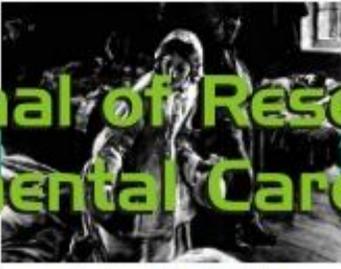


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RESEARCH

Atenção à saúde do idoso: o sistema de referência e contrarreferência nos serviços de saúde

Elderly health care: the referral and counter-referral system in health services

Cuidado de la salud del anciano: el sistema de referencia y contra referencia en servicios de salud

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ABSTRACT

Objective: this study aimed to analyze elderly health care in clinical networks through the referral and counter-referral system, considering the principle of comprehensiveness in the Unified Health System (SUS). **Method:** constructivist assessment was adopted as a method, responsive, with a hermeneutic dialectic approach, named fourth generation assessment, conducted with 10 nurses who work in the management of health services in a town at the North Zone of the state of Ceará, Brazil, between March and May 2011. **Results:** the results denote that nurses' speeches provided information portraying the weaknesses and deficiencies of the referral and counter-referral system at the local levels of health care, with fragmented and disconnected clinical practices. **Conclusion:** we found out that there is a need to rethink the practice pervading the clinical health care networks, since the elderly person lacks more effective health actions. **Descriptors:** elderly, health care, referral and counter-referral system.

RESUMO

Objetivo: o objetivo deste estudo foi analisar a atenção à saúde do idoso nas redes assistenciais por meio do sistema de referência e contrarreferência, considerando o princípio da integralidade no Sistema Único de Saúde (SUS). **Método:** adotou-se como método a avaliação construtivista, responsiva, com abordagem hermenêutica dialética, denominada avaliação de quarta geração, realizada com 10 enfermeiros que atuam na gestão de serviços de atenção à saúde de um município da Zona Norte do Ceará, entre março e maio de 2011. **Resultados:** os resultados denotam que os discursos dos enfermeiros proporcionaram informações que retratam as fragilidades e deficiências do sistema de referência e contrarreferência nos níveis locais de saúde, com práticas assistenciais fragmentadas e desconexas. **Conclusão:** Constatou-se ser necessário repensar a prática que perpassa as redes assistenciais de saúde, uma vez que o idoso carece de ações de saúde mais efetivas. **Descritores:** idoso, atenção à saúde, sistema de referência e contrarreferência.

RESUMEN

Objetivo: este estudio tuvo como objetivo analizar la atención de salud del anciano en las redes clínicas a través del sistema de referencia y contra referencia, teniendo en cuenta el principio de la integralidad en el Sistema Único de Salud (SUS). **Método:** se adoptó la evaluación constructivista como método, responsiva, con abordaje hermenéutico dialéctico, denominado evaluación de cuarta generación, realizada con 10 enfermeros que actúan en la gestión de servicios de atención de salud en un municipio en la Zona Norte del estado de Ceará, Brasil, entre marzo y mayo de 2011. **Resultados:** los resultados denotan que los discursos de los enfermeros proporcionaron informaciones que retratan las fragilidades y deficiencias del sistema de referencia y contra referencia en los niveles locales de salud, con prácticas clínicas fragmentadas e inconexas. **Conclusión:** se constató que hay una necesidad de repensar la práctica que impregna las redes clínicas de salud, ya que el anciano carece de acciones de salud más efectivas. **Descriptores:** Anciano, Atención de Salud, Sistema de Referencia y Contra Referencia.

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INTRODUCTION

Current socio-demographic conventions show that aging and the condition of being an elderly person are directly related to the quality of life that countries and their governments provide for their inhabitants.¹ Thus, being an elderly person is the final result of a set that involves aging, which is a process, and old age, which makes up one of the life stages.²

The aging index, in Brazil as a whole, expresses a rapid process. By 2025, this index will probably be 3 times higher than that observed in 2000. This demonstrates that, then, the Brazilian population will have more than 50 adults ≥ 65 years for each set of young people < 15 years, estimating that, by 2045, the number of elderly people will surpass that of children.³ Therefore, Brazil is becoming a country of old age and it needs to focus its attention on the needs of senescent people.

