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Resolution And Continuity Of Primary Health Care: Reference And Counter-Reference In The Sus (Unified Health System)

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Abstract

Objective: Understand the implications of reference and counter-references related to the resolution and continuity of primary health care (PHC).

Methods: This is the Study of Cases of Multiple Holistic qualitative, based on the Comprehensive Sociology of Everyday Life, with the participation of 41 professionals and managers of PHC in the municipality of the State of Minas Gerais, Brazil.

Results: Although the system of reference and counter-reference has the purpose of facilitating the process of (re) forward, which is not the reality of the researched scenarios. Users suffer from a lack of population coverage by the Family Health Strategy, with the lack of consultation quotas for medical specialists and other professionals; of procedures; of tests and medicines; lack of professional commitment and training of professionals in order to work in the Unified Health System (SUS). Scarce resources and poor organization in the system of reference and counter-reference concretize many problems in health care networks in solving the problems in the PHC and accessibility.

Conclusion: Although the SUS dating from the last century and being legislatively speaking quite resolute, still suffers from a lack of resources and inability responding to every demand by municipal services. The implementation of SUS goes beyond the mere extension of quotas, material resources and for diagnostics, infrastructure and human resources. It depends on the paradigm shift: the user as the center of attention in Health.

Keywords: Primary Health Care; Health Strategy; Access to Health Services; regionalization; Patient-Centered Care.

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Introduction

The Unified Health System (SUS) was driven by the Brazilian Sanitary Reform Movement and brings to focus the real need for change across the healthcare biomedical model, which is still present in the health care routine. On the principle of hierarchy of this system, it was proposed a reorganization of Primary Health Care (PHC) and focused on user attention holistically, considering each individual as unique, applying the principles of universality, comprehensiveness and equity in the assistance area [1,2].

The proposed reorganization of PHC showed the need for the creation of the Family Health Strategy (FHS) in 1994, considered essential for the coordination of care with regard to the redemption of the guidelines and principles of universal care practices, full and fair to the collective and individual needs. The FHS is committed to ensuring to the user the constitutional right for access to actions and services at different levels of health care in order to ensure continuity of care in units located closer to people [2,3], and "develop a full attention that impact on health status and autonomy of people and determinants and conditions of community's health" [4,5].

Comprehensiveness implies articulation of actions and network services and requires the correspondence between health care units, the territory and its population. The units of each level of care should be able to solve health problems of a number of people and must be designed to ensure health services with

quality. Thus, the work done by teams of FHS recommends the development of multidisciplinary actions and planned according to the needs of the enrolled population by creating links between the professional and the user to the actual realization of PHC [1-3].

To meet the needs of users at different levels of health care, the Health Care Network (HCN) was structured, setting up an integrated functional network, with coordination of the different actors working in health, proposing action paths and homogeneity to the continuity of care from the user input in the health system, the PHC, up to other levels and services to ensure user access, comprehensive care and directed to the needs of population health. It is emphasized that an isolated care system is not able to solve the user's health needs, requiring the formation of bonds and recognition of the interdependence between the levels of care to health and interdisciplinary of actions to the comprehensiveness care [2,4-5].

So for getting a comprehensive health care and a consequent integration of HCN, it is imperative to establish an effective reference and counter-reference system for routing users to the various levels of care through its needs [6].

Despite advances in the organization of the Brazilian public health system in a way of network, still prevails a fragmentation in care, the non-continuity, which creates demand overload to the system of reference and counter-reference, high cost, inefficiency and not solving the people needs [7].

So what are, in everyday life, the implications of the reference and counter-reference to the resolution and continuity of care in routine of primary health care in the municipality of Minas Gerais, Brazil?

The study aims to understand the implications of reference and counter-reference in the resolution and continuity of care in PHC.

Material and Methods

A qualitative study, outlined by the research strategy of the Study of Multiple Holistic Cases [8], based on the Comprehensive Sociology of everyday life [9].

