BMC Public Health

RESEARCH

Open Access

Possible connections between health equity and primary health care: a scoping review

Ana Júlia Nociti Lopes Fernandes[1], Luciana Cisoto Ribeiro[2] and Janise Braga Barros Ferreira[2*]

Abstract

According to the literature, primary health care plays a major role in the dissemination and operation of the principle of health equity. The study investigated how health equity is connected with primary care and public health policies in the national and international literature. Searches were made in the SCOPUS, CINAHL, BVS, PubMed, and Scielo databases, using the method proposed by the Joanna Briggs Institute. The eligibility criteria were developed based on the strategy Population (population in general), Concept (health equity), and Context (PHC). Overall, 34 materials were included in the study. Equity was mainly associated with Whitehead's theoretical conceptions, focusing on access, marginalized groups, and abstract principles and values. Connections were found in the spheres of the micro-space of health work, management, and policies. Few materials measured equity, within the aspects of access, care, funding, and outcomes. The concept was mostly used in its negative connotation and in relation to the equality/inequality binomial. The relationship between equity and primary care was developed in the fields of micro-processes, macro-processes, and health results. It was concluded that there is a need for the development of specific instruments to measure the concept and for greater clarity in publications on the topic.

Keywords Health Equity, Primary Health Care, Public Health, Health Policy, Review

Introduction

The term "equity" originates from the Aristotelian tradition, which recognizes that formal and universal laws are insufficient to apply justice. However, the use of this term in the health field is recent, and "equality" is one of the main concepts employed in the area. Despite its increasing use, the principle continues to be used about the equality/inequality binomial as a synonym for equality [1], or thinking of the two terms in a relationship of means and ends, with equity being a strategy to overcome inequality [2].

Furthermore, according to scientific evidence, the operationalization of this principle is difficult since it is an abstract value associated with a conception of social and economic organization, which makes it challenging to develop a more structured conceptualization [2–5]. The literature [6] addresses the need for studies that define this concept precisely and explain how it should be applied.

Despite these impasses, the concept has been discussed in Latin America for several decades [7–9]. The production of Latin American authors is significant, with emphasis on Jaime Breilh [10]. In the Brazilian scenario, Almeida Filho et al. [11, 12] and Buss & Pellegrini Filho [13] deserve to be highlighted. Initially, it received political visibility as a way of establishing targeted programs aimed at reducing poverty. Later, it began to be defended regionally as a way of achieving justice in health, in

*Correspondence:
Janise Braga Barros Ferreira
janise@fmrp.usp.br
[1] Postgraduate Program in Public Health, Ribeirão Preto Medical School, University of São Paulo, Bandeirantes Avenue, 3900. Monte Alegre, Ribeirão Preto, São Paulo 14049-900, Brazil
[2] Department of Social Medicine, University of São Paulo at Ribeirão Preto Medical School, Bandeirantes Avenue, 3900. Monte Alegre, Ribeirão Preto, São Paulo 14049-900, Brazil

conjunction with the social determination of the health disease process and the theory of lifestyles.

In Brazil, the understanding of how equity should be applied to the Unified Health System (SUS) is not homogeneous [14], and this principle has yet to be investigated [2, 4, 14, 15]. Despite these statements, from the perspective of Latin American theoretical production, equity is understood as necessarily linked to the form of social organization, with a focus on differences in the provision of services for equal needs (horizontal equity) and differentiated provision for groups with more significant needs (vertical equity) [10, 11]. In this sense, several authors [16] argue that Primary Health Care (PHC) is more effective in achieving health equity because it focuses on people and the community and integrates care at various points within the healthcare network. Therefore, due to its organizational and resource allocation specificities, comprehensive PHC should be the preferred entry point into the health system and be the coordinator of care. In addition, the financing and provision of predominantly public services and concrete regulation by the State for the understanding of health as a public good help to build a universal system that promotes equity [5, 17].

Thus, according to the World Health Organization [11], contemporary PHC needs to combine universal and targeted strategies to achieve equitable health outcomes. In the Brazilian case, it is worth noting that the Department of Primary Health Care of the Ministry of Health developed the "Health Equity Monitoring Panel", which contains data on the registration and care of vulnerable populations in PHC [18]. The information provided by this panel can contribute to the planning, monitoring and evaluation of health actions, mainly in PHC, targeted at specific populations to reduce health inequities. Despite all the scientific literature on health equity, there is a need to deepen the global understanding of this term in the context of PHC. In this logic, the importance of theoretical models for measuring the effects of health interventions in PHC, together with other social policies, is emphasized. This knowledge allows authorities to address social justice issues well, proactively and effectively in current and future health crises [19, 20].

Based on this reflection, the study aimed to investigate which aspects of equity are developed in PHC, which problems affect its effective implementation at this point in the health network, which populations have been targeted by this connection, which theoretical perspectives have been used, how this concept is measured and whether global equity emerges as a relevant concept when addressing public health policies, with an emphasis on PHC.

Therefore, this scoping review aimed to identify and present information that relates Health Equity to PHC and Public Health Policies in the national and international literature.

Method

Search strategy and inclusion criterias

The method proposed by the Joanna Briggs Institute (JBI) for scoping reviews was used in this study. The protocol for this review has been registered on the Open Science Framework platform (https://doi.org/10.17605/OSF.IO/QKUZG). The development of the eligibility criteria was based on the PCC strategy (Population, Concept, and Context) [21–23]. The following were considered eligible: the population in general, with no inclusion criterion (P), the concept of health equity (C), and Primary Health Care and Public Health Policies (C). Materials in Portuguese, English, or Spanish were included, available in full text and with free access.

Studies published from 1980 onwards were adopted as the temporal criterion, using the date of the Alma-Ata Declaration [24] as the time frame for the discussion on PHC. Protocols and materials that did not fulfil the research objective were excluded.

