Emergency and Urgent Health Care Network on scene: contingencies and production of care

A Rede de Atenção às Urgências e Emergências em cena: contingências e produção de cuidado

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ABSTRACT This study aims to analyze the possible transformations in health care management and production processes, in the context of practice, based on the Emergency and Urgent Health Care Network (RUE) policy. The research has a qualitative character and is characterized as a case study. Interviews were conducted with 16 health service managers in four municipalities of different population sizes. The material was analyzed with reference to the context of the Public Policy Cycle Approach practice. It is observed that the RUE is not recognized as a public policy, although some of its elements are identified, such as the implementation of Emergency Care Units, protocols, risk classification, new care technologies, regulatory arrangements, and lines of care. Looking at the 'RUE on scene' mainly points to three issues: the relationship between primary care and emergency doors in meeting spontaneous demand; the medical regulation of Mobile Emergency Care Service (SAMU), as a promoter of access and quality; and the (dis)continuity in health care. There is evidence of live movements and productions induced by the policy that qualify health care in urgent and emergency situations. However, inequities are maintained or produced, and the need for articulation between network components, although evoked, translates into fragile and non-regular connections.

KEYWORDS Delivery of health care. Emergency medical services. Health policy. Health management. Health systems.

RESUMO *Este estudo tem por objetivo analisar as transformações nos processos de gestão e produção do cuidado em saúde, no contexto da prática, a partir da política da Rede de Atenção às Urgências e Emergências (RUE). A pesquisa tem caráter qualitativo e caracteriza-se como estudo de caso. Foram realizadas entrevistas com 16 gerentes de serviços de saúde em três municípios de diferentes portes populacionais. O material foi analisado tendo como referência o contexto da prática da Abordagem do Ciclo de Políticas. Observa-se que a RUE não é reconhecida enquanto política pública, embora sejam identificados alguns de seus elementos, como a implantação de Unidades de Pronto Atendimento, protocolos, classificação de risco, novas tecnologias assistenciais, arranjos regulatórios e linhas de cuidado. O olhar para a 'RUE em cena' aponta para três questões: a relação entre a atenção básica e as portas de urgência no atendimento à demanda espontânea; a regulação médica do Serviço de Atendimento Móvel de Urgência (Samu), enquanto promotora de acesso e qualidade; e a (des)continuidade no cuidado em saúde. Há evidências de movimentos e produções vivas induzidas pela política que qualificam o cuidado em saúde em situações de urgência e emergência. Entretanto, iniquidades são mantidas ou produzidas, e a necessidade de articulação entre os componentes em rede, embora evocada, traduz-se em conexões frágeis e não regulares.*

PALAVRAS-CHAVE *Atenção à saúde. Serviços médicos de emergência. Política de saúde. Gestão em saúde. Sistemas de saúde.*

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Introduction

Emergency care is fundamental in universal and integral health systems, such as the Brazilian National Health System (SUS). The intensive use of these services, as a result of demographic and epidemiological changes, as well as the growth of accidents and violence, have imposed the need to restructure health systems in many countries[1]. Even low-and middle-income nations have invested in re-organizing emergency services in search of best results[2].

In Brazil, the attention to emergencies is presented as a priority agenda, given the magnitude of the problems and the need for intervention to improve care[3]. The history of emergency care policy in the SUS was subdivided by O'Dwyer et al.[4] in three stages: initial regulation, implementation of the Mobile Emergency Care Service (SAMU) and implementation of the Emergency Care Units (UPA). In 2011, the Ministry of Health proposed a policy for the construction of thematic networks, among which it regulated the Emergency and Urgent Health Care Network (RUE)[5]. RUE was formulated, as a more general organizational process, under the influence of the Health Care Networks (HNS) model[6], as an alternative to the fragmentation of health systems, especially in countries where chronic conditions and conditions predominate[7]. The conceptual model of the RAS proposes a polyarchic network, with centrality of primary care and regional organization[6], which, in the case of RUE, aims to articulate and integrate all health services, to expand and qualify humanized and integral access in urgent and emergency situations in an agile and timely manner[5].

The SUS has provided expansion of public services in Brazil; however, historical and structural limits, institutional legacies and project disputes have influenced the national health policy[8]. In addition, the estrangement and externality of managers with the micropolitical space are translated into policy implementation practices that seek to normalize and control such territory, disregarding that official policies are reprocessed, acquiring new designs not always planned by the formulators[9].

Recognizing the importance of the policy formulation and implementation process, the present study intends to deepen the reflection on the following questions: which transformations in the care of urgent and emergency situations were induced by RUE? Has there been a change in the guarantee of access and integrality? This study seeks to analyze the possible transformations in the processes of management and production of health care in the context of practice, that is, from the RUE policy, staged by actors who operationalize it.

Material and methods

The research has a qualitative character and is characterized as a case study[10]. It was developed in a health region chosen because it was one of the first in the state of São Paulo to have the RUE plan approved in 2012. We conducted interviews with sixteen managers of services that make up the RUE – Basic Health Units (UBS), UPA, SAMU, hospitals and home care – in three municipalities (a small, a medium, and a large one), whose identities were coded to guarantee confidentiality and anonymity (*table 1*). The interviewees were indicated by the managers following the criterion of exercising the management of direct assistance services to the population. The health service manager is considered, in this study, as a professional who performs a complex and multiple activity, whose reports can help to make visible the micropolitical processes of production of management, work and health care.

