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THE FAMILY HEALTH SUPPORT UNITS AND THE HEALTHCARE NETWORKS

OS NÚCLEOS DE APOIO À SAÚDE DA FAMÍLIA E AS REDES DE ATENÇÃO À SAÚDE

LOS NÚCLEOS DE APOYO A LA SALUD FAMILIAR Y LAS REDES DE CUIDADO DE LA SALUD

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ABSTRACT

Objective: to analyze some conceptions produced by Family Health Support Centres' (CSFH) teams about their role in the Family Health Strategy and its implication in the process of construction and articulation of the Healthcare Networks. **Method:** a qualitative, exploratory and descriptive study was performed, using analysis of ministerial documents regulating the Centres and semi-structured interviews with 36 professionals and 3 CSFH managers in Campina Grande-PB/Northeast of Brazil. The study was approved by the Ethics Committee of the State University of Paraíba: CAAE-0177.0.133.000-10. **Results:** the NASF enables the expansion of the scope of Family Health actions from two modalities, influencing in the articulation of healthcare networks. **Conclusion:** The various forms of NASF operation are arising from its implantation and direction by healthcare management, having an important role in the consolidation of certain arrangements of Primary Healthcare. **Descriptors:** Family Health Support Centre; Family Health; Primary Healthcare.

RESUMO

Objetivo: analisar algumas concepções produzidas pelas equipes de Núcleos de Apoio à Saúde da Família (NASF) sobre seu papel junto à Estratégia Saúde da Família e sua implicação nos processos de construção e articulação das Redes de Atenção à Saúde. **Método:** realizou-se estudo qualitativo, exploratório e descritivo, por meio de análise dos documentos ministeriais que regulamentam os núcleos e aplicação de entrevistas semi-estruturadas com 36 profissionais e 3 gestores do NASF de Campina Grande-PB/Nordeste do Brasil. O estudo foi aprovado pelo Comitê de Ética da Universidade Estadual da Paraíba sob CAAE-0177.0.133.000-10. **Resultados:** o NASF possibilita a ampliação do escopo das ações da Saúde da Família a partir de duas modalidades, as quais exercem influência sobre a articulação de redes de cuidado. **Conclusão:** as diversas formas de atuação dos NASF são oriundas da implantação e direcionamento desse dispositivo pela gestão, tendo importante papel na consolidação de determinados arranjos da Atenção Básica à Saúde. **Descritores:** Núcleo de Apoio à Saúde da Família; Saúde da Família; Atenção Básica.

RESUMEN

Objetivo: analizar algunas concepciones producidas por los equipos de los Centros de Apoyo a la Salud de la Familia (CASF) sobre su papel en la Estrategia Salud de la Familia y su implicación en el proceso de construcción y articulación de las Redes de Salud. **Método:** Se realizó un estudio cualitativo, exploratorio y descriptivo, mediante análisis de documentos ministeriales que regulan los núcleos y la aplicación de entrevistas semi-estructuradas con 36 profesionales y 3 gestores de CASF en Campina Grande-PB/Nordeste Brasil. El estudio fue aprobado por el Comité de Ética de la Universidad del Estado de Paraíba en CAAE-0177.0.133.000-10. **Resultados:** los CASF permiten la ampliación del alcance de las acciones de salud de la familia a partir de dos modalidades, que tienen influencia en la articulación de la atención. **Conclusión:** las diversas formas de acción de CASF surgen de la implantación de estos dispositivos y la dirección de la gestión, que tiene un papel importante en la consolidación de determinados arreglos de Atención Primaria a la Salud. **Descriptores:** Centro de Apoyo a la Salud de la Familia; Salud de la Familia; Atención Primaria.

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INTRODUCTION

Since the creation of the Unified Health System (UHS) in 1988, the result of struggles and political clashes between the Health Reform Movement and private business groups, there has been a constant attempt to re-orientate healthcare in the country, seeking to organize the sector under a model of health surveillance, with preventive and health promotion actions, in order to obtain comprehensive healthcare.¹

In this sense, the creation of the Family Health Strategy (FHS), in 1994, represented a strategy to achieve this re-orientational assistance, seeking to organize the sector from Primary Healthcare. Thus, the FHS was considered the main “gateway” to the health system, since it was responsible for managing the first contact with the service user.²