Descriptors validated by the Health Sciences Descriptors/Medical Subject Headings (DeCS/MeSH) were used to perform the search. SCOPUS, CINAHL, LILACS, and PubMed, the databases selected for the search conducted in March 2023. In each database, three searches were carried out using, respectively, each of the search keys (Table 1).

Selection of studies

The software Rayyan was used in the process of materials selection. Through it, duplicate materials were identified and two reviewers performed a blind assessment of the texts by title and abstract. Conflicts were resolved by a third reviewer. After the complete reading of the remaining materials, the review included 35 materials. All the stages can be seen in Fig. 1 (PRISMA for Scoping Reviews (ScR) Flowchart).

Table 1 Search keys used in the study

Search Keys	Search Date
1) ("equidade" OR "equidade em saúde") AND ("atenção primária à saúde") AND ("política de saúde") AND ("saúde pública") 2) ("equity" OR "health equity") AND ("primary health care") AND ("health policy") AND ("public health") 3) ("equidad" OR "equidad en salud") AND ("atención primaria de salud") AND ("política de salud") AND ("salud pública")	March 22, 2023

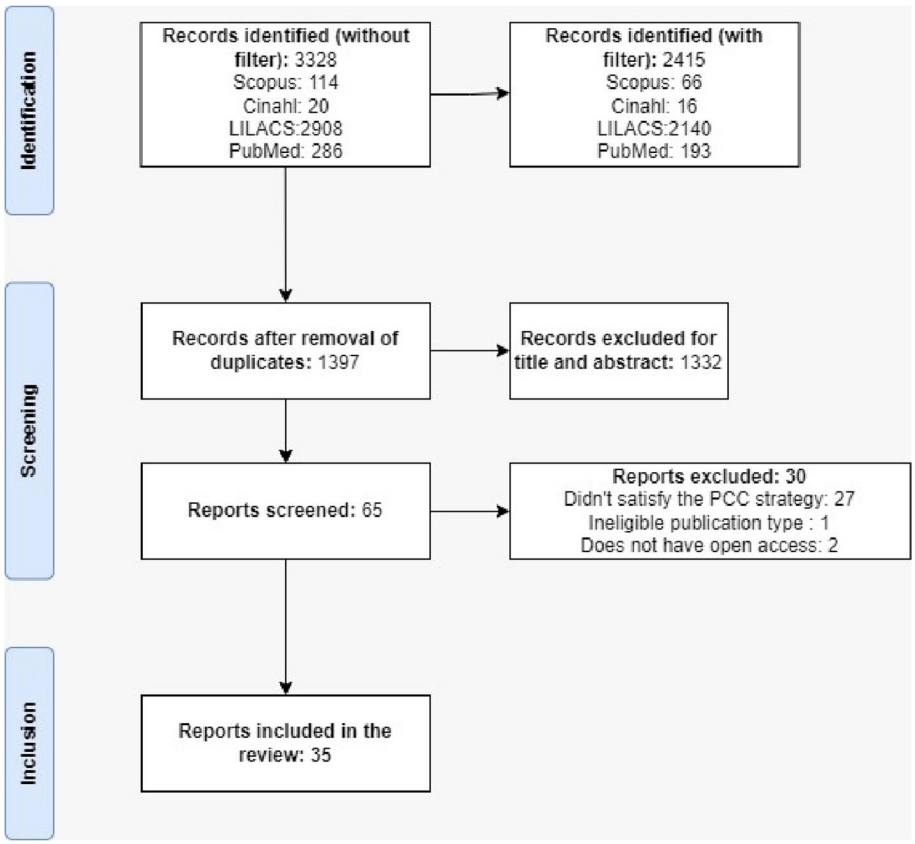

Fig. 1 PRISMA-ScR, identification of the selection process of the materials included in the review

Collection, processing, and analysis

Two instruments were developed for data extraction: a table containing each material's main bibliographic information (authors, title, year, language, type of material, journal/institution of publication, focused country), and an analytical and mapping table based on the review's questions (text's objective, method, main results/recommendations, conclusions, population, theoretical perspective, conceptualization and measurement of equity, connected PHC components/context, and connections made and proposed between equity and PHC). Thus, after data extraction, descriptive analysis was performed to characterize the evidence included in the study. Next, content analysis was performed, as proposed by the JBI [22], with the mapping of evidence that formed three categories (concept, context and connections, and measurement), detailed in themes. Further information on the methodological procedures can be found in Fernandes and Ferreira [25].

Results

The years with the highest number of publications were 2017 (5), 2012 (4), 2015 (4), 2018 (4), and 2020 (4). The oldest material was published in 2003, but a higher number was observed from 2012 onwards. The review corpus consisted mostly of primary research articles (20) and there were also 5 reviews, 3 comments, 2 summaries of recommendations from events, 2 government publications, 1 book, 1 dissertation, and 1 booklet. The materials' target countries were mainly Brazil (13), Australia (5), Canada (4), and the United States of America (2). Other countries also emerged, in 1 text each: Argentina, India, England, Peru, and Sweden (Fig. 2). The remaining texts did not focus on a specific country. In addition, 8.57% of the selected materials were published in Spanish, 40% in Portuguese, and 51.43% in English.

