in the allocation of resources compromises the distributive justice of the SUS" (2007, p. 99).

As the data indicate, racial inequalities also translate into worse clinical outcomes. Black women have higher maternal mortality, not only due to obstetric causes, but also due to institutional negligence. According to the Ministry of Health, "[...] the maternal mortality rate of black women is almost double that of white women" (Brasil, 2019, p. 22). And according to Fiocruz, "[...] institutional racism[27] is expressed in everyday practices that devalue the pain, the word, and the history of black women" (2021, p. 36).

Not only racialized populations, but also the LGBTQIA+ population faces specific difficulties. Many users avoid seeking the SUS for fear of prejudice, while professionals do not receive adequate training to meet their demands. According to the Fiocruz report, "[...]

---

[26] The regionalization model adopted by health in Brazil seeks to organize the service network based on territorial logic and articulation between the different levels of care, with the objective of promoting greater equity in access and better efficiency in the management of the SUS. However, this model has faced significant challenges, such as the fragmentation of policies, the concentration of resources in more developed regions, and the difficulty of ensuring comprehensive care in peripheral or remote territories. As Giovanella points out, "[...] the regionalization of health in Brazil has reproduced inequalities instead of reducing them, as the distribution of services remains concentrated in areas of greater economic and political power" (Giovanella, 2012, p. 275). Thus, the promise of regionalization as a health justice strategy is still confronted with deep structural asymmetries. See: GIOVANELLA, Lígia et. Al. *Policies and health system in Brazil*. 2. ed. Rio de Janeiro: Fiocruz, 2012.

[27] Institutional racism is a systemic form of discrimination that manifests itself in the practices, routines, and structures of public and private institutions, resulting in persistent inequalities in access to fundamental rights and services, such as health. Within the scope of the SUS, this type of racism is expressed, for example, in the lower supply of services in peripheral and black territories, in the dehumanized care of black women during childbirth, and in the neglect of the cultural specificities of indigenous and quilombola populations. As the National Policy for the Integral Health of the Black Population highlights, "[...] institutional racism is expressed in the inaction or inadequate response of institutions to the needs of the black population" (Brasil, 2009, p. 15). Recognizing and confronting institutional racism is essential to ensure equity in care and compliance with the principle of universality of the SUS. See: BRAZIL. Ministry of Health. *National Policy for the Integral Health of the Black Population: a policy for the SUS.* Brasília: Ministry of Health, 2009.

the absence of affirmative policies in health services contributes to the aggravation of avoidable problems" (2021, p. 49). And according to the IBGE, "[...] trans people have a life expectancy 35 years lower than the national average" (2021, p. 8).

Based on this context, it is urgent to rethink the structure of the SUS in the light of social justice, overcoming the paradigm of homogenization[28] and recognizing the multiple forms of exclusion. Whether by color, class, territory or gender identity, the right to health continues to be violated on a daily basis. As Paim states, "[...] the SUS cannot do without a critical approach that recognizes inequalities and addresses them as a priority" (2008, p. 94). And, as Giovanella points out, "[...] equity must be a guiding principle, and not just a rhetorical one, in the management of the system" (2012, p. 294).

> We believe that it is time to overcome the boastful discourse in defense of the SUS and recognize that it can only improve, gaining support from the population, when the old and new leaders of the Health Movement, in society and in the government, show solidarity with the citizen, with needs and demands in their daily lives, and start a process of consequent transformation, guided by two principles: a) intransigence and combating all forms of inequities; b) centrality of the citizen in the care and attention to SUS users. By affirming the civilizing character of the Health Reform, we are understanding that, through this process of transformation of society and the Brazilian State, we will be able to reach a civilizational level in which social and political relations are governed by the primacy of social justice (Paim, 2008, p. 126).

Crossing mighty rivers in the Amazon region to seek basic health care is a routine for thousands of Brazilians. In many riverside communities, the absence of land infrastructure forces residents to travel hours by boat[29] to reach a river health unit. As

---

[28] Overcoming the paradigm of homogenization in the field of health implies recognizing ethnic-racial, cultural, territorial, gender and social condition diversity as fundamental elements for the effectiveness of equitable public policies. The homogeneous logic, based on abstract universalization, often ignores the historical and structural inequalities that mark the experience of the subjects, resulting in the reproduction of inequities within a system that should promote social justice. As Paim points out, "[...] the SUS cannot do without a critical approach that recognizes inequalities and addresses them as a priority, abandoning the illusion of a universal, decontextualized subject" (Paim, 2008, p. 94). In this sense, it is urgent that health policies be built from a paradigm of difference, which values the plural knowledge and experiences present in Brazilian society. See: PAIM, Jairnilson Silva. *Brazilian Health Reform: contribution to understanding and criticism*. Salvador: EDUFBA; Rio de Janeiro: Fiocruz, 2008.

[29] In several riverside communities in the Amazon region, access to health services is marked by long and exhausting journeys of travel, often carried out by means of motorboats — small boats used as the main means of river transport. This reality exposes the territorial inequalities that cross the Unified Health System (SUS) and show how the right to health is conditioned by the place where one lives. Giovanella points out that "[...] geographical barriers reflect the resistance that space imposes on the displacement of potential users of health services" (Giovanella, 2012, p. 277), and that such barriers especially impact populations with low population density, whose health units are hundreds of kilometers away by rivers. Crossing mighty rivers for hours, often in emergency situations, is a daily expression of the health inequity experienced by thousands of Brazilians. See: GIOVANELLA, Lígia et. Al. *Policies and health system in Brazil*. 2. ed. Rio de Janeiro: Fiocruz, 2012.