However, a difficulty was perceived in operationalizing Primary Healthcare as the system’s main “gateway”, posed by difficult user access to specialized services. This factor led to the proposal of new forms of health services organization, in which the FHS goes from “gateway” to being responsible for the healthcare network coordination and articulation of the different levels of technological density in a given territory, contributing to the formation of comprehensive healthcare networks.³

Various devices have been used to strengthen the FSH in the articulation and ordering of regional healthcare networks, including the Family Health Support Centres (FHSC), implemented in 2008, through Ordinance 154/08, which arise as a new device management of primary healthcare, with the purpose of supporting the FHS, looking to qualify attention and healthcare management within Primary Healthcare.⁴ Therefore, FHSC professionals should be committed to the improvement of the practices developed by the FSH, acting in an interdisciplinary and intersectoral way, so that each health professional, with their specific knowledge, can contribute to solving health problems.

According to Ordinance No. 154/08, is it possible for municipalities to implement FHSC type 1 and 2. The FHSC 1 is comprised of at least 5 professionals with training in different health areas, including: acupuncturists, homeopaths, paediatricians, gynaecologists, psychiatrists, psychologists, social workers, pharmacists, physiotherapists, occupational therapists and physical educators, and connected to a minimum of 8 and maximum

of 20 family healthcare teams. FHSC 2 is composed of at least three different professional categories, differing in relation to the FHSC 1 for not having in its make-up the medical modalities mentioned above, and linked to at least three family healthcare teams.

The FHSCs have been redesigned by the Ministry of Health a few times during their short time of institution, such as the creation of the FHSC type 3, in 2010⁵, and the latest Ordinance No. 2488, in 2011, which besides including veterinarians, workplace doctors, professionals with training in art and education, and sanitary health professionals among the professionals that comprise FHSC, it also eliminated FHSC 3, which automatically became FHSC 2.⁶

This frequent redesign of FHSC’s organizational norms shows its innovative character and its constant adaptation to the demands of Primary Healthcare in the different Brazilian realities.

Understanding that FHSC plays a strategic role in the operation of regional healthcare networks to maximize the FHS in the joining of Healthcare Networks, the aim of this study is to analyze conceptions produced by teams of Family Health Support Centres (FHSC) about their role in the Family Health Strategy and the implication in the process of construction and articulation of Healthcare Networks.

METHOD

An Exploratory and descriptive study with a qualitative approach, with support from the Institutional Program for Scientific Initiation at the State University of Paraíba PIBIC / UEPB, 2010-2011. Campina Grande (PB), Brazil. The location used was the city of Campina Grande, which has nine exclusively type 1 Family Health Support Centre (FHSC) teams with the following professionals: pediatrician, psychologist, social worker, pharmacist, physiotherapist, physical educator, dietitian and speech therapist.

It can be highlighted that by dealing with experiences in a large urban centre, with 92% coverage of the Family Health Strategy (FHS)⁷ and which began FHSC implementation in 2008,⁸ some considerations obtained can be easily applied to other locations in the country.

The study’s data collection was made using the analysis of the principal ministerial documents that deal with FHSC (Ordinance No. 154/08 and the Primary Healthcare Notebooks no. 27 - FHSC Directives) and semi-

structured interviews with two groups of subjects: FHSC professionals and primary healthcare managers. Initially, it was intended that for the group of professionals, the sample was equal to the study's population (54 professionals). However, due to the accessibility and availability of the subjects, it was possible to conduct interviews with only 36 FHSC professionals. With the second group, three primary healthcare managers were interviewed, among which was one in the FHSC co-ordination and two were district managers, also chosen based on the availability of the study subjects.

The key questions that guided the semi-structured interview were formulated from the theory that guided the study, coupled with existing prior information about the FHSC in Campina Grande.⁹ The interview was driven by the search for the understanding of professionals and managers about the work of FHSCs, from the description of their activities and understanding of their role within the family health team.

To analyze the narratives produced in the encounter between researcher and research subject, content analysis was used. This data analysis technique aims to describe message content, which in this case were the conceptions produced by FHSC professionals on their roles alongside the FHS and the construction and articulation of HN.

This study was approved by the Ethics Committee of Paraíba State University under No. CAAE 0177.0.133.000-10, and all subjects were informed about the research design and their free participation by signing the Informed Consent Form.

