Global Clinical Research Journal

ORIGINAL ARTICLE

Level of resolution in secondary care of a health service in the Municipality of Avaré, São Paulo

Grado de resolución en atención secundaria de un servicio de salud en el Municipio de Avaré, São Paulo

Grau de resolutividade no atendimento secundário de um serviço de saúde do Município de Avaré, São Paulo

Alexandre Augusto de Lima[1]
ORCID: 0000-0003-2839-2846
Adilson Lopes Cardoso[1*]
ORCID: 0000-0003-2791-3937
Fernanda Augusta Penacci[1]
ORCID: 0000-0002-9300-9535
Alan Fernandes Guarato[1]
ORCID: 0000-0002-2104-3785
Elaine Cristina Navarro[1]
ORCID: 0000-0001-6638-1713
Marcia Regina Alves Rocha[1]
ORCID: 0000-0003-1867-3783
Francidalma Soares Sousa Carvalho Filha[2]
ORCID: 0000-0001-5197-4671
Stefania Dias da Silva[3]
ORCID: 0000-0002-4322-1028

[1]Faculdade Eduvale de Avaré. São Paulo, Brazil.
[2]Universidade Estadual do Maranhão. Bahia, Brazil.
[3]Centro Universitário Tocantinense Presidente Antônio Carlos. Tocantins, Brazil.
[*]**Corresponding author**: E-mail: cardosolc@uol.com.br

Abstract

The aim of this study was to identify the resolution of the health problems of users who were referred for care in the Cardiology Specialty at the Health Center I of the Municipality of Avaré. This is an exploratory descriptive study, of a qualitative-qualitative nature, which used as an instrument for data collection, an open-ended questionnaire for patients who were treated at the Health Center I of Avaré in the Cardiology Specialty who underwent the post consultation. Fifty users were interviewed. The problem-solving capacity of health services is a way of evaluating health services based on the results obtained from the service provided to the user. Thus, the resoluteness of services in the model hierarchical by levels of care can be evaluated in two ways. The first, within the service itself, regarding the ability to meet their demand and refer cases that need more specialized care, and the second, within the health system, which extends from the initial consultation of the user to the service of primary health care to the solution of your problem at other levels of health care. Secondary care consists of actions and services that aim to address the main health problems and problems of the population, whose clinical practice demands the availability of specialized professionals and the use of technological resources for diagnostic and therapeutic support.

Descriptors: Problem Solving; Universal Access to Health Care Services; High-Throughput Screening Assays; Consumer Behavior; Nursing.

How to cite this article:
Lima AA, Cardoso AL, Penacci FA, Guarato AF, Navarro EC, Rocha MRA, Carvalho Filha FSS, Silva SD. Level of resolution in secondary care of a health service in the Municipality of Avaré, São Paulo. Glob Clin Res. 2022;2(2):e29.

Chief Editor: Caroliny dos Santos Guimarães da Fonseca
Executive Editor: Kátia dos Santos Armada de Oliveira

Submission: 06-08-2022
Approval: 06-20-2022

Resumén

El objetivo de este estudio fue identificar la resolución de los problemas de salud de los usuarios que fueron remitidos para atención en la Especialidad de Cardiología en el Centro de Salud I del Municipio de Avaré. Se trata de un estudio descriptivo exploratorio, de carácter cualitativo-cualitativo, que utilizó como instrumento de recolección de datos, un cuestionario abierto a pacientes atendidos en el Centro de Salud I de Avaré en la Especialidad de Cardiología que pasó por la consulta posterior. Se entrevistó a 55 usuarios. La capacidad de resolución de problemas de los servicios de salud es una forma de evaluar los servicios de salud a partir de los resultados obtenidos del servicio prestado al usuario. Así, la resolución de los servicios en el modelo jerárquico por niveles de atención puede evaluarse de dos formas. La primera, dentro del propio servicio, en cuanto a la capacidad de atender su demanda y derivar los casos que requieran una atención más especializada, y la segunda, dentro del sistema de salud, que se extiende desde la consulta inicial del usuario hasta el servicio de atención primaria de salud para resolver su problema en otros niveles de atención médica. La atención secundaria consiste en acciones y servicios que tienen como objetivo atender los principales problemas y problemas de salud de la población, cuya práctica clínica exige la disponibilidad de profesionales especializados y el uso de recursos tecnológicos para el apoyo diagnóstico y terapéutico.

Descriptores: Solución de Problemas; Acceso Universal a los Servicios de Salud; Ensayos Analíticos de Alto Rendimiento; Comportamiento del Consumidor; Enfermería.

