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Referência e contrarreferência no cotidiano da atenção à saúde de Divinópolis-MG, Brasil: o suporte às decisões da atenção primária[1]

Reference and counter-reference in everyday health care in Minas Gerais, Brazil: the support to decisions of primary care

Referencia y contra-referencia en todos los días de cuidado de salud en Minas Gerais, Brasil: apoyo a las decisiones de la primaria

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ABSTRACT

Objective: To understand, in the perception of professionals and managers of Primary Health Care (PHC), the reference and counter-reference system in health care and the support to decisions of APS professionals. **Methods:** Qualitative study, outlined by Holistic Multiple Case Study, based on Comprehensive Sociology of Everyday Life with 41 participants. **Results:** The support to decisions of APS professionals to direct users depends on the flow and regulation of the referenced demands; the waiting time for the user service; may be harmed by unnecessary and unreadable referrals and by the professionals' view on the system. **Conclusion:** Health is a social process of collective construction, and it needs to win the welfare and curative paradigm, the excessive consumption of queries with a high rate of referrals.

Descriptors: Primary health care**,** Family health strategy, Health services accessibility, Regional health planning, Unified health system.

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RESUMO

Objetivo: Compreender, na percepção dos profissionais e gestores da Atenção Primária à Saúde (APS), o sistema de referência e contrarreferência na atenção à saúde e o suporte às decisões dos profissionais da APS. **Métodos:** Estudo qualitativo, delineado pelo Estudo de Casos Múltiplos Holísticos, fundamentado na Sociologia Compreensiva do Cotidiano com 41 participantes. **Resultados:** O suporte às decisões dos profissionais da APS ao encaminhar os usuários é dependente do fluxo e da regulação das demandas referenciadas; do tempo de espera do usuário para o atendimento; pode ser prejudicado pelos encaminhamentos desnecessários e ilegíveis e pela visão dos profissionais sobre o sistema. **Conclusão:** A Saúde é um processo social, de construção coletiva, e que precisa vencer o paradigma assistencialista e curativista, o consumo excessivo de consultas com elevado índice de encaminhamentos.

Descritores: Atenção primária à saúde, Estratégia saúde da família, Acesso aos serviços de saúde, Regionalização, Sistema único de saúde.

RESUMEN

Objetivo: Comprender, en la percepción de los profesionales y directivos de Atención Primaria de Salud (APS), el sistema de referencia y contrarreferencia en la atención de salud y el apoyo a las decisiones de los profesionales de APS. **Métodos:** Estudio cualitativo, esbozado por Estudio de Casos Múltiples Holísticos, basado en la Sociología Comprensiva del Cotidiano con 41 participantes. **Resultados:** El apoyo a las decisiones de los profesionales de APS a los usuarios directos depende del flujo y la regulación de las exigencias que se hace referencia; el tiempo de espera del servicio para el usuario; pueden ser perjudicados por referencias innecesariaseilegibles y por los puntos de vista de los profesionales en el sistema. **Conclusión:** La salud es un proceso social de construcción colectiva, y que necesita ganar el paradigma del bienestar y curativa, el consumo excesivo de consultas con una alta tasa de remisión.

Descriptores: Atención primaria de salud, Estrategia de salud familiar, Accesibilidad a los servicios de salud, Regionalización, Sistema único de salud.

INTRODUCTION

Unic Health System (UHS) is a public Brazilian policy which universalizes the right to health in an integral and equal way by offering actions and services that are part of a regional network organized in levels of assistance's complexity, based in the decentralization and participation of the community.[1]

Since the creation of UHS, the principles of regionalization and decentralization are emphasized in their policies and programs; But we still live with a system unable to guarantee the continuity of care, generating increased employment in the services everyday, high costs and inconvenience to the user access to the services they need, which shows that equitable, fair and universal access to the comprehensive health care are not yet effective and/or sufficient.[2,4]

For the implementation and integration of services in UHS attention levels is a priority that the system of reference and counter is effective and efficient considering the network of attention to local and regional health for the organization of care at the primary, secondary and tertiary[3-4].

Organize health care network so allows the continuity of health care and comprehensive care according to the health needs of each user[4]. According to Decree 2488/2011 the health care networks (HCN) are in organizational arrangements formed by actions and health services with different technological configurations and assistance missions, articulated in a complementary and territorial base form.[5:5-6]

For the constitution of the HCN must establish a reference and counter system that constitutes "the attention of security for the initial contact by Primary Health Care (PHC) as a priority gateway to the enrolled population with the "ability to handle large, heterogeneous problems and strongly influenced by social context.[6]

For the universal accessibility of people to public health services with improved attention, rationalization of spending and greater use of the assistance available supply,[5-6] they should be considered the supply and demand of services. Studies point to the need to organize the system of reference and counter the flows and the central control in order to equalize supply and not hinder the user access to services and health actions in various municipalities.[2-6]

The Family Health Strategy (FHS) provides an opportunity to reorganize the local health system, despite the difficulties still faced by municipalities to ensure users' access to services of medium and high complexity and establish the system of reference and counter.[2,6] After the twentieth anniversary of the institution of FHS and various evidences demonstrating the improvement of health indicators in places where the FHS was implemented, the scenario study made little progress in the reorganization of the care model presented in October/2014, less than 30% coverage by this Strategy. Therefore, the proposal is justified by the relevance of this research to understand the system of reference and counter health care network in a mining town.