Giovanella (2012) explains: "[...] geographic barriers reflect the resistance that space imposes on the displacement of potential users of health services" (p. 277). And according to Oliveira, Travassos and Carvalho (2004): "[...] the greater the distance, the lower the use of health services" (apud Giovanella, 2012, p. 278).

In the hinterland of Piauí, entire communities live miles from the nearest health facility, and school transportation is often the only one available to take patients, if not suspended. As reported by Marques et. al. (2007), "[...] in the region of Juiz de Fora, the absence of effective elective transportation was responsible for 35% of absences from previously scheduled procedures" (apud Redes de Atenção à Saúde, 2010, p. 150). And Fiocruz (2005) warns: "[...] the institution of the subsystem of transportation in people's health is a condition for the efficient and equitable functioning of the RASs[30]" (apud Redes, 2010, p. 150).

In the peripheral urban context, many families living in areas of irregular occupation face the absence of paved roads and insufficient public transportation, which makes it difficult to reach the Basic Health Unit. According to the Ministry of Health (2008), "[...] the economic costs of transport are added to the opportunity costs, which are usually high, impairing access" (apud Redes, 2010, p. 150). And the document highlights that "[...] the subsystem of transportation in health of people is restricted to displacements due to clinical and functional causes" (2010, p. 151).

However, not only commuting limits access: the chronic underfunding of the SUS imposes an indirect financial burden on the population to obtain care. In medium-sized cities, such as Montes Claros, users pay out of pocket for basic exams in popular clinics, since the system does not offer vacancies on a regular basis. As Paim (2010) points out: "[...] the resources transferred by the federal government have always fallen short of the needs of citizens" (p. 92). And according to the Brazilian Health Reform, "[...] in 2005, the government stopped spending R$ 9 billion on hospitals, equipment, medicines and exams" (2010, p. 253).

---

[30] The Health Care Networks (RASs) were conceived as a strategy to overcome the fragmentation of care and ensure the integrality of care in the Unified Health System (SUS). They are organized in a regionalized and hierarchical way, with the objective of articulating the different points of health care – from primary care to high complexity – in a coordinated system centered on the needs of users. According to the Ministry of Health, "[...] the implementation of the RASs aims to promote universal, continuous and quality access to health services, with a focus on the integrality and efficiency of public resources" (Brasil, 2010, p. 17). However, challenges such as insufficient resources, low coordination between levels of care, and discontinuity of public policies still compromise the effectiveness of the RASs in many Brazilian territories. See: BRAZIL. Ministry of Health. *Health Care Networks*. Brasília: Ministry of Health, 2010.

> The SUS is thus held hostage by the private sector, despite its potential for regulation. Part of this situation can be explained by the underfunding of public health in the cost and, especially, with regard to investments, which are necessary for the expansion of the federal, state and municipal network. Such a situation causes citizen dissatisfaction, denunciations in the media and, more recently, in the so-called judicialization of health, in which citizens seek in the Public Prosecutor's Office and the Judiciary a way to meet what they believe to be part of their right to health (Paim, 2008, p. 106).

In public pharmacies, the scene is recurrent: a mother leaves frustrated for not finding the antibiotic prescribed for her son with a respiratory infection. Soon, he resorts to an informal loan to buy the medicine. According to Messeder et. al. (2005), "[...] the population has increasingly used the resource of suing the public sector to obtain the medicines it needs" (apud Giovanella, 2012, p. 309). And data from the Ministry of Health show that "[...] in 2009, the SUS spent R$ 2.3 billion only on medicines of the specialized component" (2012, p. 310).

In addition, it is common for patients to give up care because they cannot afford indirect costs: food, transportation, and companion. In inland cities, informal workers stop performing procedures because they cannot be absent from work. According to Giovanella (2012), "[...] financial barriers act by increasing social inequalities in access to health services" (p. 290). And underfunding impacts the entire network, because "[...] the debate on SUS resources has not acquired centrality in the national state" (2012, p. 315).

In indigenous villages in Mato Grosso do Sul, reports of consultations with absent interpreters or professionals who refuse to listen to shamans are frequent. Indigenous women report feeling exposed in childbirth without privacy and disrespected in their culture. According to Barros (2009), "[...] Western medical culture tends to delegitimize indigenous knowledge, treating it as superstition" (apud CNDSS, 2008, p. 66). And the same document recognizes that "[...] cultural discrimination constitutes an obstacle to the universality and integrality of care" (Brasil, 2008, p. 71).

> Traditional health systems are, even today, the main resource for health care for the indigenous population, despite the presence of Western health structures. Being an integral part of culture, these systems condition the relationship of individuals with health and disease and influence the relationship with health services and professionals and the interpretation of disease cases. [...] These practices and conceptions are generally health resources of empirical and symbolic efficacy, according to the most recent definition of health by the World Health Organization. The recognition of the social and cultural diversity of indigenous peoples, the consideration and respect for their traditional health systems are essential for the execution of health actions and projects and for the elaboration of proposals for

> prevention, promotion and health education, appropriate to the local context (Brasil, 2006, p. 134).

LGBTQIA+ populations also face subtle but persistent forms of exclusion. In Belo Horizonte, a trans man reported that his gender identity was disrespected when he was called by his registered name aloud at the reception, generating public embarrassment. According to Paiva et. al. (2011), "[...] biomedical training still ignores the specificities of sexual and gender identities" (apud Giovanella, 2012, p. 307). And, as Facchini (2007) points out, "[...] the services often produce symbolic violence in the name of technical neutrality" (apud Giovanella, 2012, p. 308).

