Deployment specialized center in rehabilitation: advantages and disadvantages mentioned by local health managers*

Implantação de centro especializado em reabilitação: vantagens e desvantagens apontadas pelos gestores municipais de saúde

ORIGINAL ARTICLE

Juarez de Souza Pereira[1], Wiliam César Alves Machado[2]

http://dx.doi.org/10.11606/issn.2238-6149.v26i3p373-381

Pereira JS, Machado WCA. Deployment specialized center in rehabilitation: advantages and disadvantages mentioned by local health managers. Rev Ter Ocup Univ São Paulo. 2015 Sept.-Dec.;26(3):373-81.

ABSTRACT: This study sought to identify the advantages and disadvantages determined by the managers about the deployment of the Specialized Rehabilitation Center, as a regional reference in a municipality of Centro Sul Fluminense region, Três Rios/RJ, Brazil. Exploratory and descriptive research, quantitative approach. Data collected by personal interviews, semi-structured instructions, with 27 participants, in the first semester of 2014, analyzed in the light of Qualiquantisoft® version 1.3c. Central ideas emerged about advantages, such as: better quality of life; ease of access; provision of specialized services; to prevent the displacement; guarantee of a quality service at low cost; improvement of management in the transport sector; could not inform, and no advantage. Regarding the disadvantages: difficulties with transportation; increased demand; and concerns and responsibilities in guaranteeing health care services. Despite the advantages, it is concluded that they are not in its fullness with the benefits that network services can provide. The disadvantages point to challenges in improving the management.

KEYWORDS: Rehabilitation; Health management; Regional health planning.

Pereira JS, Machado WCA. Implantação de centro especializado em reabilitação: vantagens e desvantagens apontadas pelos gestores municipais de saúde. Rev Ter Ocup Univ São Paulo. 2015 set.-dez.;26(3):373-81.

RESUMO: Este estudo buscou identificar as vantagens e desvantagens apontadas pelos gestores sobre a implantação do Centro Especializado de Reabilitação, como referência regional em um município da região Centro Sul Fluminense, Três Rios/RJ, Brasil. Pesquisa exploratória, descritiva, abordagem qualiquantitativa. Dados coletados através de entrevistas individuais, roteiro semiestruturado, com 27 participantes, no primeiro semestre 2014, analisados a luz do *Qualiquantisoft® versão 1.3c.* Emergiram Idéias Centrais sobre vantagens, tais como: melhor qualidade de vida; facilidade no acesso; oferta de serviços especializados; evitar o deslocamento; garantia de um serviço de qualidade a baixo custo; melhora da gestão no setor de transporte; não soube informar e nenhuma vantagem. Quanto às desvantagens: dificuldades com o transporte; aumento da demanda; e preocupações e responsabilidades em garantir atendimentos. A despeito das vantagens, conclui-se que elas não coadunam em sua plenitude com os benefícios que os serviços em redes podem proporcionar. As desvantagens apontam para desafios no aprimoramento da gestão.

DESCRITORES: Reabilitação; Gestão em saúde; Regionalização.

*Article extracted from the professional master's research project "Physical rehabilitation unit of Três Rios city: placement in Health Care Network for Persons with Disabilities under the Unified Health System", Juarez de Souza Pereira, Graduate Program in Health and Technology in the Hospital Environment - PPGSTEH, Federal University of the State of Rio de Janeiro (UNIRIO).

1. Federal University of the State of Rio de Janeiro, Graduate Studies in Health and Technology in the Hospital Environment - PPGSTEH. Email: juarezpereira.fisio@gmail.com.
2. Federal University of the State of Rio de Janeiro, Graduate Program in Health and Technology in the Hospital Environment - PPGSTEH. Email: wilmachado@uol.com.br.

Corresponding address: Juarez de Souza Pereira. Av. Anibal Peixoto Lavinas, 151, Bl 03, Aptº 402. Vila Isabel, Três Rios, RJ, Brazil. Email: juarezpereira.fisio@gmail.com.

INTRODUCTION

With the emergence of the Unified Health System (SUS), the Ministry of Health instituted a new systematic for Public Health Policies for persons with disabilities (PwD) in Brazil, then structuring itself based on the principles of decentralization, hierarchization, and regionalization of programs and services, predominating the guidance that health is a right of all citizens. Prioritizing actions aimed at the needs of society, in the case of this study for PwD, aiming to achieve the care completeness[1].