In this context, in everyday life, how is the support given to professionals by the reference and counter system in health care of a municipality in the state of Minas Gerais, Brazil, in the perception of professionals and managers of Primary Health Care?

This study aims to understand, in the Primary Health Care's professional and manager's perception, the reference and counter-reference system at the health care and the support to the PHC's professional's decisions.

METHOD

It is about a qualitative approach study, outlined by the research Multiple Holistic Case Study Strategy, grounded on Comprehensive Sociology of Everyday Life. Qualitative analysis is an approach that aims to understand and interpret the reports of a holistic and reliable way.[7]

The case study is based on an exploratory research method that aims to explore, describe or explain behavior in its natural context, collecting data from each individual and providing strategy for analysis and global understanding of the phenomenon of interest.[8]

This study has more than one case, being a multiple case study holistic, to present different realities as study scenarios, with their convergences and divergences defined by health care settings, which will be analyzed completely, considering its specificities. Front method, each case must serve a specific purpose in the investigation, the views of survey participants revealed by the different rationales underlying the literal replication of the results, it is, the generalization of the results of multiple similar cases holistic.[8]

In everyday life, it creates a relationship between individual and collectivity that may indicate the existence of something in common in collective and different subjectivities may exist in what is considered common.[9] For Comprehensive Sociology in the social context, it makes sense. There are several types of knowledge, complementary attitudes as the reason and emotion that make match the different potential. In order to discover the different actors involved, "the positivist sociology finds that everything is just another symptom. However, it is the comprehensive sociology describing the lived in what is, and the phenomenon under study is "likely to be understood by a number of explanations, reintegrates, but can also be seen as an explanatory element of other groups."[9:25] Maffesoli[10:74] also argued that "everyday life, marked by the encounter with the other, can be understood in the course of the usual facts". Finally, the "comprehensive sociology, describing the lived what is, content is, therefore, to discern the target of the different actors involved,"[9:25] in this study.

The scenarios of the research were Traditional Units and Units of PHC FHS, totaling 10 units, located in the urban area of the municipality of Divinópolis-MG, which has 213.016 inhabitants[11]. According to data from Divinopolis Integrated Health System (IHS), in July 2014, part of this population was already registered, with 28.74% of the total population of the municipality are ascribed to the FHS, 71.26% are ascribed in traditional units of PHC.

The 41 participants were the teams of professionals from FHS, the doctor, the nurse, the nursing technician, the community health workers (CHW); and practitioners of Traditional Units: practitioner, pediatrician, obstetrician, psychologist, physiotherapist, nurse, practical nurse, social worker; also we were invited managers of health sectors and managers of the Units Search scenarios. As inclusion criteria, established a performance of at least one year in office work. According to the criteria of qualitative research, was not determined an exact number of respondents, data collection ended with data saturation in each case[7] this study is considered sufficient to meet the proposed objective. As a source of evidence of the data was used to open individual interviews based on the following guiding questions: 1- "Tell me about your everyday practice in primary health care (or staff of the Family Health Strategy)". 2 - "What do you understand by reference system and counter in health?" 3 - "How do you perceive the reference and counter in health in everyday life Primary Health Care (or the Family Health Strategy)?" 4 - "Do you want to add something?" (Open space for informant).

The analysis of the survey data is based on qualitative analysis[12], it is, an analysis of "meanings" second phases: pre-analysis, material exploration, treatment of results, inference and interpretation. Initially, we worked up in a group of data obtained in each case; after the grouping of convergences and divergences in both cases what it was the multiple analysis cases, and then progress was made to the logical conclusions on the subject under study face of what has been researched and described in the scientific literature, thus leading, the interpretation and description of the study results. Content analysis originated three thematic categories. This article discusses the categories: Health care in the context of primary care; and reference system and counter: notions and sterols.

The research was approved by the opinion CEPES/CCO 522.447 and developed according with the resolution CNS 466/2012, obeying the guidelines and regulatory rules about researches which evolves human beings.

RESULTS AND DISCUSSION

The nomenclatures Health Family Program (HFP) and Family Health Strategy (FHS) were used, in this article, to describe the same work process, but which happened at different moments of the public health policy articulation. Although the survey respondents have used the term HFP, we were intentionally used by the authors to FHS terminology, considering important to treat it as a political-care strategy for the establishment of a new health care logic. Noteworthy is also that the program term points to an activity beginning, development and finalization. Also, somehow, as a way to try to break up with a matrix really strong in the health area, that is the consideration of the programs as structures verticalized at the health care, with few articulations in the provided assistance group.[13]

Health Care in the Primary Care context

To the comprehension, in the Primary Care's professionals and managers' perception, from the reference and counter-reference system in the health care in Divinopolis-MG, and the support to the PHC's professionals' decisions, the daily job describe a lot of actions that contextualize the studied theme and describe the doing in health in interrelation, user/Professional/team and how it is processed the primary level assistance and the user routing by the health attention network.

