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RESEARCH ARTICLE **OPEN ACCESS**

SOCIAL VULNERABILITIES AS BARRIERS TO ACCESS TO AND CONTINUITY OF CARE IN HEALTHCARE SERVICES

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ABSTRACT

Chronic migraine is a disabling neurological disorder defined by headache occurring on at least 15 days per month for more than three months, with migraine features on at least eight days per month. This illustrative case report demonstrates how an individualised homoeopathic case may be documented while maintaining a critical evidence-based perspective. An adult woman with a long history of frequent unilateral pulsating headache, nausea, photophobia, aggravation from fasting and sleep deprivation, and improvement after sleep is presented as an educational example. The homoeopathic analysis identifies a characteristic symptom totality and demonstrates repertorial reasoning leading to an illustrative prescription. Headache frequency, intensity and disability are followed using a headache diary and MIDAS-style assessment. The clinical improvement described in this educational example is not evidence of efficacy because the case has no control group and the patient data are fictional. Published evidence concerning homoeopathy for migraine remains limited and inconclusive; systematic reviews have not established efficacy beyond placebo. The article therefore illustrates case-report methodology rather than claiming therapeutic effectiveness.

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INTRODUCTION

Social inequalities in health constitute a historically persistent phenomenon that has been widely discussed in the field of Public Health, representing one of the major challenges to the implementation of the principles of universality, comprehensiveness, and equity advocated by public healthcare systems (Da Silva, 2026). In Brazil, despite the advances promoted by the Brazilian Unified Health System (SUS) in expanding access to healthcare actions and services, important disparities related to the socioeconomic, territorial, and cultural conditions of the population persist, demonstrating that access to healthcare occurs heterogeneously across different social groups (Trindade, 2026). In this context, social vulnerabilities emerge as centrais elements in the production of health inequities, directly influencing living conditions, illness, healthcare utilization, and continuity of care (Lourenço, 2026). The concept of social determinants of health refers to the conditions in which individuals are born, grow, live, work, and age, and is influenced by the unequal distribution of income, power, and resources within society (Ramos, 2026). These determinants encompass structural and intermediary factors related to housing conditions, education, income, employment, food, sanitation, transportation access, social support, and the availability of public services (Dantas, 2026). These conditions directly affect epidemiological profiles and individuals' ability to access healthcare services in a timely, continuous, and effective manner. Thus, understanding social vulnerabilities requires a broader analysis of the health–illness process, considering the multiple social dimensions that shape experiences of illness and care (Martin, 2026).

Within healthcare networks, social vulnerabilities represent important barriers to healthcare access and utilization, particularly among historically marginalized populations exposed to poverty, social exclusion, and precarious living conditions (Da Silva, 2026). Difficulties related to geographic mobility, food insecurity, financial instability, low educational attainment, fragile family relationships, and limited access to health information significantly interfere with healthcare-seeking behavior, therapeutic follow-up, and adherence to interventions proposed by healthcare services (Trindade, 2026). Furthermore, these factors may compromise individuals' self-care capacity and intensify chronic illness processes, further exacerbating health inequalities (Ramos, 2026).

Continuity of care is a fundamental component of effective healthcare, particularly in the management of chronic conditions and situations requiring longitudinal follow-up. This process involves integration among different levels of care, the establishment of relationships between users and healthcare professionals, care coordination, and the provision of continuous and person-centered therapeutic follow-up (Lourenço, 2026). However, individuals experiencing social vulnerability frequently encounter disruptions in their healthcare trajectories, characterized by difficulties in accessing specialized consultations, treatment interruptions, poor medication adherence, and weak coordination among services within healthcare networks. These discontinuities may lead to clinical deterioration, increased avoidable hospitalizations, greater demand for urgent and emergency services, and worsening morbidity and mortality indicators (Trindade, 2026).

