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Comprehensiveness of Care in the Brazilian Unified Health System: Between Network Organization and Population Health Needs

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Abstract

Comprehensiveness of care is one of the fundamental principles of the Brazilian Unified Health System and represents an essential dimension for organizing healthcare according to the complex and diverse needs of the population. Rather than limiting care to the treatment of isolated diseases, comprehensiveness requires integration between health promotion, disease prevention, diagnosis, treatment, rehabilitation, palliative care, and health surveillance. In the Brazilian context, achieving comprehensive care depends on the organization of regionalized and integrated healthcare networks capable of coordinating different levels of care and professional competencies. This academic essay discusses comprehensiveness within the Unified Health System, emphasizing the relationship between healthcare network organization and the social, epidemiological, demographic, and individual needs of the population. The discussion addresses fragmentation, continuity of

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care, Primary Health Care, specialized services, interprofessional collaboration, regionalization, health inequalities, information systems, digital technologies, social participation, and management challenges. Comprehensiveness requires services capable of responding not only to diseases but also to people and their contexts. Strengthening this principle is therefore essential for consolidating universal, equitable, coordinated, and humanized healthcare in Brazil.

Keywords: Comprehensiveness of care; Brazilian Unified Health System; Healthcare networks; Health needs; Public health.

1. Introduction

Comprehensiveness of care is one of the central principles guiding the Brazilian Unified Health System and represents an important foundation for the organization of healthcare. Its meaning extends beyond the provision of multiple services and involves the capacity of the health system to recognize individuals and populations in their biological, psychological, social, cultural, and territorial dimensions. Comprehensive care therefore requires a broader understanding of health than the treatment of isolated diseases.

The complexity of contemporary health needs reinforces the importance of this principle. Population ageing, the increasing prevalence of chronic diseases, mental health problems, communicable diseases, disabilities, violence, social vulnerability, and emerging health threats coexist within the same territories. Individuals may experience several of these conditions simultaneously, requiring interventions from different professionals, services, and sectors. Health systems organized around isolated procedures may struggle to respond adequately to such complexity.

In Brazil, the challenge of comprehensiveness is closely connected to the organization of the SUS healthcare network. Primary Health Care, specialized outpatient services, hospitals, emergency services, rehabilitation, psychosocial care, health surveillance, and other components must operate as interconnected elements rather than independent structures. When communication and coordination between these services are weak, users may experience fragmented care and become responsible for navigating the system themselves.

The organization of healthcare networks is therefore essential for transforming the principle of comprehensiveness into actual experiences of care. Networks should facilitate appropriate movement between levels of care while preserving continuity and ensuring that information accompanies the patient. This requires referral and counter-referral mechanisms, shared clinical information, interprofessional communication, territorial planning, and clear responsibilities among services and managers.

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At the same time, comprehensiveness cannot be reduced to organizational integration. A perfectly structured network may still fail to provide comprehensive care if it does not recognize the needs and preferences of the people it serves. Social determinants, cultural characteristics, living conditions, family structures, economic resources, health literacy, and individual expectations all influence how health problems develop and how people access and use services.

This academic essay discusses comprehensiveness of care within SUS by examining the relationship between healthcare network organization and population health needs. It addresses the challenges of fragmentation, coordination, regionalization, continuity, interprofessional work, health inequalities, information management, digital transformation, and social participation. The central argument is that comprehensive care depends simultaneously on the structural capacity of healthcare networks and on their ability to remain responsive to the real and changing needs of individuals, families, and communities.

2. Methods

This study was developed as an academic essay based on a narrative and critical examination of scientific and institutional literature addressing comprehensiveness of care, the Brazilian Unified Health System, healthcare networks, Primary Health Care, regionalization, continuity of care, health needs, equity, and healthcare organization. Brazilian legislation, institutional documents, international guidelines, and scientific publications were considered in the development 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 on the relationship between healthcare network organization and the comprehensive response to population needs. 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.

3. Development

Comprehensiveness of care should initially be understood as a multidimensional concept. It involves the capacity to provide health promotion, disease prevention, diagnosis, treatment, rehabilitation, palliative care, and health surveillance according to the needs of individuals and populations. It also involves integrating these actions rather than delivering them as disconnected interventions.

