BETWEEN DISCOURSE AND PRACTICE: WHAT HAVE PUBLIC POLICIES GUARANTEED FOR PERITONEAL DIALYSIS WITHIN THE BRAZILIAN UNIFIED HEALTH SYSTEM (SUS)?

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Rita de Cassia Silva Miranda Marins[1], Siluana Baldoimo Bezerra[2], Allyson Hauan Ponciano da Silva[3], Dayanna Cristiny Souza de Castro[4], Leunice Monfardini Menuci[5], Kharlo Emmanuely Gonçalves de Oliveira e Silva[6], Francisca Angelita Carneiro[7], Maria Laura Magalhães Monte Salustiano[8], Marcos Aurélio de Oliveira Santos[9] and Rivaldo Pereira Silva[10]

[1] Medical Student
Universidade do Grande Rio - UNIGRANRIO, Duque de Caixias RJ
E-mail: rcsmmarins@gmail.com
LATTES: https://lattes.cnpq.br/4059096011914669
[2] Medical Student
Centro Universitário Estácio - ESTÁCIO, Iguatu CE
E-mail: silumedporamor@hotmail.com
LATTES: http://lattes.cnpq.br/7107247914431594
[3] Psychology Undergraduate Student
Faculdade Alpha - ALPHA, Recife PE
E-mail: psiallysonhauan@gmail.com
LATTES: http://lattes.cnpq.br/6664225801195210
[4] Postgraduate in Cardiorespiratory Physiotherapy
Centro Universitário de João Pessoa - UNIPE, João Pessoa PB
E-mail: cdayanna535@gmail.com
LATTES: https://lattes.cnpq.br/7572713717592560
[5] Postgraduate in Hospital Administration
Centro Universitário São Camilo
E-mail: Leo.menuci@hotmail.com
LATTES: https://lattes.cnpq.br/2360725328248080
ORCID: https://orcid.org/0009-0005-5145-4525
[6] Physiotherapy Undergraduate Student
Centro Universitário Faema - UNIFAEMA, Ariquemes RO
E-mail: kharlo_ariq@hotmail.com
ORCID: https://orcid.org/0009-00004-8444-0333
[7] Physiotherapy Graduate
Centro Universitário INTA - UNINTA, Sobral CE
E-mail: anngelita18@hotmail.com
ORCID: https://orcid.org/0000-0001-8829-4186?lang=pt
[8] Nursing Graduate
Centro Universitário Maurício de Nassau - UNINASSAU, Maceió AL
E-mail: marialauraa.mms@gmail.com
LATTES: https://lattes.cnpq.br/4652610903275747
ORCID: https://orcid.org/0009-0009-5136-4588
[9] Nursing Graduate
Universidade Católica de Brasília - UCB, Brasília DF
E-mail: enfermeiromarcosdf@gmail.com
ORCID: https://orcid.org/0009-0003-0182-9646
[10] Nursing Undergraduate Student
Faculdade de Educação São Francisco - FAESF, Pedreiras MA
E-mail: silvarivaldo328@gmail.com
LATTES: https://lattes.cnpq.br/8479770655870038
ORCID: https://orcid.org/0009-0005-3846-6804

Abstract

Peritoneal dialysis is a modality of renal replacement therapy with the potential to expand access to care, promote patient autonomy, and align with the principles of universality, comprehensiveness, and equity of the Brazilian Unified Health System (SUS). This study aimed to analyze the challenges and regional and institutional inequalities related to the provision of peritoneal dialysis within the SUS, considering their impact on access and quality of care for individuals with chronic kidney disease. This is a narrative literature review based on national and international scientific articles, as well as normative documents and clinical guidelines issued by the Brazilian Ministry of Health. The results indicate that, although peritoneal dialysis offers clinical, economic, and social benefits, its implementation remains limited by structural, organizational, logistical, and sociocultural barriers, in addition to regional disparities in service distribution and professional training. Weak integration between levels of health care and the lack of standardized indicators to monitor this modality were also identified. It is concluded that the equitable expansion of peritoneal dialysis within the SUS requires integrated actions in management, financing, continuing education, and strengthening of health care networks, in order to consolidate home-based care as an effective strategy for addressing chronic kidney disease.

Keywords: Chronic kidney disease, Home care, Peritoneal dialysis, Public health policies, Unified Health System.

INTRODUCTION

Chronic Kidney Disease (CKD) constitutes an important public health problem in Brazil, characterized by high prevalence, a progressive course, and significant clinical, social, and economic impacts. It is a chronic noncommunicable condition that evolves slowly and silently, and is often diagnosed at advanced stages, when the loss of renal function is already irreversible. This scenario directly contributes to increased demand for renal replacement therapies, such as hemodialysis, peritoneal dialysis, and kidney transplantation, thereby imposing growing challenges on the Brazilian Unified

Health System (SUS) with respect to organizing care, financing, and ensuring comprehensive health care (Andrade et al., 2024).