Additionally, the social, economic, and health-related transformations observed in recent years, particularly following the COVID-19 pandemic, have intensified the impact of social inequalities on population health. Increased unemployment, food insecurity, economic vulnerability, and difficulties in accessing healthcare services have intensified challenges related to continuity of care, particularly among more vulnerable population groups (Zhang, 2026). In this context, strengthening strategies for organizing healthcare networks is essential, with a focus on reducing inequities and promoting care practices guided by the principles of equity and social justice (Lourenço, 2026). Although the scientific literature has made important advances in the discussion of social determinants of health, many studies still address healthcare access in a fragmented manner, prioritizing analyses centered on isolated indicators of healthcare utilization (Zhang, 2026). Therefore, gaps remain in understanding how social vulnerabilities simultaneously affect access to, utilization of, and continuity of care across different levels of healthcare. This perspective is essential to support public policies and healthcare strategies capable of responding to the actual needs of socially vulnerable populations (Martin, 2026). Against this background, the present study aimed to analyze the influence of social vulnerabilities on access to and continuity of care in healthcare services, highlighting the main factors associated with health inequities and their implications for healthcare delivery to the population.

METHODS

This study was designed as an integrative literature review, a method that enables the systematic synthesis of evidence from empirical and theoretical studies, providing a comprehensive understanding of social vulnerabilities and their relationship with access to, utilization of, and continuity of healthcare services. This approach was adopted because it allows the critical analysis of studies with different methodological designs, facilitating the identification of trends, convergences, gaps, and challenges in the scientific literature. The integrative review was conducted systematically through predefined stages, including formulation of the research question, development of the search strategy, establishment of inclusion and exclusion criteria, identification and selection of studies, data extraction, and analysis and synthesis of the findings. This methodological process aimed to ensure transparency, reproducibility, and reliability. The guiding research question was: How do social vulnerabilities influence access to, utilization of, and continuity of healthcare services, according to the scientific literature?.

The bibliographic search was conducted in January 2026 in the PubMed/MEDLINE database, selected because of its broad coverage and relevance in indexing scientific journals in the health sciences. The search strategy was developed using controlled descriptors and free-text terms related to social vulnerability, health inequalities, healthcare access, healthcare utilization, and continuity of care, combined using Boolean operators. The search strategy was: ("Social Vulnerability" OR "Social Determinants of Health" *OR* "Health Inequalities") *AND* ("Health Services Accessibility" *OR* "Healthcare Utilization" *OR* "Continuity of Care"). Filters were applied for the publication period from 2025 to 2026, languages (Portuguese, English, and Spanish), and free full-text availability.

The search initially identified 1,441 records. After applying the free full-text filter, 535 studies remained for the screening stage. During screening, titles and abstracts were assessed, and 520 studies were excluded. Of these, 260 did not address the topic of social vulnerabilities and access to, utilization of, or continuity of healthcare services, while 260 addressed other healthcare contexts without a specific focus on the relationship between social vulnerability and healthcare access and continuity. Thus, 15 studies were selected for full-text assessment. Following full-text reading, six articles were excluded because they did not specifically address social vulnerabilities and access to or continuity of healthcare services. Subsequently, four articles were excluded because they did not fully meet the predefined inclusion criteria. Therefore, five studies comprised the final sample of this integrative review, as presented in figure 1.

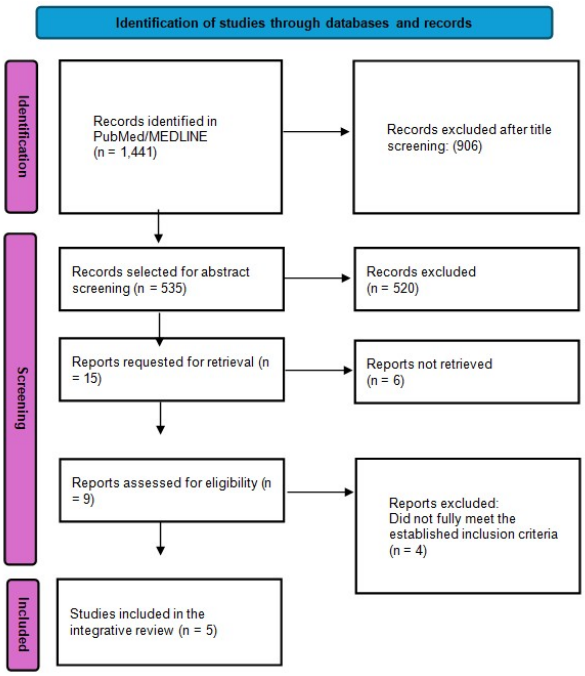


Figure 1. Flowchart of the article selection process. Source: Prepared by the authors based on the PRISMA model.