Table 1. Respondents by RUE point of attention and position/function. 2019-2020

Respondent	RUE point of attention	Position/Function
G1C	Basic Health Unit (UBS)	Coordinator
G2C	Municipal SAMU	Director
G3C	Municipal SAMU	Coordinator
G4C	UPA	Administrative Coordinator
G5C	UPA	Manager
G6C	Municipal Hospital	Director of the Emergency Room
G7C	Home Care Service	Technical Nurse
G1H	Basic Health Unit (UBS)	Manager
G2H	UPA	Manager
G3H	Regional Samu	Coordinator
G1S	Basic Health Unit (UBS)	Manager
G2S	Home Care Service	Manager
G3S	Philanthropic Hospital	Technical Nurse
G1E	State University Hospital	Emergency Unit Coordinator
G2E	Regional State Hospital	Emergency Coordinator
G3E	Regional Regulation Center	Project Coordinator

Source: Own elaboration.

The interviews took an average of forty minutes and were conducted in the workplaces, previously scheduled, upon agreement to participate in the research and signing of the Informed Consent Form. There were no refusals. We used a semi-structured script and previously collected scenes, from narratives of users of the RUE, in three lines of care: cerebrovascular (strokes), trauma and cardiovascular (Acute Myocardial Infarction – AMI)[5]. The reading and reflection on the scenes had the objective of being a 'trigger' for the interviews, whose dialogues were then complemented by the questions foreseen in the script. The content was recorded and transcribed in full. The results were codified and organized considering the RUE guidelines, provided in *table 2*.

Table 2. Guidelines of the Emergency Care Network (Brazil, 2011)

I - expansion of access and reception of acute cases demanded to health services at all points of care, contemplating the risk classification and adequate and necessary intervention to the different diseases.

II - guarantee of universality, equity and integrality in the care of clinical, surgical, gyneco-obstetric, psychiatric, pediatric emergencies and those related to external causes (trauma, violence and accidents).

III - regionalization of emergency care with articulation of the various care networks and regulated access to health services.

IV - humanization of care ensuring the effectiveness of a user-centered model based on their health needs.

V - guarantee of implementation of a multiprofessional care model, shared by teamwork, established through clinical care practices and based on the management of lines of care.

Table 2. (cont.)

VI - articulation and integration of the various health services and equipment, constituting health networks with connectivity between the different points of care.

VII - territorial action, definition and organization of health regions and care networks based on the health needs of these populations, their specific risks and vulnerabilities.

VIII - professional and managerial performance aimed at improving the quality of care through the development of coordinated, continuous actions that seek the integrality and longitudinality of health care.

IX - monitoring and evaluation of the quality of services through performance indicators that investigate the effectiveness and resoluteness of care.

X - interfederative articulation between the various managers, developing solidarity, responsible and shared action.

XI - participation and social control of users over the services.

XII - promotion, coordination and execution of strategic projects to meet collective health needs, of urgent and transitory nature, resulting from situations of imminent danger, public calamities and accidents with multiple victims, from the construction of regional and local risk maps and the adoption of protocols for prevention, attention and mitigation of events.

XIII - articulated regulation between all components of the Emergency Care Network, guaranteeing equity and integrality of care.

XIV - qualification of care through permanent education of SUS health teams in emergency care, in accordance with the principles of integrality and humanization.

Source: Own elaboration.

The empirical material was analyzed with reference to the Public Policy Cycle Approach, proposed by Ball[11], for whom a policy is always text and discourse. The Policy Cycle Approach[12] proposes that policy analysis is carried out from contexts – of influence, text production and practice – that are interrelated, do not have a temporal dimension and are not linear stages (*figure 1*). In this study, we worked with the context of practice, represented by health services, where policy is subject to interpretation and is staged in arenas constituted by actors who recreate it with their stories and values[13]. The discussion was mediated by the guiding questions proposed by Mainardes[12] for this context and guided by identified analytical questions.

Figure 1. Policy Cycle Approach
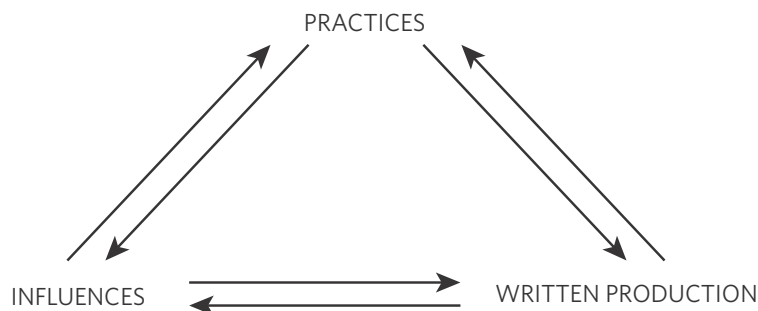
Source: Own elaboration.

The study project was funded by the National Council for Scientific and Technological Development (CNPq) and followed all ethical standards, according to Resolution No. 466/2012 of the National Health Council, being approved by the Research Ethics Committee through opinion 2,447,067/2017.

Results

RUE is not recognized as a national health policy and as a milestone of change by respondents. Some managers report not having participated in its implementation since 2012, even though they were coordinators or assistants: *"I can hardly say anything [...] I did not participate, as far as I can remember"* (G1C).

Some interviewees identify elements of RUE in their practices in management and health care:

> There was the implementation of the other UPAs at that time. (G1H).

> I can't remember that time, but there were many changes, the implementation of protocols, risk classification. (G2H).

In a specific situation, observed in one municipality, the RUE policy is taken by local actions of administrative reorganization of services: *"It changed a lot with the approach of* [municipal authority] *with the Emergency Network. That's what we felt the most"* (G1C).

The reports collected dialogue with the guidelines of RUE[5], in particular: access, integrality, articulation, territorial planning, quality, interfederative articulation and regulation. The following are elements that help analyze some guidelines and objectives proposed by the policy in the context of practice.