People with disabilities also face symbolic and practical barriers. In many posts, there is no sign language interpreter or tactile signage for the blind, and professionals show impatience with patients with intellectual disabilities. According to Andrade and Dain (2006), "[...] communicational accessibility is a challenge that is still neglected in primary care" (apud Giovanella, 2012, p. 305). And, according to Werneck (2003), "[...] the ableist culture[31] still organizes the ways in which disability is perceived in public services" (apud Giovanella, 2012, p. 306).

In large cities, the queue before the opening of the Basic Health Unit already exceeds 50 people. Users arrive at 3 am to try to get a service password. In Salvador, residents report that, even arriving early, they often cannot get an appointment. As Paim (2008) explains, "[...] the slowness and fragmentation of the system generate suffering and discredit in the population" (p. 87). And, according to Starfield (2002), "[...] the user experience with long waits deteriorates trust in the system" (apud Giovanella, 2012, p. 278).

> This model of inattention is expressed in a kaleidoscope of mistreatment and disrespect for the right to health: shameful queues for medical care since dawn or the day before; discourtesy at the counters of hospitals and health units; inattention of security guards, receptionists, assistants and health professionals in the face of

---

[31] The ableist culture is rooted in social values that attribute inferiority to people with disabilities, associating them with the idea of incapacity, dependence and inadequacy. Such logic structures not only individual attitudes, but also institutional practices that reinforce symbolic and material barriers in access to fundamental rights, such as health, education and work. In public services, this culture is expressed in the absence of communicational accessibility, in the impatience of professionals with patients with intellectual disabilities and in the neglect of the specificities of these subjects. As Werneck points out, "[...] ableism is present when the body with disabilities is seen as a missing body, a body that needs to be repaired, normalized" (Werneck, 2003, p. 25). Overcoming ableism requires a profound transformation of social and institutional practices, which recognizes human diversity as a value and promotes inclusion with dignity and respect. See: WERNECK, Claudia. *No one will be nice anymore: in an inclusive society, difference is to add, never to exclude*. 2. Ed. Rio de Janeiro: WVA, 2003.

> people weakened by advanced age, suffering and diseases; corridors overcrowded with stretchers in emergency services; disputes over records for complementary exams that are so often unnecessary; long waits in uncomfortable banks for an appointment or exam; via crucis of the patient between different health units, doctors and specialists (Paim, 2008, p. 108).

Excessive bureaucracy also directly affects the treatment of chronic diseases. In Brasília, a patient with lupus had to redo the same tests every month to maintain the supply of a medication for continuous use, as the system constantly requires new reports. According to the Ministry of Health, "[...] the fragmentation of care creates administrative obstacles that discontinue care" (Redes de Atenção And as Mendes (2002) warns, "[...] the SUS management model still prioritizes the logic of procedures to the detriment of care" (apud Redes, 2010, p. 92).

Thus, poor management of resources and teams results in sudden closures of units and discontinuity of programs. In Rio Grande do Norte, a NASF team was demobilized without warning, jeopardizing home care for bedridden elderly. According to Giovanella (2012), "[...] the turnover of professional teams compromises continuity and bonding in primary care" (p. 273). And, as Fausto (2010) reinforces, "[...] the fragility in local coordination weakens the system's problem-solving capacity" (apud Giovanella, 2012, p. 274).

> The retention of professionals in the Family Health Strategy teams is a challenge to be faced, even though recent studies evaluating the FHS indicate a higher retention rate in relation to the beginning of the strategy. The turnover of professionals, especially physicians, however, is still an obstacle to the development of work and has been attributed to various factors, such as: remuneration below expectations; working conditions; requirement of full workload; low opportunity for professional progression; low commitment of professionals; absence of previous training compatible with the model proposed by the Family Health Strategy (Giovanella, 2012, p. 273).

In this context, even with the obstacles described above, over the last thirty years, Brazil has consolidated a broad normative architecture of public policies aimed at equity in health. However, according to Giovanella (2012), "[...] although there have been important advances, equity remains the least operationalized principle among the three pillars of the SUS" [32](p. 245). And as the PNPS (2014) reinforces, "[...] the social determinants of health

---

[32] The three fundamental pillars of the Unified Health System (SUS) – universality, comprehensiveness, and equity – were established in the Federal Constitution of 1988 as guiding principles for guaranteeing the right to health in Brazil. Universality ensures that all people, without discrimination, have access to health services; comprehensiveness advocates that care should cover all dimensions of health, considering everything from promotion to rehabilitation; and equity guides the allocation of resources and actions in order to reduce historical

require intersectoral responses, with integrated actions that go beyond the health sector" (p. 14).

In the field of primary care, the National Primary Care Policy (PNAB)[33] and the Family Health Program were powerful instruments, but also strained by structural restrictions. As Paim (2010) points out, "[...] the coverage of the Family Health Strategy in large cities remains unequal and tends to be restricted to pockets of poverty" (p. 74). And, according to Giovanella (2012), "[...] the prioritization of primary care sometimes serves to mask cuts in other areas of the network, emptying the principle of comprehensiveness" (p. 289).

The National Policy for the Integral Health of the Black Population (PNSIPN),[34] instituted in 2009, brought an important symbolic milestone, but suffered from practical difficulties in implementation. According to the Ministry of Health (apud PNPS, 2014), "[...] the invisibility of institutional racism compromises equal access to care" (p. 21). And as Giovanella (2012) observes, "[...] the resistance of managers to recognize racism as a

---

and social inequalities. However, as Giovanella points out, "[...] although there have been important advances, equity continues to be the least operationalized principle among the three pillars of the SUS" (Giovanella, 2012, p. 245), revealing persistent challenges in the full implementation of these foundations, especially for vulnerable populations. See: GIOVANELLA, Lígia et. Al. *Policies and health system in Brazil*. 2. Ed. Rio de Janeiro: Fiocruz, 2012.