In the Brazilian context, the impact of CKD on the SUS has intensified in recent decades, especially due to population aging, increased life expectancy, and the high prevalence of chronic conditions such as systemic arterial hypertension and diabetes mellitus. These factors contribute to the progression of kidney disease and increase the number of individuals who require continuous follow-up and, in many cases, renal replacement therapy. This reality results in high care-related costs, overload of specialized services, and the need for ongoing planning of public policies directed at nephrology care (Andrade et al., 2024; Ferreira, 2023).

Health, as a fundamental social right, is guaranteed by the 1988 Constitution of the Federative Republic of Brazil, which establishes that it is the State's duty to ensure universal and equal access to actions and services aimed at the promotion, protection, and recovery of health (Brasil, 1988). This constitutional principle underpins the creation of the SUS, regulated by Laws No. 8.080/1990 and No. 8.142/1990, which guide the organization of the system based on universality, comprehensiveness, equity, decentralization, and social participation (Brasil, 1990a; Brasil, 1990b). In the context of CKD, these legal provisions ensure access to different modalities of renal replacement therapy as part of comprehensive health care.

With the purpose of structuring care for people with chronic kidney disease, the Ministry of Health established a set of policies, guidelines, and regulations that recognize peritoneal dialysis (PD) as an effective, safe therapeutic modality incorporated into the SUS. Among these instruments are the National Policy for the Care of People with Kidney Disease, the Clinical Guidelines for the Care of Patients with CKD, the Clinical Protocols and Therapeutic Guidelines, and the Peritoneal Dialysis Manual for Health Professionals, which regulate the indication, follow-up, and financing of PD within the public system (Brasil, 2004; Brasil, 2014; Brasil, 2018; Brasil, 2020).

Peritoneal dialysis has characteristics that make it a strategic alternative in the care of people with CKD. It is a modality that can be performed at home, allowing greater autonomy for the patient, more flexible daily routines, and reduced need for frequent travel to health services. In addition, the literature indicates that PD is associated with better preservation of residual renal function, greater hemodynamic stability, and lower cardiovascular impact when compared to conventional hemodialysis (Araújo; Souza, 2021; Preto et al., 2023). These aspects contribute to better clinical outcomes and to improvements in patients' quality of life.

From an organizational and economic standpoint, peritoneal dialysis also has the potential to contribute to the rationalization of SUS costs. The possibility of home-based treatment, combined with reduced need for complex physical infrastructure, can favor decentralization of care and expand access to renal replacement therapy in regions with fewer hemodialysis centers. Moreover, PD can reduce overload on specialized services and strengthen the Health Care Network, especially when integrated with primary care and home-care services (Pitaluga et al., 2025; Ferreira, 2023).

Despite these advantages widely described in the literature and the formal recognition of peritoneal dialysis in Brazilian public policies, a significant discrepancy is observed between normative discourse and care practice. National data indicate that hemodialysis remains the predominant modality in the country, while PD shows low uptake and underutilization in the SUS, even in situations where its clinical indication is fully viable (Andreoli et al., 2023; Barbosa et al., 2022). This reality highlights a gap between what is stipulated in official documents and what is effectively offered to users of the public health system.

The low utilization of peritoneal dialysis in Brazil is attributed to multiple factors, including institutional barriers, limitations in the training of multiprofessional teams, weaknesses in health education processes, and longstanding prejudices regarding the technique. In addition, logistical challenges related to the supply of inputs, regular clinical follow-up, and adequate home support hinder the consolidation of PD as a therapeutic alternative within the SUS (Barbosa et al., 2022; Silva; Freire,

2023). Added to this context is the concentration of nephrology services in large urban centers, which compromises equitable access, especially in peripheral and inland regions of the country.

In the field of health-care organization, the Ministry of Health established specific guidelines to structure the line of care for people with CKD, notably Ordinance No. 389/2014 and Ordinance No. 1.675/2018. These normative instruments define criteria for specialized care, reinforce the importance of individualized therapeutic planning, and recommend shared decision-making regarding dialysis modality selection, considering clinical, social, cultural aspects and patient preference (Brasil, 2014; Brasil, 2018). However, the implementation of these guidelines remains limited in the routine practice of health services.

The literature shows that planned transition to peritoneal dialysis is still uncommon in the SUS. In many cases, renal replacement therapy is initiated late and in emergency settings, generally via hemodialysis, which reduces the possibility of informed choice and compromises clinical outcomes and treatment adherence (Pilatti et al., 2022; Francisco et al., 2024). This care model reveals weaknesses in the articulation among primary care, specialized care, and hospital services, contravening the principles of comprehensiveness and continuity of care.

