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Humanized and Comprehensive Care in the Brazilian Unified Health System: Principles, Challenges, and Perspectives for Health Promotion

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Abstract

Humanized and comprehensive care represents an essential dimension of the Brazilian Unified Health System (SUS), particularly because healthcare involves not only biological conditions but also emotional, social, cultural, family, and territorial dimensions. Humanization requires recognizing users as subjects with rights,

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autonomy, preferences, and individual experiences, while comprehensiveness requires integrating health promotion, disease prevention, diagnosis, treatment, rehabilitation, palliative care, and health surveillance. This academic essay discusses humanized and comprehensive care within SUS, emphasizing its principles, organizational challenges, and perspectives for health promotion. The discussion addresses welcoming practices, active listening, autonomy, communication, equity, interprofessional work, Primary Health Care, healthcare networks, continuity of care, social participation, working conditions, technological transformation, and the importance of addressing social determinants of health. Humanized care cannot be restricted to interpersonal attitudes because the conditions under which healthcare professionals work and services are organized directly influence the quality of relationships established with users. Strengthening humanization therefore requires structural, managerial, ethical, and relational changes capable of placing people and communities at the centre of healthcare while preserving universality, comprehensiveness, equity, and the right to health.
Keywords: Humanized care; Comprehensive care; Brazilian Unified Health System; Health promotion; Patient-centred care.

1. Introduction

Humanized care has become increasingly important in contemporary healthcare because technological and scientific advances do not, by themselves, guarantee respectful, equitable, and meaningful healthcare experiences. Modern health systems possess increasingly sophisticated diagnostic and therapeutic resources, yet users may still encounter long waiting times, fragmented services, communication difficulties, lack of continuity, and relationships marked by excessive institutional distance. Humanization therefore remains a central challenge for healthcare organization.

Within the Brazilian context, humanization is closely connected to the principles and values of the Unified Health System. SUS was established on the basis of universality, comprehensiveness, and equity, recognizing health as a fundamental right and a responsibility of the State. These principles imply that healthcare should not be reduced to the provision of technical procedures but should include respect for dignity, autonomy, participation, and the diverse needs of the population.

Comprehensive care reinforces this perspective by recognizing that health problems frequently involve multiple dimensions. A person with a chronic disease may simultaneously experience psychological distress, financial difficulties, family responsibilities, occupational limitations, and barriers to accessing services. Addressing only the biological component of illness may produce technically

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appropriate but incomplete care. Humanization and comprehensiveness therefore intersect in the effort to understand people within their social and life contexts.

The relationship between users and healthcare professionals is an important dimension of humanized care. Listening, communication, empathy, respect, privacy, confidentiality, and shared decision-making can influence trust and satisfaction. However, humanization should not be interpreted as merely an individual characteristic of professionals. Institutional organization, workload, staffing, infrastructure, management practices, and access conditions also shape the possibility of establishing respectful relationships.

Primary Health Care has a particularly important role in this process. Because it operates close to communities and is designed to provide longitudinal care, it can establish relationships that extend beyond isolated consultations. Territorial knowledge, family involvement, community participation, health promotion, and coordination with other levels of care create opportunities for more comprehensive and humanized approaches.

This academic essay discusses humanized and comprehensive care within SUS, focusing on its principles, challenges, and perspectives for health promotion. The discussion addresses the relationship between humanization and comprehensiveness, the importance of welcoming practices, autonomy, equity, interprofessional work, healthcare networks, working conditions, technology, social participation, and health promotion. The central argument is that humanized care requires both ethical commitment in professional relationships and organizational conditions capable of placing people at the centre of healthcare.

2. Methods

This study was developed as an academic essay based on a narrative and critical examination of scientific and institutional literature addressing humanization, comprehensive care, patient-centred care, health promotion, Primary Health Care, healthcare networks, equity, social participation, and the principles of the Brazilian Unified Health System. Brazilian legislation, national policies, international frameworks, institutional publications, and scientific literature were considered in the construction of the discussion.

The essay does not present original empirical data and does not constitute a systematic review. Its purpose is conceptual and argumentative, integrating different perspectives concerning humanized and comprehensive care within SUS and its relationship with health promotion. The references used to support the discussion are presented exclusively at the end of the text, without in-text citations, according to the requested format. The reference list follows APA 7th edition standards.

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3. Development

Humanized care begins with recognition of the person as a subject of rights. Users of healthcare services should not be treated merely as carriers of diseases, diagnoses, or administrative records. Each person has a history, values, relationships, expectations, fears, and particular ways of experiencing illness. Recognizing these dimensions is fundamental to establishing healthcare relationships based on dignity and respect.