Population reconfiguration brings up new demands to health services, since the demographic transition has triggered changes in the epidemiological profile of society. So, in less than 30 years, Brazil went from a context of morbidity and mortality typical of a young population to another characterized by complex and burdensome illnesses, typical of older age groups.⁴

The Ministry of Health has included elderly health as a priority item in the country's health agenda, by enacting a National Elderly Person Health Policy (PNSPI), based on the model of functional capacity, which is addressed on a multidimensional way.⁵ It is worth highlighting that the efforts are *ad hoc* and disarticulated, since the burden of care is still predominant and the remarkable degree of disarticulation within the system hinders the operation of any rationale based on a multidimensional review.⁴

Comprehensiveness, as organization and articulation between services, is set up to have a system that is connected at all levels of complexity. It is understood as a network of services that works in order to provide access conditions and that solves problem and risks affecting the quality of life of population,⁶ something which makes evident the weakness of conventional health services, since they do not meet the complex and unique needs of the elderly person.⁷

The concept of comprehensiveness necessarily refers to that of articulation of health services through clinical networks. The clinical flow in networks demonstrates the interdependence of actors and organizations, given the fact that none of them has all the resources and competences required to solve the health problems of a population in its various life cycles. Then, it becomes imperative to develop effective cooperation and coordination strategies in charge of collective resources, which meets the individual health demands at the local and regional levels.⁸

The challenge of comprehensiveness is of paramount importance as one of the pillars supporting the Unified Health System (SUS). For deploying it, it is a must that, in a

connected way, actions are provided for promoting health, preventing risk factors, addressing problems, and rehabilitating, according to the dynamics of the health-illness process.⁹ Such actions flow through the network by means of the referral and counter-referral system.

Thus, there is the representation of a higher degree of complexity, where users are referred to be treated at more complex levels, such as specialized hospitals and clinics. In turn, counter-referral concerns a lower degree of complexity, when user's need with regard to health services is simpler, something which leads the citizen to be counter-referred, indicated to a rather primary care.⁹

Given the above, this study aims to understand the health care provided for the elderly person in the clinical networks in a town in the North Zone of the state of Ceará, Brazil, through the referral and counter-referral system, considering the principle of comprehensiveness in SUS.

METHOD

This is a constructivist assessment, responsive, with a hermeneutic dialectic approach, named fourth generation assessment, which is a form of assessment where claims, concerns, and issues of the interest group provide a basis for determining the needed information, implemented by means of assumptions of the constructivist paradigm.¹⁰

The study subjects were 10 nurses, encoded from N1 to N10, who work at the management of primary, secondary, and tertiary levels of health care in a town in the North Zone of the state of Ceará. Data collection was conducted between March and May 2011, by using the technique of the Dialectic Hermeneutic Circle (DHC).

Using DHC, the first interviews were less structured, allowing the respondent to freely answer about the health care provided for elderly people at the level focused. Later, as the interviews were conducted, pre-analysis enabled us to identify issues expressed in the subsequent interviews, making interviews increasingly structured, while allowing the respondent to bring up new questions, if they wished to do so.

Each subject was interviewed individually, and, at the end of each interview, the recorded speeches were fully heard and transcribed, in order to include questions in DHC for the next interview. The first interviews were shorter (10 to 15 minutes) and last longer (20 to 30 minutes), since the latter ones covered most issues.

Data were analyzed according to the method of hermeneutic dialectics, which consists of: identification of categories for analysis; condensation of information, based on the theoretical framework; and analysis of categories in accordance with the theoretical context.¹⁰

The study was approved by the Research Ethics Committee of Vale do Acaraú State University (UVA), under the Opinion 357 548.

RESULTS AND DISCUSSION

Nurses' speeches provided information depicting the weaknesses and deficiencies of the referral and counter-referral system at the local health levels. The following categories emerged: Referral and counter-referral system and Counter-referral and the functionality of networks for elderly health care.

Category 1 - Referral and counter-referral system

This category illustrates the referral and counter-referral system and the reasons driving elderly people through the clinical network.

