saúde EM DEBATE

ORIGINAL ARTICLE

Evaluation of priority criteria in Brazil's Farmácia Popular Program in relation to social vulnerability and the Mais Médicos Program

Avaliação dos critérios de prioridade do Farmácia Popular conforme vulnerabilidade social e o Mais Médicos

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ABSTRACT This study evaluates the application of priority criteria for accreditation within Brazil's Farmácia Popular Program (PFPB), as established by Decree No. 11,555/2023, which defines municipalities with high or very high social vulnerability and participation in the Mais Médicos Program as priorities. Data were obtained from the registry of pharmacies accredited by PFPB (February 2025), the Mais Médicos Program dashboard (April 2025), both from the Ministry of Health, and population estimates from the Brazilian Institute of Geography and Statistics (IBGE). The analysis revealed that 1,798 municipalities simultaneously meet both criteria, of which 80.29% already have at least one accredited pharmacy. Despite the partial effectiveness observed, the regional distribution showed persistent inequalities, with a concentration of accreditations in the Southeast and lower participation in the North and Northeast regions. The historical series indicated stagnation between 2016 and 2022, followed by a resumption in 2023, when 76.00% of new accreditations occurred in priority municipalities. The findings indicate progress in directing the program toward socially vulnerable territories, but also reveal structural constraints to reducing regional inequalities, reinforcing the need to expand program coverage in less favored regions to strengthen equity and access to essential medicines in the country.

KEYWORDS Pharmaceutical services. Health policy. Health equity. Public administration. Access to essential medicines and health technologies.

RESUMO *O presente estudo avalia a aplicação dos critérios de prioridade para credenciamento do Programa Farmácia Popular do Brasil, estabelecidos pelo Decreto nº 11.555/2023, que define como prioritários os municípios com alta ou muito alta vulnerabilidade social e participação no Programa Mais Médicos. Foram utilizados dados da planilha de farmácias credenciadas ao Programa Farmácia Popular do Brasil (fevereiro de 2025), do Painel Mais Médicos (abril de 2025), ambos do Ministério da Saúde, e estimativas populacionais do Instituto Brasileiro de Geografia e Estatística. A análise revelou que 1.798 municípios atendem simultaneamente aos dois critérios, sendo que 80,29% já possuem ao menos uma farmácia credenciada. Apesar da efetividade parcial observada, a distribuição regional evidenciou desigualdades, com concentração de credenciamentos no Sudeste e menor participação no Norte e no Nordeste. A série histórica mostrou estagnação entre 2016 e 2022, seguida de retomada em 2023, quando 76% dos novos credenciamentos ocorreram em municípios prioritários. Os resultados indicam avanços no direcionamento do programa, bem como revelam limites estruturais à redução de desigualdades regionais, o que reforça a necessidade de ampliar a cobertura do programa em regiões menos favorecidas, fortalecendo a equidade e o acesso a medicamentos essenciais no País.*

PALAVRAS-CHAVE *Assistência farmacêutica. Política de saúde. Equidade em saúde. Administração pública. Acesso a medicamentos essenciais e tecnologias em saúde.*

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Introduction

The establishment of Brazil's Unified Health System (SUS) under the 1988 Constitution marked a turning point in national health policy, enshrining the principles of universality, comprehensiveness, equity, and decentralization as its guiding foundations. Within this framework, a range of policy initiatives was developed—including the National Medicines Policy, the National Pharmaceutical Assistance Policy (PNAF), the Brazilian Popular Pharmacy Program (PFPB), and the More Doctors Program (PMM)—all aimed at broadening access to essential health services and inputs, with particular emphasis on strengthening Primary Health Care (PHC)[1,2].

Introduced in 2004, the PFPB was designed to mitigate persistent challenges faced by the SUS in ensuring a stable and continuous supply of medicines. Its reach expanded substantially with the adoption of a co-payment model through private pharmacies and the gradual incorporation of measures such as the free provision of medicines for chronic conditions. More recently, the introduction of full cost coverage for all medicines offered and the prioritization of municipalities with high levels of social vulnerability, as measured by the Social Vulnerability Index (SVI), have further consolidated the program's role as a key instrument for promoting equity and social inclusion[3].

Alongside these efforts, the PMM was launched in 2013 to address longstanding shortages of physicians in underserved and vulnerable regions. By reshaping medical training pathways and ensuring the emergency deployment of professionals to PHC services, the program contributed to the expansion of Family Health Strategy coverage and to a reduction in avoidable hospitalizations. Following periods of interruption and institutional reconfiguration, the PMM was reintroduced in 2023 with renewed emphasis on training and retaining physicians in areas of greatest need, adopting the SVI as a central criterion for the allocation of both resources and health professionals[4].

The SVI—developed jointly by the Institute for Applied Economic Research (IPEA), the United Nations Development Program (UNDP), and the João Pinheiro Foundation—captures multiple dimensions of social exclusion, including income and employment, urban infrastructure, and human capital. Its use supports the design of more targeted and effective public policies focused on vulnerable territories, as illustrated by its incorporation into priority-setting mechanisms within the PFPB and PMM[5]. The assessment of such policies, in turn, must be grounded in the public policy cycle, with particular attention to the evaluation phase, which enables systematic review based on criteria such as efficacy, efficiency, effectiveness, and equity. These dimensions are critical to ensuring that policy objectives are not only achieved but sustained over time[6].

After the issuance of Decree No. 11,555 on June 7, 20237, the PFPB shifted toward a more selective expansion strategy, introducing technical criteria to guide the accreditation of pharmacies. Expansion efforts were deliberately steered toward municipalities experiencing greater social vulnerability and those participating in the PMM[7], signaling a move away from uniform growth toward needs-based prioritization.

Relying on objective benchmarks—such as the Social Vulnerability Index (SVI) and PMM participation—to guide decision-making brings the PFPB more closely into line with the logic of the public policy cycle. These parameters allow resources to be concentrated where social and economic needs are most acute, strengthening policy execution and advancing more equitable access to essential medicines[6].