The PHC It is understood as the preferred contact level of the users and should be guided by all the principles of

the system, with a guarantee of full and equal access by the health needs of people, offering the most diverse actions and procedures, as contextualized by professionals Family Health Strategy (FHS):

> *Yes... my day to day is composed by attention in preventing and troubleshooting. In Health System we offer the part of prevention, has clinical baby is child care with babies from zero to two years, is part of care for pregnant women, the brushing of the unit once a month. And the healing part, it is composed of solution of dental problems in primary care and emergencies within the dental emergency. (E_{34})*

> *Well, I am CHW, My job is to make home visits, guide, refer the patient and, if necessary, the Health Unit. [...] If I'm in a house and I detect there is a demand to drive, then I'll guide the search for unity, if a demand for the emergency room, then I can mention, ah that there is no longer the case for primary care , you can search the Emergency Room. (E_3)*

> *Make guidance; observe what is most necessary to pass the medical, we forward it to the nurse, for her to screen, to see the need for the patient to receive medical consultation at that moment. If not, we will schedule for the next consultation. So I do dressings, vaccine, do home visits is... telephone guidance, personally too, you know? Administer some medications. (E_{13})*

Primary care is described in daily professional actions in the FHS. The statements mark out, empirically, the targeting of users by professionals, CHW forwarding them verbally to other professionals of the team or the emergency care units; as well as the orientation, disease prevention, basic nursing procedures, screening and consultations that describe the scope of curative actions with the inclusion by the professionals, issues guidance and prevention.

With the FHS, we seek to carry out integrated actions to prevent risks and diseases, treatment, maintenance and promotion of health through attention to demand, strategic, territorial health surveillance and planned actions as reality socio epidemiological local.[5]

By multivariate analysis of cases, actions of health education and the prevention of risks and hazards were named only by professionals who work in the context of the FHS and managers expressing that these actions have a direct impact on the daily care process professionals, as mark the testimonials:

> *Then it's up to the manager to the statistics of immunization, monitoring and prevention of chronic diseases, the action in acute diseases is very important. And it is up to managers are sensitive to it... Make the decision at the appropriate time. You need to take some steps in a timely manner. So, in my way of understanding it is a challenge, because they are giant public health possibilities.(E_1)*

> *In child health, are quite prevention activities such as childcare, the vaccine, more preventive than curative, which is a good part, you know?! In relation to women's health, a part of prevention is made equal groups, preventive, the request mammography, orientation to self breast exam, but it is a population that much searching HFP [...]If you schedule a nursing consultation only to guide how to use the drugs, you need to do physical activity and on food, is very low membership, got it? [...]Then the preventive part and the promotion is more complicated to make, and to the high demand of diseases, we let a little side. (E_2)*

> *So you have to make people aware when you go to her house to look for before she became ill and not only get sick here in HFP is a matter of prevention, so it's our job every day. (E_4)*

Of course, in the words of professionals FHS and manager understanding the importance of preventive strategies for risk and disease and surveillance and control of diseases, which can be exemplified by the attention to acute cases, monitoring of chronic diseases, immunization, child care, prevention of uterine and breast cancer, awareness of people for disease prevention. However, the high spontaneous demand hinders this preventive practice by professionals, in addition to poor adhesion of users for promotional activities and preventive health risks.

In the scenarios studied, it includes a new participant, the user. Who, from the education actions in health and health awareness, may have basis and tools for the prevention of health problems in attitudes, but also to have autonomy and be co-responsible in the production of individual and collective health. You can be self-carrier as a means of empowerment for healthy lifestyle choices and active participation in health, beyond the shared information, which can lead to innovative behavior and self-critical.[14-15]

According to Paulo Freire, empowerment can be cited as a social action in which the subject becomes responsible for his own life, resulting in critical thinking of their reality, promoting growth and social transformation.[16] Along with social participation, the FHS team must turn to comprehensive health care close to people's lives, considering the singular and collective level and co-participants in the production of health and life quality.[4]

There needs to be integrated actions in health care, education for healthy lifestyle choices, such as exercise of citizenship in the construction of comprehensive care in everyday services. Thus, it is essential scientific knowledge of professionals, user opening it to new behaviors, to create bonds, determining factors and facilitating the development of health comprehensiveness.[15,17]

To consider the subject as a conscious and free to make choices, we observed that this subject does not exist in Maffesoli. There is the individual in rational times or the person in emotional times.[18:451] From Foucault, Maffesoli shows us how to suffer a slow process of domestication of customs that led to the social constitution: a singularly mechanized being together, perfectly predictable and essentially rationalized. However, this social system took the direction of the team, transferring the state and distant individuals the choices that lead to the common good.[19]

