

Factors associated with difficulty in accessing healthcare services among older adults: National Health Survey, 2019

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Abstract *The objective was to analyze the factors associated with difficulty in accessing healthcare services among older population. This is a cross-sectional, analytical study using data from the 2019 National Health Survey, conducted between 2019 and 2020 with a random sample of 22,728 older adults. The outcome was the difficulty in accessing healthcare services, measured by seeking services but not being attended to, or when services were not sought despite a need due to individual difficulties. The exposures were sociodemographic characteristics, health insurance coverage, health conditions, and functional disability. Multiple logistic regression was employed, considering a 5% significance level. Stata 17 was used for the analysis. The majority of older adults were female, aged between 60 and 69 years. The prevalence of difficulty in accessing services was 13.7% (95%CI: 13.0-14.5). Being female, living in urban areas, having a cerebrovascular accident, pulmonary disease and/or chronic back pain, having fair, poor, or very poor health status, and disability in performing basic activities of daily living (BADLs) were associated with a higher likelihood of difficulty in accessing healthcare services.*

Key words Access to healthcare services, Older adult, National Health Survey, Primary health care

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Introduction

In recent years, there has been an expansion of the public health network, especially through the Family Health Strategy (FHS), with increased access to medical consultations and a reduction in hospitalizations for certain diseases. However, various challenges still persist, particularly regarding the availability and improvement of care quality¹.

Population aging leads to greater demands for access to healthcare services, posing a potential challenge for both health professionals and the healthcare system^{2,3}. This is due to the higher prevalence of age-related chronic diseases, resulting in a greater occurrence of disabilities in daily living activities, poorer quality of life, premature mortality, and, consequently, an increased demand for healthcare services among this population^{4,5}, which generates significant costs for the healthcare system. This condition underscores the need to ensure access to healthcare services in order to promote health, prevent diseases and their complications, and maintain continuous and ongoing monitoring of health conditions, aiming to address the challenges of aging^{3,4,6}.

Access to healthcare services encompasses not only the availability of services but also the user's demand for them, including individual understanding and conditions for seeking health care services⁷. In contrast, the utilization of healthcare services is characterized by the guarantee of care, meaning it refers to the portion of the population that sought healthcare services and succeeded in obtaining them. This can result from individual motivation and the behavior of seeking such services, thus proving that access was achieved⁵.

Previous studies have shown that sociodemographic, clinical, and health factors, such as not having a partner, illiteracy, negative self-perception of health, and frailty, have been associated with access to healthcare services among older adults². Additionally, socioeconomic inequalities are identified as important determinants of access to healthcare services across most populations, including in Brazil⁸.

Thus, sociodemographic factors are closely related to access to healthcare services, making it a topic of interest due to its contribution to the development of policies aimed at promoting equity and reducing access disparities. Therefore, it requires a thorough analysis of healthcare for older adults, including potential differences by sex, skin color, age group, and region of residence within this population^{4,5}.

However, most previous research on this topic has analyzed access to healthcare services solely through service utilization, without considering the user's need and the unmet demand due to individual difficulties that precede service use, such as geographical factors, financial constraints, and scheduling incompatibilities with the service. Access is often measured by the individuals who are already using the service or who experienced difficulties within the service itself, which represents only one dimension of access^{2,9}.

Moreover, although the relationship between sociodemographic factors, health insurance coverage, chronic conditions, and disability with health service utilization has been the focus of some studies^{2,10}, it is noted that many of these studies do not use a nationally representative sample of the Brazilian population or are specifically aimed at older adults living in the community¹⁰. Thus, this study utilizes data from the 2019 National Health Survey (PNS in Portuguese), which is a household-based health survey with a sample that is representative of the Brazilian population.

Thus, considering these gaps and understanding that access to services involves not only the availability of the service but also the individual's need to seek these services, this research aims to analyze the factors associated with difficulty in accessing healthcare services among the older population.