The study of holistic cases aims to explore, describe or explain behavior in its natural context, collecting data from each individual and providing strategy for analysis, contributing to the understanding of the phenomenon under study in general order [8].This study contains more than one case, being a study of multiple cases in different realities, composed of PHC Traditional Units and FHS Units, on the urban area of the municipality of Divinópolis, Minas Gerais (MG). Each case was studied comprehensively with the specific purpose of presenting the convergences and divergences described by research participants 8, faced with the reality of the scenarios, many for the structure of teams and the daily work, and the visions revealed by the research participants and the total logic fundaments underlying the literal replication. That is, the study allows the generalization of the similar results of multiple holistic cases with realities that are similar to the scenarios of this study [8] .We had as a single unit of analysis [8] "a reference and counter-reference in PHC".

Whereas the individual lives in constant (inter) social relations, Comprehensive Sociology can support theoretically the analysis of the results of the study. This (inter) relationship between individuals and or community [9] is translated and made up in the routine of services and professionals in health care. Thus, in the context of health "we understand the complementarity mechanism which is expressed in the game of the difference [of the (inter) daily relations] and that is the basis of all social structure" [10].

The positivist sociology checks that everything is just in tune with each other in order to discover the different actors involved. However, "the experience is not just a sum of individual situations, but an accumulation of collective data, most of the time not aware, delimiting life in society" [11].

For Comprehensive Sociology in the social context everything makes sense and is what describes what is experienced, as presents Maffesoli [10]: "this permanence in the analysis of society is that same that question and represents certainly is a notable feature."

The scenarios of the research were units of Traditional PHCand FHS units, located in the urban area of the municipality of Divinópolis-MG (230,848 inhabitants). In the municipality are accounted for 47 public health facilities to provide services in 10 Traditional units of PHC, 23 houses of FHS, 01 Polyclinic, 01 Regional Unit for Emergency (UPA), 01 Psychosocial Care Center (PCC), which has Emergency services and Emergency Psychiatry, Psychiatric Clinic and 01 PCC ad III, 07 pharmacies to provide basic medicines, 01 health surveillance unit, 03 auxiliary services for diagnosis and therapy, 03 Specialized health care units with attention from 18: 00h to 22: 00h. It includes the services of 32 teams of the Family Health Strategy Services (FHS). Other private / philanthropic establishments participating in a complementary way to the SUS, including 03 hospitals and 16 specialized services.

To understand the perception of professionals and managers of PHC, reference and counter-reference system in health care, this study had as research participants, professionals working in the FHS teams (doctors, nurses, nursing technicians, health community workers (HCW)), and teams of Traditional PHC units (clinical, pediatrician, obstetrician, psychologist, physical therapists, social workers, dentists, oral health aides assistances , nurses, nursing technicians), as well as the managers of the inserted units research and managers of health of the municipality sectors. It was established a performance of at least one year in the job / position work, as inclusion criteria.

As a source of evidence of the data it was used individual open interviews. The period of data collection occurred from May to September 2014 and for the closing it was adopted the saturation criteria outlined by literal [8] replication of data, the sample was composed of 41 professionals from the FHS and Traditional PHC units.

Data analysis was conducted according to content analysis of theme that exposes the "meanings", according to the phases: "pre-analysis, material exploration, treatment of results, inference and interpretation [12].The study was approved by Opinion CEPES / CCO 522,447 and developed according to the National Council of Health 466/2012, according to regulatory guidelines and standards for research involving human subjects.

Results and Discussion

To weave the system of reference and counter-reference in the context of SUS, they were established commitments and risk criteria in order to establish co-responsible referrals and reducing the difficulty of communication between professionals. A reference and counter-reference form is used in this system to facilitate continuity of care and promoting the pathway of users through the network of most municipalities' services of Brazil.

Implications of the effectiveness of this system can be contextualized in everyday services, professionals that offer references and counter-references, but also for users who are benefited by proper, objective, subjective and problem-solving attention.

Considerations were explicit, by the research participants, about the lack of resources for solving the daily services, the delay in the appointments/tests and assistance when referencing users:

E_9: It is difficult because we find several barriers. Related with people, dealing with people and also the difficulty for having enough resources, which sometimes lack, so it does not let us do right our job. For example, speaking about consultation, some tests are not covered by SUS, some medicine that SUS does not provide, those who rely solely on SUS sometimes stop treatment because they cannot afford it. There are cases coming into the court. A consultation with the ophthalmologist will take around one or two years. Then it gets difficult because we are there with the patient on a daily basis, during the visit, we know, it is the coverage area. Consultation does not happen and some months later, the patient returns with the same complaint to, even the doctor will say: I have already sent you for an appointment with that problem. Did not happen?! "It did not happen. it is already a year later.

