Objective: to analyze the regionalization of the Mobile Emergency Service from the National Emergency Care Policy. Method: it is a descriptive, exploratory and documentary research, with qualitative approach. The research subjects were nurses, nursing technicians and drivers involved in the decentralization. We have used scripts for semi-structured interviews and surveys in documents. We have adopted the thematic content analysis. The study had its research project approved by the Ethics Research Committee, under CAAE nº 0210.0.351.000-12. Results: the regionalization presented operational and political problems; the call center (base) works without medical regulation; the local and regional emergency services network was not structured for the new model and the workers have poor employment links. Conclusion: the regionalization is in the implementation process, thereby requiring the structuring of the emergency care network, according to the policies of the SUS. Descriptors: Emergencies; Regionalization; Health Management; Nursing.

RESUMO
Objetivo: analisar a regionalização do Serviço Móvel de Urgência a partir da Política Nacional de Atendimento às Urgências. Método: pesquisa descritiva, exploratória e documental com abordagem qualitativa. Os sujeitos de pesquisa foram enfermeiros, técnicos de enfermagem e condutores envolvidos na descentralização. Utilizamos roteiros para entrevista semiestruturada e para levantamento em documentos. Adotamos a análise de conteúdos temáticos. O estudo obteve aprovação do seu projeto de pesquisa pelo Comitê de Ética em Pesquisa, sob CAAE nº 0210.0.351.000-12. Resultados: a regionalização apresentou problemas operacionais e políticos; a central (sede) funciona sem regulação médica; a rede locorregional de serviços de urgência não se estruturou para o novo modelo e os trabalhadores possuem vínculos precários. Conclusão: a regionalização se encontra em processo de implantação, demandando assim a estruturação da rede de atendimento às urgências, de acordo com as políticas do SUS. Descriptors: Emergências; Regionalização; Gestão em Saúde; Enfermagem.

RESUMEN
Objetivo: analizar la regionalización del servicio móvil de emergencia de la atención política nacional al servicio de urgencias. Método: investigación descriptiva, exploratoria y documental con enfoque cualitativo. Los temas de investigación eran enfermeras, enfermeros y conductores implicados en la descentralización. Fue utilizada para encuestas y entrevistas semiestruturadas en documentos. Adoptó el análisis de contenido temático. El Comité de ética de investigación aprobado CAAE obtuvo aprobación del proyecto de investigación. 0210.0.351.000-12. Resultados: la regionalización presenta problemas políticos y operacionales; la unidad de control funciona sin control médico; la red regional de servicios de emergencia no está estructurada para la nueva plantilla, y los trabajadores tienen vínculos inseguros. Conclusión: la regionalización está en proceso de implementación, exigiendo la estructuración de la red de servicios al servicio de urgencias de acuerdo con las políticas del SUS. Descriptors: Emergencias; Regionalización; Gestión de la salud; Enfermería.
INTRODUCTION

The organization of public health services in Brazil has undergone significant changes throughout its history. The Brazilian Unified Health System (SUS), resulting from intense struggles coming from the Brazilian Sanitary Reform movement, which were started in the 1970s, emerges as a counter-hegemonic movement towards the health models in use at that time.⁴

The technical and care model of the SUS is usually described by the classical figure of a pyramid, where its base represents a set of health units responsible for the primary care as the gateway to the system. In the middle portion, the secondary care services, such as outpatient services and with diagnostic and therapeutic support are located. And, on the pyramid top, we can find the services of high complexity, being that the quaternary or tertiary hospitals are located in its vertex, whether they are regional, state or, even, national.²

It should be recognized and emphasized that the primary health care has failed to be the main “gateway” to the system, leaving this role to urgency/emergency and outpatient health care services. People, before their needs and taking into account accessibility aspects to several services, as well as the solvability thereof, end up accessing the system where it is better, by contradicting the model in the form of a pyramid.³

