

INTEGRAL HEALTH IN CONTEMPORARY TIMES: INTERDISCIPLINARY CONTRIBUTIONS TO PROMOTION, PREVENTION, AND QUALITY OF LIFE

**SAÚDE INTEGRAL NA CONTEMPORANEIDADE: CONTRIBUIÇÕES
INTERDISCIPLINARES PARA A PROMOÇÃO, PREVENÇÃO E QUALIDADE
DE VIDA**

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ABSTRACT

Integral health in contemporary times requires a broader understanding of the health-disease process, considering the articulation among different dimensions of care and the integration of knowledge and practices aimed at addressing the needs of individuals and communities. In this context, interdisciplinarity plays an important role in health promotion, disease prevention, and the improvement of quality of life. The general objective was to analyze interdisciplinary contributions to health promotion, disease prevention, and the improvement of quality of life, considering contemporary challenges related to comprehensive care. The study adopts a qualitative approach, developed through two procedures: a literature review and documentary research. The literature review included dissertations, scientific articles published in conference proceedings and scientific journals, and books, while the documentary research analyzed institutional documents from the Pan American Health Organization and the World Health Organization addressing health promotion, the health workforce, equity, and social determinants of health. The study demonstrated that integral health in contemporary times depends on the articulation among different dimensions of the health-disease process and the integration of knowledge and practices aimed at health promotion, disease prevention, and quality of life. The analysis showed that interdisciplinarity, welcoming practices, the establishment of bonds, longitudinality, participation, and shared care contribute to overcoming the fragmentation of practices and responding more effectively to users' needs. It is concluded that strengthening these dimensions provides a relevant framework for addressing contemporary challenges and organizing care practices guided by comprehensiveness.

Keywords: Integral health; Interdisciplinarity; Health promotion; Quality of life.

RESUMO

A saúde integral na contemporaneidade demanda uma compreensão ampliada do processo saúde-doença, considerando a articulação entre diferentes dimensões do cuidado e a integração de saberes e práticas voltados às necessidades dos indivíduos e das coletividades. Nesse contexto, a interdisciplinaridade assume relevância para a promoção da saúde, a prevenção de agravos e a melhoria da qualidade de vida. O objetivo geral foi analisar as contribuições interdisciplinares para a promoção da saúde, a prevenção de agravos e a melhoria da qualidade de vida, considerando os desafios contemporâneos relacionados à integralidade do cuidado. A pesquisa caracteriza-se por uma abordagem qualitativa, desenvolvida mediante dois procedimentos: revisão bibliográfica e pesquisa documental. A revisão bibliográfica contemplou dissertações, artigos científicos publicados em eventos e periódicos científicos e livros, enquanto a pesquisa documental analisou documentos institucionais da Organização Pan-Americana da Saúde e da Organização Mundial da Saúde relacionados à promoção da saúde, força de trabalho, equidade e determinantes sociais da saúde. A pesquisa evidenciou que a saúde integral na contemporaneidade depende da articulação entre diferentes dimensões do processo saúde-doença e da integração de saberes e práticas voltados à promoção da saúde, à prevenção de agravos e à qualidade de vida. A análise demonstrou que interdisciplinaridade, acolhimento, vínculo, longitudinalidade, participação e cuidado compartilhado contribuem para superar a fragmentação das práticas e responder de forma mais articulada às necessidades dos usuários. Conclui-se que o fortalecimento dessas dimensões

constitui uma referência relevante para o enfrentamento dos desafios contemporâneos e para a organização de práticas de cuidado orientadas pela integralidade.

Palavras-chave: Saúde integral; Interdisciplinaridade; Promoção da saúde; Qualidade de vida.

1. INTRODUCTION

The health-disease process cannot be explained solely by biological factors. Psychological, social, and environmental dimensions permeate people's living conditions, and understanding integral health requires considering these interactions in a manner that isolated clinical practice, by itself, does not usually provide. For this reason, health promotion and disease prevention can no longer be confined entirely to the clinical setting, as these activities currently depend on knowledge derived from fields beyond medicine, on distinct professional practices, and on the social contexts in which people actually live. Comprehensive care, as a guiding principle, presupposes precisely this articulation among different bodies of knowledge in the development of responses that address quality of life in a broad sense rather than merely the absence of disease. As health demands become increasingly complex in contemporary society, responding to them through isolated knowledge becomes progressively less appropriate.

Interdisciplinarity emerges in this context as an organizational condition for professional practices rather than merely as a complement. It creates opportunities for dialogue among different fields of knowledge that, when considered separately, address only part of a given problem, while enabling the shared development of care strategies. When health promotion, disease prevention, and

quality of life are considered in an integrated manner, the assessment of an individual's clinical conditions is no longer sufficient, since health is also shaped by the social, environmental, and relational factors present in their lives. Discussing interdisciplinary contributions to integral health, therefore, entails examining how these different perspectives can be articulated in practice in response to contemporary challenges in healthcare.