Methodology

This is a cross-sectional, analytical study with a quantitative approach that used secondary data from the 2019 National Health Survey. The PNS is a household-based epidemiological survey that describes the health situation of the population and supports healthcare practices. Cluster sampling was employed in three stages: the census units formed the first stage; households constituted the second stage; and residents aged 15 years or older were the units of the third stage¹¹.

An adult resident (15 years or older) was selected through simple random sampling per household to address specific health topics. In households with older adults, they either completed the specific questionnaire about older adult health themselves or it was answered by the household respondent or proxy¹¹.

The PNS used a sample of 90,846 individuals who participated in the individual interview. This study included only older adults (individ-

uals aged 60 years or older) from all Brazilian states. Adults, adolescents, and proxies were excluded. Thus, the sample employed consisted of 22,728 older adults selected through simple random sampling across all states of Brazil, residing in households.

Data collection occurred from August 2019 to March 2020. The data were collected by field agents from the Brazilian Institute of Geography and Statistics (IBGE in Portuguese), following prior training provided by state unit coordinators. Collection was conducted using a mobile data collection device¹².

The IBGE segmented the collected data into questionnaires divided into modules, with the 2019 PNS consisting of 26 such modules. For this study, the following modules were used: Module C (general characteristics of residents); Module D (education characteristics of residents); Module Q (chronic diseases); Module J (utilization of healthcare services); Module I (healthcare services coverage); Module H (medical care); and Module K (older adult health)¹¹.

For data analysis, version 17 of the Statistical Software for Professional (Stata) was used, along with the survey module functions for complex samples. Prevalences and 95% confidence intervals (95%CI) of the variable difficulty in accessing healthcare services were calculated, stratified by: sex (male; female), age group (60-69; 70-79; 80 or older), education level (12 years or more; 9-11 years; 0-8 years), marital status (with partner; without partner), socioeconomic index (class A or B; class C; D or E), region of residence (Southeast; South; Central-West; North and Northeast), and area of residence (urban; rural).

The exposure variables were sociodemographic characteristics, health conditions, and self-reported conditions: diabetes; heart diseases (myocardial infarction, angina, and heart failure); systemic arterial hypertension; cerebrovascular accident (cva); arthritis or rheumatism; chronic back pain (lumbago or sciatica, spinal or disc issues); cancer; chronic obstructive pulmonary disease (COPD) or emphysema or any chronic pulmonary disease; and chronic kidney disease, dichotomized into yes or no. Self-reported health was categorized as good or very good versus poor or very poor, and functional disability was assessed for at least one of five basic activities of daily living (BADL) or at least one of seven instrumental activities of daily living (IADL).

The outcome was difficulty in accessing healthcare services. This variable allowed for the

identification of access difficulties that precede the use of the service¹³. To construct this variable, three questions from the PNS were used: a) In the past two weeks, did you seek any place, service, or healthcare professional for health-related care? b) The first time you sought healthcare, were you attended to? c) In the past two weeks, why did you not seek healthcare?

An individual was considered to have experienced access difficulties if they sought healthcare services and were not attended to, or if they did not seek services despite having a need, due to any of the following difficulties: lack of funds; the service location being remote or difficult to access; incompatible service hours; the health facility lacking the appropriate specialist for the need; delayed service; perceived ineligibility; lack of accompaniment; dissatisfaction with the facility's professionals; health service strike; transportation difficulties¹³. Thus, this variable was assigned a value of one if the individual experienced access difficulties and zero otherwise. Descriptive analyses were conducted, and the prevalences of the outcome with corresponding 95% confidence intervals were estimated according to sociodemographic characteristics.

To assess the association between the exposures and the outcome, a bivariate stage was employed using the chi-square test to examine possible differences in the distributions of proportions. Variables with a p-value < 0.20 were eligible for inclusion in the multiple logistic regression model. The measure of association was the odds ratio (OR), with both unadjusted and adjusted ORs calculated for all exposures in the model.