RESULTS

The role of Family Health Support Centres to strengthen the Family Health Strategy as an articulator of regional healthcare networks is founded in Ordinance No. 154/08, which expresses that the purpose of these centres is to increase the resolution capacity of Basic Healthcare teams, expanding the coverage and scope of their actions, and supporting the inclusion of the FHS in the service network and the regionalization and regionalization process from the Primary Healthcare.⁴

Understanding the scope as the limit and coverage of work processes, through the analysis of interviews with managers and FHSC professionals in Campina Grande, it was seen that their impressions that the role of the FHSC is to broaden the scope of action of primary healthcare, with a view to increasing

their problem-solving capacity, were unanimous.

In this sense, the discussion presented here, and which underlies this study, is based on the conception of scope expansion produced from the action of FHSC and its implication for the structure of the Healthcare Networks (HN).

Understanding the implications produced by the action of FHSC for structuring regional healthcare networks demands discussions that enable understanding the extent to which these centres have been performing the role they are charged with in *expanding the scope* of actions of Primary Healthcare.

In the understanding of professionals and managers interviewed, *expanding the scope* of Primary Healthcare actions has occurred through two strategies that have a tenuous but structuring difference in the building of regional networks of healthcare. The FHSC *broaden scope* by: a) increasing the number of professional staff in Family Health, or b) by expanding the technical capacity of the existing healthcare team.

The first perspective of *expanding the scope* by increasing the number of specialties in Family Health teams was constantly perceived in the comments of FHSC professionals and managers in Campina Grande-PB, which allows to infer that the performance of this management device in this municipality has been exercised primarily in understanding *expanding the scope*, which is based in the increase of the number of actions and services produced, conferring the correct solving health problems in terms of procedures.

In FHSC, we bring secondary attention to primary healthcare, which is what is most interesting, hence the greater bond with our teams, with professionals to discuss clinical cases and thus give further strength to seeing the individual as a whole being (FHSC Manager 2). [Emphasis added]

The [FHSC] matrix organization wasn't created to substitute or to take anyone's place. It was created to add. So this matrix was created so there is a greater link between the units. It was created to add in the sense that the units can feel more empowered and can find support in FHSC for the needs that communities seek. For this are there more doctors, more social workers, more physiotherapists, more pharmacists, nutritionists, physical educators and speech therapists (FHSC Manager 1). [Emphasis added].

Logically, by increasing the number of specialists available in Primary Healthcare,

FHSC professionals begin to demand physical spaces for performing outpatient procedures, signaling their focus on meeting demands and not in the reorganization of work processes.

As much as in implementation, there is currently a lack of physical space for us. So the units are small, they're a bit crowded. And when we have to attend, advise, we need a doctor or nurse to prepare a room, there isn't a place for us to give a talk (FHSC Professional 25).

This understanding of the problem-solving capacity of Primary Healthcare seems to also justify that the FHSC professionals perform outpatient attending in the Basic Family Healthcare Units (BFHU), whether by spontaneous demand or from referrals by the healthcare team, and that they also refer patients, either to the FHS health team, to other FHSC professionals or to other services of different technological density.

We talk, evaluate the patient, refer to a doctor. If they haven't been to the doctor, refer them to the doctor. Then she refers them to us, physiotherapists, then we evaluate and request exams. (FHSC Professional 21).

We provide support to the PSF and we have the reference team, which will supports us. The cases that we can not solve, we refer to our reference team and are always in contact with them to try to resolve that case (FHSC Professional 7). [Emphasis added]

When included in the working process of Primary Healthcare as an additional specialty service available in the healthcare network, FHSC further reinforces the traditional model of technified specialized and fragmented healthcare that prevents the integrality of attention, presupposing the building of multidisciplinary teams to the detriment of interdisciplinary work.

I never had work with ACS [Community Health Care], I deal with a normal demand. For anything, I will meet their need. There are some things that do not relate to the social service professional and in the same conversation I say: look, it's not my area (FHSC Professional 2). [Emphasis added]

Regarding teamwork in Primary Healthcare, there are family health teams that must work in a horizontal and flexible way in order to ensure greater autonomy, creativity and integration for those involved in the healthcare. Furthermore, it is argued that the goal of teamwork is to influence the factors that affect the health-disease process¹¹, and when this occurs in an interdisciplinary manner, it offers

professionals the opportunity to rebuild or redirect their practices by working with others, seeking to change the current situation with a view to healthcare integrality.