Of the selected materials, 19 (55.8%) did not focus on any particular population. However, 9 texts interacted with the Equity Policies of the Brazilian Ministry

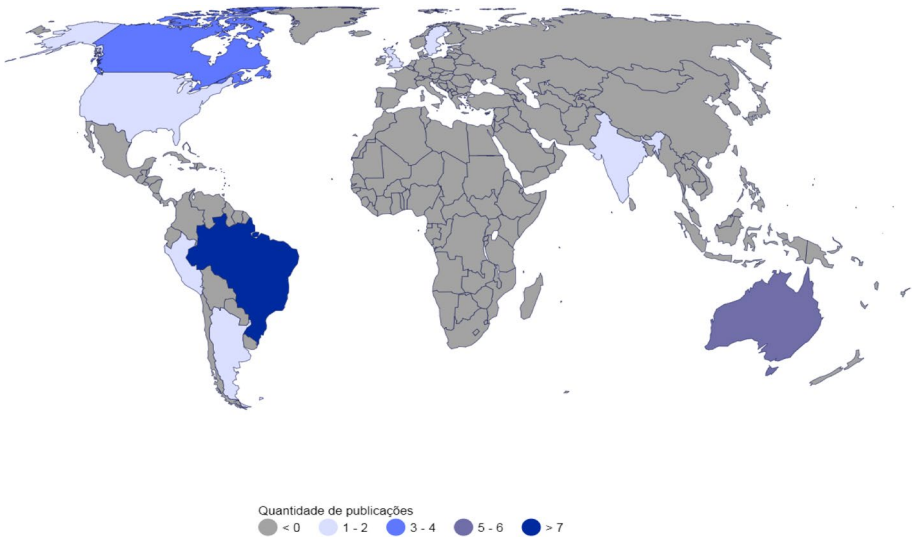

Fig. 2 Heatmap of the publications' countries of origin

of Health by approaching the homeless population [26–28], countryside, forest and water communities [29–31], indigenous communities [29, 30], migrants [26, 27], the LGBTQIA + population [32], and racial minorities [33]. Other emerging focus were socioeconomic origin [26, 32–34] and people diagnosed with non-communicable chronic diseases [34–36].

The topics below map the evidence related to the categories: the concept of Health Equity, the PHC context, the connections made with this concept, and its forms of measurement.

Concept of health equity

Regarding the concept of health equity, detailed in 18 materials (52.94%), it is important to highlight the understanding that addressed inequities as systematic, unnecessary, preventable, and/or unfair differences [30, 32, 33, 36–41]. Such understanding is associated with Whitehead [42], although not all texts mention the author. The view of equity as fair or equal opportunity, associated with the same author, emerged frequently [29, 32, 39, 41, 43]. The equality/inequality binomial was registered in the conceptualization and its use reflected a lack of consensus: either equity was proposed as a way to reach equality or equity/inequity and equality/inequality were used as synonyms.

Furthermore, many concepts incorporated the dimension of access [27, 29–32, 35, 36, 38, 43–46], either as a component of the conceptualization of equity (reduction in differences, discrimination in access, universal and/or equal access) or as a category, as equity/inequity of access, in the form of use of services appropriate to the needs, regardless of socioeconomic condition [36, 44], differentiated access [27] or generalized access, with no details [28, 31, 45]. The materials that included this dimension in the discussion originated in Brazil (4), Australia (4), and Canada (1). Two materials did not focus on a country.

In some materials, the concept was related to marginalized and vulnerable groups whose health differences derived from historical conditions [26, 27, 29, 32, 35–39, 44], an understanding expressed by the Health Equity Policies of the Brazilian Ministry of Health. The equity meanings emerged connected with assistance, addressing differences in outcomes, singular health needs, and care experiences [27–31, 36, 38, 41–44], and also with structure and policies, like funding, services provision, and intersectorality [27–29, 31–33, 35, 37, 38, 45, 47]. Some texts conceptualized equity based on abstract values and principles, like human and social rights [30], social justice [27, 38, 41, 45], universality [41, 43, 45], and awareness [41], while Carneiro Jr. and Silveira [28] argued that this relationship is grounded on moral values that are historically contextualized. It is worth mentioning that Andrade et al. [35], Schweickardt et al. [30] and Nascimento et al. [46] stated that equity is a principle of the SUS, but this was not found in its primary law (Fig. 3).

Context and connections

Some of the connections made with PHC in the microspace of health work were (1) health equity and access to PHC [27–56]; (2) equity in healthcare [34, 38, 43, 46, 50, 52–54, 57]; and (3) qualification and training of professionals involved in equitable care [29, 34, 38–41, 50, 52, 53, 55, 58].

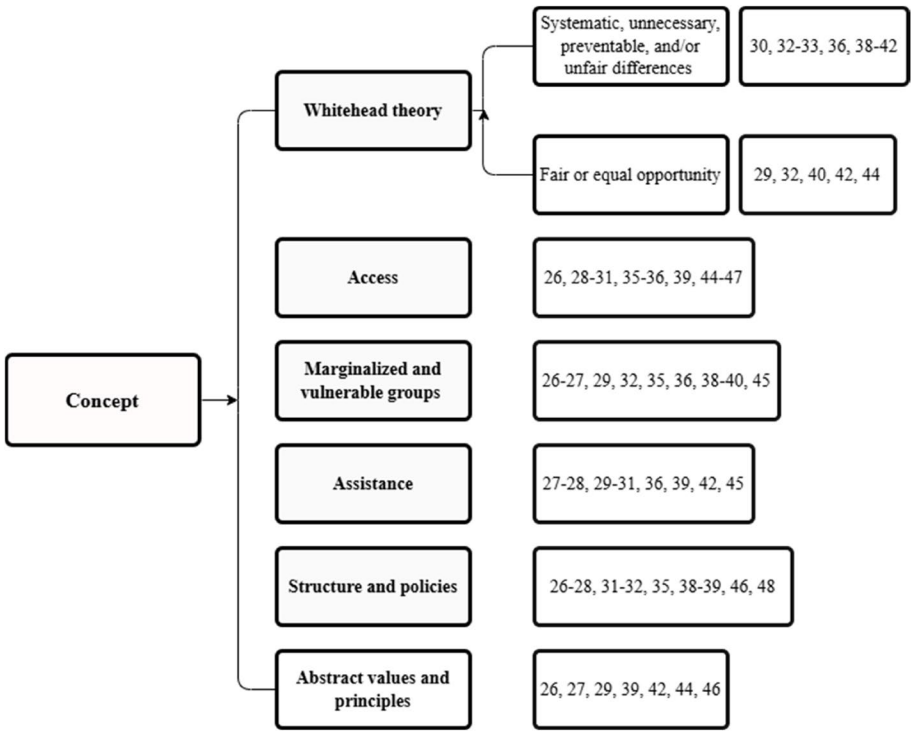

Fig. 3 Identification of the main themes observed within the category "Concept" and the respective bibliographic references