In technical-care terms, significant advances have been described regarding the safety of peritoneal dialysis, catheter implantation, and management of the main complications associated with the technique. Recent studies demonstrate the clinical feasibility of PD in different patient profiles, including pediatric populations, individuals with unplanned initiation of therapy, and patients with diverse clinical and social conditions (Franke et al., 2024; Palma et al., 2022). These findings reinforce that the main obstacles to expanding PD within the SUS are not restricted to technical aspects, but are strongly related to structural, organizational, and political issues.

Figure 1

Distribution of renal replacement therapy modalities within the Brazilian Unified Health System (SUS)

Source: Gemini – Google (2026)

In light of this scenario, it becomes essential to critically analyze the existing distance between the legal and normative framework that ensures peritoneal dialysis as a right within the SUS and the concrete reality experienced by users and health professionals. Understanding this gap makes it possible to identify weaknesses in the implementation of public policies, as well as opportunities to strengthen PD as a strategy for comprehensive, humanized, equitable, and sustainable care within the Brazilian public system.

Thus, this study aims to critically analyze what Brazilian public policies have, in fact, guaranteed for peritoneal dialysis within the scope of the Brazilian Unified Health System, discussing the distance between normative discourse and care practice, in light of current legislation, ministerial guidelines, and national and international scientific evidence.

METHODOLOGY

This is a qualitative study with a descriptive and analytical approach, developed through a literature review. This design was chosen because it enables a critical synthesis of existing scientific and normative knowledge regarding peritoneal dialysis within the Brazilian Unified Health System (SUS), allowing analysis of the distance between public policy discourse and care practice effectively observed in health services. The literature review constitutes a methodological strategy suitable for understanding complex phenomena related to the organization of the health system, the implementation of public policies, and the effectiveness of care actions.

The theoretical framework was constructed through the identification, selection, and analysis of scientific productions and official documents related to Chronic Kidney Disease (CKD), renal replacement therapy modalities—with emphasis on peritoneal dialysis—and the public health policies in force in Brazil. National and international studies were included, as well as legislation, ordinances, clinical guidelines, therapeutic protocols, and technical manuals published by official bodies, especially the Ministry of Health.

The bibliographic search was conducted in the Scientific Electronic Library Online (SciELO), Latin American and Caribbean Health Sciences Literature (LILACS), PubMed/MEDLINE, and Google Scholar databases, as they are recognized for their scope and relevance in the health field. To identify studies, controlled and uncontrolled descriptors were used, combined through the Boolean operators AND and OR, in order to increase search sensitivity. The descriptors employed were selected based on the Health Sciences Descriptors (DeCS) and Medical Subject Headings (MeSH).

Figure 2

Descriptors used in the bibliographic search

Source: Authors 2026)

The main descriptors used included: “Chronic Kidney Disease,” “Peritoneal Dialysis,” “Renal Replacement Therapy,” “Brazilian Unified Health System,” “Public Health Policies,” “Nephrology Care,” and “Quality of Life.” Combinations among the terms made it possible to identify studies that addressed both clinical and care aspects of peritoneal dialysis and its inclusion in public policies and health services. The search was conducted from March to June 2025, considering publications available in full text.

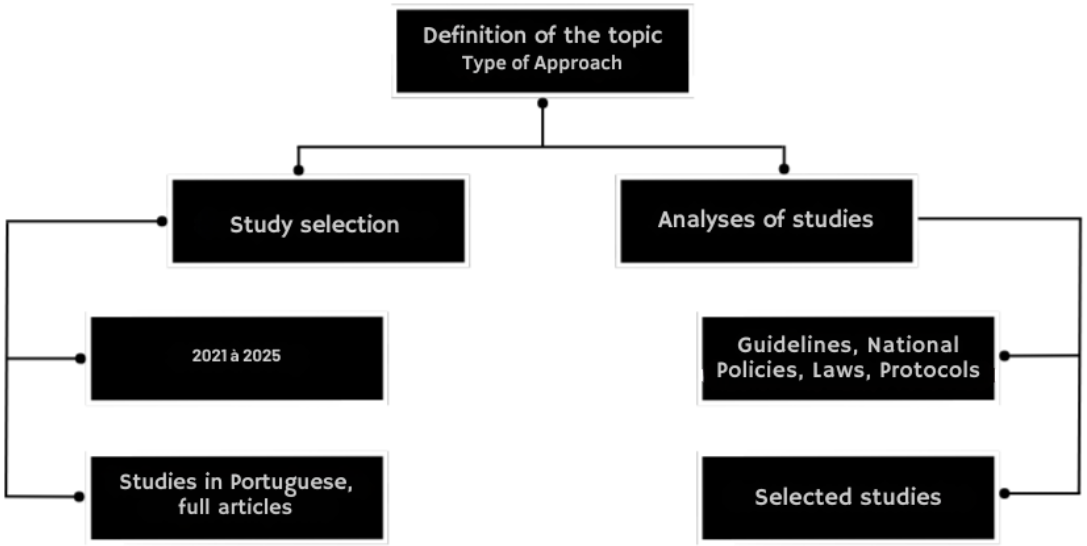
For the selection of studies, inclusion and exclusion criteria were established in advance in order to ensure the relevance, timeliness, and quality of the sources analyzed. Inclusion criteria were: scientific articles published between 2021 and 2025; studies available in full text; publications in Portuguese; research addressing peritoneal dialysis in the context of the SUS or in public health systems; studies related to public policies, clinical guidelines, organization of CKD care, and quality of life of patients on peritoneal dialysis; as well as official documents, legislation, ordinances, and technical manuals of the Ministry of Health relevant to the topic.