[33] The National Primary Care Policy (PNAB) represents one of the main instruments for organizing primary health care in Brazil, guiding principles, guidelines, and strategies to ensure continuous, problem-solving, and territorialized care for the population. Established in 2006 and updated in 2011 and 2017, the PNAB reaffirms the Family Health Strategy (ESF) as a priority model for the expansion and consolidation of primary care in the Unified Health System (SUS). However, its implementation has been marked by tensions between the normative ideal and the concrete conditions of the territories, especially in the urban peripheries and remote rural areas. As the Ministry of Health points out, "[...] primary care is the main gateway to the SUS and is characterized by accessibility, care coordination, longitudinality, and comprehensiveness" (Brasil, 2017, p. 12). Even so, regional inequalities and chronic underfunding challenge its full implementation. See: BRAZIL. Ministry of Health. *National Policy of Primary Care*. Brasília: Ministry of Health, 2017.

[34] The National Policy for the Integral Health of the Black Population (PNSIPN), instituted by the Ministry of Health in 2009, represents a milestone in the promotion of equity in the Unified Health System (SUS). This policy recognizes racism, ethnic-racial inequalities and institutional racism as social determinants that negatively impact the health conditions of the black population. Its main objective is to promote the integral health of this population segment, prioritizing the reduction of ethnic-racial inequalities and the fight against racism and discrimination in SUS institutions and services. Among the guidelines of the PNSIPN, the guarantee and expansion of access to health actions and services for the black population living in peripheral, rural and quilombola urban areas stand out; the development of specific actions to reduce ethnic-racial disparities in health conditions; and the implementation of monitoring and evaluation processes of actions relevant to the fight against racism and the reduction of ethnic-racial inequalities in the field of health. The implementation of the PNSIPN is essential to ensure the right to health of the black population, confronting historically constructed inequities and promoting social justice in the country. See: BRAZIL. Ministry of Health. *National Policy for the Integral Health of the Black Population: a SUS policy*. Brasília: Ministry of Health, 2010. Available at: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_saude_integral_populacao.pdf. Accessed on: Mar. 23, 2025

social determinant is still a barrier to the effectiveness of the policy" (p. 314). According to Merhy et. al. (2014):

> In the services that make up the psychosocial care network in the region, the place of blacks still occupies a 'non-place' in the care spaces, with little or almost no visibility for their cultural expressions. [...] It is interesting to note that the act of weaving-embroidering [...] is linked to the desire of these women to produce beautiful tapestries with the share of suffering that, historically, marks the black-female body and wounds its existence. [...] The women narrate and embroider their stories, reflecting on the process of 'embroidering themselves' and 'embroidering the world' that they are experiencing. [...] This is never weakness, but strength (p. 17).

The Stork Network[35], launched in 2011, proposed to reorganize maternal and child care, but ran into institutional discontinuity. According to Giovanella (2012), "[...] despite the humanization discourse, the model remains centered on medicalization and the fragmentation of care" (p. 275). In addition, as pointed out by Batista et. al. (2017), "[...] the programmatic and vertical logic of the Stork Network compromises its articulation with the other care networks" (p. 159).

However, the advance of equity policies took place in a context marked by ambiguities and fiscal restrictions. Constitutional Amendment 95[36], of 2016, established the ceiling on public spending, limiting the growth of investments in health. As analyzed by Machado et. al. (2017), "[...] fiscal austerity structurally compromised the expansion of the SUS and the fulfillment of the goals of the PNPS" (p. S158). And Giovanella (2012) reinforces that "[...] the legal provisions do not guarantee, by themselves, the necessary funding for the realization of equity" (p. 317).

---

[35] The Stork Network, established by the Ministry of Health through Ordinance No. 1,459, of June 24, 2011, is a strategy that aims to guarantee women the right to reproductive planning and humanized care during pregnancy, childbirth and puerperium, as well as to ensure children the right to safe birth and healthy development. Structured in four components – prenatal, labor and birth, puerperium and comprehensive child health care, and logistical system (sanitary transport and regulation) – the Stork Network seeks to promote a care model that integrates and qualifies maternal and child health services within the scope of the Unified Health System (SUS). This initiative reflects the Brazilian government's commitment to reducing maternal and infant mortality rates, as well as improving the quality of health care offered to pregnant women and children in the first years of life. See: BRAZIL. Ministry of Health. Ordinance No. 1,459, of June 24, 2011. Establishes, within the scope of the Unified Health System - SUS, the Stork Network. Federal Official Gazette: section 1, Brasília, DF, n. 120, p. 109-111, June 27, 2011. Available at: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt1459_24_06_2011.html. Accessed on: Mar. 23, 2025.

[36] Constitutional Amendment No. 95, of December 15, 2016, instituted the New Fiscal Regime in Brazil, establishing a ceiling for federal public spending for a period of 20 years. This measure limited the growth of the Union's primary expenditures to the variation of inflation in the previous year, affecting essential areas such as health, education and social assistance. The amendment was the subject of intense debates and criticism, especially for its potential impact on reducing investments in public policies that are fundamental for the promotion of equity and social development. Studies show that the implementation of this spending cap can compromise the State's ability to meet the basic needs of the population, deepening existing social inequalities. See: BRAZIL. Constitutional Amendment No. 95, of December 15, 2016. Amends the Transitional Constitutional Provisions Act to institute the New Fiscal Regime, and makes other provisions. Available at: https://www.planalto.gov.br/ccivil_03/constituicao/emendas/emc/emc95.htm. Accessed on: Mar. 23, 2025.