Urgency and emergency services routinely suffer an intense pressure arising from the difficulties in accessing other levels of the system, besides the epidemiological transition which is characterized by the population aging coupled with the significant increase of chronic non-communicable conditions that generate acute clinical pictures. Added to that, we see the increased morbidity and mortality from external causes, especially due to traumas, complications arising from the abusive use of alcohol and other drugs, violence and misuse of emergency services and of gateways to high complexity services.⁴·⁶

The emergency services, historically, are targets for some federal government initiatives, through a range of ordinances with sights to strengthen these services, which are idealized in a deductive and strategic manner, among which we could highlight the National Emergency Care Policy (PNAU) and the implementation of Mobile Emergency Services (SAMU) and the principle of integrality in this service.⁷

With the implementation of the PNAU, from the publication of the Ordinance GM/MS n. 2.048/2002, a new scenario is built involving the incorporation of an integral network of emergency care, including fixed and mobile pre-hospital services, as well as the hospital and post-hospital ones.⁸

In Brazil, prioritization of implementation of the SAMU came from the availability of this service for regulating the system with a municipal and regional coverage, duly articulated with other existing centers and their ability to monitor, in a dynamic and systematized way and in real time, all its operation.⁹·¹⁰

The implementation process of the SAMU requires planning of care needs of the population from the available resources for meeting these needs. It demands a critical evaluation of operating policies, skills and competencies of professionals, including the offering of permanent educational programs, and the arrangement of the audience itself in order to prepare it to enjoy the benefits of this service. Another point that should be emphasized is the organization of the network of public health care, with resources to receive the patient whether the care complexity is not within the reach of the degree of resoluteness of the SAMU.⁷

Operationally, it involves a transition in relation to emergency services hitherto prevalent in the reality of the SUS, which are focused on the care conducted in traditional first-aid posts, besides to rescue functions exercised by Military Fire Departments. Another aspect of this trajectory concerns the respect that the PNAU gives to local and regional characteristics and the respect for the human life, given that the results of the implementation of the SAMU are subject to the needs and characteristics of each region.⁹

It is recommended that the services of pre-hospital care are structured in order to improve, qualify and expand the emergency care, by reducing the length of hospital stay and improving the perspectives of rehabilitation.⁷ To that end, the SAMU consists of qualified multidisciplinary teams, arranged in different types of mobile units, which operate under a regulation center, where regulator doctors decide on their purposes, by having their access to activate them through a free and easily accessible telephone dial.⁴·⁸

The PNAU makes a big bet on the regulator doctor and its performance for the organization of the system at stake. The physician regulator has the authority to allocate patients in the system, by communicating its decision to the assistant
The qualitative method is applied to the study of the perceptions and opinions about the researched object, particularly, in investigations of delineated and focused groups and segments, or of social stories from the viewpoint of stakeholders, for analyzing the speeches and documents. The documentation study, in complementarity with the previous ones, appreciates the use of already existing data that are inherent to the researched organization. This type of research might provide data or primary sources about a fact or phenomenon even before its occurrence.

The study participants were intentionally chosen, i.e., those professional who were participants in the implementation process of the SAMU in the Açú Valley: managers, doctors, nurses, nursing technicians and drivers. The used inclusion criterion was acting in the regionalized unity of the SAMU in Açú since its implementation. The exclusion criterion was being in license period for length of service or medical reason.

Initially, we had planned to gather a sample with 10 professionals working in the SAMU from the Açú Valley, separated into two types of sample: managers and professionals. The first would include state and local coordination. Before the political transition at the collection time and attempts by means of telephonic contact and e-mails, they were excluded. The second was composed of six professionals: two nurses, two nursing technicians and two drivers. It should be highlighted that, in addition to the previous exclusion, there was other referring to physicians that, under the same conditions of managers, did not exist in the condition of medical regulation in the above mentioned service base of the SAMU from the Açú Valley.