Access

The expansion of access is identified by the arrangements and devices implemented in the

services. In primary care, reception emerges as a materialization of the response to spontaneous demand: *"We have reception during the time in which unit is open. There's also the flows. Patients come by spontaneous demand, and we insert them"* (GC1).

The risk classification protocol is cited as a qualification of emergency doors:

> It is based in the Manchester one [...] we receive patients and do not know what they have. Maybe it's a heart attack, and we can't wait. So, the nurse evaluates, and puts the patient inside. (G2H).

Hospital access, especially for regional references, is carried out by many routes, official or not. In this flow, the SAMU is considered a facilitating element, a 'shortcut' that dispenses with state regulation, which is given by the Central Regulation of Health Service Offerings (Cross): *"Another way to come is direct via SAMU [...] to skip the Cross step"* (G2E).

Integrality

Regarding integrality, the reports refer to specific lines of care. In the case of trauma, the question that arises is not that of immediate care, but of the continuity of post-hospital care: *"while patients are hospitalized, they are receiving treatment, but then what? What about continuity?"* (G2E).

Regarding the AMI care line, access to hemodynamic procedures stands out as a major problem in the region:

> The issue of the AMI of our city is a shame [...] you have no 'patron' for hemodynamics [...] the guy has a heart attack, comes to the UPA, and stays for three days. He leaves with note to schedule the catheterization months later! (G3C).

Articulation

The service network that make up the RUE is present in the reports and makes

it possible to analyze their articulations and disconnections (*table 3*). SAMU, whenever existing, appears as a component with greater network articulations. Hospitals and UPAs present an 'insulation' in the territories, whose necessary connections demanded by primary and home care are not always viable.

Table 3. Reports of articulations and disconnections between RUE's points of attention

Components	UBS	Samu 192	UPA 24h	Hospital	Home Care
UBS	x	*"If it is an emergency service, we have to call SAMU. Then we refer the case to Samu, because today we don't care about the service, we care about SAMU". G1H* *"The team arrived to make the home visit, it was a nephropathic pregnant woman, which they were worried about. When they arrived, she was completely edematous and hypertensive, already with signs of kidney failure, and then we called SAMU". G1C*	*"this flow, this connection, is not cool yet [...] They do not communicate with us. The patient who goes to the UPA every week because of peak pressure, should have been reported to us. Even if they refer this patient to us and he doesn't come, they need to communicate to us that this patient is going there frequently". G1H* *"We get a lot from there to here, and we really see a change. Before it was a very informal referral (...) today we have the computerized system and can already see the history of the patient who goes there [...] we are even doing work within the emergency department to identify the personnel who should be in primary care and are looking for emergency care". G1S*	*"patients who leave the hospital are sent to UBS without any opinion. So, we end up not knowing what happened, what medicine he took, what happened, what kind of alteration he had, and this complicates a lot [... what I think is wrong today are these counter-referrals...] If I don't look for this patient, what they did there, I don't know how he evolved, if he was transferred to another hospital". GH1* *"With hospitals, we already have a lot of difficulty. We always had it [...] with the hospital, we have very little articulation or dialogue". GC1*	*"Yes, these articulations happen quite a lot. [...] Sometimes, the SAD sends an e-mail, we find out via SAD; sometimes, the hospital, sometimes they already articulate the two things together. [...] it's case by case, we don't have anything systematic, organized for the case discussion meeting, but it's not a difficult conversation". G1C* *"We register via the system, but there is a separate form that is filled out according to the doctor's assessment [...] the team makes evaluation, visits the house, and verifies if it really is with the SAD criteria or not. If it is, they receive it, and if it is not, it returns to the unit directing a possible treatment". G1S*
Samu 192	*"they arrive there in the basic unit, the nurse has difficulty doing electro [...] there, the doctor looks, he begins anamnesis on the patient, but... you don't know how to work with that". G2C* *"UBS takes a little more work because it needs to close, and the doctor needs to leave". G3C*	x	*"Connected, that's how I say it, we have a very great proximity. So I know what's going on in a 24-hour UPA. It's much more finely tuned". G2C*	*"I think this way: we know that the tertiary are all "exploding", but we have to try, right? Sometimes I have patients with low or medium complexity that I don't need to take to a tertiary hospital". G3C* *"we're not having much of a problem. More serious cases, we can also direct to the state". G3H*	*"It demands a little. Do you want to know what demands more? It's in death. For the doctor to go, make the finding [...] the home service went there, received the patient, and needs to take it somewhere, and we go there". G2C*

Table. (cont.)