Humanization is therefore closely associated with the ethical foundations of healthcare. Respect for autonomy, confidentiality, privacy, informed participation, and freedom from discrimination should be incorporated into everyday practices. These principles are particularly important when individuals are experiencing vulnerability, pain, dependence, disability, uncertainty, or fear.

Communication is one of the principal instruments of humanized care. Professionals need to explain diagnoses, procedures, risks, therapeutic possibilities, and expected outcomes in language that users can understand. Communication should not be reduced to the transmission of technical information. It also requires listening to questions, concerns, preferences, and experiences.

Active listening represents a fundamental component of this process. A consultation in which the professional listens attentively can reveal information that would otherwise remain invisible. Social problems, family difficulties, emotional distress, medication barriers, and concerns about treatment may emerge when users are given sufficient space to express themselves.

The welcoming process is another important dimension. In the context of SUS, welcoming should be understood not simply as reception at the entrance of a healthcare facility but as an organizational and relational approach to responding to users' needs. It implies recognizing demands, evaluating urgency, providing appropriate responses, and avoiding unnecessary barriers.

Humanization also requires consideration of waiting times. Long waits can generate frustration, anxiety, and perceptions of disrespect, particularly when users do not receive adequate information about delays. Improving scheduling, regulation, communication, and service organization can therefore contribute to humanization without depending exclusively on interpersonal goodwill.

Access is inseparable from humanized care. A respectful consultation cannot compensate for the inability to obtain an appointment, medication, diagnostic examination, specialist assessment, or continuity of treatment. Humanization must

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therefore encompass the entire healthcare experience, including organizational processes that determine whether people can actually obtain the care they need.

Comprehensiveness expands this perspective. It requires health services to respond to people in a broad manner, integrating health promotion, prevention, diagnosis, treatment, rehabilitation, palliative care, and surveillance. The objective is not to offer every possible intervention but to ensure that care corresponds to the actual needs of users and communities.

Primary Health Care is strategically positioned to promote comprehensive and humanized care. Its proximity to territories allows teams to understand local conditions, establish longitudinal relationships, and identify needs that may not become evident during isolated encounters. The relationship between teams and communities can strengthen trust and facilitate preventive and promotional interventions.

Longitudinal care is particularly relevant. When users are followed by teams over time, professionals can understand their health trajectories, previous treatments, family circumstances, and changing needs. This continuity can reduce repetition, improve communication, and create stronger therapeutic relationships.

Healthcare networks are essential for maintaining this continuity when users require other levels of care. Humanized care cannot stop at the door of a Primary Health Care facility. Patients who need specialized consultations, hospital treatment, rehabilitation, mental health services, or emergency care should experience coordinated transitions between services.

Fragmentation can undermine humanization. When users are required to repeatedly explain their histories, search independently for referrals, obtain duplicated examinations, or move between services without clear guidance, they may feel abandoned by the system. Coordination is therefore both an organizational and a humanization strategy.

Referral and counter-referral mechanisms contribute to this coordination. Information about assessments and treatments should circulate appropriately among professionals and services. The primary care team should ideally know what occurred during specialized or hospital care and use this information to continue follow-up.

Interprofessional teamwork is another essential component. Complex health needs cannot always be addressed by a single professional category. Physicians, nurses, psychologists, social workers, pharmacists, dentists, physiotherapists, occupational therapists, community health workers, and other professionals can contribute different perspectives.

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Effective teamwork requires shared communication and recognition of complementary competencies. Hierarchical relationships that silence certain professional perspectives can reduce the quality of care. Collaborative decision-making and case discussion can facilitate broader understanding of users' needs.

The role of community health workers is particularly relevant to humanization within territories. Their proximity to households allows them to understand social and family contexts and to identify barriers that may not be visible during clinical consultations. They can also facilitate communication between communities and health teams.

Family participation may be important in situations involving children, older adults, disability, chronic disease, mental health conditions, and palliative care. However, family involvement should respect the autonomy and preferences of the person receiving care. Humanized care requires balancing support from relatives with the individual's right to participate in decisions.

Equity is another central dimension. Treating everyone identically does not necessarily constitute equitable care because people experience different barriers and have different needs. Humanized SUS services must recognize social inequalities and adapt strategies to populations experiencing greater vulnerability.

