ORIGINAL ARTICLE *DOI: 10.4025/cienccuidsaude.v17i3.43568*

CHALLENGES IN THE PROCESS OF REFERRAL OF USERS IN HEALTH CARE NETWORKS: MULTIPROFESSIONAL PERSPECTIVE[1]

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ABSTRACT

The referral and counter-referral system is one of the strategic aspects for consolidating the Unified Health System in order to guarantee the comprehensiveness of care. This is a qualitative study addressing the steps proposed by the reference of phenomenology of perception, based on the work of Merleau-Ponty and Martins, covering three moments: description, reduction and understanding. The objective was to understand the perception of the multiprofessional health team of a referral service and to unveil the challenges present in the referral process. Fifteen professionals of the outpatient clinic of a tertiary-level university hospitalparticipated in the study, including nurses, psychologists, nutritionists, speech therapists and physicians. The analysis of the data pointed to the need to improve the referral process, evidencing difficulties in its implementation which were strongly related to: excess of demand, lack of timeon the part of professionals, and insufficient service of medium complexity. The fragility of communication between the levels of attention causes fragmentation of care with consequent reduced troubleshooting. At the same time, the counter-referral occurs when there is excess demand and shortage of vacant spaces in the tertiary service. We concluded that the non-performance of the counter-referral feeds failures in the health system, impairing the integrality of care. Continuing education of the multiprofessional health team is necessary to improve the process.

Keywords: Referral and consultation. Unified health system. Universal access to health care services. Comprehensive healthcare.

INTRODUCTION

The Unified Health System (SUS), created by Law 8080/1990 and regulated by Decree 7508/2011(1), established health as a right of citizenship, with free accessof the entire Brazilian population to all levels of attention. Its guidelines intended to systematize the functioning of health care services by composing the health care network and defining its entrance doors, in order to regulate the access.

The organization of the referral and counter-referral system is one of the strategic points for the consolidation of the SUS andcomprehensive provision of care with synchronized articulations aimed at reaching a common goal, so as to be perceived by users for its continuous nature(2).

The hierarchical and pyramidal conception must be replaced by health care network (HCNs) where, respecting the differences in terms of technological density, vertical relationships may be broken down so as tocreate horizontal polycentric networks. The singularity is that thecore ofcommunication is placed in the Primary Health Care (PHC),seeking to deepen and establish stable patterns of interrelations, not having lowercomplexity but rather different technological density. The distorted view of complexity at the various levels of the system leads to an overvaluation of practices performed at the secondary and tertiary levels to the detriment of PHC, which is supposed to cover more than 85% of health problems. In this context,expanded clinicsstand out as siteswhere preferentially high complexity technologies areoffered, such as those related to health-relatedbehavioral and lifestyle changes; it is not right to say, therefore, that the complexity of PHC is lower than in the other levels(3).

Health services have a multiplicity of networks interact amongeach other through connections, forming a series of care production lines, representing lines and connections that open up into multiple directions. This structure makes it possible to interconnect all points of health care, allowing varied paths, but also being able to

[1]Extracted from the dissertation, named "THE REFERENCE AND COUNTER-REFERENCE SYSTEM IN THE CONTEXT OF THE MULTIPROFESSIONAL HEALTH TEAM", presented to the Graduate Program in Nursing from the School of Medicine in Botucatu, year 2013.

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cause conflicts in integration and communication between the various levels of attention[4].

In order to effectively implementthe desired organization of networks, it is necessary that the financing logic accompany the logic of the discourse established in health policies, especially those involving health equity. It is not a question of privileging a given level of attention to the detriment of other level, but it is rather about each level be able to count on the necessary resources so that the real carenetwork comes closer tothe idealized health carenetwork.

A single health service is not able to solve all the demands takento it; intersectoral articulations are indispensable, usually in other levels of attention, becauseeach service has a scope of responsibility. These articulation would enable the provision of comprehensive health care. In the context of a network, a service that considers a certain demand unsuitable for its scope of responsibility, this service has the duty to forwardthis patient to another service capable of providingthe necessary care. Within a HCN, there should be complementarity expressed by the continuity of follow-up through access to different interventions, at different times and at different service levels and places[5]. It is also necessary thatthe PHC be articulated with the population, introducing the active participation of the subjects in the process of knowledge and self-care[4].