Thus, difficulties are found to carry this risk prevention and health problems, in addition to the various possibilities of public health, that is, its area of operation, the scope and coverage; permanent and high rate of spontaneous demand in the area covered by health teams, which emphasizes the medical culture lived in the everyday services, which minimizes the time available in workload for activities that risk prevention and health problems; the lack of adherence of some risk groups for preventive action, which further complicate the continuity of care. This indicates that the daily lives of Health Services is uniquely mechanized, perfectly predictable and essentially rationalized.[19]

For the expansion of clinical and real resoluteness in health in the context of the FHS, considering the actors involved - professionals, managers and users - are essential some factors/actions/attitudes to generate more health: the roles played by each of the professionals; how to accommodate the demand, to share health education, to make an active search, to articulate the shared clinical care with users; and contemplate the promotion of individual and collective public health with social inclusion.[20]

There are difficulties in meeting the demands programmed in health because there are those who do not understand the assumptions of FHS and seek immediate solutions to their problems, which implies direct more professionals in time to meet the spontaneous demand and provide direct the user needs to more complex levels for not having continuous monitoring.[21]

So are paramount agenda scheduled for continuity of care and care for health needs of classification or likely risks, considering the individual fully to the achievement of a health model user-centered, focused on risk prevention before the materialization of disease. Health education, awareness of the public on the proper use of the structure of the system and services and the execution of the actual functions of primary care are relevant.[15,21-22]

In this context, the FHS should act as a first contact health empowerment of users and their families facing the health and collective well-being. The FHS should not only be recognized as a place of screening for secondary care services, should act in the host field and the link with the population, beyond that level be organizer and regulator of health system[22-24]. These assumptions may result in improvements in health, through interventions in the lived reality, real interaction with the population.[23,25]

The results demonstrate that seen in the context of Health around the "place" where people live, the "territory" of coverage, the "emergence of tribes and new myths" that the "absolute truth crumbles and gives space to partial truths "and that" groups are formed from the choices and affinities. [19] "We live in Health "the plural construction, made of different pieces" where we see a significant need for a paradigm shift from biomedical and fragmented attention to the attention focused on the user; where the first becomes less important than the health needs of each user and the community[4,22].

It was evidenced in the context of the FHS, the vicissitude of fragmented care and biomedical in health care:

> *We do not want to see get to that station situation, which reaches everyone there almost dying. That situation just wants the doctor [...].Everyone just waiting but only when it's too bad, that is just looking for the HFP. (E_4)*

We realize that this practice found in the FHS does not portray their assumptions, formulated in health education focusing on family, monitoring of priority groups and risk, health surveillance, Community Council and house calls. A place where should be a priority for disease prevention and not for the cure and treatment of diseases. However, the preventive and corrective attention should focus in the context of the FHS, the length and continuity of care, for the resolution and health equity.[26]

The fiery evidence of the population seek the medical care and the lowest interest in preventive actions, or calls to other team members, declare the high demand for medical consultations in everyday services.[22,27] We know that it is possible to live well with spontaneous demand through better organization of care, thus meeting the population's health needs.[28]

Therefore, the scope of assistance to prevent risks and injuries appears to be still insufficient to avoid high consumption of medical consultations and the high number of hospitalizations due to problems that can be sensitive to PHC and continue generating admissions or referrals to the secondary level.[22,29] Thus, it is considered that the medical culture experienced in the context of life and the Brazilian Health reveals that "I only becomes aware of himself" as a relationship,[19] and what the means, place and the model centered on actions and medical procedures express the condition of possibility, contemporary, human existence in the health services, as user, health professional or community.

The daily actions in the context of PHC, declared by the research participants, shows that in a reality where the few resolute attention, the instantaneous demand consumes the space of others actions, the attention is centered in the doctor with excessive consume for appointments by the population, the necessity to guide the user to others system levels will be frequent in the daily routine.

Reference and counter-reference System: notions and sterols

Since the 1980's, the health Brazilian system underlines the principles of the regionalization in its policies, by still today we found a precarious system, not capable of guarantee the assistance continuity, resulting in the increase of the work, of cousts and problems to the users. Thus, access to health services remains one of the most serious problems of Brazilian society. This is evidenced by several factors; among them, the lack of infrastructure, lack of resources and insufficient investment in hospitals, professionals and technologies. However, equitable, fair and universal access to health services remains disquiet of the spheres of government, managers and health professionals.[2,22]

For universal and comprehensive health care, the HCN has several attributes to emphasize that primary care should be structured as a first point of attention and main system gateway, integrating and coordinating care to meet the health needs of people, directing them to other levels as indicated, compared to benchmarks within a local health system.[5]

Thus, to achieve equitable, fair and universal health, the establishment of HCN for local and regional service is necessary, within the health system.