We have chosen and used two instruments for data collection. The first, a semi-structured interview script to interview the subjects who, free and clearly, could accept to participate in the study; and the second, a script to capture data in documents, with a view to systematizing the search of information made available for collection. The interview is a procedure used in social research for data collection through face to face conversation, methodically, in order to determine the opinions of some people about the facts.

The semi-structured interview script contained five open questions: “How was the participation of workers, including your participation, in the implementation of the SAMU192 Regional of Açú?”; “How would you describe the main advances in the care of the
observed the Code of Ethics for Nursing Professionals. 17,18 The study has obtained approval from the Ethics Research Committee from the Facene/Famene, under the Protocol no 08/12 and CAAE no 0210.0.351.000-12.

We have codified each participant with a fictional code, whose acronyms mean: ES for nurses; TES for nursing technicians and CSS for rescuer drivers; followed by Arabic numerals (Ex.: TES1, ES2, CSS1, etc.)

RESULTS AND DISCUSSION

The expansion of pre-hospital services has significantly increased in recent years, especially by the decentralization of these services for most cities and regions of Brazil. Accordingly, this study compared the operationalization process of the decentralized base of the SAMU in the Açú Valley, with a view to meeting the ministerial recommendations; we have tried to describe, in addition to the steps that made up this process, the major advances and setbacks for the region from the introduction of such a service.

The Brazilian Ministry of Health (MS) defines the mobile and pre-hospital care service as an assignment of the health area linked to a Regulatory Center, with staff and vehicle fleet compatible with the health needs of the population of a municipality or a region, and it might, therefore, extrapolate the municipal boundaries. The region of coverage should be defined by considering demographics, population and territorial aspects, health indicators, provision of services and flows normally used by customers. Moreover, it should rely on the support of the network of health services, properly regulated and available in accordance with hierarchization and regionalization criteria formally agreed among managers of local and regional systems.6

Currently, the mobile and pre-hospital care services are being extended by regionalized decentralization of the care and the settlement among managers. The Municipal organizations effectively participate in the construction of increasingly effective local and regional health services.

The recent implementation process of the SAMU from the Açú Valley is an example of local and regional service proposed by the Inter-municipal Public Health Consortium (COPIS-RN), in order to decentralize the work held by the SAMU from the Rio Grande do Norte State. The COPIS-RN, in 2010, consisted of 132 cities of the Rio Grande do Norte State’s hinterland willing to legitimize this service, being that each prefecture should...
transfer R$0.20 per inhabitant to the COPIS-RN as a cutoff value and other specific adjustments.

The irregularities and dissatisfaction in relation to the COPIS-RN drove the project to the cancellation by the State Attorney’s Office (PGE), which considered it unenforceable within the proposed model and that such a project would not have undergone through the discussion and approval of the State Health Council. Another item that was taken into account to invalidate the project is the size and the state in which the regional hospitals are placed.

According to the article 4º of the Ordinance GM/MS nº 1.864 of the Brazilian Ministry of Health, the payments related to the operating expenses of the SAMU192 should have a shared responsibility, in a tripartite way, among the Union, the State and municipalities, being that the Union is responsible for 50% of the estimated value of these costs, and the remaining should be settled by the Bipartite Inter-Managerial Commission (CIB), among states and municipalities, in accordance with its terms. Everything should be expressed in the projects that will be sent to the MS, including the mechanisms adopted for the transfer of these resources among states and municipalities.

The proposed to extend the services, according to documents from the State Government, has undergone some adjustments in juridical, legal and technical processes for the current implementation. The SAMU from the Açú Valley started its activities with approximately 20 professionals belonging to the twelve benefited municipalities. In addition to the documents data, it was noticeable that the professionals themselves had knowledge of this process and still point to a political aspect in the decision-making process.