In addition to the cultural aspects involved and the complexity of the system that encompasses different levels of care, the SUS faces disparities in terms of structure and technological resources that negatively impact the health of the population, as well as underfunding and inefficient personnel recruitment policies. The management of HCNs requires a dynamic look at the possibilities of existing resources and technologies, articulating troubleshooting possibilities in the health of the population[6].

In this context, the question raised was why, fromamultiprofessional perspective, the referral and especiallythe counter-referralprocess are not effective in the health system? The development of this study is justified by the need to complement existing scientific production and support reflectionstocontribute to the articulation ofservices and effective networking. In order to do so, theaim was to apprehend the perception of the multiprofessional health team and unveil the challenges to be overcome in the process of referral ofusers in the SUS.

METHODOLOGY

This is a qualitative study supported by phenomenology having as basic element the perception, consciousness and the subject. Respecting the steps proposed by the referenceof the phenomenology of perception, based on the work of Merleau-Ponty this reference[7], covered three moments: description, reduction and phenomenological understanding. It presents the methodological procedures of ideographic analysisrevealing the significant units of individually transcribed statements, providing a critical and reflexive understanding of the perception of the subjects and the nomothetic analysis, allowing to unveilthe general focus of the phenomenon, seeking convergences, divergences and idiosyncrasies that emerged in the synthesis of the ideographic analyses of the subjects, considering the common points, from which the themes emerged.

The study was carried out in the outpatient clinic of a public university hospital that has 500 beds, an 85% hospitalization rate, providing tertiary care and located in the countryside of the state of São Paulo. The ambulatory has approximately 150 professionals inthe multiprofessional team, besides the team of resident physicians; only 23 professionals were members of the nursing team. The other professionals take turns in the care ininpatient, outpatientand first aid units. The hospital is a reference for 68 municipalities in the region,coversa population of approximately 1,500,000 inhabitants, and receives patients, predominantly SUS users, referred from primary and secondary care or through inter-consultation among specialties, making a daily attendance of about 1000 patients.

Fifteen subjects belonging to the multiprofessional health team working in the referral outpatient clinics were interviewed: 02 nurses, 02 nutritionists, 02 psychologists, 02 dermatology resident physicians (RP), 02 medical clinicRP, 02 gynecology/obstetricsRP, 01 urologyRP, 01pediatric RP, and 01 speech therapist. The time in the institution of these professionals that ranged from 8 months to 23 years.

The motivation for the subjects' choice was to understand the experience of the professionals in the process of referral of users in the outpatient clinic. We start from the universe of professionals who most commonly receive referralsfromthe PHC. The number of interview[15] was delimited based on the principle of theoretical saturation in relation to the objectives, as recommended by the method.

The intentional sample consisted of a formal personal invitation made by the researcher to the key informants. After theiracceptance, the interview was arranged in a convenient place for the interviewee, allowing privacy and anonymity of the information of

the actors. After completing the Informed Consent Term, the interviews were started. The interviews lasted between five and fifteen minutes andwere audio-taped. The statements were transcribed verbatim and any information that could identify the interviewee was suppressed;for this reason the professional category was not identified in the excerpts of the testimonies because the professionals of the categories with low numbers of professionals in the outpatient clinics would be easily identified and this would compromise the secrecy in the research.

Exclusion criteria were: professional on vacations or on leavein the period of collection or resident physicians just starting their activity in the institution.

Data collection, carried out by the researcher, occurred in the months of September to December 2011. To this end, a semi-structured, non-directive interview was used, having as guiding questions: Based on your experience, what do you understand by referral and counter-referral? Studies show that counter-referralis practically non-existent. How do you perceive this problem? To what do you attribute this phenomenon? Would you like to add something on the subject?