E_{11}: I say for patients that specialized consultation takes time to happen. We see that the person is really in need of it, and we cannot do anything. Is a matter of time? it takes a lot to have a resolution of patient problems.

In the interviews, on the two scenarios, the FHS and Traditional PHC units, obstacles for the continuity of care are expressed: working/dealing with users; the lack of SUS coverage in relation to examinations and medicines requested; the delay for marking and assistance of specialized consultations; causing pent-up demand and ongoing user complaints; the lack of accessibility leads users to seek justice for the resolution of cases. All these aspects directly interrupt the continuity of care and necessary treatment which are rights of citizens.

These results are corroborated by the study that emphasizes that population that accesses to PHC faces every day, "the delay in scheduling, the low supply of specialist consultations and laboratory tests in referral centers, as well as the distance between the location of these services and housing of users " [2]. It is evident in the speeches of professionals; the inadequacy of solving the cases of referred users within the municipality of residence, and the use of Treatments out of Home as a strategy:

E_1: Sometimes in surgical cases (users) goes outside the state, of the municipality. So there must be a better design, in my opinion, our constant challenge is decreasing this gap every day.

E_{18}: These intercity, inter-sectorial agreements that the City has to improve something and avoid depending only on the polyclinic.

E_5: There are tests that are not made here and are sent out of here, like treatment out of home", that the Municipal Health orders. Here we miss the orthopedics.

It is observed in the statements, the constant struggle in the user pathway, in order to avoid gaps experienced in the reference system with the obligatory of referring to another municipality, becoming, in some cases, the only choice for the continuity of care. That is, the "lack", where the demand for medical and diagnostic specialties becomes larger than the actual possibility of care in the initial municipality. Professionals question the possibility of decentralization to reference, if there were greater rigor and design of actions to prevent overload in the sectors of the Municipality, in order to meet better and faster the needs of users, which could provide speed and efficiency in the regulation.

The treatment out of home is a benefit defined by Ordinance No. 055 of February 24, 1999 of Brazilian federal government, which aims to provide assistance to patients of the public health network or with an agreement/contract with SUS for care services of another municipality/State, since it is no chance for receiving health treatment in the locality in which the patient resides. It is a program responsible for funding the treatment of patients who have no position to afford their expenses, that is, relying solely on public health network, enabling them to order at the City Hall or the State Department of health where the patient lives, the financial assistance necessary to conduct the treatment health [13].

It was denoted by the research participants, that the illegible letter in and the reference and counter-reference tool can cause serious communication problems between professionals or even damage to the individual served.

E_3: The letter of the physician is unreadable (the reference and counter-reference tool), then sometimes we act in accordance what the patient tells us. The patient says, oh, it was needed to look again at the Health Unit, so it is like that, so vague or even we try to decipher the letter.

E_4: I think it might be more visible the letter of physicians, and write with more details, because the person who will have access, either nurse or doctor, is not required to understand that scrawl. Difficulties for reading, doctors know, but what is written there? I think there must be a little more consideration with another colleague and make a more detailed, specified, with a more legible writing, so I and everyone can pick up and understand.

E_{30}: The counter-references are actually unreadable, you do not read what is written, does not add anything on our daily work, not even for our users. Then when you receive the counter-reference. We had sent this piece of paper here (scribbles on a paper on the table illustrating the illegible handwriting of the doctor) then he does so. then you receive the counter-reference. (Pause and indignation) here this is written. you do not know the exam and what he prescribed.

In everyday life and especially in the reference and counter-reference process, if any, the handwriting used by medical professionals was cited as unreadable and professionals are forced to 'read' what was written. Mostly, actions are taken in front to the user's relates because of the misunderstanding the doctor's letter in the counter-reference. They emphasize that documents are filled loosely without situational user detailing and with poor information, not adding in care in the service.

The literature shows that there are clear shortcomings in the information system and to fill the reference and counter-reference documents, losing the relationship with the patient, a fact that contradicts the principles of SUS [1,5].

About legibly, the Brazilian Federal Law No. 5,991 describes "that will only be send out prescriptions that are legibly and presents readability of prescription which is mandatory since 1973" [14].