Components	UBS	Samu 192	UPA 24h	Hospital	Home Care
UPA 24h	*"We have health centers nearby. We try to support each other, but the interaction is not... [...] when we give patients discharges, we give them a referral to the Health Center as well so that they can follow up [...] we see that the patient sometimes cannot get a place in the Health Center, he cannot get an appointment, and then he comes here [...] we have to get in touch with them and send them back [...] but this is not a frequent thing. There's not a specific channel". G4C*	*"we have an excellent relationship with SAMU, SAMU really is a service of excellence [...] we see several serious patients, several patients who need a quick commute, we can do it, without loss". G5C*	x	*"when we can't solve the cases here [...] we referred them to the central hospital". G4C* *"between the UPAs and the Hospital, we are very united [...] there is a friendship between the coordinators. We created a very close bond, because there is always a meeting that one says they need something, the other answers, so there is a very close contact [...] with the WhatsApp group, then, the bond is even greater". G2H*	*"there is the service, but we do not make this relationship. Here, we either discharge or hospitalize [...] saying that a case will be discharged and go to SAD is not routine". GC4*
Hospital	*"We have a system, but it is chronic pathologies, such as hypertension, COPD. When we discharge here in the ward, you can immediately schedule at the Health Center [...] but the relationship needs to get closer, if only because nowadays there is a biparity. We have a Department of Health and an autarchy. So, it seems that there is a gap between primary care and urgency and emergency." G6C*	*"The dialogue with SAMU has improved a lot [...] So, we use the normal and personal ways to solve things [...] we try to deflect cases. When it is full, I communicate the SAMU". G6C* *"No, not even regional (SAMU). Today we use the service of the municipality. We call it 192, and then they do the removals, including in the houses [...] there are 196,000 inhabitants. We need it, right? But we don't have it." G3S*	*"we have the geography in our favor because the UPA is in front of out hospital. So, the surgeon can go there to see, the orthopedist, the vascular and the neurosurgeon". G3S* *"the idea is great, to actually take a patient out of a UPA. You put it in the Hospital and pick up a patient in the Hospital and send them home right away. The only problem is that it always goes wrong [...] as long as the big doctors aren't in charge, it's going to take a little while for us to get it done". G1S*	x	*"One thing that works really well is our SAD. Chronic patients who need home care. We manage to de-hospitalize many patients. This is a very positive factor for us". G6C*
Home Care	*"with UBS, we made a plan [...] the UBS did not know the SAD. A work of approximation begins, visiting all the UBSs, asking for a team meeting space, to introduce themselves and present what SAD was, the flow [...] we had a lot of articulated case discussion afterwards". G7C*	*"SAMU? Only in some cases. We don't have a discussion, a think-along protocol, right? We need SAMU at some point, when the family opts for the death to be at home [...] this conversation is very difficult". G7C*	*"It is done in everyday life. There are some UPAs you can get it [...] it is case-by-case in that sense. And also heterogeneous because, in other UPAs , you ask for support for the palliative patient, and they say: "No, there's nothing to do with the palliative" [...] there is no articulation, we do not sit down, we do not have news". G7C*	*"There was an attempt for us to try to do things together with the hospital network, which are the visits, to meet the patient in bed still [...] we made about three visits, but the information is lost inside the hospital [...] The thing in the hospital network is tougher, more hierarchical". G7C*	x

Table 3. (cont.)

Components	UBS	Samu 192	UPA 24h	Hospital	Home Care
Home Care	*"in the UBS, we notice a great demand for chronic cases [...] we have a referral protocol. There is a referral form filled out by the doctor with a current case report and the necessary documents". G2S*	*"it is a hindering factor, because we don't have SAMU. We don't have that service. We have the sanitary transport and the fire department". G2S*	*"It depends on the quality of each professional. It's hard say that there is a protocol. We don't have that kind of referral [...] there are professionals who prefer to report in writing [...] The telephone contact, I think, works better, usually from doctor to doctor [...] we have reports from family members that sometimes the emergency room doctor does not even pick up the letter to read". G2S*	*"at discharge, the hospital verifies that the patient is stable and already triggers us. Sometimes, the patient is still hospitalized, already makes contact with us and already directs the referral [...] especially patients who go to the emergency room for nasoenteral tube placement. Usually, they all refer to us because our sector has the Nutrition Service". G2S*	x

Source: Own elaboration.

Territorial planning

The organization of health regions and networks from territorial planning is present in the reports not only as recognition of the territories, but also of other interests that cross them:

> These things appear not only because it is an epidemiological demand, but also because there is an importance of another level, the academic one [...] depending on the need of the department, this demand ends up coming, a service is created, the routine, the flow. (G3C).

The testimonies refer to regionalization as a guideline for the organization of the RUE; however, there are reports of difficulties in operationalizing the concept:

> The more distant, the more regional, the more difficult [...] the more you expand, the more difficulty you will identify. We think about consortiums, doing things together, but the practice is very difficult. (G3C).

The location of regional hospitals arises as a problem in access, producing inequities, depending on the municipality of origin of users:

> It is one of the worst places in the region to choose because the structure of the municipality is very low [...] it has no inpatient bed [...] all demand comes here. (G2E).

And, yet:

> This hospital should be of a micro-regional role [...] as such, this medical group was always much stronger and managed to transform into an exclusively municipal hospital. (G3E).

Quality

Managers report arrangements and instruments for the qualification of care, even recognizing barriers: *"professionals are also inserted into the matrix, they become aware of the subject and then they have other positions, other decisions, other directions"* (GS1).

SAMU, absent in most municipalities in the region, is described, in particular, by the medical regulation, as a central element for the qualification of the RUE:

The medical regulation of the SAMU, which is the heart of the system... these cities there [who do not have SAMU]*, it's all via dispatcher. It's not done by doctors. Quality goes down a lot.* (G3C).

Interfederative articulation

Interfederative relations appear as a necessary condition for the management of regionalized networks. The narratives mainly refer to the relationship between municipalities and state government:

The state government only pretends to do things [...] they take no responsibility. They are more interesting in doing health propaganda [...] then appearance services are created. (G3C).

And, yet:

We realized that the state's part was still lackluster. The state says that it invests in helicopter and ends up not passing on the part of SAMU. (G3H).

Regulation

Regulation emerges as a technological arrangement capable of articulating the components of RUE. In particular, the SAMU Regulation Central is valued in the narratives:

SAMU's regulation is a plus factor, to order the quality of services a little more [...] if there is a serious accident, and the appeal does not fit in that municipal hospital, the patient will be transferred to the state one, which is a reference hospital. (G3H).

In some reports, the regulation of vacancies centralized by the state in the Cross is referred to as insufficient to guarantee qualified access, leaving for the services the burden of this 'mistake':

The UPAs are getting serious patients [...] we take the patients for 24 hours, insert them in the Cross,

[...] we feel as if it's our incompetence, not that of the regulatory body. (G3H).