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Comprehensive care therefore requires both a broad understanding of health and organizational mechanisms capable of connecting different forms of care.

The concept is particularly important because health needs rarely fit neatly into professional or institutional boundaries. A person living with diabetes may simultaneously experience depression, financial difficulties, mobility limitations, nutritional challenges, and family responsibilities. Treating blood glucose levels alone does not necessarily constitute comprehensive care. The health system must recognize the multiple dimensions that influence the person's capacity to maintain health and manage the condition.

Population ageing further reinforces this challenge. Older adults may experience multiple chronic conditions, functional limitations, polypharmacy, cognitive changes, social isolation, and dependence on caregivers. Their needs often involve Primary Health Care, specialized services, rehabilitation, home care, social assistance, and family support. Without coordination, the number of services may increase without producing genuinely comprehensive care.

The epidemiological transition also contributes to complexity. Brazil continues to face infectious diseases and other acute conditions while experiencing a large burden of chronic noncommunicable diseases. These conditions require different forms of intervention and frequently coexist within the same communities. A health system organized exclusively around episodic treatment cannot adequately respond to such a mixed epidemiological profile.

Primary Health Care has a strategic role in comprehensive care because it maintains closer relationships with individuals, families, and territories. Its longitudinal perspective allows teams to identify health needs over time and coordinate interventions across different services. Strong primary care can function as a point of integration between the user and the broader healthcare network.

Continuity of care is closely related to comprehensiveness. Users should not have to restart their health histories every time they move between services. Clinical information, previous treatments, diagnostic findings, medication use, and relevant social circumstances should be available to professionals involved in subsequent care. Continuity reduces duplication, prevents communication failures, and supports more coherent clinical decisions.

Healthcare networks are therefore fundamental organizational structures. A network is not simply a collection of services geographically located within the same region. It requires relationships, communication, coordination, shared responsibilities, and defined flows. Its objective is to ensure that different points of care operate as interconnected components capable of responding to different levels of health need.

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Fragmentation represents one of the principal obstacles to this objective. Fragmentation may occur when services operate according to separate administrative structures, incompatible information systems, different clinical priorities, or poorly defined referral pathways. Users may then encounter multiple professionals without a clear person or team responsible for coordinating the overall care process.

The referral system is an important component of network integration. When Primary Health Care identifies a need for specialized assessment, referral should occur according to defined criteria and within an appropriate timeframe. However, referral alone is insufficient. Information about the specialist's assessment and recommendations should return to the primary care team so that subsequent care can be coordinated.

Counter-referral is therefore as important as referral. Without effective communication from specialized and hospital services back to Primary Health Care, the longitudinal relationship may be interrupted. Patients may return to their communities without adequate information regarding diagnosis, medication changes, follow-up requirements, or warning signs.

Waiting times also influence comprehensiveness. A patient may receive appropriate initial care but face months of delay before obtaining specialized assessment or diagnostic testing. Such delays can worsen conditions, increase anxiety, generate unnecessary emergency visits, and compromise trust in the healthcare system. Comprehensive care requires not only coordination but timely coordination.

Regionalization is particularly important in Brazil because municipalities differ greatly in their capacity to provide specialized and hospital services. Smaller municipalities may depend on regional centres for complex procedures, diagnostic technologies, and specialist consultations. Healthcare networks must therefore be organized across municipal boundaries to guarantee access according to population needs.

Regionalization, however, requires effective governance. Different municipalities and government levels must coordinate planning, financing, service distribution, regulation, and patient flows. Without shared governance, regional networks may exist formally while remaining fragmented in practice. Cooperation among federal, state, and municipal authorities is consequently essential.

Equity must also be incorporated into network organization. Equal distribution of services does not necessarily produce equitable access because population needs vary. Territories with greater social vulnerability, higher disease burdens, geographical isolation, or older populations may require greater resources and

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differentiated strategies. Comprehensive care therefore requires attention to inequalities.

Social determinants of health influence both the emergence of health problems and the ability to access care. Housing, income, education, employment, food security, sanitation, transportation, environmental conditions, and social protection can significantly affect health outcomes. A healthcare network that focuses exclusively on clinical services may fail to address important determinants of population health.