Resumo

O objetivo deste trabalho foi identificar a resolutividade dos problemas de saúde dos usuários que foram encaminhados para atendimento na Especialidade de Cardiologia no Centro de Saúde I do Município de Avaré. Trata-se de um estudo descritivo exploratório, de caráter quali-qualitativo, que utilizou como instrumento de coleta de dados, questionário de perguntas do tipo aberta aos pacientes que foram atendidos no Centro de Saúde I de Avaré na Especialidade de Cardiologia que passaram pela pós-consulta. Foram entrevistados 55 usuários. A resolutividade dos serviços de saúde é uma forma de se avaliar os serviços de saúde a partir dos resultados obtidos do atendimento ao usuário. Assim, a resolutividade dos serviços no modelo hierarquizado por níveis de atenção pode ser avaliada por dois aspectos. O primeiro, dentro do próprio serviço, quanto à capacidade de atender à sua demanda e de encaminhar os casos que necessitam de atendimento mais especializados, e o segundo, dentro do sistema de saúde, que se amplia desde a consulta inicial do usuário no serviço de atenção primária à saúde até a solução de seu problema em outros níveis de atenção à saúde. O atendimento secundário compõe–se por ações e serviços que visam atender os principais problemas de saúde e agravos da população, cuja prática clínica demanda disponibilidade de profissionais especializados e o uso de recursos tecnológicos de apoio diagnóstico e terapêutico.

Descritores: Resolução de Problemas; Acesso Universal aos Serviços de Saúde; Ensaios de Triagem em Larga Escala; Comportamento do Consumidor; Enfermagem.

Introduction

The Unified Health System (SUS) was established by Organic Laws n.º 8080/90 and n.º 8142/90, which establishes health as a right for all and a duty of the State, providing for the conditions for the promotion, protection, recovery of health and community participation in health actions, emphasizing the principles of universality, equity, integrality and resolution[1].

The system integrates one of the health organizations that form a complex network, whose constitution includes attributes of population and territory, structure, logistics and care and management models. The definition, limits and objectives of a health system are specific to each country, according to its own values and principles. These systems define the context of health services, which can be characterized in different ways in relation to network integration[2].

According to the study, secondary care is formed by specialized services at an outpatient and hospital level, with an intermediate technological density between primary and tertiary care, historically interpreted as procedures of medium complexity. Understanding that this level of specialized medical services, being diagnostic and therapeutic support and urgent and emergency care[3].

The resolution proposed by the SUS influences the possibilities of solving health problems within the levels of complexity which are detected. It is noted that there is a tendency in Brazil, albeit with little visibility, to seek the quality of public health services, because, as resources for the sector become increasingly limited and social inequalities increase, they intensify. care and attention needs, making it a challenge to produce quality under these conditions. Resolvability is an important doctrine in the SUS, as it allows identifying and seeking out subjects with the services offered, even if these are not fully achieved.

Bringing together different aspects, it is possible to say that problem-solving involves essential aspects to demand, customer satisfaction, health service technologies,

the existence of a pre-established reference system, the accessibility of services, the training of human resources, the health needs of the population, adherence to treatment, cultural and socioeconomic aspects of the clientele, among others. Within this complexity, primary care emerges as one of the forms of care for the SUS, which is recognized as the user's gateway to the system, which should be a priority in management, because when functioning properly, it would enable the resolution of most health problems. health, leaving specialized clinics and hospitals to exercise their true purposes, thus resulting in greater user satisfaction and conscious use of existing resources[4].

> *"When we raise the issue of resolution, we want the citizen to have access to all the technology that humanity has accumulated in defense of life in cases of illness, that is, the hospital must have the ability to provide effective responses to the health problems of its users with diagnostic and therapeutic resolution in the optimal time that the case requires, eliminating or reducing suffering, risks, and promoting recovery and healing"*[5].

For a health service to be resolute, it must be able to positively transform the health condition of an individual, family or group[4].

Until 1988, the right to health was a right guaranteed only to workers affiliated to the social security system and their families. With the enactment of the Federal Constitution, in 1988, the Unified Health System (SUS) was established, which came to understand that the:

> *"[...] Health is an absolute right that derives from the condition of being human, and adopts a model of a public health system, with a universal and egalitarian character [...]"*[6].

Secondary Care (AS), often called in official documents and ordinances of the Ministry of Health as medium-complexity care, is the level of support for primary care professionals. Comprised of specialists in different areas in the so-called secondary reference units, this service involves a specialized set of outpatient and hospital actions and services. The professionals of AS, through the system of reference and against reference, support the support in the treatment of the individual. Specific cases are referenced for highly complex procedures. It aims to address the population's unresolved health problems at the primary care level. It uses higher-density technological resources in diagnostic and therapeutic support, which require large-scale production to become economically viable and achieve sustainability[7,8].