It is important to point out that the question aboutcounter-referral was madebecause this study was developed in the context of a research group that studies the topic for approximately 20 years and therefore it was not a question of directing the answer but rather of deepening findings from previous research that indicates that counter-referral is practically non-existent.

The testimonies constituted the region of inquiry to unveil the phenomenon studied. They were numbered from A01 to A15 and the units of meaning were related to the respective thematic categories. The comprehensivenessof care and the theoretical-legal framework of the SUS, as well as phenomenology itself, were used as a reference for analysis.

The study complied with the formal requirements contained in national and international standards for research involving human subjects and was approved by the Research Ethics Committee of the Botucatu Medical School, authorization 3942/2011.

RESULTS

The analysis of the statements and the observationof their convergences resulted infour central themes:

Knowledge aboutthe referraland counter-referral system

Knowledge of the system is extremely important for its realization. It is noteworthy that theory and reality are divergent; knowing the definition of referral and counter-referral does not guarantee its effective realization.

> I think it's a very valid system; it is more for physicians who arein the basic unit than for us. (A09)

> Public health sends it to specialized centers. The referralcomes and the counter-referral we send it to the service sector. It comes with an attachment; it has its own print and the physician or nurse sends it as a referral. The counter-referral we can send the patient as a return of care. For a service to work, the public network receivesthese patients, sends them to the sector of high complexity, that does all the treatment, and we return that patient; it would be something like that. (A03)

Factors contributing to non-performance of counter-referral

The reasons for not doing the counter-referral can be observed and understood as determining factors justified by the reduced number of vacancies in major outpatient clinics and excessive demand, where it is observed that the realization of the counter-referral is forgotten, directly damaging the tertiary system of the region. Associated with this is the lack of time to meet the excessive demand, worsened by the difficulty of accepting the patient to be counter-referred to the municipality of origin.

> The demand for the service, the screening is too large for you to do the counter-referral. You have to write a letter in fact, everything behind the record that was the referral, to send to the service that forwarded the patient and they are many, there's not time to write, there are too many patients. Another thing is laziness too, we got used to that way and it does not change. (A01)

The lack of financial resources for the acquisition of material inputs by the municipalities causes the hospital to absorb patients who could perform their follow-up in other levels of care, resulting in a reduced number of vacancies.

> It is difficult to do the counter-referral because we do not even have security to forwardthe patients and often we have nowhere to refer them. Despite all the changes in health policies, every day you see buses pouring patients. I would very much like to be able to do that. (A12)

Patients' refusal and lack of confidence in following up on the primary care closest to their home contribute to makingpart of the demand to have to be absorbed by the emergency department when it presents some abnormality, favoring informality in access to the system.

> It is hard to ensure thatthe patients will have a good, quality care in their city. Many cities do not have any infrastructure. I think it is very weak. Many of them are treated here in the hospital, in other outpatient clinics and are referred for follow-up and they cannot find a health unit. They think they have to go to the emergency unitand that they have to be taken care of by their physician. (A12)

> I think it is more culture, really; this return of the patients to the basic unit ends up harming the treatment because the patientsthemselves do not accept it. (A10)

Problems with infrastructure, understood as lack of space or technologies, and the absence or insufficient number of some professionals in the primary care also hinder the adherence of the patients.. This professional deficit reverberates and potentiates the shortage of new vacancies offered by the reference clinic, because this clinic will not be able to meet all the necessary demand.

> The structure of the basic units, it is precarious in terms of number of professionals and physical structure, it preventsthe professional to attend a large number of patients. (A10)

Ineffective communication among health teams is evidenced by failure to perform the counter-referral, impairing continuity of treatment. Health teams often fail to explain the conduct performed at the referral center to the primary care physician.

> Sometimes,thisdoes not exist, because we do not talk. It is difficult for you to go back to the person who made the referral, because even the mechanisms within the institution do not facilitatedialogue. (A11)

Informal access to more complex levels is favored by the precarious referral process; patients find ways to circumvent the rules and they remain in the tertiary service without that being a real need.