The decentralization of Cross is understood as a necessity, based on the premise that a regional regulation would have greater knowledge and proximity to RUE in the territory. The project that was in progress was stopped:

As in Cross a lot changes, every day a different doctor, they do not have a link with this region, they do not know it as we do [...] the project to regionalize was formalized, the appeal was carried out, it was about to begin, but there was the change of state government, so it was temporarily shelved. (G3E).

Discussion

The context of practice is where the policy is subject to interpretation and recreation; it is where it will produce effects and consequences that can represent significant changes and transformations in the original proposition[12]. In the case of RUE, the dialogue with service managers showed that the policy of reorganization of urgent and emergency services in a network is not recognized by the interviewees as a national health policy. Even with the strong federal financial inducement, RUE does not appear as an internalized policy for the teams that operate it on a day-to-day basis.

Another important aspect emerging from the research dialogues with the analysis of Jorge et al.[3], who states that the transfer of financial resources, by itself, did not guarantee the effectiveness of the networks, and that the implementation of the RUE was not accompanied by changes in the care model. In the same direction, Padilha et al.[14] observed in the Metropolitan Region of São Paulo the absence of arrangements capable of involving and articulating in communicative action all those with power in the points of attention

and management spaces of the RUE, ensuring permeability to services.

Managers identify elements of RUE in their management and care practices, such as the implementation of UPA, protocols, risk classification, care technologies, regulatory arrangements and lines of care. Ignorance of the ordinances, of the formalization of arrangements in a policy, does not prevent the network from being built and disputed in the daily life of services.

In a survey conducted with managers of RUE components in Rio Grande do Sul, it was identified the precarious knowledge of the interviewees about the flows for users affected by stroke: they seem to be unaware of their responsibility, transferring it to other managers[15]. This dimension of lack of responsibility, however, was not identified in the health region investigated.

Cecilio[9], when reporting the managers' estrangement relationship with the micropolitical space of care production, observes that many of the formulated policies are subordinated to theoretical-conceptual schemes that do not account for the complexity of reality. In the dimension of services, studies reinforce that there is no capillarization of the RUE policy for health teams. Research with managers and professionals working in a trauma center in the Midwest region of Brazil suggests the lack of knowledge of professionals regarding the insertion of the hospital in the network and the agreed flows[16]. Interviews with doctors from hospitals and SAMU in Belo Horizonte also showed the need for interventions that align concepts inherent to the organization in care networks to the conception experienced in practice[17]. To Chioro et al.[18], as important as agreeing is to produce the internalization of networks with the workers and services that compose it, without which they will be restricted to the mere registry dimension, used only to enable services and raise funds.

In this study, many of RUE's intentions, objectives and challenges were stated and reported in the interviews, allowing the context of the practice to be discussed here through two analytical questions: reflexes and contingencies of management movements in the production of networks; and RUE on stage.

Reflections and contingencies of management movements in network production

Decisions of each federative entity impact the production of the RUE with different consequences. Thus, the decision of the state government of São Paulo not to co-finance SAMU and maintain centralized regulation, in addition to the action of some municipalities to stimulate the implementation of devices and arrangements that produce care networks, ended up interfering with the construction of the RUE. Furthermore, administrative restructurings, such as the adoption of management modalities through municipalities or social organizations, directly reflect on the organization of services. The interposition of access barriers for users from other municipalities, even for agreed references, compromises the integrality of care in the regional perspective. Thus, actions of health teams in the context of practice are also modulated by decisions of different actors in a government situation.

The induction and implementation of the RUE in the territories cannot happen without integration and articulation in management strategies, when it comes to planning, programming, regulating and financing actions and services[3]. Although the three federated entities are autonomous, albeit with different powers, the Brazilian interfederative design requires the realization of competing responsibilities and a high level of cooperation for the operationalization of the SUS[18]. After decades of management decentralization, marked by municipalization, increased access to primary care and difficulties in reference to medium and high complexity care were observed, indicating the need for effective regionalization to ensure integral access to health[19].

The Regional Inter-management Committees (CIR) are the formal bodies for agreement. They were implemented as spaces for innovation, formulation and production of consensus, but their implementation is often marked by bureaucratic and clientelistic political culture[20] that perpetuates powers and does not contribute to a living regional agreement, which in fact helps in the construction of regionalized networks. To Moreira et al.[21], the political system and the state executive power are the major absentees in the coalitions supporting SUS regionalization policies. Padilha et al.[14] observed asymmetrical power relations that generate litigation, such as federal underfunding, non-state co-financing, the fragility of cooperative agreement instruments and competition between federal entities and their service networks. Regarding the action of the state entity in the construction of regional networks, studies have reported the insufficient coordination of state governments[3,19], often restricted to their role as managers of the services themselves[22]. This absence of state coordination in the RUE is also strongly reported by the respondents of this survey.

Unequal power relations between municipalities also produce inequities. To Chioro et al.[18], one of the most complex challenges for SUS is to guarantee full access to citizens of small municipalities, which can only be effective in the perspective of regionalization. Mendes et al[22] highlight the need for the pacts to include in solidarity the municipalities with the greatest socioeconomic, epidemiological, demographic and service supply difficulties. Access to medium and high complexity services is often hampered by local disputes and barriers imposed by municipal managers who do not comply with regional agreements[19], since interfederative pacts are often established as bureaucratic instruments, without the accountability of managers[18]. They end up imposing contingencies that restrict access and integrality of health care.

In this investigation, therefore, the perception of the importance of the daily production of spaces for agreement and communication between services was central, so that the combined flows and protocols leave their bureaucratic form and have an impact on the production of care, in a more integral perspective.