Against this backdrop, a central question frames the analysis: does the spatial distribution of PFPB-accredited pharmacies reflect the technical priorities established by the policy, particularly those linked to social vulnerability

and the presence of the PMM? To explore this issue, the study examines how formal prioritization rules translate into territorial outcomes, assessing regional patterns of pharmacy accreditation and identifying municipalities that, despite being designated as priorities, remain underserved.

By doing so, the analysis seeks to shed light on the practical constraints that shape public policy implementation within the SUS, especially in relation to the geographic allocation of pharmacies under the PFPB. Mapping program coverage across priority municipalities makes it possible to identify enduring territorial gaps. In this sense, the findings aim to contribute to broader discussions on territorial equity and access to essential medicines.

Material and methods

This descriptive–analytical study employed a quantitative approach using publicly available secondary data. The data were retrieved from official Ministry of Health sources, specifically the Pharmacies Certified under the PFPB spreadsheet (February 2025) and the More Doctors Program Monitoring dashboard (April 2025), both accessible through the Ministry of Health's institutional portal[8,9]. The dashboard consolidates information on vacancies, medical teams, territorial coverage, and the Social Vulnerability Index (SVI), which serves as the central metric for this analysis[8,9]. Population estimates from the Brazilian Institute of Geography and Statistics (IBGE) for July 2025 were also used to support complementary descriptive analyses adjusted for the resident population[10].

Data collection took place in June 2025 through the retrieval of the aforementioned datasets. All Brazilian municipalities with complete and consistent information across the sources were included. The analysis focused on identifying high-priority municipalities, defined by participation in the PMM and classification as having high or very high SVI, to assess the presence of PFPB-accredited pharmacies.

The following variables were analyzed: the number of municipalities participating in the PMM, the number of PFPB-accredited pharmacies per municipality, accreditation dates, SVI categories, and the total number of municipalities classified as having high or very high social vulnerability.

The data were initially organized in Microsoft Excel®, with column structuring and harmonization of IBGE municipal codes to ensure relational integrity. Data modeling was subsequently performed in Power BI®, integrating the tables using the IBGE code as a common identifier. This integration enabled the construction of indicators combining PMM participation, SVI category, and the presence of PFPB-accredited pharmacies. The analysis was conducted within Power BI®, a tool that supports interactive data integration, modeling, and visualization, with well-documented applications in indicator evaluation and complex database analysis[11,12].

The tool was selected for its ability to transform large datasets into accessible and policy-relevant visual outputs—an essential feature for assessing alignment between the guidelines of Decree No. 11,555/20237 and their implementation in practice. Interactive dashboards made it possible to clearly identify priority municipalities that still lack accredited pharmacies, revealing implementation gaps and exposing patterns of overlap, omission, and uneven coverage across federal programs.

Cross-referencing the data also made it possible to assess whether technical criteria—such as prioritizing municipalities with high or very high SVI—have been effectively applied in the accreditation of new pharmacies. The analysis, therefore, provides grounded visual evidence that may support adjustments and improvements to the operational framework of this federal policy.

The study was conducted in accordance with the ethical standards and guidelines established by National Health Council

Resolutions No. 466 of December 12, 2012, and No. 510 of April 7, 2016[13,14]. Ethics committee approval was not required, as the study relied exclusively on publicly available secondary data.

Results and discussion

According to the data analyzed, as of February 2025, the PFPB had 31,157 accredited pharmacies distributed across 4,823 municipalities. A marked concentration of establishments is observed in the Southeast (47.23%) and South (24.68%) regions, followed by the Central-West (10.13%). Conversely, the Northeast (9.85%) and North (8.11%) regions account for the smallest shares of total accreditations. To assess whether this regional distribution aligns with the population distribution across the country, *table 1* presents a comparison between the resident population and the number of PFPB-accredited pharmacies by region.

Table 1. Regional distribution of resident population and PFPB-accredited pharmacies

Region	Population(n)	Population (%)	Accredited Pharmacies (n)	Pharmacies (%)	Pharmacies per 100 thous. hab.
North	18,801,282	8.81%	2,527	8,11%	13.44
Northeast	57,244,485	26.82%	3,070	9,85%	5.36
Southeast	88,825,643	41.62%	14,717	47,23%	16.57
South	31,310,809	14.67%	7,689	24,68%	24.56
Central-West	17,238,818	8.08%	3,154	10,13%	18.30
Brazil	213,421,037	100.00%	31,157	100,00%	14.60

Source: Authors' elaboration based on Brazil[8,9] and IBGE[10].

The comparison between population share and the distribution of PFPB-accredited pharmacies reveals marked asymmetries. The Southeast and South regions host a higher proportion of pharmacies than their respective shares of the national population, whereas the North—and particularly the Northeast—remain significantly underrepresented.

The disparity is most pronounced in the Northeast, which accounts for approximately 26.82% of Brazil's population but only 9.85% of program pharmacies. This corresponds to 5.36 establishments per 100,000 inhabitants, well below the national average of 14.60. By contrast, the South records the highest regional ratio, at 24.56 per 100,000 inhabitants. Overall, these findings suggest that the territorial distribution of the PFPB does not align proportionally with population distribution, pointing to the influence of structural determinants beyond demographic weight—particularly in light of formal prioritization criteria and PMM presence.

This concentration in more economically developed regions reflects a pattern well documented in the literature on access to medicines, where the spatial distribution of service points tends to follow population density, existing infrastructure, and the economic attractiveness of local markets to private providers[15,16]. In the case of the PFPB, this market-oriented dynamic may have favored expansion in economically vibrant areas while reinforcing pre-existing territorial inequalities in access to medicines.

Although the program includes formal prioritization criteria intended to expand coverage in vulnerable territories, the February

2025 data suggest that its impact remains limited. The low representation of the North and Northeast regions, historically associated with reduced access to health services and medicines[17,18], points to persistent structural barriers, including a limited supply of private pharmacies, logistical constraints, and infrastructure deficits, all of which continue to constrain program effectiveness in these areas.