It is known that Rehabilitation Centers started to be deployed, in Brazil, at the end of 1950s. More specifically, with the deployment of a Demonstration of Rehabilitation Techniques Center of the World Health Organization, installed at Hospital das Clinicas from Faculty of Medicine of the University of São Paulo, in 1956. The care model was focused on a proposal of medical conceptions about disabilities and physical rehabilitation, legitimizing the hegemonic model of rehabilitation in Brazil[2].

Based on the hegemonic model, the care to the health of persons with disabilities was concentrated in Rehabilitation Centers, institutional care environments that concentrated all resources to prevent, rehabilitate, and deciding on therapeutic projects in rehabilitation[2,3].

It is imperative to highlight that this care model contributed to Rehabilitation Centers to be recognised as services of low coverage and limited capacity to handle wider issues, especially those of care quality. Moreover, its scope was greatly restricted to population groups residing near economically privileged urban centers, exacerbating the exclusion of people living in geographical areas distant from these groups[3].

For Mendes[4] (p.2302), SUS should structure the health care networks (HCN) to overcome the prevailing fragmented system, in order to handle the current situation of health established by the epidemiological transition, with relative predominance of chronic conditions, in addition to the demographic transition, which points to the increase in longevity and inevitable increase in the demand of typical rehabilitation care to older adults.

It is worth noting that one of the greatest challenges of SUS, in this century, will be to answer the needs of its, approximately, 32 million older adults[5]. Hence, major complications are noted for having a close relationship of the increase in disabilities (physical, visual, hearing, and mental) with the increased longevity of the population[6], in addition to the disabilities arising from external causes (car accidents and violence)[7].

However, Melo[8] (p.1718) states that the care in rehabilitation services is a major challenge for SUS, considering that the scope of its activities is being reduced, with few investments and little awareness of managers on the matter.

Seeking to change what has been established, the Ministry of Health, by Order no. 4279 of December 2010[9], established guidelines for actions and health services of SUS to be connected according to the logic of organization in HCN.

The HCN are organized with greater involvement by a set of health services that are linked through missions and common goals, developing actions that allow offering a continuous and integral care to a certain population from the coordination of Primary Health Care (PHC)[4].

The main characteristics of the networks are established by the collaboration between different components, and the points of health care are equally important and imply a continuous care in different levels[4].

In this context, the microregion 1 Centro Sul Fluminense of the state of Rio de Janeiro, composed of five municipalities, is being organized to deploy a Specialized Physical Rehabilitation Center (SRC) regionalised in accordance with what is stated by the Health Care Network for Persons with Disabilities, instituted by the Ministry of Health through Order No. 793 of April 24, 2012[10].

According to this Order, the SRC is a point of care of specialized outpatient quality and responsible for diagnosing, performing treatments, grants, adaptation and maintenance of assistive technologies. Furthermore, it also performs care in a connected way with other points of health care being a reference to the territory, involving the staff, the users, and their family in the therapeutic project[10].

Thus, the following question arose: What are the advantages and disadvantages identified by municipal health managers regarding the deployment of Specialized Rehabilitation Center?

OBJECTIVE

To identify the advantages and disadvantages determined by municipal health managers about the deployment of the Specialized Rehabilitation Center, as a regional reference in a municipality of Centro Sul Fluminense region, Três Rios/RJ, Brazil.

METHOD

This is an exploratory, descriptive research with quantitative approach, using the method of the Collective Subject Discourse (CSD) and the Qualiquantisoft® program (QQsoft) version 1.3c. Performed between January and March of 2014, in the five municipalities that constitute the microregion 1 of Centro Sul Fluminense region, Rio de Janeiro, Brazil.

The study had as theoretical reference the National Health Policy for Persons with Disabilities, guided by the Health Care Network for Persons with Disabilities[10], which comprises a set of connection parameters between health care and rehabilitation services in the network.

The municipalities involved were: Areal, Comendador Levy Gaspariam, Paraíba do Sul, Sapucaia and Três Rios. We should consider that the latter presented itself with a capacity installed on its physical rehabilitation unit to be qualified as a SRC to become reference to the remaining municipalities in the microregion 1. Decisions agreed in the sphere of Regional Intermanagerial Committee, a deliberative instance on regionalization of services in the region.

We selected 27 participants who perform typical managerial functions (coordinators, heads of departments, managers, secretaries, and assistant secretary) in their respective municipalities involved with the theme.

The interviews took place after signing of the Informed Consent Form, using a semi-structured questionnaire that sought to identify the advantages and disadvantages regarding the deployment of a regional physical rehabilitation service in the municipality of Três Rios/RJ, in the context of health care networks. We analyzed questions about the advantages and disadvantages to the citizens and the administration. It should be noted that this was the stage of planning the deployment of the SRC, period in which the managers were given an opportunity to express themselves regarding the possible advantages and disadvantages for the users of the program (citizens).