Based on this issue, the study was guided by the following research question: **How can interdisciplinary contributions in the areas of health promotion, disease prevention, and quality of life foster a comprehensive approach to health in contemporary times?** To address this question, the general objective was to analyze interdisciplinary contributions to health promotion, disease prevention, and the improvement of quality of life, considering contemporary challenges related to comprehensive care. The specific objectives were: 1. to discuss the concept of integral health and its relationship with the biological, psychological, social, and environmental dimensions of the individual; 2. to analyze the contributions of interdisciplinarity to health promotion and disease prevention initiatives; and 3. to examine the relationship between comprehensive care practices, quality of life, and the addressing of contemporary health challenges.

With regard to the methods, the study adopted a qualitative approach based on a literature review and documentary research. The literature review included dissertations, scientific articles published in conference proceedings and journals, as well as books addressing the subject under investigation. Additionally, the documentary research included institutional documents from the Pan American Health Organization and the World Health

Organization, particularly those addressing health promotion, the health workforce, equity, and the social determinants of health.

To provide a clear presentation of the research, the article is organized into four sections: Introduction, Methodology, Theoretical Framework, and Final Considerations. This structure begins with the contextualization of the research problem, research question, and objectives, followed by a description of the methodological procedures adopted and the theoretical discussion developed on the basis of the selected sources, and concludes with a synthesis of the main conclusions reached in the study.

2. THEORETICAL FRAMEWORK

The theoretical framework of this study was organized into three interconnected topics, structured to address different dimensions of integral health and their relationship with interdisciplinarity. The first topic, “3.1 Integral Health and the Multiple Dimensions of Care in Contemporary Times,” addresses a broader understanding of health and the articulation among the dimensions that constitute care. The second, “3.2 Interdisciplinarity in Health Promotion and Disease Prevention,” discusses the integration of professional knowledge and practices as a guiding element for health promotion and disease prevention actions. Finally, the third topic, “3.3 Comprehensive Care, Quality of Life, and Contemporary Health Challenges,” examines the relationship among comprehensive care practices, quality of life, bonds, continuity of care, and efforts to address contemporary health challenges. This organization provides a thematic progression that begins with an understanding of integral health, advances to interdisciplinarity as an approach to professional practice, and

culminates in an analysis of comprehensive care and its implications for quality of life.

2.1. Integral Health And The Multiple Dimensions Of Care In Contemporary Times

Thinking about integral health today requires moving beyond the idea that care is limited to diagnosing and treating disease. What is at stake is the articulation among biological, psychological, social, and environmental dimensions. In this regard, health and care concern people's concrete living conditions, the social relationships in which they are embedded, and the way healthcare practices are organized. Oliveira (2025) approaches integral health from four dimensions that cannot be considered separately: body, mind, society, and environment. Benedet (2026), in turn, identifies comprehensiveness as a necessary perspective for a broader understanding of health and well-being.

In this context, care is not limited to procedures performed by healthcare professionals or to institutionalized services. Sadruddin and Ice (2018, p. 01) use the term *caregiving* and explain that the term

Indicates care as 'specific tasks that assist children or older adults in performing everyday activities, such as dressing, bathing, preparing and managing finances,' involving 'a complex set of moral, emotional, and physical interactions between caregivers and care recipients at the individual, family, and community levels.

This conception broadens the analysis of care by recognizing it as a relational practice that permeates different spheres of everyday life.

The relational dimension of care also involves contradictory experiences that cannot be reduced to an exclusively positive understanding of assistance. According to Thelen (2021, p. 02),

Care relationships may be experienced not only as positive but also as negative. Care can transform the actors, instruments, relationships, and institutional structures involved. When care emerged outside feminist studies, it was initially a positive political counter-term to neoliberal reforms, 'care as a gentle practice of attending to needs.

This approach makes it possible to understand care as a social phenomenon shaped by relationships, inequalities, and institutional transformations. Interdisciplinarity broadens this conception by integrating different fields of knowledge and forms of intervention in response to health needs. According to Silva et al. (2019, p. 15), “Interdisciplinary teams are able to address patients’ needs more comprehensively, considering not only clinical aspects but also social, cultural, and psychological factors that influence their health.”

Thus, comprehensiveness presupposes articulation among professional knowledge and recognition of the complexity of situations experienced by individuals and communities.

The significance of this articulation lies in the fact that health and illness processes are shaped by determinants that cannot be fully addressed by a disease-centered model. Campos, Melo, and Oliveira

(2026) situate care within the relationships established among health, illness, and society, drawing on socio-anthropological approaches. This perspective already implies a particular understanding: care is not a clinical object extended into the social sphere but rather a phenomenon constituted through social relationships. Pereira et al. (2026) move in a similar direction, although with a more explicit political emphasis, by linking public health, social transformation, and the confrontation of inequalities to the strengthening of comprehensive care within the Brazilian Unified Health System (SUS). In this perspective, social conditions are not merely a factor to be considered; they constitute the context in which health responses are organized or fail to be organized.

Health promotion and disease prevention ultimately depend on the capacity to integrate these dimensions of care. A comprehensive approach cannot organize actions solely around an established disease; it must also consider the social, cultural, environmental, and subjective conditions that shape health experiences. In this regard, Oliveira (2025) brings together the four dimensions as interconnected, while Ferreira et al. (2025) discuss comprehensive healthcare in light of the challenges posed by interdisciplinary practices.