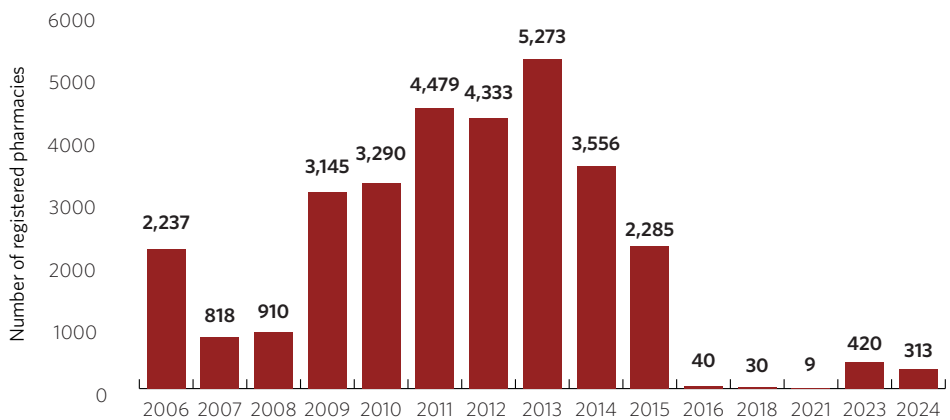
Within this context, understanding the drivers of this spatial concentration and evaluating more proactive implementation strategies—such as financial incentives, partnerships with public pharmacies, or greater flexibility in accreditation requirements for underserved areas—becomes essential if the PFPB is to fully achieve its goal of reducing regional inequalities in access to essential medicines.

Findings from the 2013 National Health Survey (PNS) already indicated that, despite overall improvements in access to and utilization of health services across all regions of the country, significant disparities persisted. The North and Northeast continued to exhibit poorer health outcomes, higher rates of activity limitation, and lower healthcare utilization, even in the context of expanded public program coverage[18].

These findings help contextualize the lower proportional participation of these regions in the PFPB observed in this study. While the North and Northeast concentrate areas with lower socioeconomic development and reduced availability of health services, the Central-West region displays intermediate to high socioeconomic development, but still faces constraints in service availability. In contrast, the Southeast and South concentrate areas with higher socioeconomic development and more extensive health infrastructure, which helps explain the greater presence of accredited establishments in these regions[19,20].

Graph 1 presents the evolution of annual accreditations in the PFPB from 2006 onward.

Graph 1. Evolution of the number of pharmacies accredited under the Popular Pharmacy Program (2006–2024)



Source: Authors' elaboration.

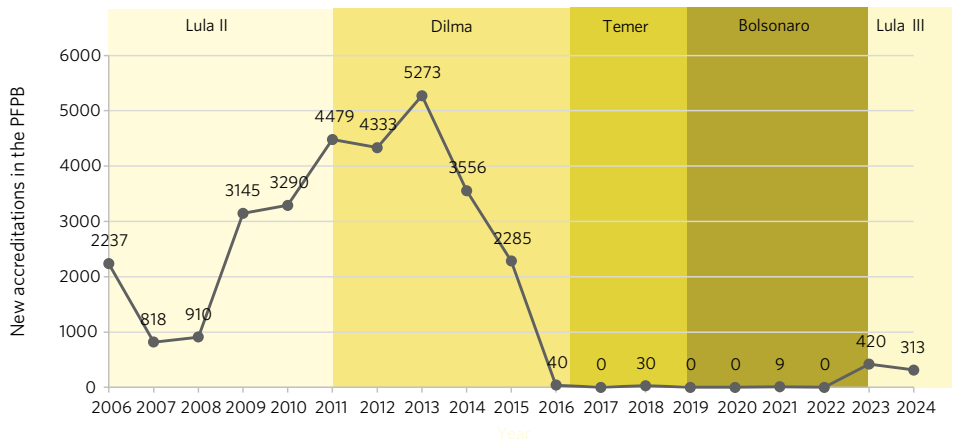
A clear concentration of new accreditations is observed in the period 2011–2013, with peaks in 2013 (5,273), 2011 (4,479), and 2012 (4,333). This was followed by a gradual decline, from 3,556 new accreditations in 2014 to 2,285 in 2015. From 2016 onward, the number of new accreditations drops sharply, with only 40 in 2016, 30 in 2018, and 9 in 2021, and no new accreditations were recorded in 2017, 2019, or 2020.

This pattern reflects a period in which the large-scale expansion of the program

was suspended, with priority shifting toward maintaining the existing network and reviewing contractual arrangements. The literature indicates that this phase coincided with fiscal constraints and changes in program guidelines oriented toward expenditure control and administrative reorganization[16]. Although this study does not establish causal relationships, these factors help contextualize the pronounced reduction in accreditations observed over the period.

Graph 2 illustrates changes in the pace of PFPB accreditation across presidential terms (2006–2024), highlighting periods of rapid expansion, stagnation, and subsequent reactivation.

Graph 2. Annual evolution of new PFPB accreditations by presidential cycle (2006–2024)



Source: Authors' elaboration.

Given that the PFPB has evolved across distinct political cycles, the historical series was organized by presidential administration, a common approach in long-term policy analysis. The most significant expansion phase occurred in the early years of implementation, corresponding to the administrations of Luiz Inácio Lula da Silva (2006–2010) and Dilma Rousseff (2011–2016). This phase was driven by the scaling up of the private pharmacy accreditation model, known as Aqui Tem Farmácia Popular, alongside a complementary publicly provided service network[1,21].

Throughout this period, the PFPB also underwent substantial organizational changes shaped by broader fiscal and economic conditions. The literature identifies the discontinuation of the public pharmacy network as a key inflection point, embedded within a wider context of fiscal austerity and a shift toward greater private-sector participation in pharmaceutical service delivery[1,21]. This shift has been interpreted as part of a broader process of partial de-statization of medicine dispensing, aligned with efforts to rationalize public expenditure and reduce the State's direct service provision role[15].

From the mid-2010s onward, a clear slowdown in accreditations is observed, followed by periods of minimal or no new entries during the administrations of Michel Temer (2016–2018) and Jair Bolsonaro (2019–2022), as shown by the empirical data analyzed in this study. This trend unfolded in a context of tightening fiscal constraints, which intensified after 2016 with the introduction of a 20-year cap on public spending in health and education. The literature suggests that this

measure limited the State's capacity to sustain and expand social policies, including those in the health sector[22].