In the multiple analysis, the Stepwise method was employed using the Forward criterion, where the variables selected in the bivariate stage were entered one by one into each model. This method was chosen because it allows for the rapid and sequential selection of the best subset of explanatory variables, adding or removing variables at each step. Thus, the introduction of variables began with the outcome, followed by the exposures of interest. Variables that remained associated with a significance level of less than 5% according to the Wald test were included in the final adjusted model.

To assess the fit of the final individual models, the Wald test was used with the svy module. In the descriptive, bivariate, and multiple analyses, sampling weights were applied to calibrate the complex survey design.

As this research utilized secondary data from the PNS 2019, it does not require approval

from an ethics committee. The data provided by IBGE ensure the confidentiality and anonymity of the participants. Thus, this research complies with the requirements of Resolution number 466/12 of the National Health Council, which guarantees confidentiality and anonymity to participants, respecting ethical principles¹⁴.

Results

The majority of older adults were female (55.5%; 95%CI: 54.5-56.5), aged between 60 and 69 years (54.8%; 95%CI: 53.8-55.8); of white color (51.3%; 95%CI: 50.2-52.4); most were without a partner (56.7%; 95%CI: 55.7-57.8); had an education level of 0 to 8 years (70.4%; 95%CI: 69.2-71.5); belonged to socioeconomic classes C, D, or E (84.7%; 95%CI: 83.5-85.7); predominantly resided in urban areas (85.5%; 95%CI: 84.8-86.1) and in the Southeast region (47.3%; 95%CI: 46.3-48.4) (Table 1).

The prevalence of difficulty in accessing healthcare services among older adults was 13.7% (95%CI: 13.0-14.5). This prevalence was higher among women (15.2%; 95%CI: 14.1-16.3), those aged 60 to 69 years (14.1%; 95%CI: 13.1-15.2), individuals with brown skin (15.6%; 95%CI: 13.5-18.1), those without a partner (14.0%; 95%CI: 13.0-15.0), individuals with low education (0 to 8 years of schooling) (13.8%; 95%CI: 12.9-14.8), and those in low socioeconomic classes C, D, or E (13.8%; 95%CI: 13.0-15.0). Additionally, it was higher among residents of urban areas (14.2%; 95%CI: 13.3-15.1) and in the South region (14.9%; 95%CI: 13.3-16.5) (Table 1).

Among the states, the highest prevalence of the outcome was in the Federal District (19.0%; 95%CI: 14.0-25.2), followed by Tocantins (17.4%; 95%CI: 14.1-21.3), Roraima (17.0%; 95%CI: 12.7-22.3), Acre (16.4%; 95%CI: 13.1-20.3), Rio de Janeiro (16.1%; 95%CI: 14.2-18.2), Rio Grande do Sul (15.7%; 95%CI: 13.3-18.5), and Amazonas (15.6%; 95%CI: 12.3-19.5), with no statistically significant differences in access difficulties to healthcare services among the states ($p = 0.0910$) (Figure 1).

In the adjusted multiple analysis, the following factors were positively associated with difficulty accessing healthcare services among the older adult population: being female (OR=1.23; 95%CI: 1.09-1.40), being aged 60 to 69 years (OR=1.41; 95%CI: 1.16-1.70) and 70 to 79 years (OR=1.28; 95%CI: 1.06-1.54), residing in an urban area (OR=1.31; 95%CI: 1.12-1.54), hav-

ing had a cerebrovascular accident (OR=1.32; 95%CI: 1.04-1.68), having chronic back pain (OR=1.41; 95%CI: 1.25-1.60), having a pulmonary disease (OR=1.50; 95%CI: 1.05-2.15), reporting health status as fair, poor, or very poor (OR=1.50; 95%CI: 1.32-1.71), and having difficulty with at least one BADL (OR=1.55; 95%CI: 1.28-1.88) (Table 2).