RUE on scene

The reported practices express possibilities and limits of the RUE, in dialogue with its intentionalities. For the analysis of the RUE on scene, three recurring issues stand out in the reports: the relationship between primary care and emergency doors in the service of spontaneous demand; the medical regulation of the SAMU as a promoter of access and quality; and the discontinuity in health care.

The relationship between the UBS and 24-hour emergency doors is a poorly resolved issue. Although access to spontaneous demand in primary care was already being worked on even before the RUE, there is resistance in conceiving UBSs as open door services. When there is an emergency situation (that is, more severe cases), there is even less recognition of primary care as part of the RUE. Defined in the regulations as responsible for expanding access and first care to urgencies and emergencies until transfer to other points of care[5], UBSs are still seen by managers, workers and users as a place of simple things[9]. In our study, a dilemma is observed about the demand for cases considered simple, serviced by the UPA, which, in the understanding of its managers, should be cared for in the UBSs. They also understand that the poor follow-up and control of chronic diseases in primary care generates a demand for acute cases for the UPA. UBS managers, on the other hand, report difficulties in establishing connections with the UPA and a great deficiency in the process of counter-referring these users to primary care.

A study carried out in Belo Horizonte observed that the demand that reaches the UBSs and emergency services was for medical consultations, motivated by mild conditions, with

a duplicity in the use of services: in general, the user usually seeks emergencies when he considers that the health problem is serious or when he evaluates that primary care will not solve his health problem[23]. The accelerated expansion of UPAs in Brazil, without effective network organization, also contributed to the reproduction of the traditional model of emergency care[24]. However, the implementation of the risk classification in the UPA, understood as an element of quality and humanization, is a powerful technology applied to the management of care and urgent and emergency services[25], as long as they are integrated into the RUE to extend the resolvability[26]. In reality, to make the network effective, there is a need for territorial integration and connections with primary care. Both need to be understood as gateways to RUE that are accessed by users in different situations, according to their own criteria and needs, and that they are co-responsible services in health care. This study reinforces the importance of overcoming this idealized design about what should be the user's gateway into the system, disregarding the autonomy of this subject in the production of their care network.

SAMU was the first component of the National Emergency Care Policy implemented in the country[27]. The results of this research corroborate the emphasis given to the central action of SAMU's medical regulation as a promoter of access and quality in the RUE. Its structuring and operation can benefit from the control of the flow and quality of services, depending on the ability to use the constituent elements of the regulation system[28]. What we observed is that the SAMU regulation center has powers to guarantee the access of users with more serious conditions to hospital services by direct access or by determining 'vaga zero' (vacancies in life-or-death cases), when the regulating physician exercises its health authority to determine the place of care. These actions lend SAMU a real and symbolic power, reinforced by the use of the standardized brand, fleet and uniform, which materialize the authority of its teams[29].

'Vaga zero' is reported by the interviewees as a shortcut to access hospital care in emergency situations. In the case of the studied region, of the 20 municipalities that compose it, only three have SAMU, leaving the other services local health transport devoid of medical regulation and health authority. In Brazil, there is uneven implementation of SAMU between states and regions, due to the capacity of states and their decision to finance and regionalize the organization of supply[27]. In the case of the state of São Paulo, reports indicate that the refusal of the state government to co-finance SAMU is an important factor to prevent its expansion. In this study, unequal coverage appeared as a producer of inequities, since some municipalities that have the service provided with medical regulation end up obtaining greater access to specialized hospital referrals; the rest (without SAMU) is dependent on centralized state regulation and subject to the operational difficulties already described.

Continuity of care is a RUE guideline to guarantee the production of integrality[5]. In the narratives of the managers, it was possible to observe both situations of greater network production and absence of networks; Hadad and Jorge[30] had already reported so in a study with guide users discharged from hospital admissions. Different understandings of the network were also observed, which express different rationalities. Some refer to formatted networks through structures and flows. There is also evidence that indicates the conformation of living networks that connect with the lives of users, produced from the fabric of care and health needs[31].

In the RUE, continuity of care should be guaranteed through the availability of technologies and resources, the articulations between the points of care and the organization of lines of care[5]. In this study, managers reported a certain organization through flows and grids of agreed references, eventually with limitations

of access and resolvability, but which are made possible by multiple paths, formal or not, and some possibilities of connections between services and health teams. The power of articulation appears directly related to the existence of living spaces of agreement and articulation between the workers of the various services.

Stroke and trauma cases are based on well-structured care and referral protocols, understood as rapid response plans for serious situations, whose resolvability is, in most cases, effective. Study conducted in the state of Rio Grande do Sul[19] demonstrated the importance of knowledge of workflows and processes for stroke care, because the lack of use of tools and devices to implement this line of care leads to fragmentation. Regarding trauma, research conducted in Minas Gerais identified movements of living networks in the search by users for continuity of care, highlighting the power of meetings between users, family members and health professionals, but also the incipience in the formation of formal networks capable of reception and problem-solving[30].

What was observed in the studied region is that emergency care, even with some limitations, was guaranteed. The SAMU, the UPA, the hospitals and even the UBS, in some situations, performed the first care, reversed serious and/or suffering and stabilized health conditions, as far as possible. The issue that arises is the difficulties for the continuity of care. Rehabilitation actions, elective surgeries and specialized diagnostic procedures were not always accessible. On the contrary, they were often not even recognized as something that should be produced in a network. In a study that analyzed access to rehabilitation for victims of traffic accidents in Brazil[32] administrative bureaucracy, insufficient supply of services and disarticulation between hospitals and outpatient services have been reported as barriers. The insulation of the hospital units observed in this study, that is, their low connectivity with the other components of the RUE, was also described by Beltrammi and Reis[33] as a cause and consequence of the

fragmentation of universal health systems in their historical processes of conformation. It was observed in the studied region that the articulations of the hospitals and the UPAs with the UBSs are fragile and based on personal relationships between professionals and managers, with no regular routines for post-discharge follow-up.