This level of assistance has become an important bottleneck in the public health service network. The managers of the Unified Health System (SUS) live with a great pressure of demand for specialized services to which they cannot respond satisfactorily, generating long waiting lines and concentrating a considerable portion of public health expenditures[9].

The municipality of Avaré, today has a health service in primary care of 07 Basic Health Units (UBS) and 07 Family Health Units (USF) and in Secondary Care of 01 Health Center (CS), 01. Care Management - NGA-5 (attached to the CS), in addition to these services, it has 01 Psychosocial Care Center (CAPS II), 01 State and Municipal Sanitary Surveillance, 01 Epidemiological Surveillance, 01 Reference Center for Workers' Health (CEREST), 01 Dental Specialty Center (CEO), 01 Popular Pharmacy in Brazil, 01 Emergency Room (regional reference), 01 STD/AIDS Outpatient Clinic (regional reference), 01 Mobile Emergency Service (regional reference), 01 UPA (Union of Emergency Room) in the finishing phase and 01 Santa Casa de Misericórdia, which is a philanthropic institution that provides services to the SUS clientele, through a contract or agreement, under the regulation of the Municipal Health System. The curative purpose of care is characteristic of the services of the contracted and contracted network, through hospitalizations, consultations or laboratory tests[10].

Cardiovascular diseases (CVD) represent more than 30% of all deaths with defined causes, as they are the main cause of death and loss of quality of life over time. These diseases contribute to mortality rates of 16.6 million people, of which 7.2 million are due to ischemic heart disease[11].

In Brazil, CVD death rates are similar to global parameters, also remaining around 30%. Within cardiovascular entities, heart failure (HF) has a prevalence of 1 to 2% in the world population, making it one of the biggest public health problems[12].

The municipality of Avaré is a secondary reference for the cardiology specialty for the 17 municipalities that make up the Jurumirim Valley (Águas de Santa Bárbara, Arandu, Avaré, Barão de Antonina, Cerqueira César, Coronel Macedo, Fartura, Iaras, Itaí, Itaporanga, Manduri, Paranapanema, Piraju, Sarutaiá, Taguaí, Taquarituba and Tejupá, with a total of 280,294 inhabitants[13].

The public health network of the city makes available for cardiology care, a specialist doctor with a public examination, who performs the consultations at the Health Center I. This professional performs an average of 60 consultations/week, distributed randomly without discrimination of the first consultation or return.

The network user residing in the city can take advantage of laboratory tests, imaging tests (radiographs, computed tomography, magnetic resonance imaging, myocardial scintigraphy and electrocardiogram), and Echocardiography with Doppler and 24 Hz Holter are available through contract signed with the private service.

According to Ordinance No. 1101/GM of June 12, 2002, it establishes the parameter for outpatient care coverage, and the parameter for calculating medical consultations for the population, providing for 2 to 3 medical consultations per inhab./year. Through the following formula: Total Population x 2 consultations/inhabitant/year = X (X is, therefore, the total of planned medical consultations), where: 12% of X = basic emergency consultations; 3% of X = pre-hospital and trauma emergency consultations; 63% of X = basic medical consultations (Medical Clinic, Gynecology, Obstetrics and Pediatrics); 22% of X = specialist consultations. Of these, 2% are destined for Cardiology[14].

Secondary care is the basis for referral and counter-referral, necessary to ensure the efficiency of the current hierarchical model of health care[15].

In Brazil, the process of implementing this model has been experiencing some difficulties and, consequently, so has family medicine. One of the difficulties seems to be the overload of referrals to specialized medical services in secondary care, a fact that can be attributed to the difficulties in resolving primary care. One of the great challenges of this level of care is deciding when to refer the patient to be evaluated by a specialist in secondary or tertiary care[16].

The municipality of Avaré, today has 82,934 inhabitants, in an area of 1,213.055 km, with a health service in primary care of 07 Basic Health Units (UBS) and 07 Family Health Units (USF) and in Secondary Care of 01 Health Center (HC). It is observed that there is a pent-up demand in the cardiology specialty, which leads to an assessment of the service's ability to meet this demand[10,17].

Access to health services at the level of specialized care is an important bottleneck in health management in the municipality of Avaré. There is a great demand for care resources, in a context of insufficient supply and, often, used irrationally, which has resulted in long waiting lines for some procedures, causing delays in the diagnosis and treatment of patients.

The Avaré Health Department has implemented several actions with the objective of restructuring its care model, proposing to organize the entrance door of the health system, through the expansion of the Family Health Strategy and expansion of the offer of medium complexity services. The municipality also has a municipal health care regulation policy, whose main objectives are the restructuring of care flows of reference and counter-reference of primary care for medium and high complexity and the regulation of access to municipal health services.