Discussion

Considering that the concept of access to healthcare services involves not only the utilization of these services, this research differs from previously published studies by encompassing access to healthcare services beyond mere usage. It also takes into account the demand for these services and the difficulties arising from individual barriers to access, such as financial constraints, geographical issues, or lack of service availability due to scheduling conflicts, shortages of professionals, etc.^{2,15,16}

This study identified that approximately 14 out of every 100 older adults experienced difficulties accessing healthcare services. Furthermore, our results indicate that the prevalence of access difficulties varies depending on sex, age group, residential area, presence of chronic diseases, self-reported health status, and presence of disability in BADL, which were highlighted as potential factors that may increase the likelihood of access difficulties.

A longitudinal study conducted with older adults indicated a higher prevalence of difficulties accessing healthcare services – 33.0%². On the other hand, a similar result was found in Chile, where 12.3% of older adults reported inadequate access to the country's services¹⁷.

Unlike the present study, a population-based survey using data from the 2013 PNS with the general population identified a prevalence of inadequate access to healthcare services among the Brazilian population at 18.1%. This suggests that access difficulties may have slightly decreased in the country from 2013 to 2019. In this context, inadequate access was defined as not being attended to during the last attempt to seek services and not attempting a new appointment due to access barriers¹⁸.

Previous research has already observed that geographical and territorial characteristics, lack of public transportation, violence in the area, excessive demand, productivity pressures on healthcare professionals, lack of family support, and absence of a connection between profes-

Table 1, Prevalence distribution of difficulty in accessing healthcare services by sociodemographic characteristics, Brazil, 2019,

Sociodemographic Characteristics	Total		Difficulty accessing healthcare services			
	N ^a	% ^b	n ^c	% ^d	95%CI ^e	p-value*
Total	22,728	100	3,163	13.7	13.0-14.5	
Sex						< 0.0001
Male	10,193	44.5	1,251	11.9	10.9-13.0	
Female	12,535	55.5	1,912	15.2	14.1-16.3	
Age group						0.0984
60-69	10,555	54.8	1,760	14.1	13.1-15.2	
70-79	7,151	31.1	999	13.8	12.6-15.2	
80 or older	3,016	14.1	404	12	10.5-13.6	
Skin color						0.2764
White	9,901	51.3	1,344	13.7	12.6-19.4	
Mixed-race	10,001	10.2	382	15.6	13.5-18.1	
Black	2,455	36.7	1389	13.3	12.3-14.3	
Other (Yellow and Indigenous)	369	1.8	47	12.0	7.7-18.1	
Marital status						0.3382
With partner	9,946	43.3	1,337	13.3	12.3-14.4	
Without partner	12,782	56.7	1,826	14.0	13.0-15.0	
Education level						0.9058
12 years or more	2,701	13.1	802	13.5	12.1-14.9	
9 to 11 years	3,613	16.5	288	13.7	11.6-16.0	
0 to 8 years	16,414	70.4	2,073	13.8	12.9-14.8	
Socioeconomic class						0.7766
A or B	3,050	15.3	394	13.4	11.4-15.8	
C, D and E	19,675	84.7	2,769	13.8	13.0-15.0	
Residence area						0.0006
Urban	17,313	85.5	2,553	14.2	13.3-15.1	
Rural	5,415	14.5	610	11.1	9.7-12.6	
Residence region						0.091
Southeast	5,825	47.3	807	13.7	12.4-15.2	
South	3,307	16.2	489	14.9	13.3-16.5	
Central-West	2,373	6.3	315	12.9	11.2-14.8	
North	3,487	5.6	546	14.9	13.3-16.7	
Northeast	7,736	24.6	1,006	12.9	11.8-14.0	

^a Absolute sample number; ^b population proportion of the total participants; ^c absolute number of older adults with difficulty accessing healthcare services; ^d proportion of older adults with difficulty accessing healthcare services, considering sampling weights; ^e 95% confidence interval for the population proportion; * p-value for the chi-square test.

Source: Authors with data from PNS, 2019.

sionals and users were also identified as barriers to accessing healthcare services¹⁹.

The shortage of professionals, particularly physicians, is another significant barrier to accessing services among older adults, leading to difficulties in securing appointments and causing delays in care⁵. This issue may be attributed to budget cuts in public healthcare⁹.