Exclusion criteria were: duplicate articles across databases; studies addressing exclusively hemodialysis without comparison or relation to peritoneal dialysis; publications not dealing with CKD or renal replacement therapies; works with incomplete text; isolated case reports; letters to the editor; abstracts from scientific events; dissertations, theses, and monographs not published in scientific journals; as well as studies not directly related to the proposed objective.

After the search stage, the identified studies underwent a screening process, initially through reading titles and abstracts in order to verify adequacy to the theme and established criteria. Next, the selected texts were read in full, allowing a more in-depth assessment of methodological relevance and contribution to the proposed discussion. Extracted data included information on authors, year of publication, country of origin, type of study, objectives, main results, and contributions related to peritoneal dialysis and public health policies.

Figure 3

Flowchart of the study development process and article selection



Source: Authors (2026)

Data analysis was conducted qualitatively and interpretively, through critical reading and thematic categorization of the content identified in the included studies. Information was organized into thematic axes covering: the organization of public policies for CKD care; the inclusion of peritoneal dialysis within the SUS; factors influencing its uptake and implementation; and the care-related, social, and organizational impacts of PD in the public health system. This approach enabled identification of convergences, divergences, and gaps in the literature, as well as articulation between normative discourse and care practice.

Because this is a literature review based on secondary data in the public domain, this study did not require submission to a Research Ethics Committee, in accordance with the guidelines of Resolution No. 510/2016 of the National Health Council. It should be noted that all sources used were duly cited and referenced, respecting the ethical principles of scientific research, academic integrity, and prevailing citation and reference standards.

The adopted methodology enabled a comprehensive and critical analysis of peritoneal dialysis within the scope of the Brazilian Unified Health System, contributing to understanding the advances, limitations, and challenges related to the implementation of public policies and the guarantee of the right to health for people with chronic kidney disease.

RESULTS AND DISCUSSION

The results of this analysis show that, although the Brazilian Unified Health System has a consistent normative framework aimed at care for people with chronic kidney disease, a significant gap persists between officially established guidelines and the reality of peritoneal dialysis provision in health services. The analyzed literature indicates that the consolidation of this dialysis modality faces structural, organizational, care-related, and regional barriers that compromise the implementation of the principles of universality, comprehensiveness, and equity. In this sense, the discussion of findings was organized into thematic axes addressing the coherence between the normative framework and care practice, peritoneal

dialysis as a home-care strategy, and regional and institutional inequalities in access to renal replacement therapy. This approach allows an integrated analysis of the factors sustaining the predominance of hemodialysis in the SUS and highlights the challenges for expanding peritoneal dialysis as a viable, humanized, and sustainable therapeutic alternative in the public health system.

COHERENCE BETWEEN THE NORMATIVE FRAMEWORK AND THE ACTUAL PROVISION OF PERITONEAL DIALYSIS IN THE SUS

The analysis of the selected scientific studies and normative documents reveals a persistent mismatch between the legal framework guiding Chronic Kidney Disease (CKD) care within the Brazilian Unified Health System (SUS) and the effective provision of peritoneal dialysis (PD) in care services. Although Brazil has a robust set of laws, ordinances, and clinical guidelines recognizing PD as a safe, effective modality aligned with the principles of comprehensiveness and equity, its practical implementation remains limited and marked by regional and institutional inequalities.

According to Andrade et al. (2024), the impact of CKD on the SUS has intensified in recent years, imposing growing challenges to the organization of the nephrology care network. The authors emphasize that, despite expanding demand for renal replacement therapies, the care model remains strongly centered on hemodialysis, highlighting difficulties in incorporating alternative modalities—such as peritoneal dialysis—envisaged in the system's normative planning.