The AMI care line is a critical node in the studied region. Despite having important structure, technical and professional capabilities in the area of cardiology, reports point to difficulties in accessing surgeries and, especially, hemodynamic procedures. A study conducted in the city of São Paulo showed that the organization of a treatment network, involving diagnosis, reperfusion, immediate transport and rear hospital, resulted in immediate improvement of results for AMI[34]. This is not evident in the region of this study, where access to the catheterization procedure and coronary artery bypass grafting is compromised.

Regarding the instruments of network articulation, formal and informal devices were observed, built for unique cases and contexts. For the regulation, for example, various devices were used, including computerized systems, personal contacts, manual systems, hospital centers and groups by applications (WhatsApp). In a study carried out in a large municipality in the state of São Paulo, technological arrangements capable of producing user-centered care were also identified: in these cases, the regulatory complex was used in an auxiliary way to guarantee access; in these services, arrangements were verified to carry out a regulation that produces network care[35]. Thus, the induction of the living production of more dialogical arrangements of articulation between points of care in the RUE constitutes a powerful strategy for the continuity of care.

It was noticed that the actors on stage in the field of practice at RUE reinterpreted and adapted the texts of the formulated health policy. There were resistances, conflicts and

tensions, explicit or not, that crossed the networks and that could reproduce or produce iniquities. However, there was production of care evidenced by the different movements of production of networks identified and valued by managers. As first-order effects, it was possible to identify, unevenly, the increase in financing and the implementation or expansion of services, arrangements and technologies. As second-order effects, the expansion of access and a restricted integrality were also observed, which, although uneven, have not ceased to be gains in the process of consolidation of the SUS.

Final remarks

The RUE on scene approach shows limits and possibilities of inducing a public health policy formulated at the national level. It demonstrates that a policy, with intentions of expanding access and producing integral care in its formulation, has its implementation disputed in the daily life of services, crossed by different forces and interests. Even so, there is evidence of movements and living productions induced by politics, or even beyond it, that qualify health care in urgent and emergency situations.

Fragile and non-regular connections between services amplify inequities and make explicit the need for articulation between networked components. SAMU, understood as an important articulator of the network and promoter of quality by emergency medical regulation, continues to have low coverage in the studied region, even though it is the oldest component of the RUE in the country. The relationships between primary care, home care, UPA and hospitals are important challenges in the production of the network and

are often more produced by informal flows than by structures, revealing the low investment in strengthening these connections so central to the production of the network.

Arrangements such as reception, risk classification and regulation are understood and implemented in different ways. A better organization and expansion of access in urgent and emergency situations was the most present result in the various services studied, as a consequence of the implementation of the RUE. However, integrality appears compromised by the disarticulation and discontinuity of network care.

In the context of practice, it is reinforced the importance of considering the dynamics and local scenarios, the arrangements that organize each health service and the connection between them, for the construction of public policies that promote equity and social justice. To understand the RUE as a public policy that promotes access and integrality and strengthens the capacity of SUS to connect and defend life and the right to health in Brazil.

Collaborators

Tofani LFN (0000-0002-1092-2450)*, Furtado LAC (0000-0001-7897-9739)* and Chioro A (0000-0001-7184-2342)* contributed to the conception and design of the study; acquisition, analysis and interpretation of the data; preparation of the manuscript and revision of the final version to be published. Andreazza R (0000-0002-3332-2183)*, Nasser MA (0000-0001-8409-7265)* and Bizetto OF (0000-0001-7839-8109)* contributed to the conception and design of the study; acquisition, analysis and interpretation of the data; critical review of the manuscript and review of the final version to be published. ∎

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References

1. Henderson AC. Patient assessment in emergency medical services: complexity and uncertainty in street-level patient processing. J. Health and Hum. Serv. Adm. 2013; 35(4):505-38.

2. Obermeyer Z, Abujaber S, Makar M, et al. Emergency care in 59 low-and middle-income countries: a systematic review. Bull World Health Organ. 2015; 93(8):577-586.

3. Jorge AO, Coutinho AAP, Cavalcanti APS, et al. Entendendo os desafios para a implementação da Rede de Atenção às Urgências e Emergências no Brasil: uma análise crítica. Divulg. Saúde debate. 2014; 52:125-145.

4. O'Dwyer G, Konder MT, Machado CV, et al. The current scenario of emergency care policies in Brazil. BMC. 2013; 13(70).

5. Brasil. Ministério da Saúde. Portaria nº 1.600, de 7 de julho de 2011. Reformula a Política Nacional de Atenção às Urgências e institui a Rede de Atenção à Urgências no Sistema Único de Saúde (SUS). Diário Oficial da União. 8 Jul 2011.

6. Brasil. Ministério da Saúde. Portaria nº 4.279, de 30 de dezembro de 2010. Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União. 30 Dez 2010.

7. Organización Panamericana de La Salud. Redes integradas de servicios de salud: conceptos, opciones de política y hoja de ruta para sua implementación em las Américas. Washington, DC: OPAS; 2010. (Serie La renovación de La atención primaria de salud en las Américas nº 4).

8. Machado CV, Lima LD, Baptista TWF. Políticas de Saúde no Brasil em tempos contraditórios: caminhos e tropeços na construção de um sistema universal. Cad. Saúde Pública. 2017; 33(2):e00129616.