In this research, we observed that females have a higher likelihood of experiencing access difficulties, which corroborates with a previous

study². This is likely due to the greater demand for healthcare services among females, which is related to cultural and gender issues, as preventive care is often associated with the female gender. Additionally, women have a longer life expectancy and a higher number of morbidities, which implies a greater frequency of multimorbidity and, consequently, higher demand for healthcare services. Previous studies have also highlighted these potential factors and observed greater access difficulties among women²⁰⁻²³.

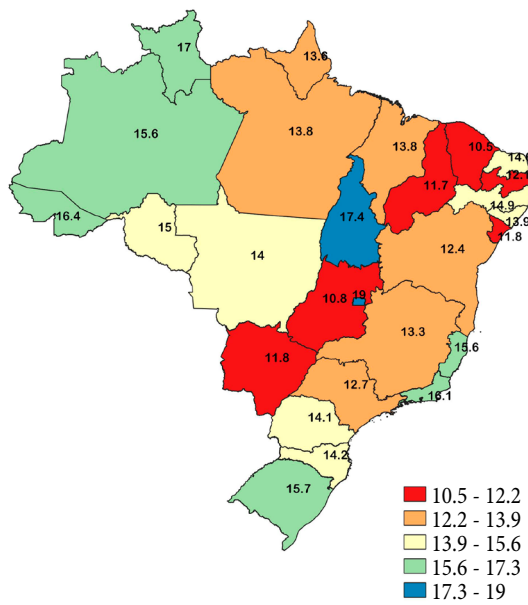


Figure 1. Distribution of prevalence of difficulty in accessing healthcare services among older adults. Brazil, 2019.

Source: National Health Survey, 2019.

Moreover, younger older adults, aged 60 to 69 years, were more likely to experience difficulties accessing healthcare services. A similar study conducted in São Paulo showed that younger older adults utilize healthcare services less frequently, which may indicate greater difficulty accessing these services. This finding is likely related to the participation of these individuals in the workforce and their schedules being incompatible with the operating hours of the FHS. A possible explanation for this difficulty is that these individuals are likely still engaged in the labor market and face barriers to accessing healthcare services²⁴. Additionally, older adults at advanced ages may have greater needs for home care and, due to a higher prevalence of disabilities, may not seek healthcare services as frequently and may be more dependent on home care.

It is important to emphasize that advancing age increases the likelihood of multimorbidity, which in turn reflects a growing demand for healthcare services and an increase in disabilities. Multimorbidity in older adults aged 80 years or older is a significant indicator of service utilization and should be considered in the

planning of management actions²⁵.

The present research, older adults residing in urban areas had a higher likelihood of experiencing difficulties accessing healthcare services compared to those living in rural areas. This result may be explained by the fact that, in Brazil, municipalities with greater size and socioeconomic development tend to have lower coverage of primary health care (PHC) provided by the Unified Health System (UHS)²⁶. Thus, urban areas are larger and more developed, and tend to have lower coverage of PHC, with greater frequency of supplementary assistance. It is also noteworthy that this research focused on access to services provided by UHS, primarily involving PHC.

Moreover, there is a higher number of older adults in urban areas, and in certain regions of the country with greater social development, there may be a gap in providing more extensive healthcare coverage through the UHS, particularly for older adults with lower socioeconomic status. This result may also be related to difficulties in accessing healthcare services due to work hours, which may coincide with the hours of operation of the FHS. Conversely, a study conducted with older adults in rural areas found a higher frequency of difficulty in accessing healthcare services in those regions²⁷.

Older adults in urban areas may face difficulties accessing healthcare services due to issues such as incompatible hours, insufficient availability of appointments, inadequate health equipment provided by the UHS, and delays in service^{26,28}, which may expose them to greater vulnerability²¹.

Studies also indicate that having a chronic condition may be associated with increased use of healthcare services²⁹. In contrast, the rise in chronic diseases among older adults exacerbates the emergence of limitations, leading to greater difficulty in accessing healthcare services^{20,24,30}.