Despite the efforts made to overcome the difficulties in accessing health services and aiming to guarantee the integrality of care, this municipality still faces problems such as repressed demand for specialized care, reflecting the long queue of users to access some specialized services and the difficulty of articulation in a network of primary care units and medium complexity units, thus compromising the health system's resoluteness.

The objective was to identify the resolution of the health problems of users who are referred for care in the Cardiology Specialty at the Health Center I of the Municipality of Avaré and the main causes that lead to difficulty and delay in scheduling specialized consultations and specific exams.

Methodology

This is an exploratory descriptive study, with a qualitative-quantitative character, which used as a data collection instrument, a questionnaire, with open-ended questions to patients who are treated at the Health Center I (CS.1) in Avaré/SP in the Cardiology Specialty who go through the post-consultation.

To carry out this scientific investigation, the deductive and inductive methods were used. According to the study, these consist of general methodological resources of science, which guide the ways of reasoning in the development of research. The deductive method guides from the general (hypotheses) to the particular (conclusions). The inductive method guides from the particular (specific facts) to the general (general conclusions). Also according to the study, both methodological resources complement each other, that is, the use of one does not exclude the other[18].

The choice of such methods was justified by the fact that, from these, it will be possible to compile the theoretical knowledge about the subject, through the theoretical foundation, as well as it will make it possible to generalize this knowledge, through the intervention proposal, in such a way that , these methods will prove to be adequate to what is proposed for the performance.

Data collection was performed after approval by the Ethics and Research Committee of the Faculty of Medicine of Botucatu (CEP/FMB) under CAAE: 43800115.0.0000.5411.

The study sample consisted of 55 patients treated in the cardiology specialty at Centro de Saúde I – Avaré/SP.

The application of the questionnaires took place from July to September 2015, the respondents answered the questionnaire after the researcher clarified the objective. All participants who agreed to participate in the study signed the Free and Informed Consent Term (FICT), thus legalizing their inclusion in this study. The rules of Resolution No. 466/2012 of the National Health Council were followed.

The information was stored in Microsoft Excel® spreadsheets, where after counting and analyzing the data, graphs were prepared with the values obtained.

Results and Discussion

Of the 55 users in the sample, 100% (55) responded to the questionnaire, with 94% (52) of respondents being over 40 years old, 60% (33) female and 40% (22) male, with 64% (35) attend the medical appointment unaccompanied.

Regarding the follow-up time at the cardiology outpatient clinic, 05% (03) are from 0 to 01 years, 29% (16) from 01 to 02 years and 65% (36) are under treatment in the specialty for more than 02 years.

All of them live in the municipality of Avaré, with 60% (33) of referrals to the Cardiology specialty coming from the UBS and 40% (22) from others referring to the Municipal Emergency Room, Santa Casa and Private Practice.

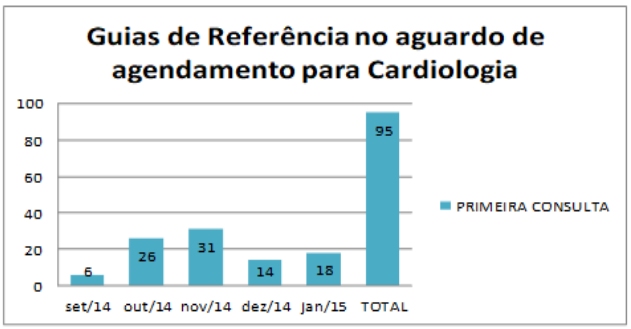
The chart below shows the number of referral guides sent from primary care to the Cardiology Specialty, in the 2nd semester of 2014, which are still waiting to be scheduled.

The low resolution of primary health care and inappropriate referrals are causes of the increased demand for specialized care, with a consequent increase in the waiting time for this level of care[19].

According to a study, the impossibility of serving the clientele according to the standards of human dignity and based on the concept of resoluteness in health leads

professionals to survive in the midst of stress. Difficulties in completing the service process, when the flow of actions and services does not materialize following the necessary steps to satisfy the demands presented because of difficulties of various types[20].

Figure 1. Schedule for cardiology. Avaré, SP, Brazil, 2015



The Health Department has carried out, through a Public Call Notice, for the accreditation of specialized professionals/companies to provide cardiology consultation services, based on Municipal Law No. 1,209/2009 amended by Laws No. No. 1,708/2013, limited to 100 (one hundred) consultations per month for each medical professional hired, in accordance with Article No. 3 of Law No. 1,665 of April 2, 2013, in the amount of BRL 50.00 by consultation carried out, but was not interested by any professional in the area[1].