Survey participants explain the knowledge of reference and counter system and declare that this system does not work effectively:

> *It is a system that you have to refer a patient standing with a diagnosis, and you need another professional to solve the patient's problem and you expect to have the answer for you to continue treatment or for that patient to result in the solution of your problem. (E_{34})*

> *You forward to the most advanced level, but the patient will always be ours, so I need to know what happened to him there for me to continue to treat him here, and it is counter-if he was in the query I asked? What the doctor asked? What happened? He changed medication, did not change, needed tertiary care? (E_{2})*

> *In fact I think it's a way of us be integrating the three types of service in primary, secondary and tertiary, and make a link with other professionals to have a general knowledge of the patient, user [...] Because I I refer to and have to get back ?! (E_{30})*

The results show that access to health services by the users should take place, preferably, from primary care, corroborating the conditions of Order 2488/2011.[2,22,28]

The reference is defined "as the routing act of a patient attended in a given health establishment to another more complex". In the other hand, the counter-reference, is "as the routing act of a patient for the establishment of origin, said that after resolving the causes responsible for the reference."[2:18]

> *We refer the patient to a service that is not in our unit. And get feedback that other service. The patient, he was met, what you think, he must continue the treatment in our unit or not. (E_{16})*

For an easier access route to the counter-professionals develop their own strategies:

> *I try to do with the patient, we assume it comes with a private doctor, a serious heart problem then is to make it instead of a doctor of HUS to bring me a counter-, he goes in this medical particular to give me a counter-because it is easier, the doctor already attached, so I try an easier access route. [...]The reference happens more frequently than before, yes. I think it's important that the reference is well filled. Why did this patient come to me? Because a specialist who is there in the polyclinic does not know the patient's life, because he did not walk with the medical record, the record is not electronic. So the reference has to be very well written, for him to know where more attention. What is the question of my colleague who is there at the end, what he wants to solve? (E_{34})*

Even with the implanted reference system "health services, public and private, do not work in an integrated manner, but alone, without the establishment of formal references and requiring the population itself exercise to find out where to get the care you need."[2:22]

The various health care levels should form a network of resources, so that one complements the action of another by previous pacts. However, this will only happen if each serve as part of meeting the health needs of the system, using the resources available in their level of care to meet the user in need.[21,28]

The statements describe the itinerary of the user forwarding:

> *Our reference is where you have job. And quotas have not much here, and some diseases are referred to TOD [Treatment Out of Domicile]. (E_{33})*

> *I make the request knowing that the patient will have to be sent out, like Belo Horizonte, for example. As well as other specialties as well, it makes it difficult to the patient. (E_{21})*

> *Some things do not go and there's no way! For example, we have no orthopedic and ophthalmological clinic, then the cases of orthopedics and ophthalmology go to out of Divinopolis. (E_{28})*

In many situations, it is clear that the concern of the FHS teams to provide comprehensive care to users is hampered by the lack of a local network of reference and counter

for assistance and resolutive services and the lack of some medical specialties. In the context of SUS in Divinópolis-MG, the cases need to be referred for treatment outside of the domicile (TOD).

Thus, "from the moment the continuity of care is broken, there is a predominance and the strengthening of the classical model of health care, which is supported by the biomedical model queries, rather than a comprehensive care."[30:32]

The existence of unnecessary referrals was observed:

Suddenly ... have more training to do this screening, if you really need (routing) because sometimes is locking because a lot of people that would not be sent. (E_{24})

In the face of unnecessary referrals observe the medical professional's failure to resoluteness of care at the primary level:

The doctor's Desk is the primary care and forwards. So we have to doctors that we call "Dr. Ao". Only forwards: forwards to this guy, that guy, those guys, to not know who. Have you ever heard this term?! AhThen I will explain it to you straight! It's that doctor meets and does not want to know anything of the patient, then the patient's complaint leg pain, he did not want to know what the problem is and already soon makes routing pro orthopedist, pro angiologist, pro rheumatologist, to not know who! (Exaltation). Did you get it?! Then he is not doing anything, it just makes the referral, then works like this, that's the "Dr. Ao, "which has in the Health Center, and several, ok?! [...]It has a lot of forwarding so, to all that is something you think. I can open the cardiology folder and show you, and the "Dr Ao" went to all that is a thing... a girl of 17, the girl of 20, you 80, one of 50... to not put a note, do not put nothing, and there is that this folder routing coarseness. Then, result: arrives on time manager make appointments, what happens? There is, say, 10 vacancies pro cardiologist and has about 200 papers there, then the manager has to call the poor nurse you have to do almost a series of... use a system, a crystal ball, I do not know what it is to guess who will need first. Did you get it? (E_{28})

The expression "Dr. Ao" emphasizes the lack of commitment to comprehensive care and waste of public resources is scarce for universal and equitable health care in. As well as the incipient training for public work from the perspective of improving the quality of care, the expansion of the scope of actions offered by the teams, changing care practices and the daily work organization.[4,22]

The history of health policies in Brazil is marked by changes that accompany the economic, socio cultural and political Brazilian society. The essence of this historical trajectory is marked by emphasis on individual health care curative and specialized form, advocating the profit generation at the expense of public health, which consequently generated scrap and precariousness of their services.[30]

The medical culture is reflected in the lack of commitment to solving the unique problems at the primary level health care. The user seeks medical attention and medical professional transfer responsibility to another professional, which determines the lack of commitment by not solve the less complex and reference to other levels only what is necessary.