The tension between universalism and targeting emerges strongly in this scenario. According to Paim (2010), "[...] the focalist strategy is expressed in the prioritization of compensatory policies, as if poverty were an individual problem and not a structural one" (p. 89). And the PNPS report itself warns that "[...] targeting can reinforce stigmas, instead of promoting the universal right to health" (2014, p. 20).

> The defense of universality thus overlaps with the measures disseminated in the neoliberal reforms of focusing government intervention in health care only on very poor groups. This targeting segments coverage and impoverishes health care, because it creates inequalities in access – and systems built for all, and accessed by all, are more likely to be equitable (Giovanella, 2012, p. 293).

The SUS, despite its normative scope, operates in a contradictory system where the private sector is constantly subsidized. According to Machado et. al. (2017), "[...] the State maintained and expanded tax incentives for companies and private providers, to the detriment of strengthening the public system" (p. S159). And Giovanella (2012) adds that "[...] dependence on private services to guarantee specialized procedures undermines the integrality of care" (p. 308).

The National Health Promotion Policy (PNPS), although articulated with several networks, also suffers from intersectoral fragmentation. According to the official document (PNPS, 2014), "[...] there is difficulty in effectively articulating sectoral policies and institutional engagement of the various actors" (p. 16). And Giovanella (2012) reinforces that "[...] health promotion is still conceived as a complementary and non-structuring action of public policies" (p. 298).

In the care of the indigenous population, for example, the subsystem created to guarantee cultural and territorial specificities suffers from political abandonment. As reported in the Brazilian Health Reform document, "[...] the absence of a State policy compromises the sustainability of the indigenous subsystem" (Paim, 2010, p. 212). And Machado et. al. (2017) observe that "[...] the effects of the DRU and the spending cap hinder regionalization and coverage in remote areas" (p. S156).

> Despite the significant contribution of financial investments, the insufficiency of human resources was one of the greatest obstacles to the implementation of the indigenous health policy. The alternative found to address the lack of personnel to work in the DSEI, which was, as already indicated, outsourcing (i.e., the hiring of third-party services to carry out health actions), has represented one of the greatest obstacles to the effectiveness of the subsystem. [...] Nevertheless, despite the political guidelines of the subsystem, it is clear that the principle of 'culturally

> differentiated' care has not been put into practice, adding to this the irregularity and low quality of the services provided (Giovanella, 2012, p. 827).

In addition, the precariousness of health work directly compromises the quality of care and the effectiveness of policies. As Paim (2010) points out, "[...] unstable work relationships impact the continuity of care and the qualification of the services provided" (p. 97). And the same author points out that "[...] the cycle of the State's lack of responsibility favors the privatization of the sector, weakening the public character of the SUS" (p. 88).

In this way, the political cycle of instability also affects the democratic management of the SUS. Although councils and conferences are fundamental spaces, their effectiveness is often symbolic. According to Giovanella (2012), "[...] the institutional capture of these spaces by corporate and partisan interests compromises the legitimacy of social participation" (p. 303). And the PNPS observes that "[...] social control needs to be strengthened as an instance of co-management of policies and not just consultation" (2014, p. 19).

Therefore, it is urgent to resume the radicality of the original Health Reform project, which proposed health as a universal right and public policy. As Paim (2010) states: "[...] the reform has already been made and is written in the Constitution; it must be fulfilled" (p. 211). And, according to Machado et. al. (2017), "[...] the future of the SUS depends on the construction of a broad coalition committed to the civilizing project it represents" (p. S160).

> Nevertheless, the difficulties encountered in the implementation of the SUS, in the face of underfunding and political-partisan clientelism, there was an extension of health service coverage to the Brazilian population. [...] Although the system we have today is far from the one enshrined in the 'Citizen Constitution', its existence is essential in a country that has enormous regional and social disparities [...]. Therefore, to those who try to present the SUS as a failed model of health care, we respond with victorious experiences [...]. In this sense, it is necessary to maintain the principle of the constitutional content of social security, including health, social security and social assistance jointly and severally. Health reform has already occurred and is in the Brazilian Constitution. It is necessary to comply with it (Paim, 2010, p. 211-212).

In view of this situation, overcoming health inequalities requires the reconstruction of a social project based on social justice, which requires actions beyond the health sector. According to Paim (2021), "[...] the segmentation of the Brazilian health system reproduces the same inequalities observed in living conditions" (p. 63). And, as Giovanella (2012) points out, "[...] it is necessary to abandon the fragmented sectoral focus and move towards planned and integrated action by the various levels of public administration" (p. 116).

Therefore, strengthening Primary Health Care (PHC) remains one of the most effective strategies to reverse inequities. As the World Health Organization points out, "[...] PHC should be the first level of contact of individuals with the health system, bringing care as close as possible to where they live and work" (WHO, 1978, apud Starfield, 2002, p. 31). And, also according to Giovanella (2012), "the clinic in primary care must be expanded, capable of understanding the subjective and social dimensions of each subject" (p. 106).

However, the effectiveness of PHC is only consolidated with the valorization of lasting bonds between teams and territories. According to Giovanella (2012), "[...] to solve 80% of health problems, it is necessary to articulate welcoming, listening and risk assessment in dialogue with the community" (p. 104). And, as Starfield (2002) recalls, "[...] quality primary care depends on orientation to the community and continuity of care" (p. 32).