RESULTS AND DISCUSSION

The analysis of the literature published between 2025 and 2026 indicates that social vulnerabilities remain strongly associated with inequalities in access to, utilization of, and continuity of healthcare services, demonstrating that the formal universalization of healthcare access has not been sufficient to ensure equity in healthcare delivery in the Brazilian context. The studies presented in Table 1 converge in demonstrating that structural factors related to income, educational attainment, geographic location, food insecurity, precarious employment, and social exclusion continue to shape different patterns of illness and unequal opportunities for healthcare utilization. These findings reinforce the understanding that social determinants of health operate as structural mechanisms underlying health inequities, reproducing historical inequalities within healthcare networks (Martin, 2026).The evidence identified demonstrates that individuals living in socially vulnerable territories have lower access to specialized services, longer waiting times for consultations and diagnostic tests, and less continuity of longitudinal care (Hua, 2025).

Recent national studies have found that populations living in peripheral areas and regions with low healthcare coverage have a higher prevalence of interruptions in therapeutic follow-up, particularly among users who rely exclusively on the Brazilian Unified Health System (SUS). Furthermore, a significant association has been observed between low household income and greater use of urgent and emergency care services, rather than preventive actions and continuous follow-up in Primary Health Care (Figure 2). These findings reveal the persistence of an access model that remains strongly conditioned by socioeconomic and territorial inequalities (Da Silva).

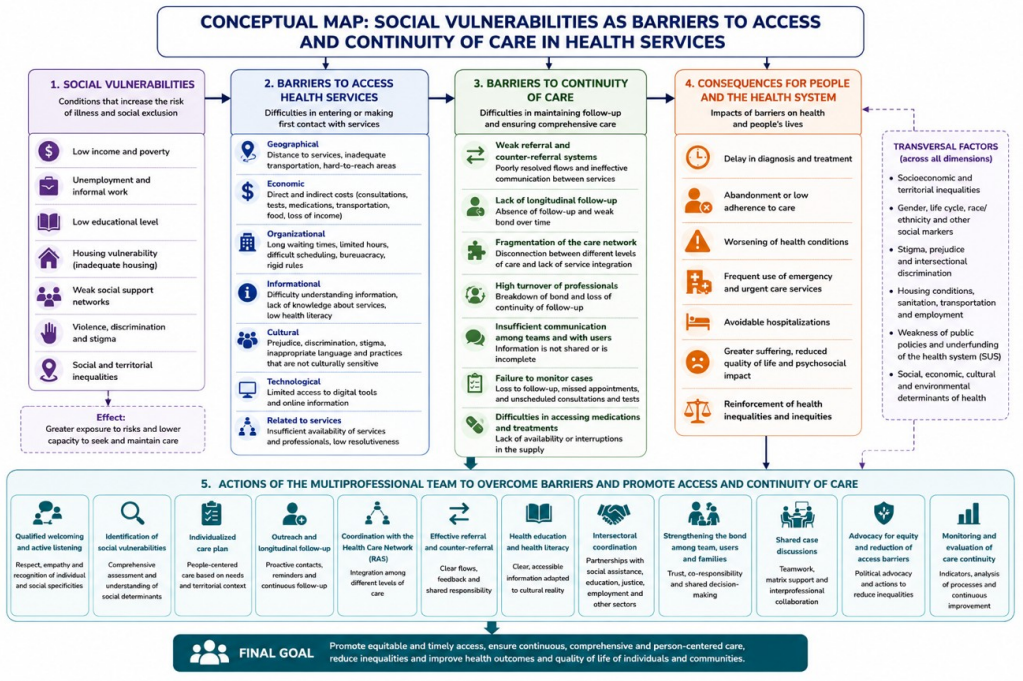
The literature also indicates that social vulnerabilities extend beyond strictly economic dimensions, incorporating subjective, cultural, and relational components that directly influence users' experiences within healthcare services. Studies grounded in the theoretical framework of health vulnerability have demonstrated that weaknesses in social support, low health literacy, and limited access to information compromise individuals' autonomy in managing their health conditions and hinder treatment adherence (Russo, 2025). In this context, vulnerability should be understood as a multidimensional and dynamic phenomenon produced through the interaction between individual conditions, social contexts, and programmatic weaknesses within public policies and the organization of healthcare services (Improta, 2026).Another recurring aspect identified in the studies concerns the fragility of continuity of care among socially vulnerable populations. Recent evidence demonstrates that discontinuity of care is associated with fragmentation of healthcare networks, difficulties in coordination between levels of care, and insufficient strategies for longitudinal follow-up (Abiri, 2025). Users exposed to greater vulnerability presented higher rates of treatment abandonment, medication discontinuation, and hospitalizations for conditions sensitive to Primary Health Care. These findings indicate that continuity of care depends not only on the availability of services but also on the health system's structural capacity to establish therapeutic relationships, provide welcoming care, and coordinate services in a territorially oriented manner centered on users' social needs.