In accordance with the Federal Constitution and Laws No. 8.080/1990 and No. 8.142/1990, SUS organization must ensure universal, equal, and comprehensive access to health actions and services (Brasil, 2022; Brasil, 1990a; Brasil, 1990b). In nephrology, these principles are operationalized through the National Policy for the Care of People with Kidney Disease, clinical guidelines, and ordinances structuring the CKD line of care, in which peritoneal dialysis is formally recognized as a valid and recommended therapeutic option in different clinical contexts (Brasil, 2004; Brasil, 2014a; Brasil, 2014b).

As established by the Clinical Guidelines for the Care of Patients with CKD and the Peritoneal Dialysis Manual for Health Professionals, PD offers relevant advantages such as greater patient autonomy, the possibility of home-based care, reduced need for frequent travel, and potential improvement in quality of life (Brasil, 2018; Brasil, 2020). However, analysis of empirical studies shows that such guidelines do not always translate into consolidated care practices within SUS services.

For Andreoli et al. (2023), the low utilization of peritoneal dialysis cannot be explained solely by clinical criteria; rather, it reflects structural, organizational, and cultural barriers that hinder adoption. The authors question the persistent preference for hemodialysis, even in scenarios where PD could be indicated, noting that resistance to shifting the care model contributes to maintaining historically established practices.

As highlighted by Barbosa et al. (2022), low adherence to peritoneal dialysis is associated with multiple factors, including limitations in health team training, failures in patient education, and insufficient home support. These elements reveal that, although PD is anticipated in the normative framework, its implementation depends on institutional conditions that are not always available, especially in regions with lower installed capacity.

From the perspective of Araújo and Souza (2021), peritoneal dialysis positively impacts the quality of life of patients with end-stage renal failure, mainly by promoting greater therapeutic flexibility and preserving family and social routines. Despite this, the authors note that many SUS users do not have access to this modality, evidencing a contradiction between the benefits recognized in the literature and the reality of care provided.

According to Ferreira (2023), the fragility of nephrology care within the SUS is related to insufficient articulation among levels of care and difficulty ensuring continuity of care. The absence of well-defined flows for early indication of peritoneal dialysis contributes to late initiation of renal replacement therapy, often in emergency conditions, where hemodialysis becomes the immediate alternative.

According to Silva and Freire (2023), evaluation of quality indicators in peritoneal dialysis services shows that, when adequately structured, this modality presents satisfactory clinical results and care safety. However, the authors point out that the lack of consistent monitoring and evaluation systems limits the expansion of PD within the SUS, reinforcing the distance between normative planning and daily practice.

As Francisco et al. (2024) state, transition to peritoneal dialysis depends not exclusively on the patient's clinical profile, but on service organization and the availability of technical and institutional support. The authors demonstrate that, in contexts where investment exists in professional training and network structuring, PD can be successfully implemented regardless of the user's geographic origin.

In Palma et al. (2022), sustainability of peritoneal dialysis in Brazil requires public policies that go beyond formal recognition of the modality and advance toward guaranteeing adequate financing, infrastructure, and multiprofessional support. The authors emphasize that the persistence of PD as a marginal option in the SUS reflects limitations in governance and in prioritizing home-care models.

Table 1

Coherence between the normative framework and the actual provision of peritoneal dialysis in the SUS

Analyzed dimension	Provision in the normative framework	Situation observed in practice
Clinical guidelines	Recognition of PD as an effective and safe modality	Predominance of hemodialysis in services
SUS principles	Comprehensiveness, equity, and patient autonomy	Unequal provision and limited access to PD
Financing	Provision for funding PD	Weak articulation among levels of care
Network organization	Structured line of care for CKD	Weak articulation among levels of care
Professional qualification	Need for trained teams	Insufficient continuing education

Source: Authors 2026)

After presenting Table 1, it is observed that the synthesis of findings reinforces the existence of a structural misalignment between legal guidelines and the concrete provision of peritoneal dialysis within the SUS, showing that limitations are not restricted to the normative field, but also involve organizational, financial, and care-related aspects.

PERITONEAL DIALYSIS AS A HOME-CARE STRATEGY AND ITS BARRIERS IN PRACTICE

According to the Ministry of Health (2018), peritoneal dialysis constitutes one of the main home-care strategies in the context of renal replacement therapy, as it enables treatment to be carried out in the family environment, with greater patient autonomy and less dependence on specialized hospital services. This modality is directly consistent with the principles of comprehensiveness, humanization, and decentralization of health care—structuring foundations of the Brazilian Unified Health System (Brasil, 1988; Brasil, 1990).