> The bond is established in the health team-user relationship, built over time based on the user's trust in the professionals and the team's responsibility for the care and promotion of the users' health. Welcoming implies receiving, listening, offering protection and support and providing a response capable of solving the problem presented by the user. In order to establish a long-term personal relationship between health professionals and patients (Starfield, 2002), the health unit must be able to identify its elective population, defining a reference population either through territorial assignment, or through voluntary enrollment and registration of patients in a health unit of the user's choice (Giovanella, 2012, p. 104).

In addition, it is essential to invest in the critical training of health professionals, especially those who work in vulnerable territories. According to Merhy et al. (2003), "[...] it is necessary to overcome the Flexnerian, biologicist and hospital-centered model" (apud Merhy et. al., 2003, p. 115). And, as Garcia et. al. (2019), "[...] the curricular guidelines should foster emancipatory practices committed to the SUS" (2003, p. 116).

However, interprofessional training is also strategic to face the complexity of health problems. As stated by the WHO (2010), "[...] interprofessionality requires cooperation between knowledges, sharing common responsibilities and objectives" (apud Merhy et. al., 2003, p. 117). And Ellery (2014) adds: "[...] the FHS team can achieve better results when it builds shared care" (2003, p. 118).

Added to this is another decisive front, which is the confrontation of structural racism and the historical inequities that cross the SUS. According to PNPS (2014), "[...] racial and gender discrimination still compromises integrality and equity in care" (p. 21). And, according to Paim (2021), "[...] it is not enough to recognize the right to health: it is necessary to confront the mechanisms that have historically denied this right to black, indigenous and peripheral populations" (p. 211).

It is in this context that the expansion of social participation becomes a democratic and ethical imperative. As Carvalho (1997) recalls: "[...] the health councils constitute legitimate instruments of social control with a deliberative character" (apud Giovanella, 2012, p. 113). And Paim (2021) highlights that "[...] the radicalization of democracy involves the strengthening of the popular base of the SUS" (p. 312).

> The construction of a democratic, fairer society, in which the direct participation of citizens sustains instances and institutions, is a constant challenge. [...] Despite the problems faced by the set of collegiate and deliberative bodies to promote participation, we certainly live a much richer experience of civic learning and tolerance, of negotiation and the search for the common good, than if this institutionality of health democracy did not exist (Giovanella, 2012, p. 113).

The democratization of health also depends on popular involvement in the definition of territorial priorities. According to Giovanella (2012), "[...] participation was no longer restricted to the health service and began to affect the set of public policies" (p. 114). And, according to the PNPS report, "[...] management must prioritize democratic and participatory processes of regulation and control" (2014, p. 15).

Therefore, intersectoriality needs to stop being just a normative principle and start guiding concrete practices. According to Paim (2021), "[...] problem-solving actions in health require partnerships with education, housing, culture, food security and other sectors" (p. 32). And the PNPS (2014) reinforces that "[...] health must be articulated with other social protection networks through common objectives" (p. 14).

Thus, sanitation, housing and access to quality basic education are policies that operate as health vectors. According to the National Commission on SDH (CNDSS), "[...] the implementation of intersectoral public policies is essential to address inequities" (2008, p. 142). And Giovanella (2012) points out that "[...] clean water, treated sewage and adequate housing are direct determinants of health" (p. 117).

> The performance of the health sector in sanitation also has the character of fostering policies and actions, research, information and support for the Special Programs of the Federal Government, such as the Solidarity Community Program, Active Community Program, Program for the Reduction of Infant and Maternal Mortality and the National Program to Combat Drought. [...] The intersectoriality between public health and sanitation policies [...] must underpin their actions: the planning, development and evaluation of sanitation actions must be carried out in conjunction with the health sector in all its phases, in order to maximize the positive impact on the sanitary conditions of the population. [...] Sanitation services are basic for public health, consequently, they must be accessible to the entire population (Brasil, 2006, p. 142).

Social control over these policies, however, depends on the "creation of new institutional grammars" that expand citizenship. According to Santos and Avritzer (2002), "[...] the realization of rights passes through the construction of instances of participation and social justice" (apud Giovanella, 2012, p. 115). And, as Paim (2021) reminds us, "[...] it is necessary to establish the project of the Sanitary Reform in the socio-community instances" (p. 312).

Therefore, more than a technical response, overcoming inequalities requires a civilizing political project. According to Paim (2021), "[...] the achievement of equity in health depends on breaking with fragmented management models and building a public, intersectoral and universal system" (p. 245). And Giovanella (2012) concludes that "[...] the radicalization of citizenship in health must be the horizon and method of collective action" (p. 298).

CONCLUSION

At the end of this investigative path, it became evident that structural inequalities persist as concrete obstacles to the realization of the right to health in Brazil. And, although the SUS represents a democratic and civilizing framework, its promises of universality, equity, and integrality remain partially frustrated in the face of the material conditions of the population. Therefore, the normative existence of a public health system is not enough if the paths that lead to it are crossed by historical and social obstacles that limit its real reach.

As demonstrated throughout the analysis, factors such as race, gender, territory, income, and education not only influence the population's illness profiles, but also decisively modulate access to services and the quality of care received. Sometimes due to the absence of equipment and infrastructure, sometimes due to symbolic and institutional discrimination, vulnerable groups have their health compromised by processes that go beyond the biomedical field. And, in this sense, health acquires the contours of a mirror of Brazilian social injustices.