During the Bolsonaro administration, these dynamics occurred within a politically contested environment regarding the role of the State in health policy coordination, further exacerbated by the COVID-19 pandemic, as documented in studies on Brazil's federal pandemic response[23].

At the beginning of Luiz Inácio Lula da Silva's third term in 2023, PFPB accreditations increased again, including in municipalities classified as highly vulnerable, as shown in this study's data. While this study does not establish causal relationships, the findings suggest that, beyond fiscal constraints, the broader political-institutional context plays a significant role in shaping the program's trajectory, reinforcing the importance of assessing the effective implementation of the technical prioritization criteria established under Decree No. 11,555/2023[7].

The PMM operates in 4,599 Brazilian municipalities, indicating broad territorial coverage. Regionally, participation is highest in the Northeast (34.81%), followed by the Southeast (26.40%) and South (21.90%), while the North and Central-West account for smaller shares, at 9.07% and 7.83%, respectively.

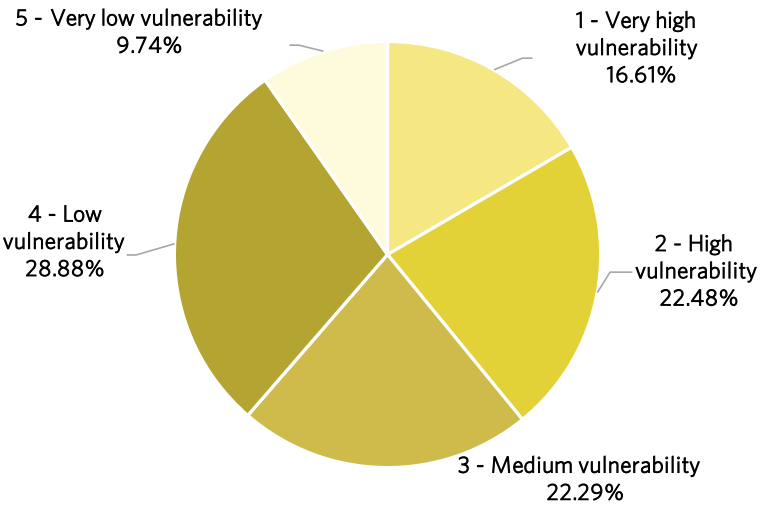
National evaluations indicate that the PMM contributed to expanding healthcare coverage and reducing inequalities in the distribution of health professionals, particularly in the North and Northeast. Nevertheless, important gaps in service provision persist, especially in rural areas, urban peripheries, and small municipalities across all regions of the country[24–26].

In this context, the integration of PMM participation as a technical prioritization criterion for PFPB accreditation, as established by Decree No. 11,555/20237, provided an important normative reference for assessing the territorial alignment of the policy.

In addition, related policies such as the PMM adopt objective criteria that prioritize remote and socially vulnerable areas, characterized by high vacancy occupancy rates and strong early retention of professionals[27]. The program has also been associated with changes in medical training, with greater emphasis on Primary Health Care (PHC) and generalist training, in line with a broader territorial equity rationale[28].

Graph 3 illustrates the distribution of PMM-participating municipalities, according to social vulnerability categories. This complements the territorial analysis by highlighting the program's concentration in highly vulnerable areas. Research suggests that this prioritization has helped expand healthcare coverage in locations facing the greatest socioeconomic and geographic barriers[25,27].

Graph 3. Distribution of PMM-participating municipalities by social vulnerability category



Source: Authors' elaboration.

When examining PMM-participating municipalities classified as having high or very high SVI, the largest proportion falls within the low vulnerability category (28.88%), followed by high (22.48%) and medium (22.29%) vulnerability. Together, these two categories account for approximately 45% of all municipalities covered by the program.

Municipalities classified as very high vulnerability represent 16.61% of PMM participants, while those in the very low vulnerability category account for the smallest share (9.74%).

Overall, the PMM maintains substantial coverage in municipalities with higher levels of social vulnerability, reaching approximately 39% when the high and very high categories are combined. This pattern is consistent with the program's original design, which prioritized areas facing greater difficulty in attracting and retaining health professionals, often associated with adverse socioeconomic conditions and geographic barriers to healthcare access[25,27].

Based on the PMM dataset, 1,798 participating municipalities meet the criteria of high or very high social vulnerability—1,034 classified as high and 764 as very high. These municipalities simultaneously satisfy the two technical prioritization criteria established for the PFPB: active PMM participation and classification as high or very high SVI, as defined under Decree No. 11,555/2023[7].

Of these 1,798 priority municipalities, 1,447 (80.48%) have at least one PFPB-accredited pharmacy, while 351 (19.52%) still lack program coverage.

Of the 1,798 municipalities meeting the priority criteria set by Decree No. 11,555/2023[7]—namely, participation in the Mais Médicos Program (PMM) and a 'high' or 'very high' Social Vulnerability Index (SVI) rating—1,447 (80.48%) have at least one pharmacy enrolled in the Farmácia Popular Program (PFPB), whereas 351 (19.52%) still lack any participating establishments

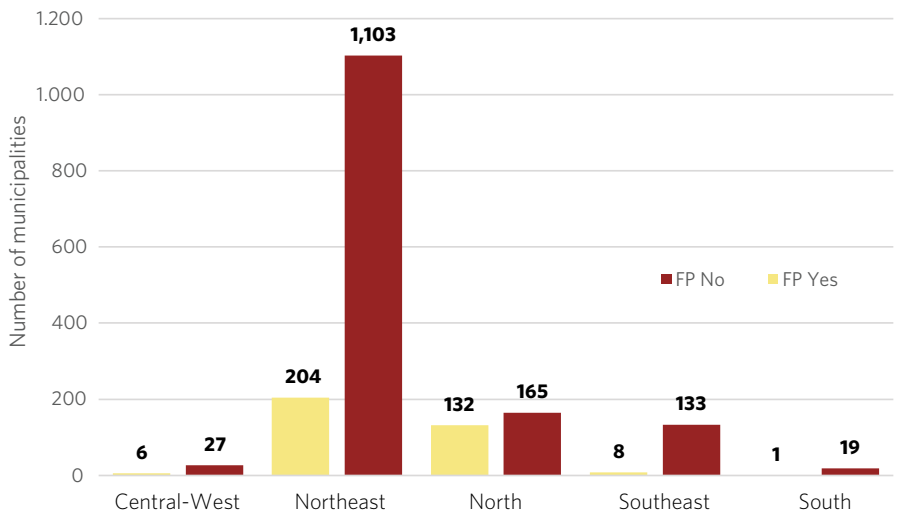
This finding is consistent with studies reporting an expansion in the availability of health services and initiatives in Brazil, as evidenced by population-based surveys12,14. It also reflects the consolidation of access to medicines as a national policy priority, increasingly embedded as a structural component of the country's public health system[15].