Understanding these two conceptions of expanding the scope of the Primary Healthcare actions of FHSC implies understanding the role of FHSC for the articulation of regional healthcare networks, identifying the potential of this management tool for structuring Healthcare Networks.

DISCUSSION

Considering the pyramidal model of healthcare has been insufficient in ensuring integrality in healthcare and the need for a new organizational model that allows the user to move along the different technological services without major problems, in 2010 the Ministry of Health published Ordinance No. 4279/10, which outlines the construction of the Healthcare Networks (HN), defined as "organizational arrangements of actions and health services, of different technological densities, integrated through technical, logistical and management support systems, to ensure comprehensive healthcare".¹²

According to Ordinance No. 2488/11, which regulates Primary Healthcare, the FHS is no longer the only gateway to the health system, assuming the coordination centre and articulation of different HN healthcare attention points, organizing horizontal and no longer hierarchical relationships, as what happened with the organization of services in a pyramidal shape.⁶

Decree No. 7508/11, to regulate Organic Health Law No. 8080/90, ratified that Healthcare Networks have as entry points, in addition to Primary Healthcare, attention to urgency and emergency, psychosocial attention and free specialized services, enabling the creation of new gateways characteristic of the Health Regions.¹³

FHSC can be considered a management device which, acting in a shared manner with the FHS, becomes an important element in the HN structuring. However, the two conceptions of expanding the scope of actions of Primary Healthcare produce distinct results for the construction of these networks, sometimes driving and facilitating their structuring, sometimes preventing them.

By expanding the scope through increasing the number of specialists, FHSC conforms to the sense of family medicine imposed by some countries, which corresponds to the implementation of specialized services in

primary healthcare.¹⁴ Furthermore, in this perspective, FHSC seems to assume responsibility for the care of the users, creating a bond with them, allowing the emergence of tensions between the professional practice of FHSC and theory that regulates the work of this management device, which says the FHSC must share health practices with the FHS in the territories under the responsibility of the latter.⁴

Moreover, in exercising specialized activity in the FHS, the FHSC professional assumes the role of “gateway” as being the user’s first contact with the health system, in opposition to Ordinance No. 154/08, which states that this device management does not represent a gateway to the services network.⁴

In this light, seeing themselves as members of the family health team, FHSC professionals allow themselves to work with the same tools as FHS professionals, for example in referrals, although Ordinance No. 154/08 states that FHSC, alongside FHS, must review such practices so that the organization of HN services makes the referral and counter-referral system obsolete, by working with shared healthcare.¹⁵

In opting for the logic of supply procedures, FHSC still does not seem to be concerned with the work process and organization of flows discussions, focusing its activities on the demands for specialized healthcare.

Based on the understanding of *expanding the scope* as an increase in available professionals in Primary Healthcare, FHSC seems to reinforce the fragmentation of FHS’s work, making it difficult to offer longitudinal and continuous healthcare, as is expected from the FHS.¹⁵

Accordingly, from a specialization perspective, it can be seen that FHSC, which should act with a view to overcoming the fragmented health rationale for the construction of HN, which, according to Decree No. 4279/10, is a mechanism for overcoming systemic fragmentation¹², ends up strengthening this model focused on specialties and fragmentation, while avoiding being part of the work process discussion, acting only as one more specialization in Family Health.

Understanding FHSC as an increase in the number of FHS specialties also seems to break with the logic of expanded clinics, since strengthening the procedure-centred model makes interdisciplinary work difficult. The fragmentation of healthcare, strengthened by

the logic of specialization, hinders collective responsibility and, therefore, breaks with the HN proposal.

The FHSC in Campina Grande, operating in specialties and supply procedures, seems not to have generated consequences for the structure of the HN, and on the other hand, has helped to strengthen the disjointed organizational model of activities and services. This trend enables the FHS to remain with difficulties in performing its function of articulating regional healthcare networks, and users are still finding it difficult to pass through the different levels of technological densities according to their needs, as prescribed in the HN construction.