Population aging involves new forms of getting ill, with the prevalence of chronic degenerative diseases; it induces a readjustment of health systems to provide an approach more qualified to demands emerging in the elderly population. Therefore, health systems have a device that organizes clinical flow in health care networks, named *referral and counter-referral system*.

There are several reasons leading elderly people to seek health services, as observed in the subjects' speeches, from acute to chronic disease processes. Except in cases of urgency and/or emergency, the gateway of health services is primary care, because family health is regarded as one of the main strategies to reorganize SUS and the redefine primary care, particularly with regard to resuming the guidelines and principle of SUS and clinical practices.¹¹

Until the middle of the last century, the main causes of death were infectious and parasitic diseases. However, currently, cardiovascular diseases are the leading cause of morbidity and mortality among individuals > 50 years of age, besides osteoarticular diseases, those which cause greater dependence and decline in quality of life, due to chronic pain.¹²

According to the reports, referrals of elderly people to clinical levels of greater complexity mostly take place in cases of hypertension, diabetes, and bone fractures due to falls, especially at home.

Referral is when it comes to an elderly person with some disease, either chronic or acute, and if she/he needs secondary or tertiary care [...] the consultations involve cardiology, hospitalization, pulmonologist. (N1)

[...] some cases of diabetes, you know, high, patients need to be hospitalized, and, in most cases, the case involves bone fractures, indeed, exposed, some elderly people end up falling at home, they end up suffering accidents at home [...], we cannot refer the patient without referral. (N2)

[...] regarding referral, we see more patients with hypertension, crises, and with altered glycemia. (N3)

We refer [...] many are high blood pressure, feeling pain, chest pain. (N4)

[...] we refer to a hospital and, when it does not involve urgency or emergency, we refer to a specialist. (N5)

[...] the patient whose problem could not be solved at primary care, she/he is referred. (N6)

We notice by means of the speeches that heterogeneity is a very particular characteristic of aging. Just as there are institutionalized elderly people with various disabilities and diseases, there are also, at the other end, elderly people from the same age group who are active and absolutely independent. This difference is mainly due to the presence of comorbidities, which play a fundamental role in the quality of life of an elderly person. Among the most prevalent comorbidities among elderly people we may mention obesity/underweight, thyroid dysfunction, depression, cognitive impairment, urinary incontinence, hypertension, and falls,¹² the latter two cited by study subjects.

Hypertension is among the most common morbidities in people > 60 years, about 2/3 of the elderly individuals are hypertensive and this prevalence increases with age. In Brazil, its inadequate control is related to higher mortality rates due to stroke and acute myocardial infarction.¹²

Regarding the risk of falls, the same authors point out that it increases with age, and this must be understood as the clue of a bigger problem, as alteration in proprioception or balance. Over 30% of elderly people fall at least once a year; if there is no early intervention, the chances of hip fracture, immobilization, and institutionalization increase.

When a health professional refers the elderly person to a more specialized service, she/he must be aware of procedures that the elderly individual has undergone, so that she/he can provide a continued treatment, in accordance with the patient's health-illness process. However, what we do observe are fragmented practices, due to lack of return from higher to lower complexity levels.

Respondents' speeches demonstrate that the situation mentioned exists and how problematic it is to offer a health care having good quality and providing solutions. People express that counter-referral cases are very subtle and these cases involve the areas of cardiology, neurology, and, sometimes, violence against the elderly individual.

[...] but cardiology provides counter-referral, especially if the patient is hospitalized, if it is just for a consultation [...] the Heart Hospital provides this counter-referral. Neurology also provides this counter-referral. (N1)

[...] to avoid saying it does not occur, it takes place when they come, when there is a neurological problem [...]. The issue, when we talk of violence, there is also counter-referral, but, you know, clinical cases rarely have a counter-referral, except neurology, it is very difficult. (N5)

The elderly population has several peculiarities, which, added to problems that culminated in the individual's referral to a specialist or to hospitalization, lead us to find out that many people return to home unable even to perform actions regarded as basic in continuity of care, such as using medicines, feeding, and adequate physical activity. This also happens in situations requiring special care, such as ostomies, wounds, and probes.¹³

This fact takes place, almost always, due to lack of guidance and social and family support. It is also worthy noticing that the person in charge of continuity of care is some member of the elderly person's family, but often she/he does not participate in this process of high complexity services, such as the hospital, being vulnerable to many errors.