Regarding regional distribution, among municipalities without PFPB coverage, 204 are

located in the Northeast, and only one is in the South. Conversely, among municipalities with program coverage, the Northeast accounts for 1,103 municipalities, while the South accounts for nineteen.

To further examine this distribution, *graph 4* presents the number of municipalities with high or very high SVI and PMM participation by region, highlighting the presence or absence of PFPB-accredited pharmacies. This regional breakdown reveals important disparities in policy implementation, with coverage heavily concentrated in the Northeast alongside persistent gaps in other regions.

Graph 4. Regional distribution of PFPB coverage in municipalities with PMM participation and high or very high SVI



Source: Authors' elaboration.

Of the 351 municipalities that meet the program's priority criteria but still lack accredited pharmacies, 204 are located in the Northeast, 132 in the North, eight in the Southeast, six in the Central-West, and one in the South. This pattern reinforces that the greatest barriers to accessing healthcare services and interventions are concentrated in the North and Northeast regions, even in the context of coverage expansion policies. This highlights persistent structural constraints that hinder the effective policy implementation in the most vulnerable territories[17].

Despite a reduction in regional inequalities regarding healthcare services, disparities persist, with the North and Northeast exhibiting the poorest indicators for access and utilization[18]. Within this context, the PFPB has predominantly reached larger municipalities and those with higher Municipal Human Development Index (MHDI) values.

However, for the program to consolidate its role as an effective strategy for addressing inequities in access to medicines across Brazilian municipalities, further expansion into more vulnerable localities remains essential—a trend that has gained momentum in recent years[29].

Policy implementation can also be evaluated during its course, allowing for timely adjustments[30]. The PFPB, established two decades ago, is a consolidated public policy that has expanded access to medicines in Brazil, with results that are widely recognized, including by the World Health Organization[17,31].

In this regard, it is crucial to monitor the effectiveness of implementing the priority

criteria for PFPB certification, officially mandated in 2023 by Decree No. 11,555/2023[7]. According to Article 1, Paragraph 5, priority must be given to pharmacies located in municipalities experiencing greater social vulnerability and participating in the PMM.

The results indicate that the program has been effective in reaching more than half of the identified priority municipalities. Overall, 80.29% of these municipalities have at least one accredited PFPB pharmacy.

Effectiveness is a key criterion in policy evaluation, as it refers to the extent to which a policy achieves social outcomes such as mitigating the core problem and generating value for the population[6,32]. More broadly, effectiveness (or impact) also encompasses observable changes within the environment where the policy was implemented, considering technical, economic, sociocultural, institutional, and environmental dimensions[30].

By reaching a substantial number of highly vulnerable municipalities with PMM presence, the PFPB demonstrates effectiveness in expanding and prioritizing access to medicines in these areas.

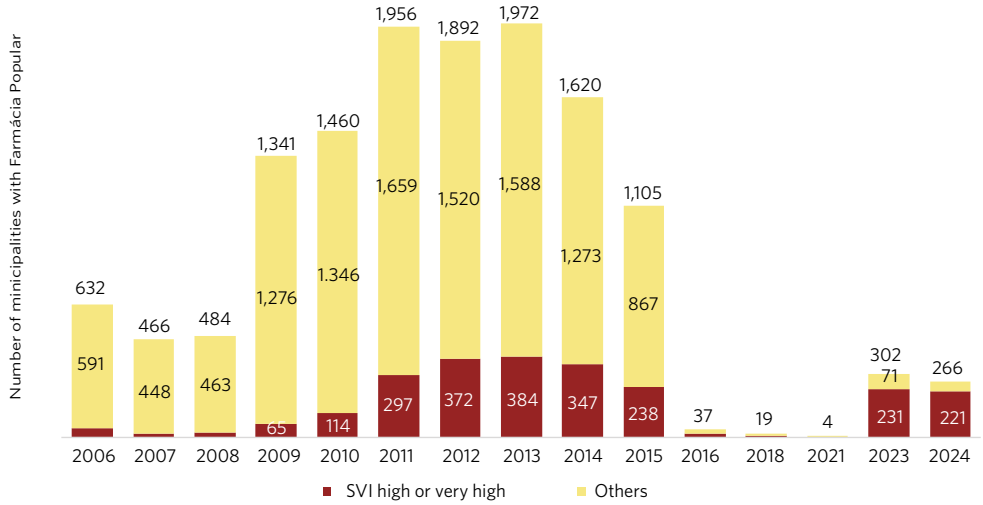
Despite these advances, the data also highlight territorial inequities in the distribution of accredited pharmacies. At the national level, the PFPB remains concentrated in the Southeast, while the Northeast and North regions account for only 9.85% and 8.11% of the accreditations, respectively.

The equity criterion in public policy evaluation seeks to measure the degree to which program benefits are distributed fairly and in accordance with user needs[30]. In other words, it allows for the assessment of whether benefits are evenly distributed, taking into account the baseline conditions of target populations, and thus the fairness of public resource allocation[6,32].

The data further reveal uneven coverage among priority municipalities, which are largely concentrated in the Northeast and North regions. Although the program shows partial effectiveness in applying its prioritization criteria, inequities in access to medicines in vulnerable territories persist. The PFPB should therefore continue to direct efforts toward expanding coverage in these municipalities, where needs are most pronounced.

Graph 5 presents the annual evolution in the number of municipalities with PFPB-accredited pharmacies, disaggregated by municipalities classified as having high or very high SVI.

Graph 5. Evolution of municipalities with PFPB-accredited pharmacies by SVI category (2006–2024)



Source: Authors' elaboration.