Intersectoral collaboration is consequently necessary. Health services may identify families experiencing housing insecurity, food insecurity, violence, unemployment, or social isolation, but healthcare professionals cannot solve these problems alone. Connections with social assistance, education, housing, employment, justice, and other sectors can contribute to more comprehensive responses.

The family and community context should also be considered. Health conditions affect not only individuals but also relatives, caregivers, and social networks. Chronic disease management, disability, palliative care, mental health, and long-term dependence often require support beyond clinical interventions. Comprehensive care must therefore recognize caregivers and families as relevant participants in care processes.

Interprofessional collaboration is another essential dimension. Different professional groups possess distinct forms of knowledge and can contribute to broader assessments of health needs. Effective collaboration allows professionals to construct shared care plans, discuss complex cases, and distribute responsibilities according to competencies. Without teamwork, services may reproduce fragmented approaches within the same institution.

Communication is central to this process. Technical information must be exchanged accurately between professionals while communication with users should be clear and understandable. Poor communication can generate misunderstandings, duplicated procedures, medication errors, and loss of trust. Comprehensive care requires both interprofessional communication and meaningful communication with patients.

Health literacy is also relevant. Users need to understand their conditions, treatment options, medication regimens, preventive recommendations, and how to navigate healthcare networks. Professionals should adapt communication to people's educational, linguistic, cultural, and cognitive circumstances. This is particularly important for individuals experiencing multiple chronic conditions.

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Patient-centred care strengthens comprehensiveness by recognizing people as active participants rather than passive recipients of interventions. Preferences, values, expectations, and life circumstances should be incorporated into decisions whenever possible. The best technically available intervention may not be the most appropriate if it is incompatible with a person's circumstances or priorities.

Shared decision-making can contribute to this approach. Professionals provide technical knowledge while users contribute information about their preferences, experiences, and capabilities. Decisions become more meaningful when these forms of knowledge are combined. Such approaches are particularly relevant for chronic conditions, where long-term adherence depends partly on whether care plans are compatible with everyday life.

Mental health illustrates the importance of comprehensive organization particularly clearly. Psychological distress may coexist with chronic diseases, social vulnerability, substance use, family conflict, and unemployment. Mental health services should therefore not function as isolated structures. Primary care, psychosocial care, hospitals, emergency services, social assistance, and community resources need to communicate and coordinate their interventions.

Similarly, oral health should be integrated into broader healthcare planning. Oral diseases can affect nutrition, communication, quality of life, and social participation, while systemic conditions may influence oral health. Integrating dental services into healthcare networks contributes to a more comprehensive understanding of people's health needs.

Rehabilitation represents another frequently underestimated component. People recovering from stroke, trauma, surgery, neurological conditions, or chronic diseases may require physiotherapy, occupational therapy, speech therapy, psychological support, and social assistance. Without adequate rehabilitation pathways, treatment may focus on survival or acute management without supporting functional recovery and social participation.

Palliative care also demonstrates why comprehensiveness cannot be restricted to curative treatment. Patients with advanced illnesses may require symptom control, psychological support, family assistance, communication, and attention to dignity and preferences. These needs may arise across hospitals, primary care, home care, and community settings. Effective networks must therefore provide continuity throughout the course of illness.

Home-based care can strengthen continuity for individuals with mobility limitations, severe chronic diseases, disabilities, or dependence. It allows professionals to understand the environment in which people live and identify barriers that may not be visible in clinical settings. However, home care requires workforce capacity, transportation, coordination, and integration with other services.

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Health surveillance is another dimension of comprehensiveness. Epidemiological, environmental, occupational, and sanitary surveillance can identify risks and guide preventive interventions. Integrating surveillance with clinical care allows health teams to move from reacting to illness toward anticipating risks and addressing population-level determinants.

Information systems are essential for this integration. Electronic health records and interoperable databases can facilitate the exchange of information across services. Managers can also use aggregated data to identify gaps, monitor population health, evaluate access, and plan resources. However, technological integration requires interoperability, data quality, privacy protection, cybersecurity, and professional training.