At the international level, studies published in public health and health equity journals demonstrate that social inequalities continue to significantly affect universal healthcare systems, even in countries with broad healthcare coverage (Yuan, 2026). Research conducted in European and Latin American contexts has shown that populations exposed to poverty, housing insecurity, and precarious employment have lower access to preventive services, higher prevalence of chronic diseases, and poorer health outcomes. These findings reinforce that health inequities arise from structural processes associated with the unequal distribution of resources, power, and social opportunities, extending beyond strictly organizational limitations within healthcare systems (Wiltshire, 2026). Additionally, recent literature indicates that the social and economic effects of the COVID-19 pandemic significantly increased social vulnerabilities and intensified inequalities in access to healthcare services. Rising unemployment, food insecurity, and poverty contributed to worsening living conditions among historically marginalized populations, directly affecting continuity of care and healthcare utilization. Post-pandemic studies identified a substantial increase in unmet demand for specialized consultations, diagnostic tests,

Table 1. Studies on social vulnerabilities, inequalities, and access to health services in Brazil, 2026

Author/Year	Topic	Study design	Main findings
Coelho *et al*. (2025)	Racial inequalities in access to health services in Brazil	Cross-sectional observational study using data from the 2019 National Health Survey	The study identified racial inequalities in access to health services. Part of the differences between racial groups was explained by socioeconomic conditions, healthcare access, and healthcare needs, demonstrating that race/skin color and social conditions remain associated with healthcare inequalities.
Ferezin *et al*. (2025)	Inequalities in healthcare utilization among vulnerable populations	Cross-sectional study with an intersectional analysis	The findings showed that vulnerabilities related to sex/gender, race/skin color, and educational level overlap and influence healthcare utilization. More vulnerable groups showed greater reliance on the Brazilian Unified Health System (SUS) and lower use of private services, highlighting the importance of inclusive policies to promote equitable access.
Oliveira *et al*. (2025)	Inequalities in access to health services in Latin America	Scoping review	The main barriers to healthcare access included socioeconomic and geographic factors, service availability, cultural and ethnic aspects, communication barriers, and architectural limitations. Income, education, transportation, and housing conditions were among the main determinants of inequalities.
Martin *et al*. (2026)	Social determinants and access to public health services among migrants in Brazil	Observational study	The study demonstrated that social determinants influence migrants' access to public health services, indicating that social and contextual conditions may create barriers even within a healthcare system based on universal access.
Ribeiro, Almeida, and Vilasbôas (2026)	Continuity of care for people with hypertension in Primary Health Care	Scoping review	The review identified limitations and strategies related to continuity of care in Primary Health Care, reinforcing that initial access to healthcare services needs to be integrated with continuity and coordination of care.