According to Araújo and Souza (2021), home-based care provided by peritoneal dialysis supports reorganization of the daily routine of people with end-stage chronic kidney disease, allowing greater flexibility in treatment schedules, preservation of social ties, and better adaptation to everyday activities. The authors emphasize that these benefits positively affect quality of life, especially when compared to conventional hemodialysis, which requires frequent travel and greater dependence on high-complexity outpatient infrastructure.

According to Andreoli et al. (2023), home-based peritoneal dialysis also represents a relevant strategy for rationalizing health system resources by reducing indirect costs associated with sanitary transportation, hospital bed occupancy, and overload of hemodialysis services. From this perspective, the modality aligns with the principles of efficiency and sustainability of the SUS, particularly in a scenario of continuous growth in CKD prevalence in Brazil.

For Andrade et al. (2024), the marked increase in CKD incidence and prevalence imposes significant challenges to organizing nephrology care within the SUS. The authors note that, although

peritoneal dialysis is recognized as an effective and cost-effective alternative, its incorporation remains limited, evidencing a mismatch between the existing normative framework and the predominant care practice in the country.

As highlighted by Barbosa et al. (2022), despite its potential, implementing peritoneal dialysis as a home-care strategy faces major barriers related to low patient adherence. Among associated factors are weaknesses in health education processes, inadequate communication between professionals and users, and insecurity regarding management of the technique in the home environment, which undermines informed and shared decision-making.

In the view of the Ministry of Health (2014), choosing a dialysis modality should consider clinical and social criteria as well as the patient's informed preference—presupposing early therapeutic planning and continuous multiprofessional follow-up. However, in care practice, initiation of renal replacement therapy frequently occurs in an unplanned manner, limiting the possibilities of enrolling the patient in home-based peritoneal dialysis (Pilatti et al., 2022).

According to Ferreira (2023), insufficient articulation between primary health care and specialized nephrology services compromises early diagnosis of chronic kidney disease and hinders timely referral of patients. This fragmentation of the care network favors hemodialysis as an immediate response to situations of clinical worsening, to the detriment of peritoneal dialysis, which requires prior preparation and continuous support.

According to Francisco et al. (2024), successful transition to peritoneal dialysis depends less on patients' sociodemographic characteristics and more on how health services are organized. The authors show that defined care flows, team training, and institutional technical support are determinants for safe adoption of the modality, regardless of regional context.

Table 2

Potentialities of peritoneal dialysis as a home-care strategy and main barriers to its implementation in the SUS

Dimension	Potentialities of home-based peritoneal dialysis	Barriers identified in care practice
Clinical	Preservation of residual renal function; lower hemodynamic instability; possibility of planned initiation of therapy	Late and emergency initiation of RRT; professional insecurity regarding home management
Care-related	Strengthening self-care; greater protagonism of patient and family; humanized care	Weaknesses in health education; insufficient training of multiprofessional teams
Organizational	Decentralization of care; reduced dependence on hemodialysis centers	Concentration of specialized services; professional turnover
Logistical	Reduced need for frequent travel; lower overload of hospital units	Difficulties in supply and regular distribution of inputs
Economic	Potential cost rationalization for the SUS; reduction of indirect expenditures	Failures in budget planning and contract management
Sociocultural	Greater integration of treatment into the patient's routine	Longstanding prejudices; perception of greater risk and complexity of the technique
Care network	Possibility of articulation with Primary Health Care	Disarticulation among levels of care; irregular follow-up

Source: Authors (2026)

Based on the systematization presented in Table 2, it is observed that barriers to consolidating peritoneal dialysis as home-based care within the SUS are multifactorial, extending beyond the technical-care field and involving organizational, logistical, economic, and sociocultural dimensions. These factors, when combined, contribute to low adherence to the modality and to its underutilization in the public health system.

As Silva and Freire (2023) state, the absence of systematic monitoring and specific quality indicators weakens evaluation of peritoneal dialysis outcomes within the SUS. The lack of consolidated data hinders identification of failures, improvement of care practices, and implementation of strategies based on scientific evidence.

In Palma et al. (2022), especially in the context of pediatric peritoneal dialysis, sustainability of the modality requires continuous investments in infrastructure, logistics of supplies, and multiprofessional

support. Although the study focuses on the pediatric population, its findings reflect structural challenges common to peritoneal dialysis as a whole within the Brazilian public system.

As national guidelines indicate, weak articulation among levels of care and the absence of well-structured lines of care compromise continuity of home-based treatment (Brasil, 2014; Brasil, 2020). The lack of clear operational protocols for follow-up of peritoneal dialysis limits standardization of care and patient safety.