Note: No new accreditations were recorded in 2017, 2019, 2020, and 2022.

A marked increase in the total number of accreditations occurred between 2009 and 2013, with peak values recorded in 2011 (1,956) and 2013 (1,972). This period is also characterized by a substantial rise in the inclusion of vulnerable municipalities, reaching its highest level in 2013, when 384 municipalities classified as having high or very high SVI were covered.

This trend may be explained by the incorporation of the PFPB into the framework of the Plano Brasil Sem Miséria (Brazil Without Extreme Poverty Plan, BSM), launched in 2011 to reduce social inequalities. At the time, priority was given to accrediting private pharmacies in municipalities with high levels of extreme poverty and limited access to healthcare services[16]. This suggests that, even before technical criteria were explicitly formalized into regulation, there was already some degree of policy sensitivity toward vulnerable territories.

From 2016 onwards, accreditations declined sharply, reaching minimal levels between 2016 and 2021, with only four new accreditations recorded in 2021. A recovery is evident in 2023 and 2024, particularly in municipalities with higher social vulnerability, with 231 and 221 accreditations, respectively. This shift indicates a possible association with the new regulatory framework introduced in 2023[7], which formally established the prioritization of municipalities with high or very high SVI and active PMM participation.

The historical analysis reveals that, while the PFPB significantly expanded its coverage between 2009 and 2015, the prioritization of vulnerable territories only became more pronounced in recent years, following the formal incorporation of technical criteria. Nonetheless, the data reinforce the need to sustain and consolidate these measures to ensure greater territorial equity in access to medicines.

Recent trends indicate a reorientation of accreditation toward more socially vulnerable municipalities. Specifically, 76% of recent accreditations occurred in municipalities classified as having high or very high SVI, while 24% were allocated to other vulnerability categories. This marks a substantive improvement compared with previous years, when pharmacy distribution was largely concentrated in municipalities with more favorable socioeconomic conditions.

This pattern reflects the Ministry of Health's recent efforts to align program expansion with equity and distributive justice principles, as

outlined in Decree No. 11,555/2023[7]. Equity remains one of the central challenges of public health in Brazil, particularly given historical patterns of resource allocation within the SUS and the persistent and profound income inequalities across regions and social groups[33].

Moreover, public policies should be assessed not only in terms of outcomes but also during implementation, allowing for timely adjustments[30]. The increased proportion of accreditations in priority municipalities suggests that the PFPB may be responding, at least in part, to previous critiques regarding regional concentration and unequal access.

However, despite this progress, the consolidation of territorial equity within the PFPB still depends on the continuity of this trend in the coming years, ensuring that technical prioritization criteria are not only normatively established but also effectively implemented in practice. In contexts of structural inequality, principles such as universality and equity must be actively operationalized rather than merely declared[34].

This limitation is also evident in other health systems across the region, allowing for a broader analysis beyond national borders. Studies on access to medicines in Latin America indicate that unequal availability of essential treatments is driven by structural, historical, and political factors embedded in national health systems. Economic disparities, institutional fragmentation, and technological dependence on external pharmaceutical inputs limit the translation of legal universalism into effective access[35].

In response, several countries have implemented public programs aimed at expanding access. In Mexico, for instance, the Seguro Popular (established in 2003) provides a healthcare intervention package that includes medicines, although only a portion of beneficiaries are fully exempt from co-payments. Other examples include Argentina's REMEDIAR program, the FONASA public insurance system in Chile, and initiatives such as Medicaid and Medicare in the United States of America, all of which involve public administration and distinct financing and provision mechanisms[36].

Despite important advances, countries such as Argentina, Paraguay, and Colombia continue to face constraints that undermine equity. In Argentina, the coexistence of multiple subsystems and economic instability affects policy continuity; Paraguay operates under chronic underfunding and pronounced territorial disparities; and Colombia relies heavily on a private-sector–driven model, which limits universal access to health goods and services[35].

Recent Latin American experiences reinforce that expanding access to medicines requires sustained effort and coordinated action among governments. Within the Southern Common Market (MERCOSUR) and the Union of South American Nations (UNASUR), joint price negotiation initiatives—such as those led by the Ad Hoc Committee on Price Negotiation of High-Cost Medicines (CAHPM)—have successfully lowered benchmark values for essential drugs, enabled access to new therapies, and created fiscal space for national policies. Despite these advances, sustaining such initiatives relies heavily on technical coordination, political commitment, and cross-border cooperation. This underscores that reducing inequalities—within and beyond Brazil—requires persistent and regionally integrated action[37].

Conclusions

This analysis evaluated the extent to which the priority criteria established by the PFPB have been effectively applied during the accreditation process, with a focus on social vulnerability and the presence of the PMM.

The findings indicate that 80.50% of municipalities meeting the policy's technical criteria have at least one PFPB-accredited pharmacy, while 19.50% still lack any program-linked units. These data suggest that the accreditation policy has largely aligned with the established regulatory criteria, reflecting partial effectiveness in territorial prioritization.

The regional analysis showed that, among high-priority municipalities without accredited pharmacies, the majority are concentrated in the Northeast and North regions, which together account for less than 20% of the program's establishments. In contrast, the Southeast and South regions account for over 70% of the total, exposing structural inequalities and highlighting the need to expand coverage in historically underserved areas.

The historical analysis revealed stagnation in accreditations between 2016 and 2022, with a turnaround emerging only from 2023 onwards. Within this new cycle, 733 new accreditations were recorded in municipalities with an active PMM presence, 76% of which are located in territories with high or very high SVI. This outcome demonstrates clear progress in prioritizing highly vulnerable areas, representing a significant shift in direction after years of program retrenchment.

Moreover, the data reinforce the policy's alignment with regulatory directives for territorial prioritization. When considering only 2023 and 2024 accreditations in PMM-participating municipalities, new entries predominantly occurred in territories that also present high social vulnerability. This constitutes an important step forward in addressing disparities in access to medicines.

Overall, the results indicate that the PFPB has made significant progress in applying its recently defined technical prioritization criteria, particularly by expanding accreditations in municipalities characterized by greater social vulnerability and an active PMM presence. However, the persistence of regional disparities in the distribution of accredited pharmacies shows that territorial equity has not yet been fully achieved.