Writing illegibly can also be scored for the evolution in medical manuals and made referrals to the continuity of care. The act of illegible writing in addition to infringing a federal law also hurts the Medical Ethics Code which states:

"It is prohibit for health professionals to prescribe, certify or reports issues on secret or illegibly without a proper identification of their registration number in the Regional Council of Medicine of their jurisdiction, as well as sign blank sheets of prescriptions, certificates, reports or any other medical documents" [15]. Inadequate communication directly influences to the quality of care, the interaction between doctor/ staff and users and even with the companion, which underscores the need for better training of doctors in the use of tools for proper communication [16].

The FHS teams and Traditional APS units' teams cite the provision of inadequate physical resources and scarce human resources for assistance and greater resolution support:

E_{27}: Look at this, for seeing our dental office. (refers to infiltrations with mold on the walls and ceiling). The two dentists painted it here (with own resources). And we are without doing the dental extraction, because the Health Surveillance was here and says for not doing anything because it is a source of infection.

E_{8}: There are lack of professionals, lack of infrastructure and human resources organization. Now we have a professional to assist patients with special needs in the municipality. We served what was in our hands, and the rest was not served. The service at SERSAM (Mental Health Services) was closed because we need to work here, this causes a certain overhead.

The precariousness of facilities related to physical infrastructure, size or layout of the rooms, poor ventilation and insufficient materials generate discontent of users and professionals, making the service and the waiting uncomfortable in these environments and interfering with the continuity of care. These factors constitute obstacles, reaching inhuman situations, causing instability in the accessibility of health services [1].

The testimonies of professionals demonstrate concern for the care that you receive and the waiting for solving their problems:

E_{27}: I think that needs to greatly improve the health, care for people, like is done by doctors. Referrals must be scheduled faster because we feel sorry for users, for poor people that are out there. The doctor's care we see how it meets. oh no!? Very sad, oh my goodness (laughs) I would not like to be user! Although with us is different, right? I think we need to have more humility, between doctors with people and with those who work.

E_{28}: A lot of people left, a lot of people waiting, some people are waiting two years and will never be assisted. It can only be assist the one who is asking for too much and we very willingly question for patient: What do you have? Oh, I feel this. but are you taking any medication? You take the role of it and put a note, the patient does this and this, to see if it passes, because the doctor do nothing, nothing in the referral, do you understand?! Then, that does not work.

It is clear, in the interviews, the feeling of 'mercy' in relation to the form of care and precariousness of services offered to users in the public service. There are obvious limitations to the professional experiences related to the power of solving users' problems. These limitations create disbelief in the effectiveness of the system and difficulties in the continuity of care.

The first contact to for users, should be easily accessible, but has not yet been possible to reduce bureaucracy for access to services, generating the low resolution and the postponement of solutions, raising the suffering of population [1].

For not setting up in a flawed system, it is essential joint work and coordination between the levels of complexity and available resources. However, the implementation of SUS as resolving system in a universal, comprehensive and equal attention has been a challenge in the daily life of health services, the obstacles are frequent [17]. The realities studied denote 'holes' in health care networks as the testimonials provided:

E_{14}: Flawed! (exaltation). Flawed, we do not have the whole system (reference and counter-reference) complete, we need some experts that we do not have, then the patient is lost, these same holes in the network integral health care. As the network is broken, then (the reference and counter-reference) does not work.

E_{32}: We suffer here with the lack of jobs, because in the case of endodontic, and other treatment, we have many patients to assist, but the ne-ce-ssi-ty (emphasized the word) is much higher than the number of professionals we have to provide care to large numbers of people.

E_{18}: Some types of tests, procedures, needed to be a little more streamlined. For example, management is more than three months with the X-ray machine spoiled in the polyclinic.

E_{9}: Oh, it is that the demand which is big, I understand that would be the case to increase this quota, promoting, which we does not exist here.

E_{24}: In dentistry, for service work properly, you must have more professionals to secondary care. Then this reference would be faster and the counter-reference too. Lack of ultrasound and professional to do it.

E_{28}: The health system is wonderful on paper, on paper the best

health plan that exist in the world is our system. But in reality it is very far from this wonderful thing. So we have several experts who assist only half of users, we have dietitian who serve a patient per month for each unit, the endocrinologist which is not far from it, we have acupuncture but do not know how many are attended by month.