> The functioning of this system is still very precarious. Patients are referred to another level, yes, but in a very informal way. (A06)

Factors contributing to the realizationof counter-referral

The scarcity of vacancies in the various specialties of the tertiary service causes some professionals to perform the counter-referral process. There is a lack of knowledge about the quality of care provided to patients in primary care; however, the professionals end up doing the referral because it is the only available resource.

Counter-referral is performed when patients have comorbidities that may interfere with scheduled outpatient treatment. This separation between treatment of comorbidities and specialized therapy favors the reduction of the waiting list and causes the patients to return to the service only to evaluate the problem that causedtheir referral. With this, there can be a programming of high-level specialty without being definitively inserted into the tertiary service.

> In the outpatient clinic the counter-referral is done more frequently than in screening. Whenpatients have aclinical comorbidity that interferes with the treatment, we usually make a letter for them to take with them. Sometimes even medical help we write to the physician who accompanies that patient at the health clinic in order to have a closer follow up of these patients. (A02)

The participation of the leader responsible for the guidanceof the multiprofessional teammembers is decisive for the effectiveness of the counter-referral. The professionals, in some moments, end up following what is imposed on them. When there is no such requirement, the counter-referral is not performed.

> I see the counter-referral happens more often in the screening, because there is a teacher who requires thatmore often, and demands that wedo it. (A14)

Importance of the counter-referral

Effective counter-referral favors the reduction of referrals to tertiary service without need or sense, so that the patients do not remainforever as a captive clientele of the institution.

> If we could do the counter-referral, we would reduce the number of patients who are here unnecessarily. (A13)

The follow-up of health treatment at BHUs is extremely important and for this to happen, it isnecessary to know and establish an effective system toguarantee the provision of integral care closer to the patients' residence, with a team that is knowledgeable of the conduct accomplished with the patients.

> It is important for the patients because they will return to another service without having the information of what was done here and when they arrive there they will not be able to move on, in what they would need. It is important that the referral and counter-referral service be well done so that progress can be made in the treatment of patients. (A01)

DISCUSSION

The SUS must provide universal, comprehensiveand equitable access to the entire population[1]. These principles, when worked out in the concept of HCN, promote an improvement in the care and follow-up of treatment provided to patients at any point in the system.

What we observe is that there are a number of factors that lead to the non-realizationof counter-referral. This has impacts, as for example, on the number of new cases offered to primary care because the excess demand in the tertiary service is not solved due to the lack of articulation between the levels of attention.

We noticed that referralof patients from primary care tospecialized care and the mechanisms used for this purpose are known bythe multiprofessional team. However, despite knowing the concepts and roles to be performed at each level of attention, it was evident, as in another study[8], that there are difficulties for users who do not have theircounter-referral fulfilled, leading to losses for the continuity of care.

The phenomenological understanding allowed us to focus on the phenomenon of the process of referral, that is, to "go to the same thing", in a dialectical relationship in synthesis, that is, man is situated in the world, a world that hides and gives itself to his perception. By focusing or "situating" the phenomenon, thisis placed within parentheses, reaching the essence that illuminates and clarifies the world as it presents itself[7].

It is, therefore, urgent to insist on the training of professionals who work or will work in the SUS, in order to perform a care practice that actually follows the precepts of this system[9].

It is a fact that the lack of counter-referral contributes to lower troubleshooting the population's health problems, leading to unnecessary worsening of their conditions. The lack of accountability of the multiprofessional team, besides overloading in the units of greater complexity, compromises the principle of comprehensiveness[9,10].

Another worrying factorthat appears in the speeches finds similarity in the literature: the disparity in the structural conditions of PHC for the clinical practice where the lack of offices, equipment and supplies compromises the attendance and the follow-up of the recommended therapy[9,11]. Furthermore, the absence of professionals, mainly physicians, restricts the provision of consultations in health units and decreases access to diagnostic and treatment actions[12].

On the other hand, the insufficient supply of specialized multiprofessional team entails an increase in the time to obtain careand, often, the quality of the consultation does not correspond to the expectations of the users. There is a work overload and an incessant search of users for services of high complexity[11].