Data were collected through interviews and recorded by audio recording and later transcribed. Such interviews were carried out in the health care units where the managers work. Exclusive environments, free of noise and the possibility of interference, in such a way to not compromise the quality of the answers of the participants about the questionnaire.

After the transcriptions, the material was subjected to analysis using the QualiQuantiSoft® version 1.3c program, which contributed to the organization of Key Expressions (KE), of central ideas (CIs) and, consequently, to the development of the CSD[11].

It is known that KE are excerpts or segments that show the essence of the discourse selected by the researcher. On the other hand, the CIs are understood as an expression or name given to the meanings of KE, since, in the end, the CIs are named categories[11].

After several readings of the KE of each answer, it was possible to organize the categories according to the CIs, which have on the theory of social representations the base of the CSD method[11].

For each CI/Category, the CSD that empirically expresses the set of opinions/thoughts of the group interviewed was built, which culminates in "discourses-summaries" gathering responses from different people, with discursive content of similar meaning. Then, the CSD represents a set and not an individual, characterizing a collective thinking entity that has something to say about the topic of the question in the researched population[12].

According to Lefevre[11] (p.82) the attribute "Intensity/ Strength" of the CSD refers to the number of people who have contributed with their KE relative to CIs, similar or complementary, for the CSD elaboration. It was through this attribute that we identified the degree of sharing of thoughts/opinions showed in the population of this research and presented in percentage for each CI/Category identified.

The study was submitted to the Ethics Committee of the Federal University of the State of Rio de Janeiro, via Plataforma Brasil, and approved with opinion no. 502,802 on 12/19/2013.

RESULTS AND DISCUSSION

The sociodemographic profile of the participants comprised the following characteristics: regarding schooling, 2 participants with high school 25 with college degree; regarding sex, 20 were female and 7 were male; regarding the time of performance in the area of rehabilitation, 9 declared they have never worked in the area, while 4 reported to have worked in a period inferior to 1 year, 5 work between 1 and 5 years, 4 between 6 and 10 years, 3 between 11 and 15 years, 1 between 16 and 20 years, and 1 between 21 and 25 years.

Chart 1 presents findings elaborated from Central Ideas (CI) emerged in the study, in an order that demonstrates advantages and disadvantages both for the citizens and the administration.

Chart 1 - Summary of advantages and disadvantages for citizens and administration, deployment of SRC, Microregion 1, Centro Sul Fluminense, Três Rios/RJ, 2015

Advantages and disadvantages for the citizens	
1. Advantages	**2. Disadvantages**
CI 1.1 - Better quality of life [7.41%] CI 1.2 - Ease of access and provision of specialized services [66.67] CI 1.3 - To prevent displacement [22.22%] CI 1.4 - No advantage [3.7%]	CI 2.1 - No disadvantage [70.37%] CI 2.2 - Difficulty in transportation [25.93%] CI 2.3 - Increase in demand [3.7%]
Advantages and disadvantages for the administration	
3. Advantages	4. Disadvantages
CI 3.1 - Guarantee of a quality service at low cost [62.97%] CI 3.2 - Improvement in management of transportation sector [33.33%] CI 3.3 - Could not inform [3.7%]	CI 4.1 - Did not identify [74.08%] CI 4.2 - Difficulty in transportation [14.81%] CI 4.3 - Concerns and responsibilities in guaranteeing the care [11.11%]

Source: Elaborated from central ideas (CI) extracted from key expressions (KE).

Advantages for the citizens

Central ideas of the collective subject discourse concerning advantages for citizens with the implementation of SRC.

Question 1: What are the advantages to the citizens?

CI/Category 1.1: Better quality of life. [7.41%]

[CSD 1.1] - I think we will be able to greatly improve the quality of life of these people. They will have the care, indeed, on the site where, today, it does not have that flow within SUS.

CI/Category 1.2: Ease of access and provision of specialized services. [66.67]

[CSD 1.2] - The very provision of the service is already an advantage with more resource, with a more specialized labor, with a quicker system of reference and counter-reference, at low cost, in a physical environment properly prepared for this type of care that, throughout the region, is very needy, in addition to reduce the time in the queue. We have a demand for the city of Rio de Janeiro, and being a nearby town, it will be easier for the access of the citizens.

CI/Category 1.3: To prevent the displacement of citizens. [22.22%]

[CSD 1.3] - The issue of displacement, to shorten the distance that we have today with Rio de Janeiro. With the deployment of the network here, they won't need to move in search of prostheses, of ortheses; it also decreases a little the transportation of these patients.