We focus, here, the need for providing a comprehensive care for the elderly individual, aimed at a holistic attention, as well as the possibility to keep a flow in the clinical network, in accordance with her/his health demands. However, what is observed are reductionist and fragmented clinical practices, where health care levels do not maintain communication with each other, executing isolated actions that are not problem-solving, which eventually recur at various points of the network, generating a duplication of demand in a health service.

The referral and counter-referral system aims to enable the exchange of information between health services, an aspect that could avoid duplication of efforts and, as a consequence, could lead to an improved quality of care and reduced clinical costs.¹³

Communication is a need in the clinical network, since, today, elderly health must be based on continuity, as individual medical care sporadic and restricted to complications has not met the needs of this population. To achieve the goal of care continuity, health professionals must, therefore, break away from the standard of isolated, paternalistic, and authoritarian care, renew the working method, and adopt, as a philosophy, interdisciplinary teamwork, looking at the comprehensiveness of a human being, so that the elderly person is viewed as a whole, considering her/his social context.¹³

In this context, we observe the influence that the absence of counter-referral, or its restricted applicability, exerts on the elderly person, and it also negatively influences on the functionality of clinical networks, as they are discontinued, have fragmented clinical flows.

Category 2 - Counter-referral and the functionality of networks for elderly health care

Today, society is configured as a "network society", and the concept of network is used in various organizations, such as those of health. When organizing a network, everyone must explicitly recognize her/his dependences and interdependences, with no room for centralized powers, impositions, unbalanced powers - everyone must, together, construct legal, administrative, and informational conditions to operate services, systems, and organizations.¹⁴

We observed in respondents' speeches the reality of the local health system, with regard to the referral and counter-referral system, which rather than a mediator, a connector between points of the clinical network, is seen as an impediment to a faster process, as this is something else to worry about, to fulfill. Moreover, health services technologically denser do not provide return to lower levels, making the clinical network a

tangled of practices disarticulated and *ad hoc*. Then, we emphasize the virtual absence of counter-referral.

[...] it is very subtle, very little, I will need it to be more used [...] I think it is poor, very poor, professionals must be aware of its importance. (N1)

In fact, they do not have the sensitivity of referring the patient back by means of this counter-referral to primary care units, in fact, I do not know if they do not have time, there are many people for them to treat, and they cannot provide an answer, or if they do not think this is important. (N2)

Referring the elderly person, counter-referral is almost none, there is no return... (N3)

No, I think there are a lot of failures in counter-referral, many failures, indeed [...] we, from FHP [Family Health Program] are very required [...] then, if we do not seek, asking for the health work to seek it [...] it seems that primary care says one thing and secondary and tertiary care see something else, completely different. (N5)

[...] the counter-referral I just mentioned, it is virtually non-existent. (N6)

The concept of health care comprehensiveness shapes the health system as a network of services and relationships. Comprehensiveness derives from the systemic view of life, which comprises that we are integrated wholes, whose crucial properties will always belong to the whole, since no part possesses them alone.¹⁵

However, according to the subjects' speech, the meanings of comprehensiveness with regard to care provided for the elderly individuals are still disarticulated in terms of the efforts involved in elderly care, sporadic and disconnected.¹⁶ This goes against the proposals of PNSPI, which aims, within SUS, guarantee a comprehensive health care for the elderly population, highlighting a healthy and active aging based on the paradigm of functional capacity, addressed in a multidimensional way.

Solving the problem here, it is OK. (N7)

There is no connection [...] counter-referral, for me, it does not occur. (N8)

The network of health services is the way to organize actions and services for health promotion, prevention, and rehabilitation, at all levels of complexity, in a particular territory, in order to enable the coordination and interconnection of all kinds of knowledge, wisdom, technologies, professionals, and organizations therein, so that the citizen can access them, according to her/his health needs, in a rational, harmonic, and systemic manner, regulated according to a technical and health-driven rationale.¹⁷

This disarticulation in the network and the absence or ignorance of background services available, besides compromising the ability to solve problems in primary care, constitute a burden for professionals, by adding to their multiple tasks that of dealing with problems of the system.¹⁸ This aspect is portrayed in the speech of a male respondent,

when he indicates that the community health worker (CHW) acts as a compensator of system disconnection.