Link between services and respect for the principle of comprehensiveness requires that the network of services of greater and lesser complexity be reorganized. Primary care should be responsible for solving most of the health problems of its users, administrating their flowwithin the system[10,13].

Thus, the perspectiveof the care model - curative, physician-centered and hospital-centered - and the search for fast and resolute care ends up overloading urgency and emergency services. It is common to see emergency units acting as the gateway to the tertiary service. Raising awareness of the population is needed with respect toseeking this type of care[10,14].

The "biomedical model" has influenced professional training, the organization of services and the production of health knowledge, not only in Brazil. This model is associated with the Flexner Report, published in the United States in 1910, which criticized the situation of medical schools in the United States and Canada. Thebiomedical model is prominent in the health field. Movement of critiques to the hegemony of the biomedical model assumed international relevance since the 1970s[15].

Returning to the question of the gateway, the host, as a tool of access and resolubility, favors links and acomprehensive view of users[13,16].

Parallel to this, we can mention the work developed in Canada and Cuba, countries recognized for developing primary health care strategies and emphasizing health promotion. In Canada, primary care physicians establish initial contact with the conventional medical care system, controlling the access to specialists and hospital admissions. In Cuba, where there is a referral and counter-referral system, primary health care is also the gateway to the National Health System. It is observed that these countries have builtpublic systems that have attached great importance to PHC and they structure their services around family care[17].

It is emphasized that comprehensivenessin all levels of attention is ensured in the constitutional principles of both Brazil and Cuba. In the Canadian health system, the principle ofcoverage is related to the clinically necessary care[17].

The unpreparedness concerning networking is evident and points to limitations of management. Investing in multiprofessional care will trigger integrated and troubleshootingactions[18]. Increased funding of SUS would lead to an expansionof the multiprofessional team and improvement of the infrastructure ofunits, with organization of the work process[11].

Precariousness in terms of communication and information impairs the functioning of the referralprocess of the areas involved[8], since besides guiding and indicating to the patients a more complex

care, it is fundamental that the health services provide feedback of the results obtained by establishing a interaction to discuss them, and also plan new care strategies[12].

Adequate communication in networks promotes rationality in care, avoiding duplication of consultations and examinations[9], besides being fundamental in the care process. It may also be considered insufficient considering the conduct used when it brings inconsistencies such as discontinuation of care with consequent harm to patients[19].

We still have to consider that the communication within HCNsrepresents an interchange node in which the flows and counter-flows of the system are coordinated. Its absence interrupts this link, hampering the continuity of careand directly affecting the population, which is the focus of the careoffered[4].

Health workers should not only be involved in the improvement of the system, but alsoview the network as a broader set, with the capacity to guarantee greater articulation among health services with a focus meeting the principle of comprehensiveness.

Information and knowledge must circulate internally and externally through a communication system with adequate technological infrastructure that facilitates dialogue with other spheres, promoting greater integration between the different levels[20].

The fragile integration between thelevels ofattention and low troubleshootingconstrains numerous system actions and guidelines, promoting an form of access that is far from universal. The scope of an ideal interface requires, in addition to the investment of managers, the implementation of articulated actions based on the real health needs of users[8].

FINAL CONSIDERATIONS

It is clear from the data that the multiprofessional team knows the operation and importance of the system of referralof users in the SUS, although they do not practice it in all situations.

The factors contributing to counter-referral, including shortage of positions in the tertiary service and comorbidities,were examined. Despite some facilitating aspects, there were also problems that favored the non-performance of the counter-referral, such as excess of demand, lack of financial resources in primary care, refusal of patients, among others.

The analysis of the testimonies demonstrated the importance of this reflection for the SUS and can contribute forproposals toadvance and improve the care; there is still much to improve. In this sense, the multiprofessional health team has the important role of reducing the communication gap, making clear, effective and consistentreferral of users, so that they donot become victims of a fragmented system.