Apart from this micro dimension, targeted at the endpoint of care, other emerging themes were the inclusion of equity in policies [29, 37, 38, 45, 49, 54, 55, 57] and the issue of funding and allocation of resources, mainly related to the health need [31, 33, 36, 37, 44, 49–53, 55, 56, 58, 59]. Moreover, in the same sphere of management, the following aspects were related: equity, PHC, and territorial distribution [36, 41, 44, 49, 52], organization in networks and the regionalization process [29, 36, 47–49, 52], services coverage [29, 32, 35, 40, 54, 55], provision [30, 55], and organization [37, 41], intersectorality [39, 50], work organization [27], and model of care [49].

Some materials related equity to the sphere of observed results and impacts, such as equity in the outcomes [33, 34, 36, 38, 53, 54, 57], in PHC quality [33, 37, 40, 54], and in the use of these services [60]. Figure 4 presents the main themes discussed in the category "context and connections" and their respective bibliographic references.

Measurement

Only 16 materials (47%) referred to or performed some kind of equity measurement, and four of them did not define the concept [34, 55, 59, 60]. Most of them measured equity in access, which was the case of (1) White and Newman [28], who focused on policies (funding and organization), characteristics of the systems (availability and organization), use of the services, specificities of the vulnerable population, and satisfaction, (2) Thomas et al. [30], who approached services provision, (3) Carneiro Jr. and Silveira [26] and (4) Carneiro Jr. et al. [27], who addressed marginalized populations' enrolment in the service, (5) Fisher et al. [44], who analyzed the dimensions of acceptability, accessibility and availability, highlighting the effects of universal and focal policies, and (6) Thomas et al. [31], who connected funding with need and access. It is important to notice that, although all these authors mentioned health equity measurement, none used validated instruments nor agreed on how equity of access should be measured.

In addition to access, some authors sought to measure equity of care, such as Guimarães et al. [43], who aimed to understand social representations by means of interviews, and Ford-Gilboe et al. [38], who investigated attitudes of health professionals through the self-report scale Equity-Oriented Health Care Scale.

Two materials focused on funding based on differences in outcomes, access, and PHC quality according to race and socioeconomic condition [33] or social vulnerability [59]. Likewise, only two materials discussed equity measurement based on differences in outcomes, focusing either on morbidity and mortality [34] or the population with non-communicable diseases [36].

Two articles brought validated indicators to measure equity, but they were not developed specifically for it,