The organization of healthcare services constitutes another element related to comprehensiveness, particularly when different professionals need to work in coordination. Rafael et al. (2024, p. 25) suggest that

Financial and technical incentive programs can be effective in fostering interdisciplinarity, particularly in resource-limited regions. In addition, the incorporation of information and communication technologies can facilitate coordination among teams and improve the quality of care provided.

The articulation among professionals, resources, and technologies, therefore, forms part of the discussion on improving healthcare practices.

Telehealth constitutes a significant example of the articulation among professionals, resources, and technologies within the Brazilian healthcare context. Catapan et al. (2024) highlight that the acceleration of digital transformation in healthcare, driven by the COVID-19 pandemic, contributed to the expansion of modalities such as teleconsultation, teleinterconsultation, and telemonitoring. The authors argue that these strategies achieve their interdisciplinary potential only when they remain connected to Primary Health Care and integrated into existing healthcare networks, thereby preventing technological innovation from generating new forms of fragmentation in care. This perspective demonstrates that the incorporation of technologies, although important for expanding access and improving service effectiveness, does not replace the collective construction of care pathways among professionals and teams. Its effectiveness depends on appropriate regulatory mechanisms, interoperability among information systems, and equitable access to digital resources. In the absence of these conditions, technological innovations may, rather than promoting greater integration of care, contribute to deepening

existing digital inequalities among different regions and population groups.

In this context, the health workforce plays an important role in developing coordinated responses to population health needs. The World Health Organization (2025) situates the social determinants of health and equity in relation to people's living conditions and the inequalities that influence their health processes. The Pan American Health Organization (2023) highlights the health workforce as a key component in strengthening resilient health systems, referring to the institutional capacity to organize health services and professionals in response to the needs of diverse populations.

It is also necessary to understand comprehensive care in relation to quality of life, which does not result solely from positive health conditions. Psychological, social, environmental, and relational factors influence both individual and collective health experiences. Benedet (2026) approaches health and well-being from the perspective of comprehensiveness, while Ferreira et al. (2025) discuss the challenges involved in developing interdisciplinary care practices. This articulation makes it possible to position quality of life as a dimension related to actual living conditions and to the opportunities for care developed in different social contexts.

Therefore, in contemporary times, integral health can be understood as an approach that integrates health promotion, disease prevention, care, and quality of life by bringing together multiple dimensions and bodies of knowledge. In this sense, interdisciplinarity is not merely the combination of specialists from different fields but rather the collaborative development of actions that respond to individuals' needs and the contexts in which they

are situated. This understanding is consistent with the approach proposed by Campos, Melo, and Oliveira (2026), the interdisciplinary perspective addressed by Silva et al. (2019) and Ferreira et al. (2025), and the relationship among public health, inequalities, and comprehensive care discussed by Pereira et al. (2026).

To synthesize the main dimensions underlying the understanding of integral health and its relationship with interdisciplinary care, Table 1 presents the biological, psychological, social, environmental, and relational aspects in articulation with health promotion, disease prevention, and quality of life.

Table 1. Dimensions of integral health and their articulations with interdisciplinary care

Dimension	Central Elements	Relationship with Health Promotion, Prevention, and Quality of Life	Interdisciplinary Contribution
Biological	Body, clinical conditions, health needs, and disease prevention	Promotes health promotion, prevention, monitoring, and care of clinical conditions	Integrates clinical, therapeutic, and preventive knowledge
Psychological	Mental health, subjectivity, emotions, and individual experiences	Contributes to well-being and to addressing conditions that interfere with quality of life	Articulates different bodies of knowledge related to the psychological and social dimensions of care
Social	Family and community	Makes it possible to consider social	Integrates health, social assistance,

	relationships, inequalities, and social conditions	factors that influence health and disease processes	education, and other fields related to living conditions
Environmental	Relationships between individuals and the environment, and living conditions	Expands health promotion and prevention beyond the individual, considering the environmental context	Fosters articulation among health, environment, and social conditions
Relational	Care, bonds, participation, and relationships among caregivers, users, and teams	Enhances the experience of care and the development of responses oriented toward users' needs	Promotes communication, cooperation, and articulation among professionals, users, families, and communities
Interdisciplinary	Integration of knowledge, professionals, services, and technologies	Fosters articulated responses to complex health needs	Expands care coordination and the integration of healthcare practices

Source: Prepared by the author, based on Sadruddin and Ice (2018), Thelen (2021), Silva et al. (2019), Rafael et al. (2024), Ferreira et al. (2025), Oliveira (2025), Pan American Health Organization (2023), World Health Organization (2025), Campos, Melo, and Oliveira (2026), and Pereira et al. (2026).

As shown in Table 1, integral health results from the interaction among interconnected dimensions. Interdisciplinarity, therefore, makes it possible to bring together different fields of knowledge to understand needs that cannot be adequately addressed by a single

area of study. The connection among health promotion, disease prevention, and care increases the likelihood of developing contextually appropriate responses, particularly when the social, environmental, psychological, and biological conditions that influence health experiences are taken into account.