As Andreoli et al. (2023) argue, low adoption of peritoneal dialysis is not related to technical infeasibility, but to insufficient institutional strategies that facilitate its implementation. Cultural and organizational barriers persist, reinforcing the hegemony of hemodialysis even in the face of evidence favorable to peritoneal dialysis.

In Pitaluga et al. (2025), peritoneal dialysis demonstrates relevant clinical, social, and economic benefits compared to hemodialysis, particularly regarding patient autonomy and reduced overload of health services. However, these benefits remain underused in the SUS due to structural and management limitations.

In this context, the results discussed show that peritoneal dialysis, although normatively recognized as a home-care strategy aligned with SUS principles, remains underutilized in care practice. Overcoming these barriers requires integrated actions involving management, professional qualification, health education, and strengthening care networks in order to consolidate home-based care as an effective, safe, and equitable alternative within renal replacement therapy.

REGIONAL AND INSTITUTIONAL INEQUALITIES IN ACCESS TO PERITONEAL DIALYSIS

According to Andrade et al. (2024), regional inequalities in access to renal replacement therapies constitute one of the main challenges to consolidating the principles of universality and equity in the Brazilian Unified Health System (SUS). In the context of peritoneal dialysis, these inequalities become

even more evident, since provision of the modality depends on adequate infrastructure, trained teams, and organized logistics for home follow-up—conditions that are unevenly distributed across the national territory.

According to Ferreira (2023), the concentration of nephrology services in large urban centers contributes to limiting access to peritoneal dialysis in peripheral and inland regions. In these locations, hemodialysis tends to be prioritized because it is associated with already consolidated services, whereas peritoneal dialysis remains underprovided, despite its potential to reduce travel and expand access to treatment in areas with lower density of specialized services.

As indicated by the data analyzed by Andrade et al. (2024), regional differences in health-care organization reflect historical inequalities in financing, management capacity, and availability of qualified human resources. Regions with lower structural investment face greater difficulties in implementing and maintaining peritoneal dialysis programs, reinforcing asymmetries in access to renal replacement therapy and compromising equity of care within the SUS.

For Andreoli et al. (2023), institutional inequalities are also expressed in the heterogeneity of management models adopted by services that provide renal replacement therapy. While some institutions structure peritoneal dialysis programs with trained multiprofessional teams and well-defined care flows, others restrict provision of the modality, either due to operational limitations or managerial decisions that prioritize hemodialysis.

As highlighted by Barbosa et al. (2022), the logic of financing and service organization directly influences the availability of peritoneal dialysis. In certain institutional contexts, the perception of greater operational and financial predictability of hemodialysis discourages investments in structuring peritoneal dialysis programs, even when it is recognized as a safe, effective modality aligned with national guidelines.

From the perspective of the Ministry of Health (2014), inequality in access to peritoneal dialysis is also related to variability in health professional training across different regions and institutions.

Insufficient training in nephrology and home care limits indication of the modality and reinforces care practices based on institutional experience rather than current clinical recommendations (Brasil, 2014; Brasil, 2018).

In line with national guidelines, weaknesses in articulation among levels of care aggravate regional inequalities, especially when primary care is not integrated with specialized nephrology services (Brasil, 2014). The absence of well-established care flows hinders early therapeutic planning and reduces opportunities to choose peritoneal dialysis, particularly in regions with lower density of specialized services.

According to Araújo and Souza (2021), regional socioeconomic factors directly influence the feasibility of home-based care. Inadequate housing conditions, limited access to basic sanitation, and lack of family support networks negatively affect the indication and maintenance of peritoneal dialysis, widening regional and social disparities in access to treatment.

As Preto et al. (2023) affirm, populations in situations of greater social vulnerability tend to face additional barriers to accessing home-care modalities, compromising clinical outcomes and quality of life. This scenario shows that inequalities in access to peritoneal dialysis are not restricted to the geographic dimension, but also involve social and institutional determinants of health care.

Table 3

Factors associated with regional and institutional inequalities in access to peritoneal dialysis in the Brazilian Unified Health System

Dimension	Observed aspects	Impacts on access to peritoneal dialysis
Geographic	Concentration of nephrology services in large urban centers	Restricted access in peripheral and inland regions
Structural	Unequal infrastructure across regions and institutions	Limitations in implementing and maintaining PD programs
Human resources	Unequal distribution of professionals trained in nephrology	Low PD indication and technical insecurity
Organizational	Heterogeneity of service management models	Irregular and institution-dependent provision
Financial	Financing logics perceived as more favorable to hemodialysis	Institutional disincentives for PD
Care-related	Weak articulation among levels of care	Late initiation of RRT and less informed choice
Sociodemographic	Social vulnerability and inadequate home conditions	Reduced feasibility of home-based care
Health management	Lack of standardized indicators and regional monitoring	Persistence of inequalities and ineffective planning

Source: Authors 2026)

The synthesis presented in Table 3 shows that inequalities in access to peritoneal dialysis within the SUS are multifactorial and interdependent, involving geographic, structural, organizational, financial, and social dimensions. These findings reinforce the need for regionalization strategies and planning guided by the principle of equity, as established by the system's legal framework (Brasil, 1988; Brasil, 1990).