Source: Prepared by the authors, 2026.



Source: Prepared by the authors, 2026.

Figure 2 – Conceptual map of social vulnerabilities as barriers to access to and continuity of care in healthcare services Recife, Pernambuco, 2026

and follow-up of chronic conditions, particularly among individuals experiencing economic vulnerability. This scenario demonstrates that the impacts of the health crisis deepened pre-existing weaknesses within healthcare networks and intensified challenges related to equity in healthcare delivery (Berishaj, 2023).

Another widely discussed issue in contemporary literature concerns inequalities resulting from digital exclusion within the technological transformation of healthcare systems. Although telehealth, interoperability, and healthcare digitalization strategies have the potential to strengthen care coordination and expand access to services, recent studies

warn that socially vulnerable populations frequently have less access to digital technologies, limited connectivity, and difficulties related to digital health literacy. Consequently, there is a risk of reproducing new forms of exclusion and further deepening health inequities in the context of digital health, particularly among older adults, rural populations, and individuals living in poverty (Cerqueira Mousinho, 2025). The evidence analyzed also demonstrates that historically marginalized groups, including Black populations, transgender individuals, people experiencing homelessness, and populations living in peripheral areas, remain exposed to multiple forms of social and institutional vulnerability that hinder qualified access to healthcare services. Processes of structural discrimination, institutional racism, and social stigmatization have frequently been associated with weaker therapeutic relationships, lower healthcare-seeking behavior, and greater discontinuity of care. These findings reinforce the need to incorporate an intersectional perspective into the formulation of public health policies, recognizing that different social markers generate distinct and overlapping forms of social exclusion and health vulnerability (Davies, 2025).

Given this scenario, the studies converge in indicating that addressing health inequities requires the strengthening of intersectoral public policies and the reorganization of healthcare networks from an equity-oriented perspective. Strategies focused exclusively on expanding the supply of services are insufficient given the complexity of the social vulnerabilities that permeate the health–illness–care process. Therefore, it is essential to strengthen actions aimed at social protection, food security, health education, territorialized healthcare delivery, and the qualification of Primary Health Care as the coordinator of care. Furthermore, the literature highlights the need to incorporate socially responsive approaches into health management and planning, capable of recognizing the multiple dimensions of vulnerability and promoting comprehensive, longitudinal, and humanized care (Maciel, 2025). The findings of this review reinforce that inequalities in access to and continuity of care are socially produced and structurally determined phenomena, demonstrating that achieving equity within the Brazilian Unified Health System depends on the articulation of social, economic, and health policies. Therefore, understanding social vulnerabilities ascentral determinants of health inequities is essential for developing healthcare strategies and public policies guided by social justice and the strengthening of the right to health.

CONCLUSION

The evidence analyzed demonstrates that social vulnerabilities persistently influence access to, utilization of, and continuity of healthcare, revealing structural health inequities within universal health systems, including the Brazilian Unified Health System (SUS). Although universality formally guarantees the right to health, its implementation remains shaped by socioeconomic, territorial, and social determinants that generate unequal opportunities for care. Barriers to healthcare access extend beyond service availability and are associated with low income, limited education, precarious employment, food insecurity, weak social support, and digital exclusion. These factors, combined with fragmentation of healthcare networks, compromise care coordination and continuity, contributing to preventable hospitalizations and greater reliance on emergency services among socially vulnerable populations. Addressing these inequities requires strengthening Primary Health Care as the coordinator of care and implementing intersectoral policies focused on reducing social vulnerabilities and promoting equitable, continuous, and comprehensive healthcare. Further studies should investigate the relationship between social vulnerability and continuity of care across different populations and territories, particularly through intersectional and mixed-methods approaches.

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