Therefore, comprehensive care constitutes an analytical and intervention framework that acknowledges the complexity of contemporary health processes. Contributions from different disciplines enable the integration of diverse forms of knowledge, practices, and professionals in the development of solutions oriented toward the actual needs of communities. The interrelationship among care, equity, service organization, the health workforce, and living conditions supports the understanding that health promotion, disease prevention, and quality of life are themselves interdependent dimensions of a comprehensive approach.

In the same direction, the psychological dimension of comprehensive care has assumed an increasingly central role in view of the significant increase in mental health demands observed in the post-pandemic context. In their investigation of interprofessional collaboration and matrix support in Primary Health Care, Anéas and Viana (2025) highlight that the underfunding of the Expanded Family Health and Primary Care Center (NASF) and its replacement by Multiprofessional Primary Health Care Teams (eMulti) contributed to weakening collective spaces dedicated to the discussion, analysis, and sharing of cases, although the establishment of eMulti, instituted by Ordinance GM/MS No. 635/2023, signals the possibility of resuming these collaborative practices.

This context demonstrates that promoting mental health and implementing comprehensive care do not depend exclusively on the availability of specialized professionals but also on the existence of institutional conditions that foster articulation among different forms of knowledge and practices in healthcare. Thus, the consolidation of spaces for dialogue, the improvement of communication processes, and the strengthening of shared responsibility among teams constitute essential elements for sustaining a comprehensive approach to care, particularly in view of the increasing complexity of contemporary psychosocial demands.

2.2. Interdisciplinarity In Health Promotion And Disease Prevention

Interdisciplinarity in healthcare is an approach to work organization that goes beyond the juxtaposition of specialized knowledge. It operates through the articulation of knowledge, practices, and shared responsibilities, enabling health problems to be understood in their social, cultural, economic, environmental, and biological complexity. In this regard, comprehensive care requires cooperative processes that integrate diverse forms of professional knowledge and different levels of healthcare.

Health promotion goes beyond simply providing individuals with guidance on healthy habits, as it involves a set of coordinated actions aimed at living conditions, territories, and social determinants that affect the health-disease process. Disease prevention, in turn, requires the identification of risks, continuous monitoring, and the planning of interventions that address population needs. The consistency of these actions is enhanced

when they are developed by teams that exchange information, discuss real cases, and establish objectives collectively.

The implementation of Primary Health Care (PHC) through health promotion seeks to establish a new model of healthcare capable of improving the well-being and quality of life of the population. This new healthcare model transcends cultural dogmas and can be characterized by a holistic and interdisciplinary conception, collective and community-oriented benefits, social participation, a commitment to equity, actions addressing the Social Determinants of Health (SDH), and the full development of multistrategic and sustainable actions (Coelho et al., 2023, p. 15).

The interdisciplinary approach also modifies the understanding of healthcare users. Rather than considering them merely as individuals with a disease or risk factor, they are recognized as subjects embedded in family, community, and institutional networks. This shift broadens teams' capacity for planning, promotes qualified listening, and enables interventions to take into account material conditions, social bonds, subjective aspects, and cultural practices that shape the experience of illness.

Rezer and Matsuêr (2020, p. 25) argue that:

Adopting an interdisciplinary approach means recognizing the need and possibility of learning to identify common problems that generate mutual engagement and give meaning to opportunities for dialogue among participants from different fields of knowledge. In other words, interdisciplinary practices emerge from common problems, [...] and are carried out through shared practices, in which dialogue is fundamental.

For interdisciplinary practices to be established, institutional conditions that promote dialogue among professionals, the joint definition of responsibilities, and collective evaluation of outcomes are essential. It is not merely a matter of bringing different professional categories together within the same service but of establishing processes of communication, planning, and collective decision-making. Interdisciplinarity also requires recognition of the boundaries of each field of knowledge and a willingness to combine different ways of understanding and addressing health-related issues.

Primary Health Care already provides a favorable context for incorporating this perspective because it is territorially based and follows issues that require continuous care. Within this setting, health education, vaccination, chronic disease monitoring, surveillance, social support, and community-based actions can be integrated into coordinated projects. Interdisciplinarity enriches the response of healthcare services by interweaving clinical, educational, preventive, and territorial actions, as argued by Murta et al. (2021), Pereira et al. (2023), and Martins (2025).

The literature also demonstrates that cooperation among professionals can improve practices carried out in family health units. Fumagalli et al. (2025) emphasize the relevance of collaborative interprofessional practices within teams, where the exchange of experiences and joint analysis of demands foster more coordinated approaches to action. This arrangement can reduce service fragmentation and increase teams' shared responsibility for addressing population needs.

In addition to cooperation among professionals within the same team, the implementation of interdisciplinarity in Primary Health Care depends on broader organizational factors. Kanno et al. (2023), in applying the Consolidated Framework for Implementation Research (CFIR) with Family Health Strategy workers, identified that the quality of formal communication spaces, team stability, and participatory leadership directly influence the sustainability of interprofessional collaboration. The authors highlight that the absence of protected time for meetings and high staff turnover undermine the shared discussion of cases, even though such discussions are recognized by the workers themselves as decisive for developing more effective responses to population needs.

Health promotion and disease prevention also require actions guided by epidemiological data, with community participation and the identification of inequalities across territories. The articulation among surveillance, healthcare delivery, and health education makes it possible to identify populations at greater risk and plan actions aligned with their living conditions.