From the perspective of the Ministry of Health (2004), the absence of specific regional policies and effective induction mechanisms contributes to maintaining asymmetries in access to peritoneal dialysis. Although the normative framework recognizes the modality as a component of comprehensive care for people with chronic kidney disease, unequal implementation of guidelines limits its equitable expansion across the national territory.

As indicated by Silva and Freire (2023), the lack of standardized indicators to evaluate the provision and quality of peritoneal dialysis hinders identification of regional and institutional inequalities. The absence of systematized data compromises health planning, rational allocation of resources, and evidence-based decision-making.

Consistent with Ferreira (2023), overcoming regional and institutional inequalities in access to peritoneal dialysis requires strengthening health care networks, with emphasis on regionalization, qualification of primary care, and integration with specialized services. Strategies such as continuing education, matrix support, and telehealth have the potential to expand local capacity to provide the modality.

As argued by Pitaluga et al. (2025), equity-oriented public policies must consider regional and institutional specificities, promoting differentiated investments and strategies adapted to local realities. In the case of peritoneal dialysis, home-based care represents a concrete opportunity to reduce inequalities, provided it is accompanied by adequate technical, logistical, and institutional support.

In Andreoli et al. (2023), regional and institutional inequalities in access to peritoneal dialysis reflect structural limits of the SUS in operationalizing the principle of equity. Although the system has consistent clinical and normative guidelines, the lack of effective regionalization and monitoring strategies contributes to maintaining disparities in access to renal replacement therapy.

Thus, the results discussed in this section demonstrate that inequalities in access to peritoneal dialysis within the SUS are multifactorial and cut across geographic, institutional, social, and economic dimensions. Reducing these asymmetries requires integrated actions in management, financing, professional training, and organization of care networks to ensure that peritoneal dialysis is consolidated as an equitable and accessible strategy for caring for people with chronic kidney disease throughout the national territory.

CONCLUSION

This study allowed a critical analysis of the distance between normative discourse and care practice regarding peritoneal dialysis within the scope of the Brazilian Unified Health System. Analysis of the legal framework, ministerial guidelines, and scientific evidence showed that, although peritoneal dialysis is formally recognized as an effective, safe modality aligned with SUS principles, its provision remains limited and unequal, revealing weaknesses in implementing public policies directed at care for people with chronic kidney disease.

The results showed that the Brazilian normative framework is coherent with international recommendations and includes fundamental aspects such as shared decision-making regarding dialysis modality, comprehensive care, and the valorization of home-based treatment. However, in care practice, the hegemony of hemodialysis is observed, often associated with late and unplanned initiation of renal replacement therapy, which restricts user autonomy and compromises equity of access to peritoneal dialysis in the public system.

The analysis of peritoneal dialysis as a home-care strategy highlighted its potential to promote humanization of care, decentralization of attention, and improvement of patients' quality of life. Nevertheless, organizational, logistical, educational, and cultural barriers still limit its consolidation within the SUS. Weaknesses in team training, difficulties in supplying inputs, and insufficient articulation among levels of care constitute recurrent obstacles to implementing home-based care.

Additionally, the study evidenced profound regional and institutional inequalities in access to peritoneal dialysis, marked by the concentration of specialized services in large urban centers and by heterogeneity in management models adopted by institutions affiliated with the SUS. These asymmetries reflect structural limits of the system in operationalizing the principle of equity and reinforce the need for regionalization strategies, adequate financing, and strengthening of health care networks.

In view of this scenario, it is imperative that public policies move beyond norm-setting toward effective implementation of peritoneal dialysis as an accessible and sustainable therapeutic alternative.

Investments in continuing education, strengthening the role of primary care, valuing multiprofessional practice—with emphasis on the nurse—and improving monitoring and evaluation mechanisms are fundamental strategies to reduce the distance between discourse and practice within the SUS.

As a suggestion for future research, empirical studies are recommended to analyze the experience of users and health professionals with peritoneal dialysis within the SUS, as well as evaluative investigations on the impact of regionalization strategies and home-care models on expanding access and reducing inequalities. Such studies can help support managerial decisions and strengthen peritoneal dialysis as a strategic component of comprehensive care for people with chronic kidney disease in the Brazilian public system.

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