Several problems constitute the 'holes' in the care network that cause malfunctions or even failure of the system. For the health referral system to be effective it is necessary to decrease the distance and identification of units for providing assistance with proper calculation on the supply over demand [5,18].

Spontaneous excess of demand creates overload work preventing the expansion of the clinic. There is also the flow of excessive demand specialized causing failure and little resoluteness. It is necessary to better know the supply and demand on local health services, with the intention of a rational use of resources, regulation, to a full and equal access [1,2,5,18].

We still experienced a welfare system centered in the cure, emphasizing the complaint, surrounded by fragmentation in work processes and perpetuating isolated actions. [1]

The health is in crisis. "Economic recession, moral or physical disturbance, tense situation in the political or institutional domain. You can multiply at will the settings and fields of application of this mysterious ectoplasm that is the crisis" [19]. "Modern social matrix proves to be increasingly barren. The economy, the social movements, the imaginary, and even politics are suffering the hangover of a tidal wave whose real extent still cannot be evaluated".

In both contexts studied, was present in the statements the lack of interest and political will for improving the system of reference and counter-reference:

E_1: The social control is very important. And encouraging and sharing the ideas, so that people be aware of their rights and seek for them. So when when people get there at the Health Unit, they does not come just only with criticism, but also bring suggestions and participate in an integral way. From my point of view this is fundamental, to unite all social actors, the integration of society, because in Health everything is interdependent. It is not use I only offer that medical consultation, either I just talk, I just do training, I have to sensitize people, I think maybe it pass unnoticed.

E_2: I just wanted that all services have a flow, certain protocols to work, you know? Things to be more standardized to happen in the same way here or there, for the municipality are more organized?! I think that's important. Then the polyclinic sends reference, but the SERSAM does not send the reference, CREAS [Reference Center for Social Assistance Specialized] reference is perfect. They have some medical in polyclinic that only write consultants and also the counter-reference has to be more demanded, more verified because it is important.

E_{23}: I think there is one disregard for the health of Brazil, the health of Brazil is very sick, right? They are very poorly paid, overworked. Health does not vote unfortunately. If this voted I think they were more concerned We had a meeting and were present representatives of the Public Ministry, the City Hall and doctors, when a colleague showed paycheck how much she earned at City Hall, one representative prosecutors said, "Look I'm paying an assistant of mason more than that" (pause). It says it all, does not it? (Pause) How do you do? How are you going to call this professional? How are you going to encourage? How are you going to tease him, in such a situation? Is not difficult? It is so hard!

E_{28}: I think I needed to have enough political will to solve the issues, you know? Because health in this country is bad political will, it is only interest. They only do things when it is their will, why we're in this hole like that. We need new politicians in our region who are aware of what they are doing, because if not I, you and a lot of people who are wanting to work there and do service working properly, we all might get frustrated after all, we will work, work, and work, and then we will realize that it did not help.

Professionals and the population are included in the health process as passive agents, not strengthening health democracy, for not being invited to participate in the political construction through state-debates, and become disposable part in the context of fighting for their rights, and out of reflections and changes in the context of SUS [20].

The policy to Maffesoli [21] became general mistrust object. Throughout human history, there has always been an immaterial force, imagining that provided sustenance to politics. The politician is an instance that, in its strongest sense, determines the social life, limited to, constrains it and allows you to exist.

The policy guidelines and population pent-up demand end reflecting in health work and its organization [22]. In the health sector "to participate in this work is not, of course, useless task", so it is essential that the daily work has allowances to be played [23].

Informants from the FHS teams have pointed out, besides, the lack of professional knowledge and willingness to counter-reference which was observed only in the realities of the FHS teams:

E_{34}: There is often a lack of professional background and good will on the side of professionals. I see often unwillingly, certain laziness, certain lack of knowledge of professionals to look at the patient and counter-reference for us that is.

E_2: I think it's important to counter-reference. You should keep assisting the patient, even though they need of other specialties. Three years ago, things were different, did not return any counter-reference. Now, does counter-reference exist? From Polyclinic it exists. For example, the SERSAM no longer exists, you know? So it exists, but it is fragmented, it happens in certain sectors, in certain services, it is not a standard thing, is not a document that is well filled, you know?