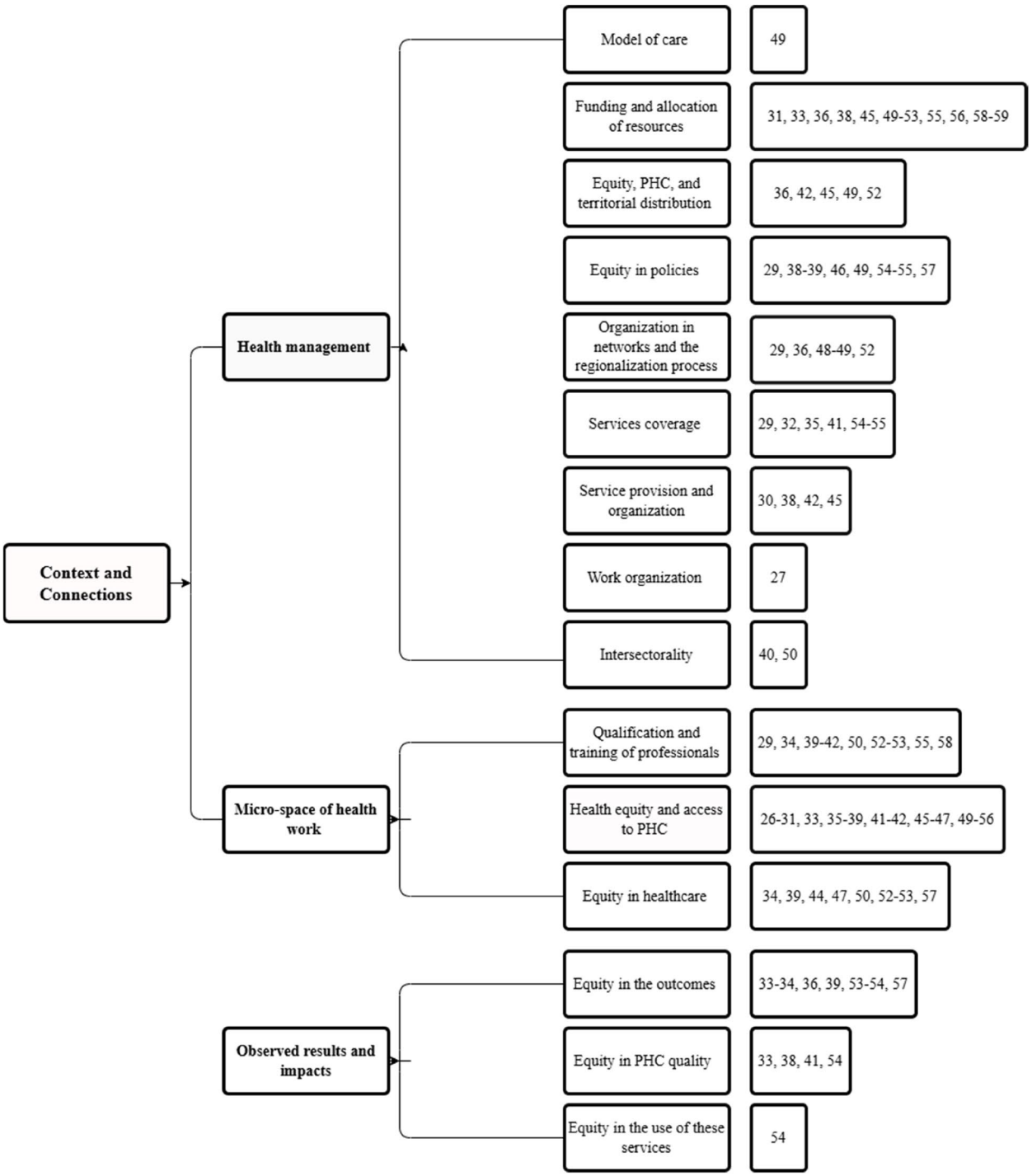

Fig. 4 Identification of the main themes observed within the category "Context and connections" and the respective bibliographic references

like the Gini Index, Theil-L Index, income ratio [32], or the Relative Index of Inequality [60].

In one case [55], various objectives and goals related to equity, policies, human resources, and funding were observed. However, the indicators measuring if these proposed items were achieved lacked clarity.

Finally, two materials did not measure equity but contributed to the discussion: Burstrom et al. [57] argue that

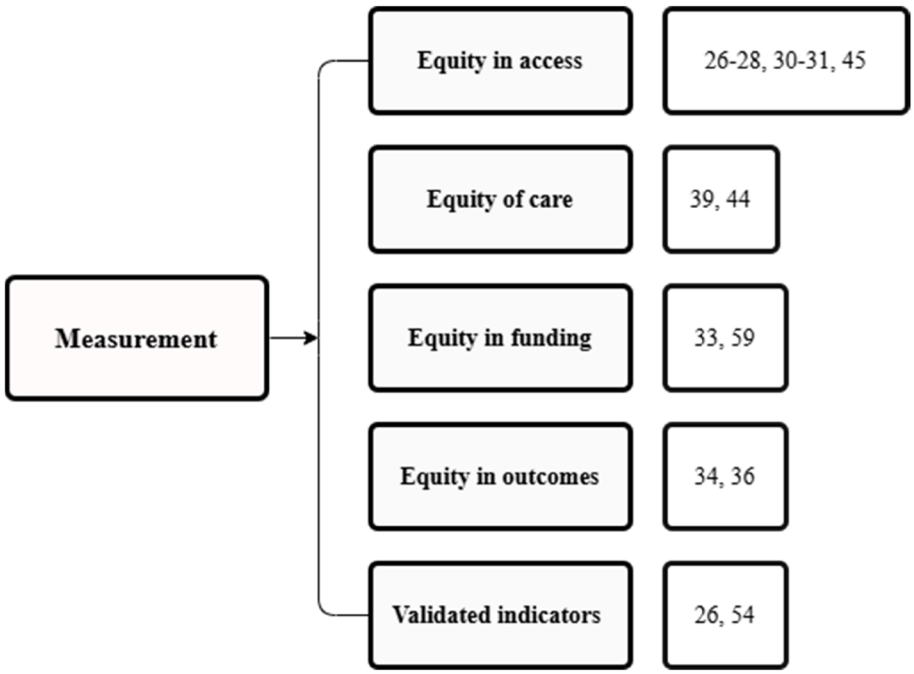

Fig. 5 Identification of the main themes observed within the category "Measurement" and the respective bibliographic references

impacts on equity can be observed in structural aspects, processes, and outcomes, and understand that the non-prioritization of disadvantaged areas/groups or areas/groups with greater needs indicates negative impacts on health equity; and CONASS [37] attributes the responsibility of monitoring inequities and the impact of policies on them to the health sector. Figure 5 presents the main themes discussed in the category "Measurement" and their respective bibliographic references.

Discussion

The data analysis showed the predominance of conceptions proposed by Whitehead [42]. However, this approach was used without sufficient discussion or in-depth analysis, despite the author having previously expressed it was needed. This may point to a dissemination of the concept, but one that lacks the necessary reflection. In addition, the conceptualization of equity in this theoretical perspective is based on its negative connotation (inequity), which reflects the difficulty in defining it per se as a positive concept.

The equality/inequality binomial associated with this concept emerged constantly and without consensus, raising some questions: do equity/inequity deal with the same notion addressed by equality/inequality? Are they different concepts? Does equity promote equality? What relation is established between these terms and why do so many different meanings emerge? This situation was highlighted by other authors [2], but it is not possible to say that there has been an advance in the debate.

The conceptualization process demonstrated the incorporation of the access dimension but did not differentiate access from accessibility, nor did it clarify whether it is a component of the concept or a category of equity. The corpus analysis showed that this association, the relationship to justice, and the absence of discrimination and needs were approached by other authors [4, 5, 61, 62].

The few materials that approached/explored equity measurement did not define the concept. The meanings expressed in the indications of equity measurement were associated with the connections and components to be measured by the studies. In the absence of a theoretical framework, it is difficult to understand what equity will be measured and how.

The corpus analysis showed the relationship established between health equity, PHC, and historically marginalized and disadvantaged groups. This connection occurred in the conceptualization and the populations targeted by the materials. Although this is a well-established association, it is necessary to overcome the belief that PHC focuses only on poor and vulnerable populations. Such belief may foster the dependence of certain groups on compensatory policies that crystallize prejudices, stigmas, and lack of autonomy, and may contribute to the misunderstanding that the SUS, in the Brazilian case, is an exclusive service for low-income individuals [27, 45, 46].

This argumentation involves the choice of the PHC model to be developed, which can be a form of care, organization strategy, and equitable philosophy close to the population's health needs, or a selective PHC that focuses on low-income populations and basic service packages [63, 64].