Digital technologies can also support continuity through telehealth and remote monitoring. Patients in remote areas may obtain specialist guidance without travelling long distances, while professionals can communicate across territories. Digital tools can reduce certain access barriers, although they should complement rather than replace face-to-face care when physical assessment or interpersonal contact is necessary.

The digital divide must be considered carefully. Not all populations have equal access to internet connectivity, smartphones, computers, or digital literacy. If healthcare networks become excessively dependent on digital platforms, some groups may experience new forms of exclusion. Comprehensive care therefore requires technology to be implemented according to principles of accessibility and equity.

Management plays a decisive role in network integration. Managers must organize services, define flows, allocate resources, monitor indicators, coordinate teams, and address bottlenecks. Comprehensive care cannot be achieved only through individual professional commitment if organizational structures prevent effective communication and coordination.

Financing is similarly important. Networks require sustained resources for workforce, transportation, information systems, diagnostic capacity, infrastructure, medicines, and specialized services. Underfunded networks may create bottlenecks at particular points, leading to long waiting lists and interruptions in continuity. Resource allocation should therefore consider the functioning of the network as a whole.

Evaluation should move beyond counting procedures. A service may perform a large number of consultations while still failing to provide comprehensive care. Indicators should examine continuity, access, waiting times, coordination, patient experience, health outcomes, avoidable hospitalizations, equity, and other dimensions of network performance.

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Population participation can contribute to this evaluation. Users frequently identify barriers that are not visible in administrative databases. Difficult appointment systems, transportation problems, communication failures, disrespectful treatment, and long waits may become apparent through community feedback. Social participation mechanisms within SUS can therefore contribute to more responsive network organization.

The principle of comprehensiveness also requires recognition of diversity. Brazil contains populations with different cultural practices, languages, family structures, geographic conditions, and socioeconomic realities. A standardized service model may not adequately address all these differences. Comprehensive care requires flexibility to adapt interventions to local contexts.

The COVID-19 pandemic exposed the consequences of fragmentation and the importance of integrated networks. The need to combine surveillance, vaccination, primary care, emergency services, hospitals, laboratories, communication, and community action demonstrated that health problems cannot always be managed within a single level of care. Crisis situations reinforce the importance of previously established coordination mechanisms.

The same lesson applies to future emergencies. Climate-related events, infectious disease outbreaks, disasters, and other crises require healthcare networks capable of rapidly reorganizing services. Strong relationships between levels of care and sectors facilitate the redistribution of resources and the maintenance of essential services.

Comprehensiveness should therefore be understood as a dynamic process rather than a fixed organizational state. Population needs change over time, technologies evolve, epidemiological patterns shift, and social conditions transform. Healthcare networks must continuously evaluate their performance and adapt their organization accordingly.

Ultimately, the effectiveness of comprehensive care depends on the ability to connect two dimensions that are sometimes treated separately: the organization of services and the lived reality of populations. Networks can be technically sophisticated but socially unresponsive, while community-oriented services may lack the structural connections necessary to address complex needs. Comprehensive care requires both dimensions to operate together.

The future of SUS depends partly on its capacity to strengthen this integration. Healthcare networks must be organized around people and territories rather than around isolated institutions. Primary Health Care should coordinate care, specialized and hospital services should communicate effectively with primary teams, surveillance should inform clinical and territorial action, and social participation should contribute to defining priorities.

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In this perspective, comprehensiveness becomes more than an abstract constitutional principle. It becomes a practical criterion for evaluating whether the health system is actually capable of responding to the complexity of people's lives. A comprehensive system is one that recognizes needs, coordinates responses, reduces barriers, supports continuity, and adapts its organization to the diversity of the population it serves.

4. Conclusion

Comprehensiveness of care is essential to the consolidation of SUS because health needs cannot be adequately addressed through fragmented interventions or isolated services. The organization of healthcare networks must facilitate access, continuity, coordination, and communication among Primary Health Care, specialized services, hospitals, rehabilitation, psychosocial care, surveillance, and other components of the system. Regionalization, interprofessional collaboration, appropriate financing, qualified management, and integrated information systems are fundamental conditions for making these connections effective.