[...] we want to know what happened to the elderly person, we ask the health worker, you know, actually through the home visit. (N3)

In this field it still does not meet the needs, because if we want to know what happened to the elderly person, we ask the health worker, you know, actually through the home visit [...] there is a gap, indeed, the service does not work. (N4)

Fragmented health systems are those that are organized by means of a set of health care points isolated and non-communicated to each other that, as a consequence, are unable to provide continued care for the population. In general, there is no population obliged to take accountability, something which makes impossible grounding management in the population. Primary health care does not communicate fluidly to secondary health care, and these levels also do not communicate to tertiary health care or to support systems. In such systems, primary health care cannot play its role as communication center, coordinating care.¹⁹

When services do not provide counter-referral to lower levels of health care, the latter are forced to create strategies for provisional solution. Primary care has the assistance of CHW to try providing the elderly person with a comprehensive care, with which this professional, through her/his home visits, seeks to be aware of the procedures the elderly people have undergone, as well as their diagnoses and the therapeutic process.

CHW has a unique role, as she/he constitutes a “link” between the community and the health service, working in accordance with attitudes and values required by work situations, taking actions to support in guiding, monitoring, and providing health education, aiming, above all, to promote population’s quality of life and well-being.²⁰ However, although she/he can contribute to inform the population’s needs, CHW has limitations in assessing and understanding the complexity of problems that elderly people and family member may face at this time of vulnerability the illness process is.¹³

This clinical fragmentation, as seen in previous speeches, demonstrates that of health care systems are going through a contemporary crisis, which manifests itself to a greater or lesser extent in all countries, and it stems from an inconsistency between a health situation of complete demographic and epidemiological transition in developed countries, and a double or triple burden of diseases in developing countries, besides the way how deliberate social responses are structured to meet the population’s needs.¹⁹

Health networks are interconnected in order to provide the population with continued health services and an organized flow. However, if the referral and counter-referral system does not work, there is a significant gap in elderly care. This is observed in the following speeches, where counter-referral is addressed as an explanation that a health care level provides the other with; moreover, they also mention clinical regression when the network is deficient, due to poor comprehensiveness, or even absent, and thus there is a repetition of events and illnesses throughout the clinical network.

[...] an explanation to FHP [Family Health Program] of what happened here, only if the patient provides it by her/himself, because it is not written. (N9)

This functionality [...] is poor, in my view, but [...] because there is not a specific routine for this, no feedback [...] there is a need for an interaction of services. (N10)

Health care networks are polyarchic organizations of health service sets, linked together by a single mission, common goals, and a cooperative and interdependent action, enabling us to offer a continued and comprehensive attention to a certain population, coordinated by primary health care - provided at the right time, the right place, the right cost, the right quality and a humanized way, as well as with health and economic responsibility in relation to this population.²¹

This organizational system in networks must not be assigned only as a response, explanation from one health care level to another, but a feedback to the individual, with which the latter has a guaranteed access to problem-solving and humanized health services that turn the elderly client into the actual focus of assistance.

CONCLUSION

Working in elderly care networks implies looking at the actual health needs, as well as maintaining a dynamic and continuous flow through the clinical network, in order to qualify the provision of care. However, we notice, within the local health care system, fragmented and disconnected care practices, in which the elderly person goes back and forth from one health service to another, often without any solution in face of her/his health-illness process.

The study enabled an in-depth theoretical approach to SUS, the clinical networks, comprehensiveness, and the weaknesses of a health system that still does not follow the steps of the aging process at the same speed, where rescuing actions are frequently mentioned, both in practice and in the literature. The latter, in turn, has become scarce and outdated, something which brought a significant bias to the study, since the theoretical framework enables a move away from simple empiricism.

Given the above, there is a need to rethink the practice permeating the clinical networks, as the elderly person lacks more effective actions on her/his health, in order to improve her/his quality of life.

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