Understanding that *expanding the scope* is an increase in the technical capacity of the existing family health team, the role of the FHSC becomes offering the support matrix with backup healthcare and technical-pedagogical support to the FHS, understanding that the support matrix implies the construction of clinical and sanitary guidelines for referral and specialized teams.¹⁶

The reference team - in this case, the family health teams - should be responsible for the longitudinal accompaniment of an individual, family or community, with the goal of creating links between professionals and users, and being responsible for the treatment of cases even when specialized support is implemented.¹⁶

In this perspective of expanding the scope, supporting the reference team implies offering continuing education, seeking to facilitate work processes that enable co-management and co-responsibility of healthcare, the interdisciplinary nature of the team and broadening of treatment.¹⁵

Continuing education in this way relies on the uniqueness of the work processes and healthcare production, introducing mechanisms, areas and themes that enable questioning and experimentation of health practices.¹⁷

In addition, health education seeks to ensure equal opportunities, as well as empower users so that they become able to manage and take responsibility for their own health.¹⁹

In this way, the support matrix can lead to the production of new practical knowledge and operate the collective management of healthcare processes, in which different actors contribute to the formation of a more committed and participatory treatment, as well as enhancing the therapeutic actions,

enabling a process of reorientation for the interdisciplinary teamwork.

Expanding clinical management is proposed, which means going beyond the practice based solely on regularity and predictability, giving equal attention to the particularities of cases and the unpredictability of their treatment process.²⁰ Therefore, professionals are required to work communicatively and in an interdisciplinary way, or in other words, supported in co-management.

Under shared management, initial discussions between the different actors in the healthcare process on the factors that concern each of them must be emphasized, enabling the emergence of strategies agreed upon by team members and by the team and the users.¹⁶

The support matrix also exists to support the FHS in the operation of their working tools, contributing to the construction of Therapeutic Singular Projects (TSP), which consist of establishing articulated therapy arising from the collective discussions of an interdisciplinary team,²⁰ and Regional Health Projects (RHP), which are implicated in the reach of the health region, with the identification of risk/vulnerable areas, as well as their environmental and socio-cultural potentials, to build integrated health actions.²¹

From this conception of matrix support, FHSC should support FHS in making the regionalization of healthcare real, with understanding the territory not only of as a geographical space, but as a living space, in which relationships, feelings, ways of living and promote health and/or disease are produced.²²

With the prospect of *expanding the scope* through the technical training of the existing team, the design of the FHSC support matrix and its implementation along these lines are consistent with the HN proposal, insofar as they aim for shared work and co-managing actions. FHSC's role is more a strengthening element for the HN in order to ensure maximum resolution in Primary Healthcare, as they share the actions and decisions, supporting FHS in the articulation of access to higher-technological services.

Collectively, FHSC and FHS are organized to obtain programs and services targeted to specific population and are formed from the articulation between different services available in the regions. Therefore, FHSC has more power in its role of strengthening HN, through expanding the technical capacity of

the existing team, assisting FHS in the operation and expansion of their work (TSP, TSP Clinic Management, teamwork, bonding).

Thus, the proposed support matrix implies operationalizing HN, considering that FHSC, working from this perspective, contributes to the reorganization of the FHS's work process, allowing it to play its role as coordinator of the healthcare network, with a view to the integrality and continuity of healthcare, working from a new model of organization of attention to health.

From the exposure of these two understandings about *expanding the scope* of FHS actions, it is noteworthy that both lead to increased resolution, but under different logics. FHSC, as an expansion of the team, increases the resolution by increasing the number of procedures; FHSC by increasing the technical expertise of existing staff increases resolution, to provide the team with basic strategies to reorganize work processes with a view to the qualification of healthcare.

FINAL REMARKS

It can be understood that the implementation of Family Health Support Centres in Brazilian municipalities from 2008, represented the possibility of reorganizing the work process in Basic Healthcare and restructuring the very organization of healthcare, with a view that the Family Health Strategy has faced difficulties in coordinating healthcare and articulating the assistance technological densities levels.

The intent is not to show how correct one or another form of understanding *expanding the scope* produced from the performance of FHSC professionals, but rather identify the consequences of these processes to the structuring of the Healthcare Networks.

Taking as reference the experiences in the city of Campina Grande-PB, highlighted are the weakness in the regulation of FHSC, represented by the performances of different professionals and managers who have directly reflected on the (un) structuring or Healthcare Networks in the municipality, which may represent a major obstacle to the effectiveness of FHSC, and consequently the organization of Primary Healthcare.

Finally, the importance of the FHSC format is clear as it has been established and implemented in the country, by becoming management devices in changing the healthcare model, are directly implicated in healthcare, teamwork, the use of technology and the organization of the service network, and the locally defined direction strongly

represents what is desired or not in this change.

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