CI/Category 1.4: No advantage. [3.7%]

[CSD 1.4] - You know, I see no advantage. Because what I think they're going to have are difficulties. Maybe in some references, I don't know how this treatment is going to be, but as to prosthesis, something like this, is going to be closer. [...] that would be the only advantage that I see.

Except as pointed out in [CSD 1.4], most managers emphasized that the deployment of SRC will bring substantive advantages to the citizens.

The advantages here identified emerge from the shortcomings that microregion 1 presents in rehabilitation programs available to potential users. Inheritance of the still hegemonic model of rehabilitation with services concentrated and available in Rehabilitation Centers in capitals[3].

It is noteworthy that the shortcomings showed in this study may be common in other health regions of the country, since these services were, for a long period, underfunded and away from the focus of public sector policies and of the interest of health managers[8].

The SRC advocated by the Health Care Network for Persons with Disabilities aims to overcome these difficulties through guarantees of access and the improvement of the quality of services, organized and regionalized in health care network. Beginning to provide integral care under the logic of a multiprofessional and interdisciplinary assistance, with

connection and integration between the points of care, and the provision of orthoses, prostheses, and auxiliary means of locomotion[10].

Hence, conceptual contributions in a study on access[13] indicated a distinction between two dimensions that constitute the term accessibility: the socio-organizational and the geographical. Noting that the socio-organizational accessibility relates to issues involving all the nuances of the service provision, excluding the geographical aspects that block or facilitate the access of people to the use of the services.

This, the proximity of municipalities with the future SRC was identified as an advantage for citizens to have access to rehabilitation services, considering the long distance between the municipalities and the current references in the area, located in the city of Rio de Janeiro.

In the study of Aguilera et al.[14] (p.1031) the long distances between municipalities and the specialized services was cited as a difficulty for users to have access to services, characterizing a logistic barrier very reinforced due to socioeconomic conditions of the population and of the public authority in facilitate the transportation to meet the demand.

The Health Care Network for Persons with Disabilities has among its purposes the challenge of approximating rehabilitation services of PwD through the PHC. In addition, the network also establishes actions that range from the early identification of disabilities to the encouragement and development of programs connected with resources of the very community, which promote inclusion and quality of life of people with disabilities[10].

It is known that the perception about the quality of life is influenced by two dimensions: subjective and objective. The subjective dimension relates to culture and individual actions. The objective dimension relates to the organization and the provision of public programs responsible for improving the life condition of a society, influencing positively or negatively on the perception of the well-being of people involved in this context[15].

As noted in [CSD 1.1], managers pointed out that they will be able to "improve the quality of life" of persons with disabilities with the deployment of SRC.

Disadvantages for the citizens

Next, we present central ideas of the collective subject discourse concerning disadvantages for citizens with the deployment of SRC.

Question 2: What are the disadvantages for the citizens?

CI/Category 2.1: No disadvantage. [70.37%]

[CSD 2.1] - I can't see any disadvantage. They may come with the passage of time.

CI/Category 2.2: Difficulty in transportation. [25.93%]

[CSD 2.2] - The disadvantage that I see today is the issue of transportation. We don't have the transport adapted to meet the demand.

CI/Category 2.3: Increase in demand. [3.7%]

[CSD 2.3] - I don't want to understand that there will be a disadvantage, but the access will be equal to the region as a whole, so the number of care will increase.

The disadvantages cited in [CSD 2.2] and [CSD 2.3] constitute logistic and operational challenges about guaranteeing the rights of PwD greater than a disadvantage regarding transportation and the increased in the demand for these users.

On the other hand, it is important to highlight that one of the challenges of the management, in relation to the increase in the demand, is to meet what was established in the concept of sufficiency, understood as the base of the HCN. Thus, sufficiency means the set of actions and services available in quantity and quality to meet the health needs of the population[9].

Regarding the disadvantage identified in [CSD 2.2], concerning the difficulty in transportation, a study performed in Campo Grande, MS, brings considerations for the omission of public authorities in ensuring social rights to citizens, which end up seeking alternatives[16].

Furthermore, the study of Silva et al.[16] (p.80) shows that respondents reported that the displacement for the physiotherapy service was carried out by means of public transport, car, on foot, or by bicycle, transportation that prevent or hinder the access to people with greater motor impairment, in addition to those of unfavorable financial conditions to afford transport costs to get to the clinics.

Advantages for the administration

According to what was identified, next we have the central ideas of the collective subject discourse concerning advantages for the administration with the deployment of SRC.

Question 3: What are the advantages for the administration?