However, it is not only a matter of recognizing such inequalities, but of understanding how they operate in an articulated way within the health system itself. Whether in the endless queues of the urban peripheries, in the long river trips of the riverside dwellers or in the listening denied to black women in obstetric services, what is observed is the reproduction of patterns of exclusion under the veil of universality. And, therefore, highlighting these asymmetries is a necessary step so that fairer public policies can be formulated.

In addition, it was clear that the social determinants of health do not act in isolation, but overlap, forming layers of vulnerability that affect certain populations more strongly. Therefore, an intersectoral approach is urgent and cannot be postponed. Because it is not possible to think about health policies without integrating them with the areas of education, transportation, housing and sanitation. Therefore, addressing health inequalities requires much more than political goodwill: it requires planning, articulation, and ethical commitment to social justice.

As it was also possible to observe, official documents, institutional reports and scientific production itself show the limits of the current model. Not only do the data reveal gaps, but also the reports of the population and health professionals reinforce the abyss between what is recommended in the regulations and what is experienced in the territories. However, despite the limitations, concrete experiences of care in communities, extension projects and resistance practices show that the SUS is still alive, sustained by subjects committed to its democratic radicalism.

However, this transformative potential can only be fully realized when the State assumes the centrality of equity as a structuring principle of public policies. And, for this, it is essential that institutional racism, sexism, ableism and forms of coloniality of knowledge be faced as priorities. Because no policy will be effective if it continues to deny or silence the subjectivities and knowledge of the populations it intends to serve.

In the midst of the contradictions, it is necessary to affirm that the right to health should be read not as a concession of the State, but as a historical achievement of social movements and subjects who daily resist the precariousness of life. And, in this sense, the strengthening of social participation, the qualified listening of users and the valorization of popular knowledge are fundamental pillars for the construction of truly inclusive health policies.

Therefore, rethinking the SUS does not mean denying it, but, on the contrary, deepening its public, intersectoral and democratic vocation. And this implies confronting the privatist interests that undermine its integrality, denouncing the effects of austerity policies and fighting for adequate financing. Because without resources, without territorial planning and without valuing health work, any equity project will be doomed to failure.

It is understood, therefore, that overcoming inequalities requires, above all, a change in the logic that structures the production of public policies. In other words, it is necessary to shift the focus from individualized and fragmented care to care centered on collectivities, territories and subjects in their entirety. And this change will only be possible with critical training of professionals, political commitment of managers and active mobilization of society.

Thus, health in Brazil will continue to be marked by deep inequalities as long as social determinants are neglected in institutional practices. Therefore, fighting for a truly universal, equitable, and integral SUS is, above all, a commitment to life. And, in the face of so many avoidable losses, to omit oneself is to condone injustice.

REFERENCES

1. Adams, V. (2016). *Metrics: What counts in global health*. Durham, NC: Duke University Press.

2. Anderson, M. I. P., Padula, R., & Rodrigues, P. H. A. (2023). *Territories and vulnerabilities: Primary care in times of crisis*. Rio de Janeiro, Brazil: Cebes.

3. Arouca, S. C. (2003). *The preventive dilemma: Contribution to the understanding and critique of preventive medicine*. São Paulo, Brazil: UNESP.

4. Brazil. Ministry of Health. (2008). *The social causes of health inequities in Brazil: Final report of the National Commission on Social Determinants of Health – CNDSS*. Brasília, Brazil: Ministry of Health.

5. Brazil. Ministry of Health. (2017). *National Policy of Primary Care*. Brasília, Brazil: Ministry of Health.

6. Brazil. Ministry of Health. (2010). *National Policy for the Integral Health of the Black Population: A SUS policy*. Brasília, Brazil: Ministry of Health.

7. Brazil. Ministry of Health. (2010). *Health Care Networks*. Brasília, Brazil: Ministry of Health.

8. Brazil. (2016). *Constitutional Amendment No. 95, of December 15, 2016. Amends the Transitional Constitutional Provisions Act to institute the New Fiscal Regime*. Retrieved March 23, 2025, from https://www.planalto.gov.br/ccivil_03/constituicao/emendas/emc/emc95.htm

9. Brazil. Ministry of Health. (1986). *8th National Health Conference: Final report*. Brasília, Brazil: Ministry of Health.

10. dos Santos, A. N. S., et al. (2025). For a transformative primary care: Training and professional training to strengthen work in family health care. *Aracê, 7*(3), 11001–11030. https://doi.org/10.56238/arev7n3-054

11. dos Santos, A. N. S., et al. (2025). Desmedicar a vida – Um olhar crítico sobre doenças psíquicas, diagnósticos psiquiátricos e a expansão da medicalização no Brasil. *Aracê, 7*(2), 7636–7665. https://doi.org/10.56238/arev7n2-179

12. Farmer, P. (2003). *Pathologies of power: Health, human rights, and the new war on the poor*. Berkeley, CA: University of California Press.

13. Fassin, D. (2012). *Humanitarian reason: A moral history of the present*. Berkeley, CA: University of California Press.

14. Freeman, M. (2018). *Law and sociology*. Oxford, England: Oxford University Press.

15. FUNASA. National Health Foundation. (2004). *Health of the black population in Brazil: Contributions to the promotion of equity*. Brasília, Brazil: FUNASA.

16. Garcia, L., Luz, R., & Nascimento, R. (2019). *Medical education and collective health: Rethinking education from the SUS*. São Paulo, Brazil: Hucitec.