9. Cecílio LCO. Escolhas para inovarmos na produção do cuidado, das práticas e do conhecimento: como não produzirmos "mais do mesmo"? Saúde Soc. 2012; 21(2):280- 289.

10. Stake RE. Case Studies. In: Denzin NK, Lincoln YS, organizadores. Handbook of qualitative research. Thousand Oaks: Sage Publications; 2000. p. 435-454.

11. Ball SJ. What is policy? Texts, trajectories and toolboxes. Discourse. 1993; 13(2)10-17.

12. Mainardes J. Abordagem do Ciclo de Políticas: Uma Contribuição para a Análise de Políticas Educacionais. Educ. Soc. 2006; 27(94):47-69.

13. Mainardes J, Marcondes MI. Entrevista com Stephen J. Ball: um diálogo sobre justiça social, pesquisa e política educacional. Educ. Soc. 2009; 30(106):303-318.

14. Padilha ARS, Amaral MA, Oliveira DC, et al. Fragilidade na governança regional durante implementação da Rede de Urgência e Emergência em Região Metropolitana. Saúde debate. 2018; 42(118):579-93.

15. Pinno C, Birrer JA, Colpo APF, et al. Acidente Vascular Encefálico: Desafio para os Gestores na Rede de Atenção à Saúde. Rev. Enferm. UFSM. 2014; 4(4):667-677.

16. Soares EP, Scherer MDA, O'Dwyer G. Inserção de um hospital de grande porte na Rede de Urgências e Emergências da região Centro-Oeste. Saúde debate. 2015; 39(106):616-26.

17. Lima DP, Leite MTS, Caldeira AP. Redes de Atenção à Saúde: a percepção dos médicos trabalhando em serviços de urgência. Saúde debate. 2015; 39(104):65-75.

18. Reis AAC, Sóter APM, Furtado LAC, et al. Reflexões para a Construção de uma Regionalização Viva. Ciênc. Saúde Colet. 2017; 22(4):1045-1054.

19. Pinafo E, Carvalho BG, Nunes EFPA. Descentralização da gestão: caminho percorrido, nós críticos e perspectivas. Ciênc. Saúde Colet. 2016; 21(5):1511-1524.

20. Mello GA, Pereira APCM, Uchimura LYT, et al. O processo de regionalização do SUS: revisão sistemática. Ciênc. Saúde Colet. 2017; 22(4):1291-1310.

21. Moreira MR, Ribeiro JM, Ouverney AM. Obstáculos políticos à regionalização do SUS: percepções dos secretários municipais de Saúde com assento nas Comissões Intergestores Bipartites. Ciênc. Saúde Colet. 2017; 22(4):1097-1108.

22. Mendes A, Louvison MCP, Ianni AMZ, et al. O processo de construção da gestão regional da saúde no estado de São Paulo: subsídios para a análise. Saúde Soc. 2015; 24(2):423-437.

23. Pires MRGM, Göttems LBD, Cupertino TV, et al. A utilização dos serviços de atenção básica e de urgência no SUS de Belo Horizonte: problema de saúde, procedimentos e escolha dos serviços. Saúde Soc. 2013; 22(1):211-222.

24. O'Dwyer G, Konder MT, Reciputti LP, et al. O processo de implantação das unidades de pronto atendimento no Brasil. Rev. Saúde Pública. 2017; (51):125.

25. Sacoman TM, Beltrammi DGM, Andreazza R, et al. Implantação do Sistema de Classificação de Risco Manchester em uma rede municipal de urgência. Saúde debate. 2019; 43(121):354-367.

26. Uchimura LYT, Viana ALA, Silva HP, et al. Unidades de Pronto Atendimento (UPAs): características da gestão às redes de atenção no Paraná. Saúde debate. 2015; 39(107):972-983.

27. O'Dwyer G, Konder MT, Resciputti LP, et al. O processo de implantação do Serviço de Atendimento Móvel de Urgência no Brasil: estratégias de ação e dimensões estruturais. Cad. Saúde Pública. 2017; 33(7):e00043716.

28. Barbosa DVS, Barbosa NB, Najberg E. Regulação em Saúde: desafios à governança do SUS. Cad. Saúde Colet. 2016; 24(1):49-54.

29. Veloso IS, Araujo MT, Alves M. Práticas de poder no serviço de atendimento móvel de urgência de Belo Horizonte. Rev. Gaúcha Enferm. 2012; 33(4):126-132.

30. Hadad ACAC, Jorge AO. Continuidade do cuidado em rede e os movimentos de redes vivas nas trajetórias do usuário-guia. Saúde debate. 2018; 42(4):198-210.

31. Tofani LFN, Furtado LAC, Guimarães CF, et al. Caos, organização e criatividade: Revisão integrativa sobre as redes de atenção à saúde. Ciênc. Saúde Colet. 2021; 26(10):4769-4782.

32. Oliveira WIF, Sousa KMS, Melo LOM, et al. A qualitative study analyzing access to physical rehabilitation for traffic accident victims with severe disability in Brazil. Disabilities Rehabilitation. 2017; 39(6):568-577.

33. Beltrammi DGM, Reis AAC. A fragmentação dos sistemas universais de saúde e os hospitais como seus agentes e produtos. Saúde debate. 2020; 43(5):94-103.

34. Caluza ACV, Barbosa AH, Gonçalves I, et al. Rede de infarto com supradesnivelamento de ST: sistematização em 205 casos diminui eventos clínicos na rede pública. Arq. Bras Cardiol. 2012; 99(5):1040-1048.

35. Freire MP, Louvison MCP, Feuerwerker LCM, et al. Regulação do cuidado em redes de atenção: importância de novos arranjos tecnológicos. Saúde Soc. 2020; 29(3):e190682.