In addition to unnecessary referrals, the results showed that the reference counter is uncommon:

If he (the patient) I did not come here and not tell us we do not have (the information counter-reference). (E_{25})

Who gives me the reference that has been met is the patient himself when he returns [...]Then, when he returns, he tells me it was serviced, what happened, happened by psychiatrist if he was medicated and brings the recipe for me. So who makes me against reference is the patient, not the institution, is not professional, it's usually how it happens. (E_{29})

We get the reference explaining what was done. What can be done here and pass pro patient (the counter-reference) so it take for those who sent. (E_{36})

Health work is organized from meetings between workers and between workers and users. These meetings are in political flows, communication, subjective, forming an intricate network of relationships for the development of care. The reference and counter system composes this network of relationships to articulate various units, from the organization of referrals. The relational network approaches the worker flows-connective with other teams and health units as well as have their expanded for the user connections to establish care meet their needs.[4,30]

The approach of the CHW front of the reference shows the verbal conduct to direct and formal, to understand that reference, not assignment of this professional category:

Look... for me, community agent, the reference is the doctor who makes or nurse and we do not work with reference. (E_{12})

If the family has a pregnant woman, I I forward pro prenatal care, or if the family thus has a social risk, an alcoholic, because often drugs are rare people who come to us, I must refer to the CERSAM. (E_{33})

These facts refer to reflections about the formation processes, training and continuing education of the CHW, especially because they have specific training in health and

need meet demands of various orders. It is possible that from the effective implementation of the system of reference and counter in the service routine, the question to be placed in evidence and treated properly. In this context, "view is the role of the CHW as articulator in the care process, as they are the main links between the basic health units and communities and are responsible for facilitating access to consultations, tests, medications, among other actions."[30:35]

The need and usefulness of reference and counter were also addressed:

> *I think it would be interesting if you could make awareness to the professionals on the importance of the instrument. That reference chip and counter is not just another paper. It is really a learn of the patient's condition to direct the conduct that will have about the case. I think people need to have greater clarity about what it is for this and had to have a same awareness. (E_{37})*

> *The reference had to happen, all right in law, in fact it is in 8080 and does not happen, so... terrible! I do not know where we're stopping... (E_{30})*

The results show the need to have more information on the objectives, operation and fulfillment of references and against references for better interaction between professionals and interdisciplinary actions, facilitating and speeding up the service and offering a more effective care and qualified.

According to the interviewed speaking, Law nº 8.080/199031 mentions the organization, direction and management of HUS and it is established that the Bipartite and Tripartite Commissions will aim:

> *"establish guidelines on the health regions, health district, integration of territories, reference and counter and other aspects related to the integration of actions and health services among the federal entities."*[31:Cap. III, Art. 14-a]

A disturbing and inherent in PHC in the Latin American context factor is the lack of resources such as human, financial and infrastructure, uniting with the lack of completeness of the care network.[2,22]

The solving of the health problems is viewed and searched by the user easiest way to stagnation of their problem, not being, many times, your gateway to PHC. The solutions of health problems remain fragmented and biological focus, with consequences for the health care of the individual who could be holistic; this denotes the professional profile that continues to meet the same curative, with no pretense of preventing risks and diseases and health promotion.[4,22]

The professionals of PHC and managers expressed notions and sterols on the system of reference and counter and declared that access to health services becomes precarious and impractical when several negative factors become present in everyday PHC and network services, such as unnecessary referrals, little resolving medical actions at the primary level, offbeat counter-, lack of resources and structures, insufficient investment. These factors unfeasible the HCN's integrality attention, and consequently the reference and counter-reference path, stopping the integral and the equal process care.

CONCLUSIONS

When we consider that the HUS was structured as Unic and universal, with equality and integrality principles, that has the OHC as preferential entrance door from the user and the FHS as re-guider of this assistance level, this System should be more resolute and answer the health needs from the people integrally.

However, reality shows us otherwise. Even with the door open by PHC, there is fragmentation of activities and services that are the HCN; We see the lack of adherence of the population to preventive practices; users seek immediate solutions to their problems, favoring huge spontaneous demand and hurting the daily work in primary health care units; perpetuates the experience of the biomedical care model and fragmented.

As for the decision support of PHC professionals to direct users according to their health needs was understood in this study, which is linked to the act of reference, the act of receiving or not the counter-the professional/reference source drive; the resoluteness or reply to the user health problem that did generate referral. It is dependent on flow and regulation in the mentioned demands; the user waiting time for the requested service and referenced by PHC. This support may be harmed by unnecessary referrals and unreadable; the professional view of the reference and counter reference system in daily work in PHC and managers who live daily with the management of available resources for universal coverage, comprehensive and equal.