At the same time, comprehensive care must remain centred on the actual needs of individuals, families, and communities. Social determinants, inequalities, cultural contexts, health literacy, preferences, and living conditions must be incorporated into healthcare planning and delivery. Strengthening comprehensiveness therefore requires combining organizational integration with a humanized and territorially sensitive approach. When healthcare networks are structured around people rather than isolated procedures, SUS becomes better able to fulfil its principles of universality, equity, and comprehensive care and to transform the right to health into meaningful experiences of care.

References

Brasil. (1988). *Constituição da República Federativa do Brasil de 1988*. Presidência da República.

Brasil. (1990a). *Lei nº 8.080, de 19 de setembro de 1990: Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes*. Presidência da República.

Brasil. (1990b). *Lei nº 8.142, de 28 de dezembro de 1990: Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS)*. Presidência da República.

CC BY

RSV
ISSN 2674-8584

Received: 13/08/2026 - **Accepted:** 10/09/2026
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DOI: 10.66104/s5p0xb81
Pages: 1-12

Brasil. Ministério da Saúde. (2010). *Portaria nº 4.279, de 30 de dezembro de 2010: Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde*. Ministério da Saúde.

Brasil. Ministério da Saúde. (2017). *Portaria de Consolidação nº 3, de 28 de setembro de 2017: Consolidação das normas sobre as redes do Sistema Único de Saúde*. Ministério da Saúde.

Brasil. Ministério da Saúde. (2017). *Portaria nº 2.436, de 21 de setembro de 2017: Aprova a Política Nacional de Atenção Básica*. Ministério da Saúde.

Castro, M. C., Massuda, A., Almeida, G., Menezes-Filho, N. A., Andrade, M. V., de Souza Noronha, K. V. M., Rocha, R., Macinko, J., Hone, T., Tasca, R., Giovanella, L., Malik, A. M., Werneck, H., Fakhruddin, A., Atun, R., & Rocha, R. (2019). Brazil's unified health system: The first 30 years and prospects for the future. *The Lancet, 394*(10195), 345–356. https://doi.org/10.1016/S0140-6736(19)31243-7

Giovanella, L., Franco, C. M., & Almeida, P. F. (2020). Política Nacional de Atenção Básica: Para onde vamos? *Ciência & Saúde Coletiva, 25*(4), 1475–1482. https://doi.org/10.1590/1413-81232020254.01842020

Mendes, E. V. (2019). *As redes de atenção à saúde* (2nd ed.). Organização Pan-Americana da Saúde.

Mendes, E. V. (2012). O cuidado das condições crônicas na atenção primária à saúde: O imperativo da consolidação da estratégia da saúde da família. *Organização Pan-Americana da Saúde*.

Mendes, E. V. (2011). *As redes de atenção à saúde* (2nd ed.). Organização Pan-Americana da Saúde.

Organização Pan-Americana da Saúde. (2019). *Relatório 30 anos de SUS: Que SUS para 2030?* OPAS.

Paim, J. (2018). Sistema Único de Saúde (SUS) aos 30 anos. *Ciência & Saúde Coletiva, 23*(6), 1723–1728. https://doi.org/10.1590/1413-81232018236.09172018

Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. *The Milbank Quarterly, 83*(3), 457–502. https://doi.org/10.1111/j.1468-0009.2005.00409.x

Tasca, R., Massuda, A., Carvalho, W. M., Buchweitz, C., & Harzheim, E. (2020). Recomendações para o fortalecimento da atenção primária à saúde no

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Pages: 1-12

Brasil. *Revista Panamericana de Salud Pública, 44*, e4. https://doi.org/10.26633/RPSP.2020.4

World Health Organization. (2018). *Declaration of Astana: Global Conference on Primary Health Care*. World Health Organization.

World Health Organization. (2021). *Primary health care measurement framework and indicators: Monitoring health systems through a primary health care lens*. World Health Organization.

World Health Organization. (2021). *Integrated care for older people (ICOPE): Guidance for person-centred assessment and pathways in primary care* (2nd ed.). World Health Organization.

World Health Organization. (2023). *Primary health care on the road to universal health coverage: 2023 monitoring report*. World Health Organization.

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