In this regard, the Pan American Health Organization (2024) notes that both health promotion and the surveillance of

noncommunicable diseases and conditions depend on interventions that are coordinated, continuous, and adapted to the realities of specific social contexts.

Table 2, presented below, systematizes how interdisciplinarity can operate across different layers of service organization, action planning, user follow-up, and outcome evaluation. Its role in health promotion and disease prevention lies precisely in its capacity to articulate education, surveillance, healthcare delivery, participation, and care management. Therefore, collaborative work enables more coordinated responses to the needs of populations.

Table 2. Contributions of Interdisciplinarity to Health Promotion and Disease Prevention

Interdisciplinary Areas of Action	Contributions to Health Promotion	Contributions to Disease Prevention	Articulation Strategies among Areas
Integrated planning	Organization of educational, community, and territorial actions according to population needs	Identification of risk factors and definition of preventive measures	Meetings for territorial diagnosis and development of shared plans
Health education	Development of educational and participatory practices	Guidance on self-care, health promotion, and reduction of risk behaviors	Joint action by health professionals, education professionals, and social assistance services
Health surveillance	Recognition of social and environmental conditions	Monitoring of diseases, health problems, and populations in	Integration among epidemiological surveillance,

	affecting collective health	situations of greater vulnerability	Primary Health Care, and specialized services
Person-centered care	Consideration of biological, psychological, social, and cultural dimensions	Continuous monitoring and identification of health needs	Discussion of cases, referral, and interprofessional therapeutic planning
Community participation	Strengthening individual autonomy and social co-responsibility	Identification of local problems and development of responsive strategies	Councils, groups, community organizations, community health workers, and intersectoral actions
Teamwork management	Integration of knowledge and improvement of care processes	Reduction of fragmentation of actions and greater continuity of care	Systematic communication, definition of responsibilities, and collective evaluation
Use of technologies and information	Expanded access to health services and care	Improved recording, monitoring, and communication among services	Information systems, telehealth, and ethical sharing of data
Addressing inequalities	Direction of actions toward groups and territories with greater needs	Reduction of barriers to access and exposure to risk factors	Cooperation among health, education, social assistance, sanitation, and public management

Source: Prepared by the author, based on Aguiar, Silva, Torres e Souza (2018), Oliveira (2022), Pereira et al. (2023), Coelho et al. (2023),

Silva et al. (2023), Fumagalli et al. (2025), Martins (2025), Silva et al. (2025), Rezer and Matsuêr (2020), and Pan American Health Organization (2024).

In the follow-up care of people with chronic diseases, interdisciplinarity emerges as a practical requirement rather than merely a methodological choice, since the needs of these users can rarely be addressed through isolated clinical interventions. What is at stake involves monitoring risk factors, treatment adherence, health education, and the adaptation of care approaches to the social conditions of each individual, aspects that cannot be adequately sustained by a single professional. Silva et al. (2025) discuss this integration in Primary Health Care, precisely where care fragmentation has a particularly significant impact on individuals living with chronic conditions.

This requires a broader understanding of care that is not limited to performing procedures or complying with protocols. Silva et al. (2023) approach care from an interdisciplinary perspective as a practice that involves dialogue among different bodies of knowledge, recognition of the complexity of each situation, and articulation among diverse actors. This conception brings health promotion closer to the actual experiences of communities and the specific needs of healthcare users, rather than maintaining it as an abstract guideline.

However, none of this can be sustained solely through the goodwill of healthcare teams. The consolidation of these practices depends on working conditions, professional training, institutional support, and available resources. When there is insufficient time for meetings, communication is inadequate, certain forms of

knowledge are positioned above others, and services operate in a fragmented manner, cooperation becomes difficult to establish. Therefore, interdisciplinarity should be understood as an ongoing process of collective construction rather than as a state that can simply be achieved. Its sustainability depends on management policies, continuing professional education, and evaluation mechanisms.

In-service training has been identified as one of the most concrete institutional approaches for sustaining this collective construction. Martini, Souza, and Manzini (2025), in analyzing a pedagogical proposal aimed at developing interprofessional collaboration in Multiprofessional Residency Programs, emphasize that educational spaces based on dialogue and interaction among different professional categories promote the recognition and appreciation of diverse forms of knowledge. In addition, they contribute to reducing processes of hierarchization among fields of knowledge, which are frequently present in training models centered on a single profession. These findings demonstrate that interdisciplinarity depends not only on management mechanisms or institutional incentives, as pointed out by Rafael et al. (2024), but also on the educational processes that accompany professional development. Thus, continuing professional development emerges as an important element in strengthening collaborative practices and consolidating more integrated, effective, and user-centered care.

2.3. Comprehensive Care, Quality Of Life, And Contemporary Health Challenges

Comprehensive healthcare involves a broader understanding of the health-disease process, taking into account the connections among

clinical conditions, subjective aspects, social interactions, and living contexts. This perspective shifts the emphasis from isolated actions toward continuous and integrated care, in which different professionals share their knowledge to better understand individual and collective needs. Lima and Sousa (2020) emphasize comprehensiveness as a guiding principle for care practices that consider the complexity of human experiences and the needs encountered in healthcare services.