The above testimonies bring the professional neglect for counter-referring properly. Noteworthy is the emphasis on fragmentation of attention, the (im) possibility of continuing the monitoring PHC due to lack of counter-reference. Moreover, expressing the lack of professional knowledge enough to exercise counter-referring function and the lack of a holistic look at the service to users within their specialty.

Some professionals are not responsible for the population's real health problems, where only the basic care is provided without greater interest than cure. This is the result of the biomedical model where it is preferred that the professional is permanently in a room 'serving' the people, without interest of the team to reverse these concepts within the FHS, exemplifying laziness and neglect of professionals to the principles of PHC [24].

The desired for optimal operation of FHS would be that every professional or team seek autonomously ways of solving the problems of their respective areas. However it is hampered by bureaucratic processes, queues, processes and not resolute professionals and precarious referrals of demands to other sectors, preventing the construction of RAS. There is a difficulty of professionals to understand the user flows, the fragmentation of the service and the lack of dialogue between public bodies administration. In conclusion, is not need just a single action for the effectiveness of SUS, "you need to monitor, evaluate, and try it again and always seeking partnership, several times" [24].

Despite questions about the functioning of the SUS and the organization of the system of reference and counter-reference, we found, in the speech of two traditional PHC units professionals, that users have good support and are well attended:

E_{20}: I think users are well assisted. The material comes and we work well. When is needed more material, always the manager makes the request. So I do not know what all that encompasses primary care, but I think users are well served.

E_{22}: We have much here to serve the people, do you see? Within the resources that the City has everything works well. You know, anyone of any level, is entitled here. I think everyone was very pleased with it, within the standards that we can offer. And the SUS is as you say, it has a lot of good things. There is a delay in treatments out of home. But nowadays even in private practice it happens. For scheduling, an test, so I think (pause), to me there is not missing anything.

However, over nearly three decades since the implementation of SUS, it is still noticeable the existence of problems and imbalances in the system, such as lack of material resources, human and physical, and also managers questioning the team and users regarding their operation generating various dissatisfactions and disagreements between workers and users, and the prevalence of the model centered on cure. [20,22]

In Brazil, it is not possible to establish "a strategy that acts in full, at all levels of attention and care lines, integrated and continuously". Since "investments and interventions proposed in the SUS were not enough to meet the population's needs".

We could really achieve a good service and a real resoluteness if there were essential resources available for comprehensive care, a reorganization and co-responsibility of teams and users in front of the most appropriate interventions to the population's needs, so that the health work reached interdisciplinary and make possible the comprehensive care and improvements in quality of care provided [5].

Although the SUS coming from the last century and represent itself as quite resolute legislatively speaking, still suffers from a lack of resources, the delay in the scheduling consultation and examinations, the impossibility of the municipal service meet all the demand and the need to make use of treatment out of home. These are implications for poor solutions in everyday services and interfere with the continuity of people care.

Conclusion

The PHS has as assumptions the universal guarantee of comprehensive health care, the continuity and coordination of care and the act of reference to other levels of care according to the needs of each user and public.

However, after analyzing the research results, it is concluded that, although the system of reference and counter-reference have been set up to facilitate the process of (re) forward, that is not the reality of the scenarios. Research participants live daily with the lack of resources for the resolution and continuity of user care. Users suffer from a lack of population coverage by the FHS, lack of consultation quotas for medical specialists and other professionals; of procedures; examinations and medicines; lack of professional commitment and training of professionals for working in the SUS.

The illegible to fill the reference and counter-reference make difficult the care and solving the problems presented. In addition to the precariousness of physical infrastructure and shortage of material resources for the implementation of actions and procedures, realizing the lack of user accessibility to health and methods of treatment.

Thus, even if they see many problems in the health care network, such as poor organization in the system of reference and counter-reference, in addition to the scarce resources for solving problems in PHC. Informants also point to the need of cooperativeness of the population for demanding their rights, of co-responsibility of the multidisciplinary team of PHC and other levels of care; and of political reorganization to meet the demands for a more effective and decisive working production for health care offered to the population.

The implementation of SUS goes beyond the mere extension of quotas, resources, infrastructure and human resources; It depends on the paradigm shift: the user to be the center of attention in Health.

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