The study found a positive association between CVA and difficulty accessing healthcare services. It is likely that older adults who have had a CVA may experience sequelae that impair their mobility, thereby hindering their access to healthcare services. In contrast to these findings, a previous study with a smaller sample did not identify such an association². However, longitudinal evidence suggests that these individuals often fail to complete rehabilitation due to difficulties in accessing healthcare services, such as lack of available slots, referrals, transportation, and so forth³¹. Additionally, residing in rural areas, with the inherent geographic dis-

Table 2. Unadjusted and adjusted association between sociodemographic factors, self-reported health status, self-reported health conditions, health insurance coverage, and functional disability with difficulty accessing healthcare services.

Exposure variables	Difficulty accessing healthcare services			
	Unadjusted OR	95%CI	OR adjusted	95%CI
Sex				
Male	Ref.			
Female	1.32	1.17-1.49	1.23	1.09-1.40
Age group				
80 or older	Ref.			
70-79	1.18	0.98-1.41	1.28	1.06-1.54
60-69	1.21	1.01-1.44	1.41	1.16-1.70
Residence area				
Rural	Ref.			
Urban	1.32	1.12-1.55	1.31	1.12-1.54
Residence region				
Northeast	Ref.			
Central-West	1.00	0.83-1.20	-	-
Southeast	1.07	0.92-1.25	-	-
South	1.18	1.00-1.38	-	-
North	1.18	1.00-1.40	-	-
Health insurance coverage				
Yes	Ref.			
No	1.07	0.93-1.24	-	-
Heart disease				
Sim	Ref.			
No	1.28	1.10-1.50	-	-
Arterial hypertension				
No	Ref.			
Yes	1.26	1.12-1.41	-	-
Cerebrovascular accident				
No	Ref.			
Yes	1.56	1.25-1.96	1.32	1.04-1.68
Chronic back pain				
No	Ref.			
Yes	1.59	1.41-1.79	1.41	1.25-1.60
Lung disease				
No	Ref.			
Yes	1.82	1.30-2.55	1.50	1.05-2.15
Self-reported health				
Good and very good	Ref.			
Fair, poor, and very poor	1.66	1.47-1.87	1.50	1.32-1.71
Disability for BADL				
No	Ref.			
Yes	1.85	1.54-2.22	1.55	1.28-1.88
Disability for IADL				
No	Ref.			
Yes	1.40	1.23-1.60	-	-

Source: National Health Survey, 2019.

person and high demands on the health team, further complicates access for these users, re-

flecting the fragility in managing care for these individuals³².

This analysis revealed that older adults with chronic back pain had a higher likelihood of experiencing difficulty accessing healthcare services compared to those without this condition. This is possibly due to the physical limitations resulting from a condition that can be debilitating. Additionally, having chronic back pain may be associated with difficulty obtaining care from healthcare services, particularly physiotherapy services, leading individuals to seek alternative methods to manage the pain, including medication, abdominal braces, and other rest strategies³³.

This research observed that the likelihood of experiencing difficulty accessing healthcare services was higher among participants who reported having pulmonary disease compared to those without such conditions. This is likely because these individuals require healthcare services more frequently due to exacerbations and acute episodes of their chronic respiratory condition, and thus may encounter access difficulties more often. A study conducted in the Northeast and Southeast regions of the country revealed that having to visit healthcare services multiple times to obtain a diagnosis and start treatment, transportation problems, the need for motorized transport, and transportation costs were the main difficulties reported in accessing tuberculosis diagnosis³⁴.

Difficulty accessing healthcare services due to pulmonary disease was also significantly evident during the COVID-19³⁵ pandemic. Due to the stigma associated with the disease, individuals faced challenges accessing healthcare services, resulting in lower treatment adherence, difficulties in screening and monitoring patients, and increased likelihood of disease transmission³⁶.