Generally speaking, it is possible to synthesize the connections that crossed the discussion about health equity and PHC in three spheres: (1) micro-processes and assistance (access, care, and human resources); (2) macro-processes and policies (territorial distribution, model of care, networked organization/regionalization, policies, funding, provision and organization of services, qualification, intersectorality, and coverage); (3) health results (outcomes, use of services, and PHC quality). In this sense, Burstrom et al. [57] argue that impacts on health equity can be observed in structural aspects, processes, and outcomes. However, the studies tend to focus more on the sphere of the micro-processes, with insufficient debate about observed results and impacts. Starfield [63] highlights the importance of assessing the health status to improve the provision of clinical assistance and enhance the documentation of differences between populations, to inform activities and policies, manage resources according to needs, and measure health results.

This discussion is related to the absence of validated and standardized instruments to assess health equity in the PHC context and the repercussions this lack has for micro- and macro-processes in the health area: without an analysis of the effect of policies and actions on health results, it is not possible to identify what must be improved. In this regard, Schweickardt et al. [29], Thomas et al. [31] and Starfield [63] recognize the importance of using information systems and planning instruments in the construction of an equitable health system, which is related to the need for adopting equity measures in PHC.

Cookson et al. [62] show the lack of appropriate analytical instruments to measure health equity and recommend the creation of panels containing information on equity and quality for managers, understanding the production of equity indicators as the first step to reducing inequalities in access and improving health outcomes.

The limitation of the present study consisted in the use of inclusion criteria related to language, which hinders access to literature published in languages other than Portuguese, English, and Spanish.

Conclusion

This scoping review aimed to understand the concepts and contexts present in the literature on health equity to subsidize decision-making, rather than to present a single concept.

Relationships were found between equity and equality, access, vulnerable groups, policies, and health outcomes. However, gaps associated with the measurement of this principle were identified.

Considering the need to combat unfair inequalities in health and given the growing use of the term 'health equity' in public policies and academic discourses, we propose that studies be conducted to develop specific instruments to measure this concept and that the produced knowledge clarifies the instruments'forms of measurement.

Acknowledgements
Not applicable.

Authors' contributions
A.J.N.L.F and J.B.B.F. wrote the main manuscript text A.J.N.L.F, L.C.R. and J.B.B.F. selected the articles for review. All authors reviewed the manuscript.

Funding
This study was financed in part by the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior - Brasil (CAPES) - Finance Code 001.

Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
Not applicable in this study.

Consent for publication
Not applicable in this study.

Competing interests
The authors declare no competing interests.

Received: 6 August 2024 Accepted: 17 January 2025
Published online: 07 February 2025

References

1. Corgozinho MM, Oliveira AAS. Equidade em saúde como marco ético da bioética. Saúde Sociedade. 2016;25(2):431–41.
2. Siqueira SAV, Hollanda E, Motta JIJ. Políticas De Promoção De Equidade em Saúde para grupos vulneráveis: o papel do Ministério Da Saúde. Ciênc saúde Coletiva. 2017;22(5):1397–406.
3. Carvalho AMP, Silva GA, Rabello ET. A equidade no trabalho cotidiano do SUS: representações sociais de profissionais da Atenção Primária à Saúde. Cad Saúde Coletiva. 2020;28(4):590–8.
4. Albrecht CAM, Rosa RS, Bordin R. O conceito de equidade na produção científica em saúde: uma revisão. Saúde Soc. 2017;26(1):115–28.
5. Pinheiro WR, Silva FM, Bezerra IMP, Batista HMT, Akerman M. Equity in Health: conception of Professional in the Primary Network of the Unified Health System. Int Archives Med. 2015;8(110).
6. Mújica OJ, Moreno CM. De La retórica A La acción: medir desigualdade en salud para no dejar a nadie atrás. Rev Panam Salud pública. 2019;43:1–7.
7. Campos GWS. Reflexões Temáticas Sobre Equidade E Saúde: o caso do SUS. Saúde Sociedade. 2006;15(2):23–33.
8. Barata RB. Como e por que as desigualdades sociais fazem mal à saúde. FIOCRUZ Temas em Saúde. 2009:120.
9. Rajan D, Rouleau K, Winkelmann J, Kringos D, Jakab M, Khalid F, editors. Implementing the Primary Health Care approach: a primer. Geneva: World Health Organization; 2024. (Global report on primary health care).