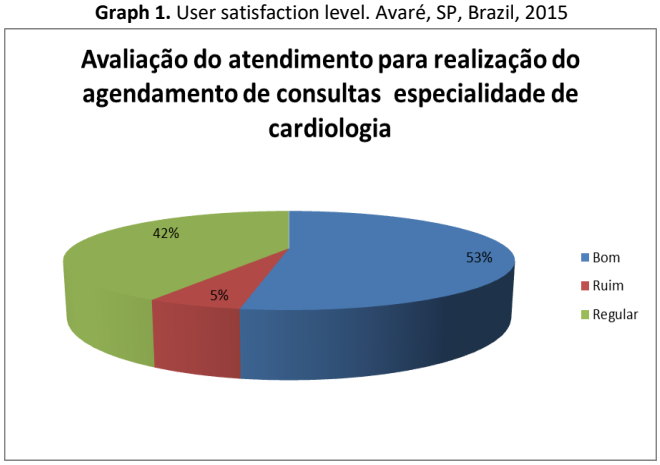
Graph 1 demonstrates the level of user satisfaction regarding the appointment of Health Center I.

Although the majority considered the appointment satisfactory, 54% (30) of the interviewees reported that they found the service difficult. The other 45% (25) said they did not encounter any difficulties. Faced with the difficulties, the most reported in their speeches was the delay in scheduling.

According to studies, this situation is opposed to the concept of access, where the patient's entry into the health service must be articulated, giving continuity to the treatment with the receipt of subsequent care. Having the availability of a service does not guarantee its effectiveness in use, in practice it has not yet managed to reduce the bureaucracy of access to services[21,22].

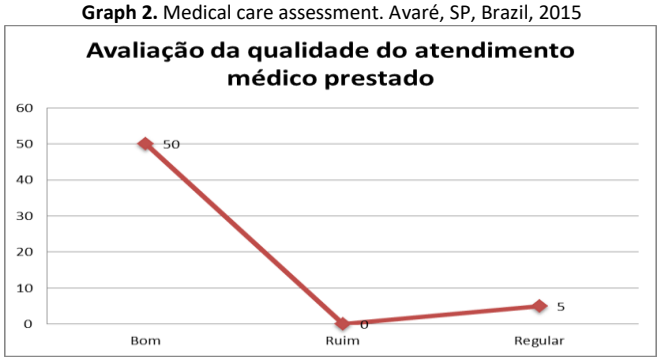
Among the users of the system, 87% (48) responded that they receive the necessary guidance when looking for the scheduling service, and 13% (07) said that sometimes, using a score from 0 to 10 regarding the level of understanding of the guidelines received , varied between 08 and 10.

Graph 1. User satisfaction level. Avaré, SP, Brazil, 2015



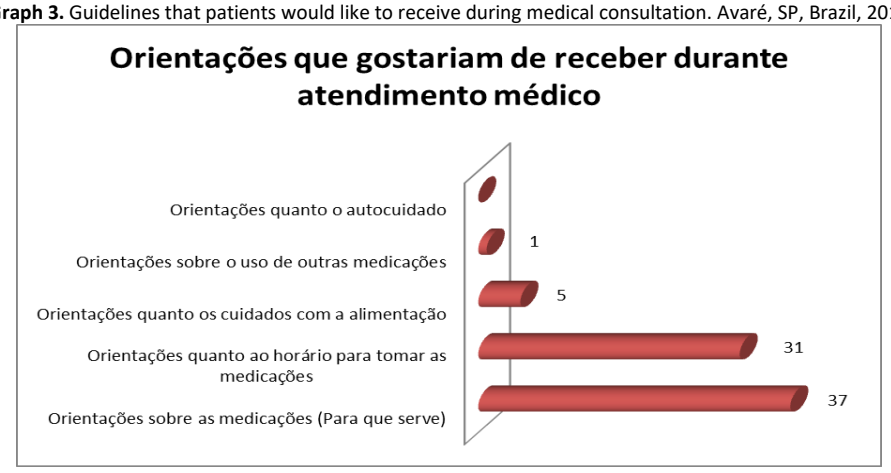
Regarding the medical care provided, 90% (50) of the patients who went through the consultation with the cardiologist reported their satisfaction with the care and only 10% (05) reported that the care was regular, as shown in the chart below.

Graph 2. Medical care assessment. Avaré, SP, Brazil, 2015



According to a study, the level of customer satisfaction is mainly influenced by social, cultural and geographic access; opportunity in waiting time at the consultation, as well as the time needed to establish a diagnosis and indicate treatment; courtesy; solution of the medical problem that motivated the demand for service[23].