The COPIS-RN does not go on, it was not accepted by the current management and there was a consortium with the secretaries to implement the SAMU. Nowadays, we are a team of twelve municipalities, with one representative from each city, but the city of Itajá has two members. (TES2)

The MS establishes, through the Ordinance GM/MS nº 1.864, that the first stage of implementation of the PNAU should comprise, besides the implementation of the SAMU itself, the functionality of the Regulatory Centers (SAMU192 Call Center) and their Emergency Education Centers. Currently, The SAMU from the Açú Valley is deployed without the complete establishment of these pre-hospital and mobile components, as seen in the subjects’ speech, TES1 and ES2, respectively.

[...] We have no regulation 192; we work through cell phones; we don’t have doctors; we have only nurses. (TES1)

We still do not have [Emergency Education Center], but this team has been thought about creating its own team for training [...] (ES2)

Ministerial recommendations require the Regulatory Medical Center as an organizer and advisor component of Urgency and Emergency State Systems, structured at the state, regional and/or municipal levels. They are articulated and related to the various services, by improving the flow of patients in the SUS and generating an opened communication port to the general public, through which the care request are received, evaluated and hierarchized.

The lack of technical and managerial functions of medical regulation of urgency and emergency maximizes the daily prejudices in attendances conducted by the SAMU from the Açú Valley. We could exemplify, in this service, the lack of discerning on the assumed degree of urgency and priority of each case and the failure to link the different levels of care in the system, hence, there are no possible answers to the patients’ needs.

[...] We are still missing the regulator doctor, right? That is the principal at the SAMU. This guides us to do procedures, medications that we do not [...] (TES2)

To assure an effective answer to the specific demands of urgency, the grids of reference, according to the MS, should be sufficiently detailed, by taking into account amounts, types and schedule of offered procedures, as well as the specialty of each service. The local and regional SAMU Call Centers should provide access to users, through the free, public and national phone number 192, which is exclusive to medical emergencies and to health care professionals belonging to any level of the system.

In this context, more broadly, all other health care services should be structured in form of network to meet the demands of a system with a large gateway, such as the case of SAMU. In the Açú Valley region, the strategy of reorganization of emergency services networks has occurred at a slow pace, according to the statements below.

The arrival of the SAMU to our region has brought us a different gaze towards the health, but the city itself still needs to further qualify the professionals who receive these patients that the SAMU carries. (CSS1)

All municipalities are adapting themselves to meet at least in a similar way, right.

Regionalization of the mobile emergency...
Regionalization of the mobile emergency...

from the Açú Valley is fragmented. This fragmentation is described as networks that are organized through a set of isolated points of health care that, in turn, are unable to provide a permanent care to the population.¹⁹

The proposal of the PNAU is expressed when recommending that the different levels of care relate to each other in a complementary way through mechanisms organized and regulated in the reference and counter-reference system, given that it is paramount having the recognition of each service like a part integrating in this system, by hosting and serving, in an adequate way, the portion of demand that searches for it.

The main benchmark for the SAMU192 from the Açú Valley has been the Regional Hospital Nelson Inácio dos Santos (HRNIS) in the city of Açú. It is characterized as a general public hospital of urgency and emergency that provides care of medium complexity to the population of Açú and more 12 agreed municipalities surrounding this city, with population coverage of 130,000 inhabitants, besides to meeting the spontaneous demands of the municipalities that are out of the agreement. It also integrates the II Regional Public Health Unit, based in the city of Mossoró/RN.

Our reference is the Regional Hospital of Açú, but it is still necessary to equip that hospital, even others of smaller size could be an option for when severity is lower, could be useful, but we don’t have yet; the Regional Hospital of Açú always conducts everything. In most occurrences, patients are referred to there, but it still does not work as it should work, since it is a reference for us, there. (ES1) […] We fear much, due to the entrance door, because we need to take the patient to Mossoró, ok. Taking him to Natal, something that is not an issue of the SAMU, but we do all this because this hospital is very poor. (CSS2)

The HRNIS is a benchmark unit for the care of urgencies and emergencies of the types I, II and III, according to the Agreed and Integrated Programming (PPI). This programming is considered relevant in structuring the regionalized and hierarchized network, as well as in organizing services and regulating access. However, the registration in the grids of reference and counter-reference of local and regional emergency plans, ministerially required, demands some prerequisites that still were not met.