The organization of multiprofessional teamwork is one of the important dimensions of this approach to care, particularly in Primary Health Care. For multiprofessional practice to become a reality, it is necessary to overcome organizational fragmentation, in which each professional category remains within the boundaries of its own responsibilities without extending its practice beyond them, as argued by Machado et al. (2021).

Machado et al. (2021, p. 155) point out:

[...] the historical fragmentation of health education and the reproduction of professional hierarchies as limiting factors to genuinely integrated work. This highlights the need to restructure institutional practices, invest in continuing education, and value the knowledge of all team members, reducing medical centrality and promoting shared protagonism.

In this regard, quality of life cannot be understood merely as the absence of disease, but rather as encompassing actual living conditions, opportunities for social participation, and the way

individuals perceive and manage their health. It is also defined as “the individual's perception of their position in life, in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns” (WHOQOL Group, 1995 apud Carvalho et al., 2024).

In this regard, quality of life cannot be understood merely as the absence of disease, but rather as encompassing actual living conditions, opportunities for social participation, and the way individuals perceive and manage their health. Among Primary Health Care users living with chronic noncommunicable diseases, care that is sustained over time and well coordinated can enable interventions to be better adapted to identified needs, taking into account factors that extend beyond immediate clinical treatment (Goulart et al., 2020). Queiroz et al. (2021) also address the challenges involved in implementing comprehensive care in Primary Health Care, highlighting the need to organize practices capable of addressing the complexity of users' demands.

The relationship between comprehensive care and quality of life also involves health literacy, understood as people's ability to access, understand, and use information to care for their own health. Abreu, Facin, and Orlandi (2025), in a study involving older adults who use Primary Health Care services, found inadequate health literacy and only moderate quality of life in the sample studied, associated with educational attainment, income, comorbidities, and self-perceived health, with no direct correlation between the two constructs. This finding suggests that continuous educational actions supported by interdisciplinary teams are necessary for access to health information to translate, in practice, into improvements in quality of life.

These dimensions, which involve welcoming practices, health literacy, and continuity of care, find a conceptual synthesis in the person-centered care perspective. Ribeiro, Signor, and Forgiarini (2023), in an integrative review on the subject, emphasize that this approach shifts the focus of care from disease to the experience of the person receiving care, considering their preferences, life context, and participation in therapeutic decisions as fundamental elements of healthcare, together with clinical aspects. From this perspective, person-centered care does not contradict the interdisciplinarity discussed throughout this article but rather contributes to putting it into practice. Interdisciplinarity becomes effective when the coordinated work of different professionals enables the development of responses that are more consistent with the individual needs of each user, going beyond the mere presence of different professional categories in the care of the same case.

The multidisciplinary approach has become a fundamental pillar in overcoming fragmented models of care traditionally centered solely on the biomedical dimension. The literature highlights that multiprofessional teams enable knowledge sharing, increasing clinical problem-solving capacity, user satisfaction, and the humanization of care (Oliveira, 2024, p. 25).

In this regard, professional integration is not merely a management strategy but a way of organizing care based on the complementarity of knowledge, responsibilities, and different ways of perceiving health needs.

Welcoming practices constitute another relevant dimension of comprehensiveness, as they influence the quality of the relationship established between users and professionals. This process involves listening, recognizing demands, and developing responses compatible with the particularities presented, thereby strengthening relationships of trust and shared responsibility.

This welcoming approach is fundamental to ensuring accessibility and establishing a relationship of trust between healthcare professionals and users, enabling the expression of the other person's subjectivity through a communicative process based on qualified listening and appropriate responses to identified demands, with the potential to strengthen interpersonal bonds, reorient health practices, and promote comprehensive care based on shared responsibility, respect, and human dignity (Silva et al., 2018, p. 250).

The dimensions presented in Table 3 systematize the articulation among comprehensive care, quality of life, bonds, and the addressing of contemporary health challenges.

Table 3. Dimensions of Comprehensive Care and Their Contributions to Quality of Life and the Addressing of Contemporary Health Challenges

Care Dimension	Characterization	Contribution to Quality of Life	Related Strategies
Comprehensiveness	Articulation of the biological,	Broader understanding	Integrated care plans and

	psychological, and social dimensions of the health-disease process	of users' needs	continuous follow-up
Multiprofessional teamwork	Integration of different forms of professional knowledge and competencies	Greater coordination of responses to health needs	Shared case discussions and collective planning
Welcoming	Qualified listening and recognition of users' needs	Strengthening of trust, respect, and shared responsibility	Qualified communication and development of bonds
Longitudinality	Continuity of follow-up over time	Greater knowledge of needs and living conditions	Systematic follow-up and care coordination
Bonding	Relationship of trust among professionals, users, and teams	Greater participation and adaptation of practices to individual needs	Listening, dialogue, and shared responsibility
Social participation	Involvement of users in processes related to collective health	Strengthening of autonomy and capacity for participation	Participatory management and community dialogue spaces
Care management	Integrated organization of resources, professionals, and actions	Greater continuity and coordination of interventions	Planning, monitoring, and evaluation of practices
Addressing Contemporary Challenges	Coordinated response to social, epidemiological, and organizational changes	Adaptation of practices to emerging needs	Continuing education, team integration, and intersectoral coordination

Source: Prepared by the author based on Lima and Sousa (2020), Machado et al. (2021), Oliveira (2024), Queiroz et al. (2021), Silva et al. (2018), Goulart et al. (2020), Guimarães et al. (2025), and Guimarães, Silva, and Coutinho (2026).