Graph 3. Guidelines that patients would like to receive during medical consultation. Avaré, SP, Brazil, 2015



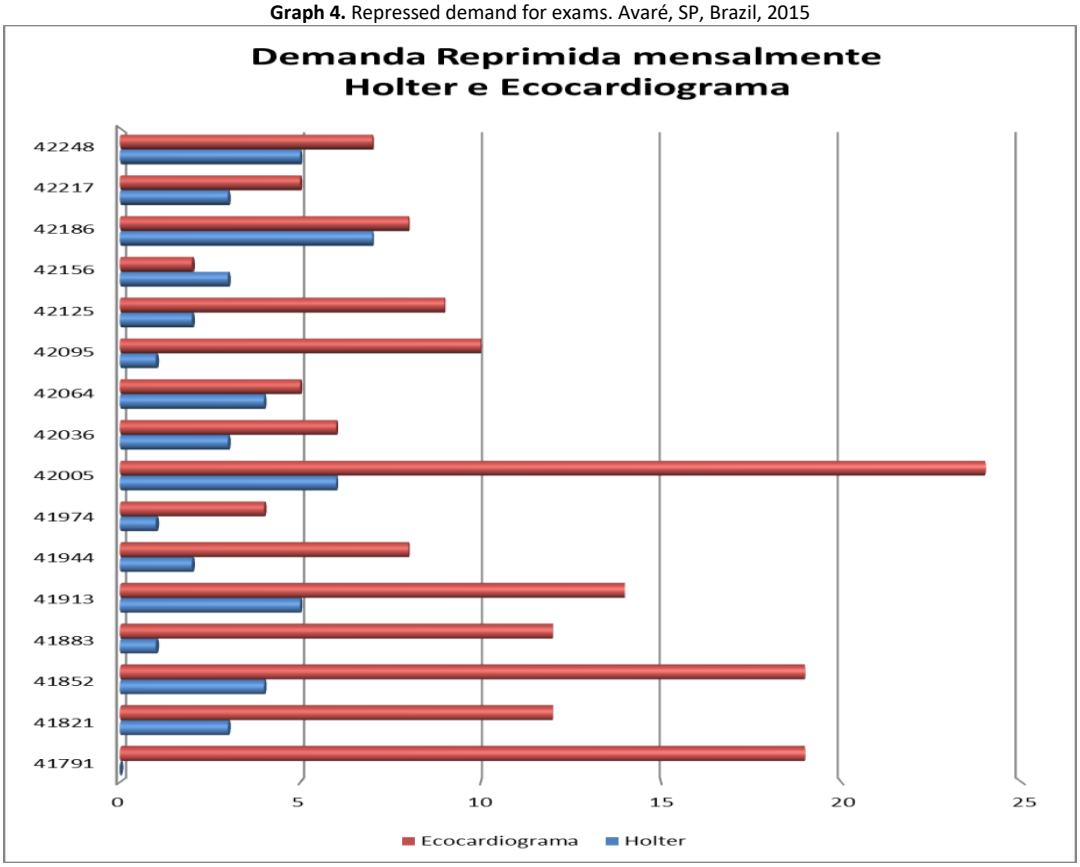
Information about your illness and its treatment, the relationship that the doctor establishes with the patient, the criteria that the patient has about the doctor's competence and, in addition to the coherence of the health team's work, are important aspects in patient satisfaction[24].

The chart above shows what guidance patients would like to receive during care, the biggest question being about the times and medications prescribed.

In the following graph, there is a repressed demand of 135 users who are waiting to schedule echocardiogram exams with Doppler (88) and 24 Hz Holter (47), in the years 2014 and 2015. Such exams are available through contract signed with the private service, but for 01 (one) year and three months they have not been carried out, due to lack of contract. The municipality of Avaré, makes a Public Call for Accreditation of Medical Clinics to provide the service, according to the values of the SUS Table, for R$ 39.94, but does not obtain interest from the private service.

In item 2.4 of Ordinance No. 1101/2002 GM, it establishes other procedures for diagnosis and therapy on specialized consultations, being for Holter 0.5% of the total of cardiological consultations and Echocardiogram 13% of the total of cardiological consultations[14].

Graph 4. Repressed demand for exams. Avaré, SP, Brazil, 2015



The Health Care Secretariat (SAS) of the Ministry of Health defines medium complexity as the set of actions and services that aim to address the main health problems and problems of the population, whose clinical practice requires the availability of specialized professionals and the use of technological resources, for diagnostic and therapeutic support[25].

When analyzing the segments of the offer of health services in Brazil, it is stated that the SUS, today, seems to be moving towards the basic care plan and the offer of health services of greater complexity would be left to the private sector[26].

According to studies, difficulties in accessing health care are linked to several conditions, such as geographic, economic and functional. Functional access involves the actual entry to the services that the citizen needs, including the types of services offered, the scheduled times and the quality of service[27].