Another important finding highlighted was that having a fair, poor, or very poor health status may increase the likelihood of experiencing difficulty accessing healthcare services compared to those with good or very good health. Individuals who self-assess their health as fair, poor, or very poor likely have a higher incidence of multiple chronic diseases and, consequently, a greater need for healthcare services, which in turn leads to increased difficulties in accessing care. A previous study also found this association².

One explanation for this association is that poor self-rated health reflects an increased demand for healthcare services⁹. Thus, these individuals likely experience functional decline, health issues, or other conditions that lead to a greater need for healthcare services².

Moreover, older adults with limitations in BADLs may have an increased likelihood of experiencing difficulty accessing healthcare services compared to those without functional dependency. This is likely due to motor impairments, loss of autonomy, and dependency. Previous research revealed that among older adults with BADL limitations, only a small minority received home visits in the past year, suggesting that these individuals face challenges accessing healthcare services³⁷. Another home-based study also observed a relationship between functional status and the use of healthcare services in this population³⁸.

Similar results were reported in a systematic review, which indicated that having limitations in performing activities of daily living is a factor associated with the utilization of healthcare services³⁹. Thus, older adults with functional decline generally experience greater difficulties accessing basic healthcare services^{40,41}.

Thus, as established by Law number 8,080, it is crucial that health policies ensure impartial and universal access to healthcare services, with the State bearing the responsibility to guarantee health, implement policies aimed at reducing health risks, and provide equal and universal access to actions related to the promotion, protection, and recovery of health⁴².

Furthermore, it is necessary to enhance the organization of the Health Care Networks (HCNs), establishing intersectoral actions aimed at facilitating and maximizing the utilization of services, considering the individual barriers to accessing these services. Brazilian Ministry of Health Ordinance number 4,279 of 2010 outlines the strategy for organizing HCNs as a means of structuring healthcare services through a system of referral and counter-referral (RCR), which enables communication between healthcare services, thereby forming care pathways. This approach aims to ensure comprehensive care through coordinated service flows⁴³. In addition to these legal provisions, the National Policy on Older Adult Health underpins actions within the healthcare system aimed at providing comprehensive care for the older adult population, also highlighting the need for expanded and continuous access to services⁴⁴.

Despite the significant findings of this research, our results are susceptible to reverse causality, and the associations observed do not imply cause and effect, due to the cross-sectional nature of the data. However, we utilized a metric of access that is rarely seen in national literature, making this study pioneering in em-

ploying an indicator that considers both service availability and user demand, as well as the individual barriers preceding the use of the service. Additionally, we employed a robust, asymptotic sample, which can provide estimates that may closely approximate population parameters.

Finally, the objective of this study was achieved, as it was observed that the difficulty in accessing healthcare services, encompassing both the supply and demand for these services, is associated with individual variables such as sex, age group, residential area, and chronic health conditions, including disability and chronic diseases.

Access to healthcare services can be influenced by factors preceding service utilization, such as lack of money, long wait times, service location being far away, and lack of transporta-

tion. Using representative data from older adults in Brazil, it was observed that difficulty accessing healthcare is a frequent and significant problem among older adults. Public policies should pay special attention to the most vulnerable subgroups, such as women, older adults aged 60 to 69 years, those with chronic morbidities and their sequelae, individuals who self-report their health status as poor or very poor, and those with disabilities, particularly in BADLs.

These findings can contribute to the assessment and development of intersectoral, cross-cutting policies and assistance actions by the multidisciplinary team, aimed at addressing the primary access difficulties faced by this population, with the goal of mitigating inequities related to access to healthcare within the public health system.

Collaborations

DST Oliveira-Figueiredo was responsible for the conception, analysis, interpretation of data, writing of the manuscript, critical review, and review of the final manuscript. JEGS Silva was responsible for the interpretation of data, writing of the manuscript and review of the final manuscript. PYO Feitosa was responsible for interpreting the data, writing the manuscript and review of the final manuscript. MPGPC Silva was responsible for interpreting the data, writing the manuscript and review of the final manuscript. A Alexandrino was responsible for the interpreting the data, writing of the manuscript, critical review and review of the final manuscript.

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