The bond established between professionals and users expands the possibility of understanding health trajectories beyond isolated episodes of care. Continuity in this relationship facilitates the recognition of changes in clinical, social, and family conditions, allowing interventions to be adjusted according to identified needs. “This bond of trust enables an in-depth understanding of the individual’s health history, social context, and preferences, facilitating the development of personalized care plans that are consistent with their needs” (Goulart et al., 2020, p. 10).

Longitudinality and user participation become particularly important when considering the challenge of maintaining follow-up for chronic conditions and ensuring continuity of care. According to Guimarães, Silva, and Coutinho (2026), longitudinality and bonding are connected to the contributions of Public Health to the consolidation of public healthcare, while Guimarães et al. (2025) discuss participatory management as an approach to implementing local public policies. This articulation enables the organization of services around continuity, dialogue, and the participation of the various actors involved.

Current health challenges also require institutional capacity to integrate healthcare practices, community participation, and service management. Comprehensiveness is related to processes that enable teams to recognize changes in population needs and, in a coordinated manner, adjust their care strategies. Lima and Sousa

(2020), Machado et al. (2021), and Queiroz et al. (2021) point, from different perspectives, toward overcoming fragmentation in favor of organizational approaches capable of integrating professionals, users, and multiple dimensions of care.

In other words, quality of life does not refer solely to clinical outcomes but also to the continuity, humanization, and adaptation of practices to lived realities, consistent with the understanding that it also encompasses spiritual, physical, mental, psychological, and emotional well-being, social relationships involving family and friends, health, education, housing, basic sanitation, and other areas of life (WHOQOL Group, 1995 apud Carvalho et al., 2024).

Thus, building comprehensive care requires a combination of technical competence, effective communication, the establishment of bonds, participation, and teamwork. It is not simply the presence of different professionals in the same settings that overcomes the fragmentation of care models, but rather the establishment of shared objectives and the development of integrated responses to users' needs. According to Oliveira (2024), Guimarães et al. (2025), and Guimarães, Silva, and Coutinho (2026), comprehensiveness is related to team organization, as well as to forms of participation and continuity that are established within the everyday practices of care. Therefore, addressing current health challenges requires practices that integrate knowledge, shared responsibility, and consideration of each individual's particular circumstances.

3. METHODOLOGY

Integral health in the contemporary context cannot be sustained without a scientific understanding that articulates health promotion,

disease prevention, quality of life, and the different dimensions of care, since health systems currently face a problem that cannot be addressed through isolated responses: the social, environmental, and healthcare conditions that shape population well-being require integrated rather than fragmented approaches. Accordingly, this study investigates the contributions of interdisciplinarity to the development of comprehensive care practices by systematizing existing knowledge and supporting a broader understanding of healthcare.

A qualitative approach was adopted because it is appropriate for the interpretive analysis of complex phenomena and for understanding the relationships, meanings, and contexts that structure the object under investigation. In contemporary research, this approach has gained increasing prominence across different fields of knowledge, particularly because it addresses phenomena that cannot be fully understood through quantitative measurement alone. Lösch, Rambo, and Ferreira (2023) similarly argue that qualitative research contributes to understanding complex issues, experiences, and perspectives associated with the phenomena under investigation.

Two procedures were adopted: a literature review and documentary research. The literature review makes it possible to identify, systematize, and critically analyze knowledge already produced on the subject, contributing both to the conceptual delimitation of the study and to the development of its theoretical framework.

According to Sousa, Oliveira, and Alves (2021, p. 65), “bibliographic research is primarily situated within the academic environment and aims to improve and update knowledge through scientific investigation of previously published works.” Braucks et al. (2025)

likewise characterize this procedure as a methodological resource for organizing and analyzing existing scientific production.

The literature review included dissertations, articles published in scientific conference proceedings, articles published in scientific journals, and books selected based on their direct relevance to the topic under investigation, rather than through an exhaustive survey of everything previously published on integral health, interdisciplinarity, health promotion, disease prevention, and quality of life. Salge, Oliveira, and Silva (2021) argue that organizing sources according to explicit criteria, rather than simply accumulating them, provides a solid scientific foundation for research. This principle guided the selection of the materials included in the present study.

The documentary research followed a different approach, focusing on institutional documents related to health and healthcare policies. Three documents were analyzed: *Integrated Health Promotion and Surveillance of Noncommunicable Diseases and Conditions*, published by the Pan American Health Organization (2024); *Policy on the Health Workforce 2030: Strengthening Human Resources for Health to Achieve Resilient Health Systems*, document CD60/6 of the Pan American Health Organization (2023); and *World Report on Social Determinants of Health Equity*, published by the World Health Organization (2025). These documents have distinct scopes: the first addresses health promotion and surveillance of noncommunicable diseases and conditions; the second focuses on the health workforce and the resilience of health systems; and the third examines the social determinants of health equity. Although this thematic diversity could initially appear to compromise coherence, each document addresses a distinct component of the theoretical framework adopted in the research. Thus, the diversity of themes

contributes to the construction of a broader analytical framework rather than reproducing the same perspective across the three sources.