The large number of users looking for a medium-complexity service demonstrates that they are in need of health care and attention, thus overloading the Clinic. Supply is the amount of health actions offered by the services, the availability of human resources and the availability of physical resources that having state-of-the-art technology in health services, leads us to believe that it is possible to offer quality care to users in a more humane and agile way, thus being able to exhaust the possibilities of what we can offer the user[28].

Conclusion

Through this study, it was possible to visualize the process of care and access of the SUS user in the search for a service of medium complexity, which involves the Consultation with the Cardiology Specialty and the Echocardiogram and Holter exams, and on the user's satisfaction in regarding scheduling and the quality of

medical care provided. It appears that the cardiology specialty is today one of the great care problems of the SUS – in the SMS of Avaré -, with great repressed demand.

It can be observed that the user's access difficulties, such as: the waiting time to get a medical appointment, even those who are undergoing treatment were unable to perform the requested exam. It is believed that the resolution capacity of secondary care in the municipality is compromised, as there is a repressed demand both for those seeking inclusion in the service, and for those who are already included in the cardiology service.

Although users are satisfied with the appointment and with the medical care provided, the greatest difficulty encountered is linked to the issue of delay both in carrying out the consultation with the cardiologist and in carrying out the exams and difficulties related to access. This delay in being able to perform the exams can worsen the health status of users, as they have been in treatment for about 2 years or more.

It appears that the Health Department faces difficulties with regard to contracting with the private service, with the lack of more cardiologists and the lack of specialized clinics to perform the exams, which leads to a low resolution of secondary care in the country, municipality of Avaré.

It is evident, therefore, that the service needs to be reorganized so that it can serve with quality and speed, as the use of health services should positively impact on increasing comfort and reducing suffering.

References

1. Souza GCA, Costa ICC. O SUS nos seus 20 anos: reflexões num contexto de mudanças. Saúde e Sociedade. 2010;19(3). DOI: 10.1590/S0104-12902010000300004
2. Ministério da Saúde (BR). Sistema Único de Saúde (SUS): estrutura, princípios e como funciona. Saúde de A a Z [Internet]. Brasília (DF): MS; 2020 [acesso em 23 nov 2020]. Disponível em: https://www.gov.br/saude/pt-br/assuntos/saude-de-a-a-z/s/sus-estrutura-principios-e-como-funciona#:~:text=O%20Sistema%20Único%20de%20Saúde%20(SUS)%20é%20composto%20pelo%20Ministério,ente%20tem%20suas%20co-responsabilidades
3. Silva SF. Organização de redes regionalizadas e integradas de atenção à saúde: desafios do Sistema Único de Saúde (Brasil). Ciên Saúde Coletiva.2011;16(6):2753-62. DOI: 10.1590/S1413-81232011000600014
4. Degani VC. A Resolutividade dos problemas de saúde: Opinião de usuários em um Unidade Básica de Saúde [Monografia]. Curso de Enfermagem da Escola de Enfermagem da Universidade Federal do Rio Grande do Sul [Internet]. Rio Grande do Sul; 2002 [acesso em 21 nov 2020]. Disponível em: https://lume.ufrgs.br/bitstream/handle/10183/1862/000310803.pdf
5. Bittencourt RJ, Hortale VA. A qualidade nos serviços de emergência de hospitais públicos e algumas considerações sobre a conjuntura recente no município do Rio de Janeiro. Ciência e Saúde Coletiva. 2007;12(4). DOI: 10.1590/S1413-81232007000400014
6. Vicava F, Oliveira RAD, Caravalho CC, Laguardia J, Bellido JG. SUS: oferta, acesso e utilização de serviços de saúde nos últimos 30 anos. Ciênc. Saúde colet. 2018;23(6). DOI: 10.1590/1413-81232018236.06022018
7. Paim JS. Sistema Único de Saúde (SUS) aos 30 anos. Ciênc. Saúde colet. 2018;23(6). DOI: 10.1590/1413-81232018236.09172018
8. Araujo MD. O trabalho em saúde: olhandi e experenciando o SUS no cotidiano. Trab. Educ. saúde. 2004;2(2). DOI: 10.1590/S1981-77462004000200014
9. Roese A, Gehardt TE. Fluxos e utilização de serviços de saúde: mobilidade dos usuários de média complexidade. Rev Gaúcha Enferm [Internet]. 2008 [acesso em 24 out 2020];29(2):221-9. Disponível em: https://lume.ufrgs.br/handle/10183/23593?locale-attribute=en
10. Secretária Municipal da Saúde de Avaré (SMS Avaré). Audiência Pública Municipal do 3º Quadrimestre de 2014 [Internet]. São Paulo (SP): SMS; 2014 [acesso em 24 out 2020]. Disponível em: https://camaraavare.sp.gov.br/view.php?NOT_id=1007
11. Conceição AP, Santos MA, Santos B, Cruz DALM. Autocuidado de pacientes com insuficiência cardíaca. Rev. Latino-Am. Enferm. 2015;23(4):578-86. DOI: 10.1590/0104-1169.0288.2591
12. Godoy MF, Lucena JM, Miquelin AR, Paiva FF, Oliveira DLQ, Junior JLA, et al. Mortalidade por doenças cardiovasculares e níveis socioeconômicos na população de São José do Rio Preto, estado de São Paulo, Brasil. Arquivos Brasileiros de Cardiologia. 2007;88(2). DOI: 10.1590/S0066-782X2007000200011
13. Instituto Brasileiro de Geografia e Estatística (IBGE). Conheça cidades e estados do Brasil [Internet]. Brasília (DF): IBGE; 2010 [acesso em 20 set 2020]. Disponível em: http://cidades.ibge.gov.br
14. Ministério da Saúde (BR). Portaria GM nº 1102. GM em 12 de junho de 2002 [Internet]. Brasília (DF): MS; 2002 [acesso em 20 set 2020]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2002/prt1101_12_06_2002.html
15. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457502. DOI: 10.1111/j.1468-0009.2005.00409.x
16. Junior KMAS, Tomita S, Kos AOA. O problema da fila de espera para cirurgias otorrinolaringológicas em serviços públicos. Rev Bras Otorrinolaringol. 2005;71(3):25662. DOI: 10.1590/S0034-72992005000300001
17. Moimaz SAS, Marques JAM, Saliba O, Garbin CAS, Zina LG, Saliba NA. Satisfação e percepção do usuário do SUS sobre o serviço público de saúde. Physis. 2010;20(4). DOI: 10.1590/S0103-73312010000400019
18. Zago LH. O método dialético e análise do real. Kriterion. 2013;54(127). DOI: 10.1590/S0100-512X2013000100006
19. Conill EM, Giovanella L, Almeida PF. Listas de espera em sistemas púbicos: da expansão da oferta para o acesso oportuno. Considerações a partir do Sistema Nacional de Saúde espanhol. Cien. Saúde Colet. 2011;16(6):2783-2794. DOI: 10.1590/S1413-81232011000600017
20. Rosa RB, Pelegrini AHW, Lima MADS. Resolutivade da assistência e satisfação de usuários da estratégia saúde da família. Rev. Gaúcha Enferm. 2011;32(2). DOI: 10.1590/S1983-14472011000200019