As limitation, we mention the fact that the study cannot be generalized. Nevertheless, because it was developed in a regional majorcenter, it can represent what occurs in other health regions, with similar characteristics.

Data collected were sufficient to respond to the proposed objectives. It is possible to stimulate future studies and contribute to the understanding of the phenomenon of referral ofusers. Understanding this process is fundamental to meet the principle of comprehensiveness, strengthening the SUS and the implementation of health care networks.

DESAFIOS NO PROCESSO DE REFERENCIAMENTO DE USUÁRIOS NAS REDES DE ATENÇÃO À SAÚDE: PERSPECTIVA MULTIPROFISSIONAL

RESUMO

O sistema de referência e contrarreferência é um dos pontos estratégicos para consolidação do Sistema Único de Saúde, a fim de garantir a integralidade da assistência. Estudo qualitativo respeitando os passos propostos pelo referencial da fenomenologia da percepção, com base na obra de Merleau- Ponty e Martins, abrangendo três momentos: a descrição, a redução e a compreensão. Objetivou apreender a percepção da equipe multiprofissional de saúde de um serviço de referência e desvelar os desafios no processo de referenciamento. Participaram quinze profissionais atuantes no ambulatório de um hospital universitário de nível terciário, dentre eles: enfermeiros, psicólogos, nutricionistas, fonoaudiólogo e médicos. A análise dos dados apontou a necessidade de aprimorar o processo de referenciamento evidenciando dificuldades na sua efetivação, fortemente relacionadas a: excesso de demanda, falta de tempo do profissional, insuficiência de serviço de média complexidade. A fragilidade de comunicação entre os níveis de atenção provoca uma fragmentação da assistência, com consequente diminuição na resolução dos problemas. Paralelamente, a contrarreferência ocorre quando há excesso de demanda e escassez de vagas no serviço terciário. Conclui-se que a não realização da contrarreferência alimenta falhas no sistema de saúde, prejudicando a integralidade da atenção. A educação permanente da equipe multiprofissional de saúde é necessária para a melhoria do processo.

Palavras-chave: Referência e consulta. Sistema único de saúde. Acesso universal aos serviços de saúde. Assistência integral à saúde.

DESAFÍOS EN EL PROCESO DE REFERENCIACIÓN DE USUARIOS EN LAS REDES DE ATENCIÓN A LA SALUD: PERSPECTIVA MULTIPROFESIONAL

RESUMEN

El sistema de referencia y contrarreferencia es uno de los puntos estratégicos para consolidación del Sistema Único de Salud, a fin de garantizar la integralidad de la atención. Estudio cualitativo respetando los pasos propuestos por el referencial de la fenomenología de la percepción, con base en la obra de Merleau-Ponty y Martins, abarcando tres momentos: la descripción, la reducción y la comprensión. El objetivo fue entender la percepción del equipo multiprofesional de salud de un servicio de referencia y aclarar los desafíos en el proceso de referenciación. Participaron quince profesionales actuantes en el ambulatorio de un hospital universitario de nivel terciario, entre estos: enfermeros, psicólogos, nutricionistas, fonoaudiólogo y médicos. El análisis de los datos señaló la necesidad de perfeccionar el proceso de referenciación evidenciando dificultades en su cumplimiento, fuertemente relacionadas a: exceso de demanda, falta de tiempo del profesional, insuficiencia de servicio de media complejidad. La fragilidad de comunicación entre los niveles de atención provoca una fragmentación de la asistencia, con consecuente disminución en la resolución de los problemas. Paralelamente, la contrarreferencia ocurre cuando hay exceso de demanda y escasez de puestos en el servicio terciario. Se concluye que la no realización de la contrarreferencia alimenta fallas en el sistema de salud, perjudicando la integralidad de la atención. La educación permanente del equipo multiprofesional de salud es necesaria para la mejoría del proceso.

Palabras clave: Referencia y consulta. Sistema único de salud. Acceso universal a los servicios de salud. Atención integral en salud.

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Submitted: 03/07/2018
Accepted: 11/09/2018