Combining the literature review with documentary research was appropriate because each procedure addresses aspects that the other does not fully encompass. The academic literature discusses concepts, their interrelationships, and the debates surrounding them, whereas institutional documents demonstrate how these concepts are formulated in current guidelines and policies, an aspect that academic literature does not always capture with the same degree of contemporaneity. This combination provided greater analytical consistency than would have been possible through the exclusive use of a single type of source, although this assessment reflects the methodological trajectory of the present study rather than an externally measured comparison.

4. FINAL CONSIDERATIONS

The discussion of integral health today requires moving beyond restricted conceptions of the health-disease process, since health promotion, disease prevention, quality of life, and comprehensiveness of care do not occur separately in people's everyday lives. Interdisciplinarity becomes particularly important in this context because it promotes the integration of knowledge, practices, and perspectives in understanding individual and collective health needs. This concern established the relevance of the present study, as the challenges involved in organizing care and the complexity of contemporary demands require more articulated responses than those typically produced by the fragmentation of knowledge.

The research question, “How can interdisciplinary contributions in the areas of health promotion, disease prevention, and quality of life contribute to an integral approach to health in contemporary times?”, was addressed throughout the analysis, within the limits of a theoretical study. The theoretical framework made it possible to understand that interdisciplinary articulation contributes to broadening the understanding of health needs, integrating dimensions of care that are often treated separately, supporting preventive actions, and guiding practices based on continuity, bonding, participation, and quality of life.

The general objective, which focused on analyzing interdisciplinary contributions to health promotion, disease prevention, and the improvement of quality of life, considering contemporary challenges related to comprehensive care, was achieved insofar as the study sustained this relationship without presenting it as fully resolved. Regarding the first specific objective, integral health was examined in relation to its biological, psychological, social, and environmental dimensions. The analysis showed that these dimensions should not be treated in isolation, as they are interconnected both in the formation of health needs and in the way care practices are organized.

The second specific objective, which was to analyze the contributions of interdisciplinarity to health promotion and disease prevention actions, was addressed through the discussion that interdisciplinarity does not simply involve bringing professionals from different fields of training together within the same service. Rather, it requires dialogue, shared responsibilities, integration of knowledge, and collective planning. When these elements are present, actions become more coordinated, particularly in primary

health care, health surveillance, health education, and the follow-up of chronic conditions.

The third specific objective was likewise addressed by examining the relationship among comprehensive care practices, quality of life, and contemporary health challenges. The third topic of the theoretical framework indicated that welcoming practices, bonding, longitudinality, social participation, multiprofessional teamwork, and care management are dimensions associated with the development of more integrated practices. From this perspective, quality of life is related to clinical outcomes while also depending on continuity of care, humanized relationships, and the adequacy of interventions to users' concrete living conditions.

In the first topic of the theoretical framework, the analysis showed that integral health requires a broader understanding of the health-disease process, considering the different dimensions of human existence and their interrelationships. Care restricted to the biomedical dimension overlooks psychological, social, environmental, and relational aspects that influence people's health conditions and the concrete possibilities of providing care. This understanding supports an approach guided by comprehensiveness and by the integration of different fields of knowledge.

In the second topic of the theoretical framework, interdisciplinarity emerged as a form of work organization capable of reducing the fragmentation of practices and fostering shared responses to health needs. The analysis also made it possible to recognize that its implementation does not occur automatically, as it depends on institutional conditions, communication among professionals, continuing professional education, recognition of different forms of

knowledge, and user participation. Thus, interdisciplinarity should be understood as a process of collective construction that goes beyond the mere formal composition of multiprofessional teams.

In the third topic, comprehensive care was directly associated with the quality of relationships established within health services, continuity of follow-up, and each team's ability to recognize the singular characteristics of each user. Contemporary challenges require coordinated and participatory practices capable of bringing together care, prevention, health promotion, and care management within an integrated approach. This systematization, namely, bringing these dimensions together within an integrated understanding, was precisely what this study sought to contribute, reinforcing interdisciplinarity as an organizing axis of health practices.

Because this was a theoretical study, the remaining gaps point toward the empirical field. Future research should examine how interdisciplinary teams effectively implement health promotion and disease prevention in different territories and healthcare settings. Qualitative investigations involving professionals and users, comparisons among services, and longitudinal studies addressing the relationship between interdisciplinarity, continuity of care, and quality of life would also be appropriate. Studies of this nature could complement the theoretical analysis developed here and provide evidence on how these practices actually occur across different contexts.

The contribution of this article lies in bringing together, within a single discussion, integral health, interdisciplinarity, health promotion, disease prevention, quality of life, and responses to

contemporary challenges. The resulting synthesis reinforces the need to overcome fragmented practices and strengthen care based on the integration of knowledge, shared responsibility, bonding, and continuous follow-up. In this sense, the study reaffirms the relevance of an integral approach to understanding and organizing health practices in contemporary times.

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