Multiple analysis of cases showed that in situations where you do FHS gateway, preventive actions and health education are already present in everyday life and referrals appear to demands that can't be resolved in PHC. In the context of traditional basic units, professionals describe the system of reference and counter as a way to refer unresolved issues to the secondary or tertiary level, which showed the removal of individual and collective bond to expand the clinic in the daily life of these services. The health is a social process, from collective construction that needs to overcome the welfare and curative paradigm, where the medication and the commercialization of the disease guide our daily routine.

REFERENCES

1. Brasil. Constituição 1988. Constituição da República Federativa do Brasil. Brasília, Senado Federal. 1988; p.133-4: Seção II. Da Saúde.
2. Serra CG, Rodrigues PHA. Avaliação da referência e contrarreferência no Programa Saúde da Família na Região Metropolitana do Rio de Janeiro (RJ, Brasil). Ciênc saúde coletiva. [periódico na Internet]. 2010; nov [acesso 2013 out 02]; 15(3): 3579-3586. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232010000900033&lng=en.
3. Finkelsztejn A, Acosta LMW, Cristovam RA, Moraes GS, Kreuz M, Sordi AO. et al. Encaminhamentos da atenção primária para avaliação neurológica em Porto Alegre, Brasil. Physis [periódico na Internet]. 2009; [acesso 2014 jul 20]; 19 (3): 731-741. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-73312009000300010&lng=en.
4. Viegas SMF, Penna CMM. O SUS é universal, mas vivemos de cotas. Ciênc saúde coletiva. [periódico na Internet]. 2013; [acesso em 2014 fev 02]; 18(1):181-190. Disponível em: http://www.scielo.br/pdf/csc/v18n1/19.pdf
5. Brasil. Ministério da Saúde. Gabinete do Ministério da Saúde. Portaria Nº 2.488, de 21 de outubro de 2011. Brasília: 2011; 37 p. Disponível em: http://portal.saude.gov.br/portal/arquivos/pdf/portaria_2488_21-out 11_politica_atencao.pdf
6. Oliveira KG, Cotta RMM, Araújo RMA Cherchiglia ML, Martins PTMC. Atenção Primária à Saúde - a "menina dos olhos" do SUS: sobre as representações sociais dos protagonistas do Sistema Único de Saúde. Ciênc saúde coletiva. [periódico na Internet]. 2014; [acesso 2014 jul 20]; 16(1), 881-892. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232011000700020&lng=en&tlng=pt. 10.1590/S1413-81232011000700020.
7. Minayo MCS. Análise qualitativa: teoria, passos e fidedignidade. Ciênc saúde coletiva. [periódico na Internet]. 2012; mar [acesso 2014 ago 02]; 17(3): 621-626. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232012000300007&lng=en.
8. Yin RK. Estudo de caso: planejamento e métodos. Grassi D, tradutor. 3 ed. Porto Alegre(RS): Bookman, 2005.
9. Maffesoli M. O conhecimento comum: compêndio de sociologia compreensiva. Tradução de Aluizo Ramos Trinta. São Paulo: Brasiliense, 1988.
10. Maffesoli M. O Tempo das Tribos: o declínio do individualismo nas sociedades de massa. Tradução de Maria de Lourdes Menezes. Rio de Janeiro: Forense-Universitária. 1997.
11. Instituto Brasileiro de Geografia e Estatística (IBGE). Minas Gerais; Divinópolis; Infográficos: Dados gerais do município. 2013; [acesso 2014 ago 12]. Disponível em:http://cidades.ibge.gov.br/xtras/perfil.php?codmun=312230
12. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2011.
13. Viegas SMF. A integralidade no cotidiano da Estratégia Saúde da Família em municípios do Vale do Jequitinhonha-Minas Gerais [tese]. Belo Horizonte: Universidade Federal de Minas Gerais; 2010.
14. Baquero RVA. A situação das Américas: democracia, capital social e empoderamento. Rev. Debates. [periódico na Internet]. 2012; jan-abr [acesso 2014 ago. 12]; 6(1):173-187. Disponível em: http://seer.ufrgs.br/debates/article/viewFile/25918/17096
15. Viegas SMF, Penna CMM. O vínculo como diretriz para a construção da integralidade na Estratégia Saúde da Família. Rev Rene. [periódico na Internet]. 2012; [acesso 2014 set 03]; 13(2):377-87. Disponível em: http://www.revistarene.ufc.br/revista/index.php/revista/article/view/221/pdf
16. Freire P. Educação como prática para a liberdade. 17a Edição, Rio de Janeiro: Paz e Terra, 1986.21