Thus, while the PFPB has demonstrated stronger adherence to the technical prioritization criteria established in 2023, consolidating territorial equity in pharmaceutical access still depends on sustaining and deepening this policy direction in the coming years. In contexts marked by deep-seated social and regional inequalities, principles such as universality and equity require more than formal regulation; they demand continuous monitoring, systematic evaluation, and institutional capacity to translate policy directives into concrete outcomes on the ground.

This study presents limitations stemming from the use of secondary databases, which were not originally designed for public policy evaluation. This may introduce information gaps and restrict the scope of available variables. The analysis was limited to processing these databases and drawing descriptive inferences, without establishing causal relationships among the studied variables. Furthermore, the selected timeframe reflects the reality of the period analyzed and does not account for subsequent changes. Finally, this study does not incorporate qualitative insights from managers or users, which could have broadened the understanding of how these priority criteria are implemented in practice.

Authorship contributions

Assis IP (0009-0005-5258-4313)* contributed to the study conception, data collection, data analysis and interpretation, manuscript writing, and critical revision of the manuscript content. Silva AM (0009-0001-6072-9579)* contributed to the study conception, data collection, data analysis and interpretation, and manuscript writing. Rocha JBA (0000-0002-0591-7972)* contributed to the study conception, data analysis and interpretation, manuscript writing, critical revision of the manuscript content, and approval of the final version of the manuscript. Conceição AF (0000-0002-0085-6146)* contributed to the study conception and design, critical revision of the manuscript content, and approval of the final version of the manuscript. Garcia LAA (0000-0003-0984-2688)* contributed to critical revision of the manuscript content and approval of the final version of the manuscript. ■

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References

1. Alencar TOS, Araújo PS, Costa EA, et al. Programa Farmácia Popular do Brasil: uma análise política de sua origem, seus desdobramentos e inflexões. Saúde Debate. 2018;42(Esp 2):159-72. DOI: https://doi.org/10.1590/0103-11042018S211

2. Ministério da Saúde (BR), Secretaria de Ciência, Tecnologia e Insumos Estratégicos, Departamento de Assistência Farmacêutica e Insumos Estratégicos. Assistência farmacêutica no SUS: 20 anos de políticas e propostas para desenvolvimento e qualificação: relatório com análise e recomendações de gestores, especialistas e representantes da sociedade civil organizada [Internet]. Brasília, DF: Ministério da Saúde; 2018 [acesso em 2025 ago 10]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/assistencia_farmaceutica_sus_relatorio_recomendacoes.pdf

3. Ministério da Saúde (BR). Farmácia Popular. Gov.br [Internet]. [data desconhecida] [acesso em 2025 ago 10]; Composição. Disponível em: https://www.gov.br/saude/pt-br/composicao/sectics/farmacia-popular

4. Cury GC, Fonseca AF. A retomada do Programa Mais Médicos em 2023. Trab Educ Saúde. 2023;21:e02415229. DOI: https://doi.org/10.1590/1981-7746-ojs2415

5. Marguti BO, Costa MA, Pinto CVS, organizadores. Territórios em números: insumos para políticas públicas a partir da análise do IDHM e do IVS de municípios e Unidades da Federação brasileira: Livro 1 [Internet]. Brasília, DF: IPEA; INCT; 2017 [acesso em 2026 jan 4]. 340 p. Disponível em: https://repositorio.ipea.gov.br/entities/book/5b8887a3-265d-4c73-9536-9d7684ca28d3

6. Secchi L, Coelho FS, Pires V. Políticas públicas: conceitos, casos práticos, questões de concursos. São Paulo: Cengage Learning; 2019. 272 p.

7. Presidência da República (BR). Decreto nº 11.555, de 7 de junho de 2023. Altera o Decreto nº 5.090, de maio de 2004, que regulamenta a Lei nº 10.858, de 13 de abril de 2004, e institui o Programa Farmácia Popular do Brasil [Internet]. Diário Oficial da União, Brasília, DF. 2023 jun 7 [acesso em 2025 ago 10]; Seção I:1. Disponível em: https://www.planalto.gov.br/ccivil_03/_Ato2023-2026/2023/Decreto/D11555.htm

8. Ministério da Saúde (BR). Farmácias Credenciadas ao Programa Farmácia Popular do Brasil [Internet]. Brasília, DF: MS; 2025 [acesso em 2025 ago 10]. Disponível em: https://www.gov.br/saude/pt-br/assuntos/saude-de-a-a-z/farmacia-popular

9. Ministério da Saúde (BR). Painel de Monitoramento do Programa Mais Médicos [Internet]. Brasília, DF: MS; 2025 [acesso em 2025 ago 10]. Disponível em: https://mais.medicos.gov.br/painel

10. Instituto Brasileiro de Geografia e Estatística. Estimativas da população residente para os municípios e para as Unidades da Federação com data de referência em 1º de julho de 2025 [Internet]. Rio de Janeiro: IBGE; 2025 [acesso em 2025 dez 30]. Disponível em: https://www.ibge.gov.br

11. Parthe RM. Comparative analysis of data visualization tools: Power BI and Tableau. Int J Sci Res Eng Manag. 2023;7(10):1-11. DOI: https://doi.org/10.55041/IJSREM26272

12. Müller F, Polesello E. Uso do Power Business Intelligence na avaliação de indicadores da construção civil. In: Góes MB. Tecnologias e Inovações na Construção Civil: os avanços em técnicas, materiais e processos de construção. V. 2. Guarujá: Editora Científica Digital; 2024. p. 75-97. DOI: https://doi.org/10.37885/240316058

13. Conselho Nacional de Saúde (BR). Resolução nº 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Diário Oficial da União, Brasília, DF. 2013 jun 13; Edição 112; Seção I:59-62.

14. Conselho Nacional de Saúde (BR). Resolução nº 510, de 7 de abril de 2016. Dispõe sobre as normas aplicáveis a pesquisas em Ciências Humanas e Sociais.

Diário Oficial da União, Brasília, DF. 2016 maio 24; Edição 98; Seção I:44-46.