Our gateway is the Regional Hospital of Açú, then, often, we get a rough from Itajá or Carnaubais, an example, and we arrive at Açú, so it becomes complicated, it doesn’t solve the need. Fractured arm that is the
Soares FRR, Moura LMS, Soares JD’AD et al.

simplest thing to solve, but it’s an emergency, we don’t have orthopedist, right. A TBI, we don’t have neurologist, we don’t have the tomography scanner in Açu. So, I mean, a digestive complication, we don’t have gastroenterologist, right. Heart problems, we don’t have a cardiologist 24 hours a day. Finally, the gateway, that is to say, the Regional Hospital is still very poor [...] (ES2)

The Ordinance GM n° 2.048 requires that the proof of the hiring of human resources fully meets the legislation in force. Thus, it avoids the precariousness of the employment link in the labor relationships, which, usually, are regulated by the Municipal Governments of the several cities that comprise the region benefited by the service. 20

(...) It was an agreement of municipalities, twelve municipalities that compose the SAMU of the Açu Valley, in which they asked the municipalities to provide skilled people, who were nursing technicians, gazetted and that had a rescuer’s course. And that was an indication of the municipality. (TES1)

Several municipal rearrangements emerge in the hiring (including salary adjustment) and in the delimitation of the weekly working time (at most 30 hours), which force them to seek a wage complementation. As a solution, they resort to the SAMU192 from other municipalities, through other types of employment contracts and jobs in private pre-hospital services. 20

It still misses the partnership of municipalities, many have refused to give a staff to work; the wages need to be improved, because it is a work of great importance, in which professionals put their lives at risk. Not to mention that we get a different type of wage, for example, I am from Carnaubais and I earn less than the drivers from Açu. (CSS2)

It should be inferred that these situations lead to a deterioration of the health care work, in other words, a context in which the workers put themselves in worrisome situations between the life and the death, by dealing with the stresses and risks of their own labor activity in the daily routine, associated with socioeconomic problems and lack of functional isonomy and stability.

**FINAL REMARKS**

This research performed an analysis of the implementation of the SAMU192 from the Açu Valley in light of the National Emergency Care Policy, whose processes of structuring, regulation and hiring of human resources occur at a slow and fragmented rhythm. It should be recognized the limitations of the study, but they do not make it less meaningful, relevant and enlightening on the routine of SAMU192 in associated municipalities of medium and small size.

It should be considered that the regionalization process in force fight against the fragmentation of the provided services and in favor of the warranty and maintenance of the service network for caring of the regional urgencies, which are considered the major challenges and problems for the effective implementation of the SAMU192.

It should be observed that the entrance and exit doors of the urgencies of the Açú Valley and other care units of the region require structural, organizational and professional solutions to meet the demands of care coming from the SAMU, by making them successful before the care system to urgencies. Accordingly, it depends on other components recommended by the PNAU.

The Regional Plan of the Açu Valley was proven, in this study, to be ineffective and disjointed with the State Plan for Emergency Care, due to the lack of regulation centers (Dial 192) of local nature and linked to the national emergency number (192) and the Emergency Education Center recommended by the guidelines contained in the Technical Regulation of Emergencies.

The results found in the reality refer to the deterioration of the work processes and of the use of human resources, given the weakness and variability of the available labor contracts. We recommend the accomplishment of a critical and reflective discussion with the involved managers to overcome the challenges and give the population of the Açú Valley the effective answers to the specificities of the urgent demands.

**REFERENCES**

Regionalization of the mobile emergency...