17. Soares MC, Mishima SM, Silva RC, Vargas CR, Meinckes SMK, Corrêa ACL. Câncer de colo uterino: atenção integral à mulher nos serviços de saúde. Rev Gaúcha Enferm. [periódico na Internet]. 2011; set [acesso 2014 set 03]; 32 (3): 502-508. Disponível em: http://seer.ufrgs.br/index.php/RevistaGauchadeEnfermagem/article/view/17626
18. Silva MA, Guareschi PA, Wendt GW. Existe Sujeito em Michel Maffesoli? Psicol USP. [periódico na Internet]. 2010; [acesso 2014 mar 14]; 21(2): 439-455. Disponível em http://www.scielo.br/pdf/pusp/v21n2/v21n2a11.pdf
19. Maffesoli M. Notas sobre a pós-modernidade: o lugar faz o elo. Rio de Janeiro: Atlântica, 2004.
20. Santos AM, Giovanella L, Mendonça MHM, Andrade CLT, Martins MIC, Marcela CS. Práticas assistenciais das Equipes de Saúde da Família em quatro grandes centros rrbanos. Ciênc saúde coletiva. [periódico na Internet]. 2012; out [acesso 2014 set 30]; 17 (10): 2687-2702. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232012001000018&lng=en.
21. Pimentel FC, Albuquerque PC, Martelli PJL, Souza WV, Acioli RML. Caracterização do processo de trabalho das equipes de saúde bucal em municípios de Pernambuco, Brasil, segundo porte populacional: da articulação comunitária à organização do atendimento clínico. Cad Saúde Pública. [periódico na Internet]. 2012; [acesso 2014 set 30]; 28: 146-s157. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2012001300015&lng=en.
22. Viegas SMF, Penna CMM. A construção da integralidade no trabalho cotidiano da equipe saúde da família. Rev Esc Anna Nery (impr.) 2013; jan-mar 17(1):133-141.
23. Coscrato G, Bueno SMV. Concepção de enfermeiros de uma rede pública de saúde sobre educação para a saúde. Rev esc enferm USP. [periódico na Internet]. 2013; [acesso 2014 set 30]; 47(3): 714-721. Disponível em: http://www.scielo.br/pdf/reeusp/v47n3/0080-6234-reeusp-47-3-00714.pdf
24. Moutinho FFB, Campos MG, Jesus PBR. A importância da implementação de ações educativas em vigilância sanitária pelas equipes da estratégia saúde da família: breve revisão. Rev APS. [periódico na Internet]. 2012; abr/jun. [acesso 2014 jul 20] 15(2): 206-213. Disponível em: http://www6.ensp.fiocruz.br/visa/?q=node/5932
25. Jesus MCP, Santos SMR, Amaral AMM, Costa DMN, Aguilar KSM. O discurso do enfermeiro sobre a prática educativa no programa saúde da família em Juiz de Fora, Minas Gerais, Brasil. Rev APS. (impr.) 2008; 11(1): 54-61.
26. Mello GA, Viana ALA. Centros de Saúde: ciência e ideologia na reordenação da saúde pública no século XX. Hist cienc saude-Manguinhos. [periódico na Internet]. 2011; [acesso 2014 fev 12]; 18(4): 1131-1149. Disponível em: Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-59702011000400010&lng=en.
27. Farias SF, Gurgel Jr. GD, Monteiro AC, Lino Lino RB, Rebelo RB. A regulação no setor público de saúde no Brasil: os (des)caminhos da assistência médico-hospitalar. Ciênc saúde coletiva. [periódico na Internet]. 2011; [acesso 2014 set 30]; 16(1):1043-1053. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232011000700037&lng=en.
28. Landsberg GAP, Savassi LCM, Sousa AB, Freitas JMR, Nascimento JLS, Azagra Rl. Análise de demanda em Medicina de Família no Brasil utilizando a Classificação Internacional de Atenção Primária. Ciênc saúde coletiva. [periódico na Internet]. 2012; nov [acesso 2014 set 30]; 17(11):3025-3036. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232012001100019&lng=en.
29. Ferreira M, Dias BM, Mishima SM. Internações por condições sensíveis: possibilidade de avaliação na atenção básica. Rev Eletr Enferm. [periódico na Internet]. 2012; [acesso 2014 set 03]; 14(4):760-770. Disponível em: http://www.fen.ufg.br/fen_revista/v14/n4/pdf/v14n4a03.pdf
30. Machado LM, Colomé JS, Beck CLC. Estratégia de saúde da família e o sistema de referência e de contrareferência: um desafio a ser enfrentado. Rev Enferm UFSM. [periódico na Internet]. 2011; jan/abr. [acesso 2014 ago 30]; 1(1):31-40. Disponível em: http://cascavel.ufsm.br/revistas/ojs-2.2.2/index.php/reufsm/article/view/2337
31. Brasil. Lei no. 8.080. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes, e dá outras providências. Brasília: 19 setembro de 1990; 19 p. Disponível em:http://portal.saude.gov.br/portal/arquivos/pdf/LEI8080.pdf Acesso em 12 de setembro de 2008.

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