17. Gil, A. C. (2008). *Methods and techniques of social research* (6th ed.). São Paulo, Brazil: Atlas.

18. Giovanella, L., et al. (2012). *Policies and health system in Brazil* (2nd ed.). Rio de Janeiro, Brazil: Fiocruz.

19. Guarantee of access and care: The importance of Health Care Networks. (2010). In Brazil. Ministry of Health, *Health Care Networks*. Brasília, Brazil: Ministry of Health.

20. Machado, C. V., Lima, L. D., & Baptista, T. W. F. (2017). Health policy in Brazil in the 2000s: The federal agenda of priorities. *Cadernos de Saúde Pública, 33*(Suppl. 2), e00129616. https://doi.org/10.1590/0102-311X00129616

21. McKeown, T. (1980). *The role of medicine: Dream, mirage, or nemesis?* Princeton, NJ: Princeton University Press.

22. Merhy, E. E. (2007). *In search of lost time: The micropolitics of living work in health*. São Paulo, Brazil: Hucitec.

23. Minayo, M. C. de S. (2007). *The challenge of knowledge: Qualitative research in health* (10th ed.). São Paulo, Brazil: Hucitec.

24. Paim, J. S. (2008). *Brazilian Sanitary Reform: Contribution to understanding and criticism*. Salvador, Brazil: EDUFBA; Rio de Janeiro, Brazil: Fiocruz.

25. Paim, J. S. (2006). *What is the SUS*. Rio de Janeiro, Brazil: Fiocruz.

26. Paim, J. S. (2009). Universal health systems and neoliberal reforms: The case of SUS. *Saúde em Debate, 33*(81), 161–176.

27. Scheper-Hughes, N. (1993). *Death without weeping: The violence of everyday life in Brazil*. Berkeley, CA: University of California Press.

28. Starfield, B. (2002). *Primary care: Balance between health needs, services and technology*. Brasília, Brazil: Unesco, Ministry of Health.

29. dos Santos, A. N. S., et al. (2025). Collective health and equity – Challenges and strategies for an inclusive and sustainable health system. *Observatório de la Economía Latinoamericana, 23*(2), E8946. https://doi.org/10.55905/oelv23n2-041

30. dos Santos, A. N. S., et al. (2024). Cultural policies and mental health in childhood: Public policies of culture and its importance for the development of children's mental

health. *Cuadernos de Educación y Desarrollo, 16*(4), e4045. https://doi.org/10.55905/cuadv16n4-136

31. dos Santos, A. N. S., et al. (2024). "The invisible fortress": Reflections on socio-emotional and mental health aspects of single mothers in Brazil. *Cuadernos de Educación y Desarrollo, 16*(6), e4510. https://doi.org/10.55905/cuadv16n6-101

32. dos Santos, A. N. S., et al. (2024). "Intertwined lives": Subjective experiences and assemblages of caregivers of cancer patients in palliative care. *Cuadernos de Educación y Desarrollo, 16*(7), e4773. https://doi.org/10.55905/cuadv16n7-051

33. dos Santos, A. N. S., et al. (2024). "The silent cry": Unraveling the invisible knots of suicide and self-injury among young people in Brazil. *Contribuciones a las Ciencias Sociales, 17*(8), E9319. https://doi.org/10.55905/revconv.17n.8-144

34. dos Santos, A. N. S., et al. (2024). "Dialogues that cure": The perception of patients about the communication of health professionals in the SUS. *Contribuciones a las Ciencias Sociales, 17*(6), E7404. https://doi.org/10.55905/revconv.17n.6-100

35. dos Santos, A. N. S., et al. (2024). Weaving the threads of public health: The impact of basic sanitation on the quality of urban life and the environment. *Cuadernos de Educación y Desarrollo, 16*(5), e4259. https://doi.org/10.55905/cuadv16n5-079

36. dos Santos, A. N. S., et al. (2024). "De portas fechadas e uma infância fragmentada": A importância da creche e pré-escola para abrir caminhos e garantir uma primeira infância plena no Brasil. *Contribuciones a las Ciencias Sociales, 17*(6), E7843. https://doi.org/10.55905/revconv.17n.6-335

37. dos Santos, A. N. S., et al. (2024). "Health order, family norm": Interweaving the technical-scientific knowledge of sanitarians and the popular cultural knowledge of family medicine in the collective imagination. *Observatório de la Economía Latinoamericana, 22*(9), E6930. https://doi.org/10.55905/oelv22n9-202

38. dos Santos, A. N. S., et al. (2024). The new asylums: Psychiatric counter-reform, the commodification of madness and the rise of therapeutic communities in Brazil. *Pedagogical Notebook, 21*(12), e11224. https://doi.org/10.54033/cadpedv21n12-245

39. dos Santos, A. N. S., et al. (2025). Maternal mental health – Deconstructing the "myth of motherhood" and facing depression and anxiety in the postpartum period. *Observatório de la Economía Latinoamericana, 23*(3), E9369. https://doi.org/10.55905/oelv23n3-128

40. dos Santos, A. N. S., et al. (2024). Between the weight of care and invisible exhaustion: The biopsychosocial exhaustion of education and health professionals from Byung-Chul Han's "Fatigue Society". *Cuadernos de Educación y Desarrollo, 16*(13), e6979. https://doi.org/10.55905/cuadv16n13-101

41. Vilaça Mendes, E. (2011). *Health care networks*. Brasília, Brazil: Pan American Health Organization.

42. Weber, M. (1949). *Ensaios de sociologia* (4th ed.). São Paulo, Brazil: LTC.

43. Wilkinson, R., & Marmot, M. (2003). *Social determinants of health: The solid facts* (2nd ed.). Copenhagen, Denmark: World Health Organization.