21. Sanchez RM, Cocinelli RM. Conceitos de acesso à saúde [Internet]. 2012 [acesso em 25 out 2020];31(3):260-8. Disponível em: https://www.scielosp.org/pdf/rpsp/2012.v31n3/260-268/pt
22. Ministério da Saúde (BR). Saúde da Família Panorama, Avaliação e Desafios [Internet]. Brasília (DF): MS; 2005 [acesso em 25 out 2020]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/saude_familia_panorama_avaliacao_desafios.pdf
23. Castro MSN, Travassos C, Carvalho MS. Efeito da Oferta de Serviços de Saúde no Uso de Internações Hospitalares no Brasil. Rev. Saúde Pública. 2005;39(2). DOI:10.1590/S0034-89102005000200020
24. Erdman AL, Andrade SR, Mello ALSF, Drago LC. A atenção secundária em saúde: melhores práticas na rede de serviços. Rev Latino-Am. Enfermagem. 2013;21(spe). DOI: 10.1590/S0104-11692013000700017
25. Souza FOS. O processo de trabalho em saúde e a demanda por assistência especializada na rede básica de saúde do Recife [dissertação]. Programa de Pós Graduação em Saúde Pública do Repositório Institucional da Fiocruz [Internet]. Pernambuco; 2010 [acesso em 25 out 2020]. Disponível em: https://www.arca.fiocruz.br/handle/icict/13680
26. Santos MAB, Gerschamn S. As segmentações da oferta de serviços de saúde no Brasil – arranjos institucionais, credores, pagadores e provedores. Ciência e Saúde Coletiva.2004;9(3)1:795-806. DOI: 10.1590/S1413-81232004000300030
27. Farias LO, Melamed C. Segmentação de mercados da assistência à saúde no Brasil. Ciênc. Saúde coletiva. 2003;8(2). DOI: 10.1590/S1413-81232003000200019
28. Rezende CAP, Peixto MPB. Metodologia para Análises Funcionais da Gestão de Sistemas e Redes de Serviços de Saúde no Brasil. Brasília: Editora Brasília; 2003