10. Breilh J. Critical epidemiology and the people's health. Oxf Univ Press. 2021;1:258.
11. Almeida Filho N, et al. Research on health inequalities in Latin America and the Caribbean: bibliometric analysis (1971–2000) and descriptive content analysis (1971–1995). Am J Public Health. 2003;93:2037–43.
12. Almeida Filho N. A problemática teórica da determinação social Da saúde (nota breve sobre desigualdades em saúde como objeto de conhecimento). Saúde em Debate. 2009;33(83):349–70.
13. Buss PM. Pellegrini Filho. A Saúde e seus determinantes Sociais. PHYSIS: Rev Saúde Coletiva. 2007;17(1):77–93.
14. Barros FPC, Souza MF. Equidade: seus conceitos, significações e implicações para o SUS. Saúde Soc. 2016;25(1):9–18.
15. Segura MC, Anderson MIP, Martin TM. La Medicina Familiar Y Comunitaria como eje central de la Equidad en Los Sistemas De Salud de Latinoamérica: un análisis exploratorio de la región. Rev bras med fam Comunidade. 2016;11(2):17–25.
16. Eslava-Schmalbach J, Garzón-Orjuela N, Elias V, Reveiz L. Incorporación De equidad en salud en la investigación sobre implementación: revisión De Los modelos conceptuales. Rev Panam Salud pública. 2017;41:e126.
17. Giovanella L, Mendonça MHM, Buss PM, Fleury S, Gadelha CAG, Galvão LA, Santos RF. De Alma Ata a Astana. Atención primaria de salud y sistemas universales de salud: compromiso indisociable y derecho humano fundamental. Cad Saúde Pública. 2019;35(3):e00012219.
18. Painel de Monitoramento da Equidade em Saúde. Ministério da Saúde. Available from:https://www.gov.br/saude/pt-br/composicao/saps/equidade/painel-de-monitoramento-da-equidade-em-saude.
19. Giovanella L, Veja R, Tejerina-Silva H, Acosta-Ramires N, Parada-Lezcano M, Ríos G, Iturrieta D, Almeida PF, Feo O. ¿Es La atención primaria de salud integral parte de la respuesta a la pandemia de Covid-19 en Latinoamérica? Trabalho. Educação E Saúde. 2021;19:e00310142.
20. Zelner J, Masters NB, Naraharisetti R, Mojola SA, Chowkwanyun M, Malosh R. There are no equal opportunity infectors: epidemiological modelers must rethink our approach to inequality in infection risk. PLoS Comput Biol. 2022;18(2):e1009795.
21. Peters MDJ, Godfrey C, Mcinerney P, Khalil H, Larsen P, Marnie C, Pollock D, Tricco AC, Munn Z. Best practice guidance and reporting items for the development of scoping review protocols. JBI Evid Synthesis. 2022;20(4):953–68.
22. Peters MDJ, Godfrey C, Mcinerney P, Soares CB, Khalil H, Parker D. In: Aromataris E, Munn Z, editors. Chapter 11: scoping reviews. Joanna Briggs Institute Reviewer's Manual. JBI; 2017. *In*:.
23. Tricco AC, Lilie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, Moher D, Peters MDJ, Hosley T, Weekds L, Hempel S, Aki EA, Chang C, McGowan J, Stewart L, Hartling L, Aldcroft A, Wilson MG, Garritty C, Lewin S, Godfrey CM, MacDonald MT, Langlois EV, Soares-Wiser K, Moriarty J, Clifford T, Tunçalp O. Straus SE. PRISMA Extension for scoping reviews (PRISMA-ScR): Checklist and Explanation. Ann Intern Med. 2018;169(7):467.
24. Conferência. Internacional Sobre Cuidados Primários de Saúde. Declaração de Alma-Ata. 1978:2.
25. Fernandes AJNL, Ferreira JBB. Articulações possíveis entre Equidade em Saúde E Atenção Primária à Saúde: uma revisão de escopo. Open Sci Framew (OSF). https://doi.org/10.17605/OSF.IO/EH7PA.
26. Carneiro Junior N, Andrade MC, Luppi CG, Silveira C. Organização De práticas de saúde equânimes em atenção primária em região metropolitana no contexto dos processos de inclusão e exclusão social. Saúde Soc. 2006;15(3):30–9.
27. Carneiro Júnior N, Silveira C. Organização das práticas de atenção primária em saúde no contexto dos processos de exclusão/inclusão social. Cad saúde pública. 2003;19(6):1827–35.
28. White BM, Newman SD. Access to primary care services among the homeless: a synthesis of the literature using the equity of access to medical care framework. J Prim Care Community Health. 2015;6(2):77–87.
29. Schweickardt JC, El Kadri MR, de Lima RT. S. Atenção Básica na Região Amazônica: saberes e práticas para o fortalecimento do SUS. 2020;8:311–311.
30. Thomas SL, Wakerman J, Humphreys JS. Ensuring equity of access to primary health care in rural and remote Australia - what core services should be locally available? International Journal for Equity in Health. 2015;14(1). Disponível em: https://www.scopus.com/inward/record.uri?eid=2-s2.0-84946050513&doi=10.1186%2fs12939-015-0228-1&partnerID=40&md5=6fed452dfd7707e1a103453d79a89aa7.
31. Thomas SL, Wakerman J, Humphreys JS. What does it cost to provide equity of access to high quality, comprehensive primary health care in rural Australia? A pilot study. Rural Remote Health. 2017;17(1).
32. Guimarães RM. A teoria da equidade reversa se aplica na atenção primária à saúde? Evidências De 5 564 municípios brasileiros. Rev Panam Salud pública. 2018;42:e128–128.
33. Tao W, Agerholm J, Burström B. The impact of reimbursement systems on equity in access and quality of primary care: a systematic literature review. BMC Health Serv Res. 2016;16(1):542.
34. Cookson R, Mondor L, Asaria M, Kringos DS, Klazinga NS, Wodchis WP. Primary care and health inequality: difference-in-difference study comparing England and Ontario. PLoS ONE. 2017;12(11):e0188560.
35. Andrade MV, Noronha K, Barbosa ACQ, Rocha TAH, da Silva NC, Calazans JA, et al. A equidade na cobertura da Estratégia Saúde Da Família em Minas Gerais, Brasil. Cad saúde pública. 2015;31(6):1175–87.
36. Fisher M, Freeman T, Mackean T, Friel S, Baum F. Universal Health Coverage for Non-communicable Diseases and Health Equity: lessons from Australian primary Healthcare. Int J Health Policy Manag. 2022;11(5):690–700.
37. Conselho Nacional de Secretários de Saúde (Brasil). Seminário Internacional atenção primária à saúde: acesso universal e proteção social. CONASS Doc. 2013;27:146–146.
38. Ford-Gilboe M, Wathen CN, Varcoe C, Herbert C, Jackson BE, Lavoie JG, et al. How equity-oriented Health Care affects Health: Key mechanisms and implications for Primary Health Care Practice and Policy. Milbank Q. 2018;96(4):635–71.
39. O'Neill B, Ferrer R, O'Brien P, Watt G, Gottlieb L, Pinto A, et al. Improving Equity through Primary Care: Proceedings of the 2019 Toronto International Conference on Quality in Primary Care. Ann Fam Med. 2020;18(4):364–9.
40. Shadmi E, Wong WCW, Kinder K, Heath I, Kidd M. Primary care priorities in addressing health equity: Summary of the WONCA 2013 health equity workshop. International Journal for Equity in Health. 2014;13(1). Disponível em: https://www.scopus.com/inward/record.uri?eid=2-s2.0-84920862787&doi=10.1186%2fs12939-014-0104-4&partnerID=40&md5=fb49b8f4241c370a0937fb22bda1879c
41. de Souza ÂC. Estratégias de inclusão da saúde mental na atenção básica no Rio de Janeiro: um movimento das marés. 2012;xiii,156-xiii,156.
42. Whitehead M. The concepts and principles of equity and health. Volume 6. Oxford University Press; 1991. pp. 217–28. 3.
43. Guimarães R, de CP, Cavadinha ET, Mendonça AVM, Sousa MF. Assistência à saúde Da população LGBT em uma capital brasileira: o que dizem os Agentes Comunitários De Saúde? Tempus (Brasília). 2017;11(1):121–39.
44. Fisher M, Harris P, Freeman T, Mackean T, George E, Friel S, et al. Implementing Universal and targeted policies for Health Equity: lessons from Australia. Int J Health Policy Manag. 2021;11(10):2308–18.
45. Franco-Giraldo A. Atención primaria en salud (APS). ¿De Regreso Al Pasado? Rev Fac Nac Salud Pública. 2012;30(1):83–94.
46. do Nascimento LC, Viegas SM, da Menezes F, Roquini C, Santos GR. O SUS na Vida Dos Brasileiros: assistência, acessibilidade e equidade no cotidiano de usuários Da Atenção Primária à Saúde. Physis (Rio J). 2020;30(3):e300330–300330.
47. São, Paulo (Estado) Secretaria da Saúde, editors. Cosems/SP. Diretrizes e estratégias para estruturação da política estadual de atenção básica do Estado de São Paulo. 2012; Disponível em: http://docs.bvsalud.org/biblioref/ses-sp/2012/ses-25131/ses-25131-3670.pdf. Citado 1º de janeiro de 7DC.
48. Paremoer L. Universal Health Coverage for Non-communicable Diseases and Health Equity: reflections on the role of ideas and democratic Decision-Making; Comment on Universal Health Coverage for Non-communicable Diseases and Health Equity: lessons from Australian primary Healthcare. Int J Health Policy Manag. 2022;11(5):711–3.
49. Díaz CA. Atención primaria fortalecida como principal ingreso al sistema de salud argentino. Medwave. 2013;13(8). Disponível em: http://www.medwave.cl/link.cgi/Medwave/Revisiones/Analisis/5792. Citado 1º de janeiro de 9DC.
50. Eissa A, Rowe R, Pinto A, Okoli GN, Campbell KM, Washington JC, et al. Implementing high-quality primary care through a Health Equity Lens. Ann Fam Med. 2022;20(2):164–9.

51. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Seminário Nacional de Atenção Primaria e sobre as relações público-privadas no Sistema Único de Saúde: 08 a 11 de novembro de 2010. 2010;3–3.
52. Brasil. Ministério Da Saúde. Secretaria De Atenção à Saúde. Departamento De Atenção Básica. PNAB: Política Nacional de Atenção Básica; 2012. pp. 108–108.
53. Haggerty J, Chin MH, Katz A, Young K, Foley J, Groulx A, et al. Proactive strategies to address Health Equity and disparities: recommendations from a bi-national Symposium. J Am Board Fam Med. 2018;31(3):479–83.
54. Hone T, Macinko J, Millett C. Revisiting Alma-Ata: what is the role of primary health care in achieving the Sustainable Development Goals? Lancet. 2018;392(10156):1461–72.
55. Ministerio de Salud. Plan Nacional De fortalecimiento del primer nivel de atención 2011–2021. Lima: Perú; 2011.
56. Williams O, Mutch A, Douglas PS, Boyle FM, Hill PS. Proposed changes to Medicare: undermining equity and outcomes in Australian primary health care? Aust N Z J Public Health. 2015;39(2):106–8.
57. Burström B, Burström K, Nilsson G, Tomson G, Whitehead M, Winblad U. Equity aspects of the Primary Health Care Choice Reform in Sweden - a scoping review. Int J Equity Health. 2017;16(1):29.
58. Edelman A, Marten R, Montenegro H, Sheikh K, Barkley S, Ghaffar A, et al. Modified scoping review of the enablers and barriers to implementing primary health care in the COVID-19 context. Health Policy Plan. 2021;36(7):1163–86.
59. Drachler M, de Lobato L, de O MA, Lermen JI, Fagundes S, Ferla AA, Drachler CW, et al. Desenvolvimento E validação De um índice de vulnerabilidade social aplicado a políticas públicas do SUS. Ciênc Saúde Colet (Impr). 2014;19(9):3849–58.
60. Vellakkal S, Gupta A, Khan Z, Stuckler D, Reeves A, Ebrahim S, et al. Has India's national rural health mission reduced inequities in maternal health services? A pre-post repeated cross-sectional study. Health Policy Plan. 2017;32(1):79–90.
61. Barchifontaine CP, Trindade MA. Bioética, saúde e realidade brasileira. Rev Bioética. 2019;27(3):439–45.
62. Cookson R, Asaria M, Ali S, Show R, Doran T, Goldblatt P. Health equity monitoring for healthcare quality assurance. Soc Sci Med. 2018;198:148–56.
63. Starfield B. Atenção Primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: UNESCO, Ministério da Saúde; 2002. p. 726.
64. Paula EKAS, Samico IC, Caminha MFC, Barista Filho M, Silva SL. Avaliação da atenção básica à saúde sob a ótica dos usuários: uma revisão sistemática. Rev Esc Enferm USO. 216;50(2):335 – 45.

Publisher's Note