Discrimination represents a direct contradiction of humanized care. Race, gender, age, socioeconomic status, disability, geographic origin, migration status, appearance, diagnosis, or other characteristics should not determine whether users receive respectful treatment. Equity requires active measures to identify and reduce discriminatory practices.

Health literacy also influences humanized care. Users may have difficulty understanding technical language, treatment instructions, appointment systems, or healthcare pathways. Professionals should communicate in accessible ways and verify whether information has been understood. This approach strengthens autonomy rather than merely transferring responsibility to the patient.

Shared decision-making is particularly relevant when multiple therapeutic options exist. Professionals provide evidence and technical recommendations, while users contribute information about their preferences, priorities, daily circumstances, and ability to follow different strategies. The resulting plan can be more realistic and meaningful.

Humanized care also requires attention to emotional and psychological dimensions. Illness frequently generates fear, uncertainty, sadness, anger, or anxiety. Even when psychological care is not the primary intervention, professionals should recognize these experiences and respond appropriately. Emotional needs are not secondary to physical health.

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Mental health should consequently be integrated into comprehensive care. Individuals may seek health services for physical complaints while experiencing depression, anxiety, substance use, family conflict, or social isolation. Primary Health Care can identify these conditions and coordinate appropriate support within psychosocial care networks.

Chronic disease management represents another context in which humanization is essential. Long-term treatment requires sustained engagement rather than isolated interventions. Patients need support to understand their conditions, adapt treatment to daily life, manage symptoms, and address barriers that interfere with self-care.

Self-care should not be interpreted as abandonment of responsibility by the health system. People can actively participate in managing their health, but their capacity to do so depends on access to information, medication, food, housing, transportation, income, social support, and appropriate healthcare. Humanized care recognizes these structural conditions.

Health promotion further expands the scope of humanization. Rather than waiting for illness to occur, health services can work with communities to strengthen protective factors and reduce risks. Physical activity, healthy eating, vaccination, mental health, sexual and reproductive health, tobacco cessation, healthy ageing, and prevention of violence are examples of areas for action.

Community participation can make these interventions more relevant. Residents possess knowledge about their territories and can identify barriers that may not be visible to healthcare professionals. Participatory planning can strengthen trust and ensure that health promotion activities respond to actual priorities.

Social participation is also part of the democratic foundations of SUS. Health councils, conferences, community meetings, and other participatory mechanisms can provide opportunities for citizens to influence health policies. Humanization should therefore extend beyond individual encounters to include how institutions listen to communities.

Working conditions are fundamental to humanized care. Professionals experiencing excessive workloads, insufficient staffing, inadequate infrastructure, insecurity, low autonomy, and emotional exhaustion may have difficulty maintaining the level of attention and communication that humanized care requires. Organizational policies must therefore protect healthcare workers.

Humanization should not become a mechanism for transferring institutional responsibilities to individual professionals. Asking workers to be endlessly empathetic while maintaining inadequate staffing and excessive workloads is

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neither sustainable nor fair. Organizational changes are necessary to create conditions in which respectful care is possible.

Leadership and management influence these conditions. Managers can promote collaborative environments, improve communication, support professional development, address conflicts, and use service data to identify barriers. Management should therefore be considered part of the humanization agenda rather than a separate administrative domain.

Infrastructure also influences users' experiences. Privacy, accessibility, cleanliness, ventilation, seating, signage, safety, and physical comfort can communicate respect or neglect. Humanized environments should consider the needs of children, older adults, people with disabilities, pregnant women, caregivers, and other groups requiring specific accommodations.

Technology presents both opportunities and challenges. Electronic health records, telehealth, digital appointment systems, remote monitoring, and decision-support tools may improve continuity and access. They can also reduce unnecessary travel and facilitate communication between professionals.

However, technology should not replace human relationships when interpersonal interaction is clinically or emotionally necessary. Digital systems may become dehumanizing when professionals focus primarily on screens rather than users. The appropriate use of technology requires balancing efficiency with attention, privacy, communication, and human presence.

Data protection is another dimension of humanized digital care. Health information is highly sensitive and should be handled with confidentiality and appropriate security. Users should understand how their information is collected and used, particularly when digital platforms and artificial intelligence are involved.

Artificial intelligence may increasingly influence SUS through risk prediction, administrative management, clinical decision support, and population health monitoring. These tools may improve efficiency but can also reproduce biases present in data or algorithms. Human oversight, transparency, accountability, and ethical governance are therefore essential.