15. Garcia MM, Guerra AA, Acúrcio FA. Avaliação econômica dos Programas Rede Farmácia de Minas do SUS versus Farmácia Popular do Brasil. Ciênc saúde coletiva. 2017;22(1):221-33. DOI: https://doi.org/10.1590/1413-81232017221.15912015

16. Pinto CBSP, Miranda ES, Esher ÂFM, et al. A provisão de medicamentos pelo 'Saúde Não Tem Preço' em municípios prioritários para o Plano Brasil Sem Miséria em Mato Grosso do Sul. Physis. 2018;28(1):e280106. DOI: https://doi.org/10.1590/S0103-73312018280106

17. Palmeira NC, Moro JP, Getulino FA, et al. Análise do acesso a serviços de saúde no Brasil segundo perfil sociodemográfico: Pesquisa Nacional de Saúde, 2019. Epidemiol Serv Saude. 2022;31(3):e2022966. DOI: https://doi.org/10.1590/S2237-96222022000300013

18. Viacava F, Porto SM, Carvalho CC, et al. Desigualdades regionais e sociais em saúde segundo inquéritos domiciliares (Brasil, 1998-2013). Ciênc saúde coletiva. 2019;24(7):2745-60. DOI: https://doi.org/10.1590/1413-81232018247.15812017

19. Calvo MCM, Lacerda JT, Colussi CF, et al. Estratificação de municípios brasileiros para avaliação de desempenho em saúde. Epidemiol Serv Saúde. 2016;25(4):767-76. DOI: https://doi.org/10.5123/S1679-49742016000400010

20. Viana AL, Bousquat A, Melo GA, et al. Regionalização e Redes de Saúde. Ciênc saúde coletiva. 2018;23(6):1791-8. DOI: https://doi.org/10.1590/1413-81232018236.05502018

21. Martins CLPC, Soler O, Silva MVS. Programa Farmácia Popular do Brasil e serviços de assistência farmacêutica: revisão de escopo. Cad Pedagógico. 2024; 21(13):e12107. DOI: https://doi.org/10.54033/cadpedv21n13-252

22. Almeida SRP, Véras MPB. O programa farmácia popular: alcance e limites como alternativa de acesso a medicamentos essenciais. Cad Gest Pública Cid. 2017;22(72):278-95. DOI: https://doi.org/10.12660/cgpc.v22n72.64639

23. Santos JS, Teixeira CF. Análise política da ação do Movimento da Reforma Sanitária Brasileira na pandemia da COVID-19: 2020–2021. Ciênc saúde coletiva. 2023; 28(5):1287-96. DOI: https://doi.org/10.1590/1413-81232023285.14042022

24. Gasparini MFV, Furtado JP. Longitudinalidade e integralidade no Programa Mais Médicos: um estudo avaliativo. Saúde Debate. 2019;43(120):30-42. DOI: https://doi.org/10.1590/0103-1104201912002

25. Santos W, Comes Y, Pereira LL, et al. Avaliação do Programa Mais Médicos: relato de experiência. Saúde Debate. 2019;43(120):256-68. DOI: https://doi.org/10.1590/0103-1104201912019

26. Nassar LM, Passador JL, Pereira Júnior GA. Programa Mais Médicos, uma tentativa de solucionar o problema da distribuição médica no território brasileiro. Saúde Debate. 2021;45(131):1165-82. DOI: https://doi.org/10.1590/0103-1104202113116

27. Santos CMJ, Andrade SZD, Wollmann L, et al. Programa Médicos pelo Brasil: primeiros resultados. Ciênc saúde coletiva. 2023;28(11):3273-9. DOI: https://doi.org/10.1590/1413-812320232811.00072023

28. Matias MC, Verdi M, Finkler M. Instituintes e instituídos na formação médica: movimentos desencadeados pelo Programa Mais Médicos. Saúde Debate. 2023;47(138):504-15. DOI: https://doi.org/10.1590/0103-1104202313810

29. Silva WRO, Lima RF, Cavalcanti ITN, et al. O financiamento dos medicamentos nos municípios do Brasil: de quem é a responsabilidade? Rev Saúde Pública. 2024;58:48. DOI: https://doi.org/10.11606/s1518-8787.2024057005565

30. Costa FL, Castanhar JC. Avaliação de programas públicos: desafios conceituais e metodológicos. Rev Adm Publica [Internet]. 2003;37(5):969-92 [acesso em 2025 ago 12]. Disponível em: https://periodicos.fgv.br/rap/article/view/6509

31. World Health Organization. The pursuit of responsible use of medicines: sharing and learning from country experiences [Internet]. Geneva: WHO; 2012 [acesso em 2025 ago 10]. 64 p. Disponível em: https://www.who.int/publications/i/item/WHO-EMP-MAR-2012.3

32. Secchi L. Análise de políticas públicas: diagnóstico de problemas, recomendação de soluções. São Paulo: Cengage Learning; 2016. 475 p.

33. Carnut L, Mendes Á, Leite MG. Metodologias para alocação equitativa de recursos financeiros em saúde: uma revisão integrativa. Saúde Debate. 2020;44(126):902-18. DOI: https://doi.org/10.1590/0103-1104202012624

34. Agostini R, Castro MC. O que pode o SUS em tempos de necropolítica. Saúde Debate. 2019;43(Esp 7):177-88. DOI: https://doi.org/10.1590/0103-11042019S813

35. Billig O, Portillo L. Assimetrias no acesso a medicamentos essenciais na América Latina: determinantes sociais e justiça global. Rev Eletr Estácio Recife [Internet]. 2026 [acesso em 2026 jan 10];12(3):417-35. Disponível em: https://reer.emnuvens.com.br/reer/article/view/899

36. Vieira FS. Modelos de organização da assistência farmacêutica na atenção ambulatorial: uma análise comparada. Brasília, DF; Rio de Janeiro: Ipea; 2022. 74 p. DOI: http://dx.doi.org/10.38116/td2734

37. Oliveira BNL, Oliveira MA. Acesso a medicamentos e cooperação Sul-Sul: um estudo de caso de negociação conjunta de preços na América do Sul. Cad Saúde Pública. 2021;37(10):e00170920. DOI: https://doi.org/10.1590/0102-311x00170920

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