Humanized care must also be responsive to cultural differences. People interpret health, illness, suffering, family responsibilities, and treatment according to cultural experiences and social contexts. Professionals should avoid imposing assumptions and should seek to understand the meanings attributed to health problems by the people they serve.

Palliative care offers an especially clear example of the importance of humanization. When cure is no longer possible or is no longer the principal goal,

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quality of life, symptom control, communication, dignity, family support, and respect for preferences become central. Humanized care is therefore inseparable from the recognition of dignity throughout the course of illness.

Care for older adults similarly requires attention to autonomy and functional capacity. Ageing should not automatically be equated with dependence. Humanized services should support independence, social participation, mobility, cognitive health, and the right to make decisions whenever possible.

Children and adolescents require approaches adapted to developmental stages. Humanized care includes listening to young people, respecting their dignity, involving families appropriately, and creating environments in which they feel safe. Preventive and promotional activities should recognize the broader contexts of family, school, and community.

People living with disabilities also require accessible and inclusive services. Physical accessibility, communication resources, appropriate equipment, and professional training are essential. Humanization means recognizing disability as a dimension of diversity rather than treating people exclusively through a deficit-oriented perspective.

The COVID-19 pandemic reinforced the importance of humanized care under conditions of uncertainty. Infection-control measures, isolation, resource shortages, and service disruption challenged traditional forms of interaction. The experience demonstrated the importance of communication, psychosocial support, continuity, and community trust during health emergencies.

Public health emergencies also reveal the importance of balancing collective protection and individual rights. Measures such as isolation, vaccination campaigns, surveillance, and restrictions may be necessary under certain circumstances, but they should be implemented transparently, proportionately, and with attention to equity and communication.

Evaluation of humanization should include the perspective of users and workers. Patient satisfaction surveys, complaints, qualitative interviews, community discussions, and professional feedback can identify problems that conventional productivity indicators fail to capture. Quality should therefore be evaluated through both quantitative and experiential dimensions.

Indicators can monitor access, waiting times, continuity, complaints, patient experience, avoidable hospitalizations, preventive actions, and other aspects of care. However, numbers alone cannot determine whether a healthcare relationship was genuinely respectful. Qualitative approaches remain valuable for understanding experiences and meanings.

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The long-term perspective is also important. Humanized care can strengthen trust in health institutions and encourage people to seek preventive and therapeutic services. When users perceive healthcare as respectful and responsive, they may be more willing to communicate their needs and participate actively in treatment and prevention.

Ultimately, humanization is not an additional component of healthcare that can be implemented after technical services are organized. It is a way of organizing and delivering care. It influences how services are designed, how professionals work, how users participate, how decisions are made, and how healthcare networks respond to people's needs.

The integration of humanization and comprehensiveness can therefore strengthen the foundations of SUS. Humanization ensures that people are treated with dignity and recognized as subjects of rights, while comprehensiveness ensures that their needs are considered across different dimensions and levels of care. Together, these principles support a health system oriented toward people rather than procedures.

The future of humanized care will depend on the ability of SUS to reconcile technological development with human relationships, efficiency with equity, specialization with integration, and institutional organization with individual needs. These challenges require not only professional commitment but also political, managerial, financial, and organizational investment.

Humanized and comprehensive care ultimately depends on a simple but profound premise: healthcare exists for people. Services, protocols, technologies, indicators, and institutions are instruments designed to support this purpose. When organizational structures facilitate listening, access, continuity, participation, and dignity, SUS becomes better equipped to promote health and respond to the complexity of contemporary population needs.

4. Conclusion

Humanized and comprehensive care represents an essential expression of the principles of SUS and requires more than respectful interpersonal relationships. It involves recognizing users as subjects of rights, respecting autonomy, promoting active listening, ensuring equitable access, coordinating healthcare networks, strengthening continuity, and integrating biological, psychological, social, family, cultural, and territorial dimensions. Primary Health Care occupies a strategic position in this process because its proximity to communities creates opportunities for longitudinal relationships, health promotion, prevention, and coordination of care.

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The consolidation of humanization also depends on structural and organizational conditions. Adequate financing, qualified and protected professionals, appropriate infrastructure, effective management, integrated information systems, social participation, and equitable healthcare networks are necessary to make humanized care sustainable. Humanization should therefore be understood as a permanent commitment to reorganizing healthcare around people's needs and dignity. By integrating humanization with comprehensiveness and health promotion, SUS can strengthen its capacity to provide care that is technically qualified, ethically responsible, socially responsive, and centred on the real lives of the population.

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