CI/Category 3.1: Guarantee of a quality service at low cost. [62.97%]

> *[CSD 3.1] - I think that from the moment you create the assistance network, you have a decrease, mainly in the cost allied to the quality of work. Everything that today is provided for a smaller population, material purchases, purchases of equipment, all this will be done on a larger scale to meet the population with the partnership of other nearby towns. So, you're going to centralize all these demands within the municipality.*

CI/Category 3.2: Improvement in management of transportation sector. [33.33%]

> *[CSD 3.2] - I think it facilitates the cost, reduces expenses of the management to transport these people to other locations. I believe it will be able to transport even more people, for being closer.*

CI/Category 3.3: Could not inform. [3.7%]

> *[CSD 3.3] - I don't know. I don't know how to answer, I really don't know.*

In [CSD 3.1] are recorded advantages for administration, which are consistent with concepts of economy of scale, inter-federative solidary cooperation, and quality in the assistance. Fundamental concepts for the organization of HCN[9]. The application of these concepts aims the establishment of completeness with lower cost and a greater systemic rationality in the consumption of resources[17].

In this context, we highlight the logistical systems as members of HCN and which consists in the establishment of an effective system of reference and counter-reference of people, of the efficient exchange of products and information throughout the health care points. Thus, are confirmed parts of the logistics systems, the identification and monitoring of users, the emergency call centers, the electronic record, and the health transportation systems[9].

It is worth noting the highlighted in [CSD 3.2], when it identifies as advantage for the improvement in transportation management, conforming to the concept of geographic accessibility[13] towards the implementation of the regional SRC. Greatly contributing to the operationalization of the administrative transportation system, tracing specific routes to minimize the linear distance, locomotion time, and cost of travel, both for the management and for the user.

Disadvantages for the administration

Question 4: What are the disadvantages for the administration?

CI/Category 4.1: Not identified. [74.08%]

> *[CSD 4.1] - I think there is none. This will bring only advantages, especially because it's going to be near our municipality. I think everything is organized, with an elaborated management, being favorable to the municipal administration.*

CI/Category 4.2: Difficulty in transportation. [14.81%]

> *[CSD 4.2] - I still have a disadvantage in the transportation issue, because the municipality would have expenditure with it. It will depend on a good transportation structure, on a staff structure, to monitor these patients until there, you know? Because, sometimes, you get your own PPI (Negotiated and Integrated Programming), and you can schedule a patient to 7 am and other to 5 pm. The patient of 7 am will have to stay until 5 pm, hoping to be able to come back.*

CI/Category 4.3: Concerns and responsibilities in guaranteeing the care. [11.11%]

> *[CSD 4.3] - I think it's responsibility. Because the municipality becomes responsible for ensuring the care, not only for its population, but for a referenced population as well. There is, indeed, on the part of the municipal management, a concern about providing the care to a region as a whole. There are more health care, concerns about a more dedicated, more qualified professional, so there is a concern and not a disadvantage.*

It is observed that the transportation theme was mentioned in the four response options in different situations (as we can see in Chart 1): in [CSD 1.2] and [CSD 3.2] they are presented as advantages for both the citizens and the administration. In [CSD 2.2] and [CSD 4.2], transportation has been indicated as a disadvantage for both the citizens and the administration.

In [CSD 4.2], the difficulty in the transportation is related to the way in which the schedule is carried

out, causing physical and emotional strain to users due to the discrepancy between the schedules of clinical exams, specialized consultations, among other therapeutic procedures outside the municipality, and their return to the city where they reside.

A similar fact was reported in the study of Machado et al.[18] (p.278), when they identified users' complaints regarding the time they spend at the clinic, since most of them arrived in the morning, using public transportation provided by the municipality of origin, and the return occurred when the last patient was provided the care.

It is worth reflecting in order to gradually eliminate the discrepancy mentioned in the previous paragraph, based on [CSD 4.2], since the SRC has as users people with disabilities or with reduced mobility whose extended wait can compromise the cutaneous integrity, for remaining seated in a different structure than the usual, in addition intensify the emotional, provoking emotional stress triggers.

It is suspected that the transportation management in the health sector has been treated as an irrelevant topic, a subtopic. Furthermore, the study of Andrade et al.[19] presented reports on the difficulties in transportation, pointing some barriers to maintain the organization and the relationship between the primary health care programs (PHC) and the home care services (HCS), compromising the quality and continuity of care in these structures of public health/rehabilitation services.

It is noteworthy that the benefits of the services organized in networks come true when these are improved, exceed the instituted, eliminate obstacles, and enhance their mechanisms, allowing and ensuring full care to users through the full access to different services to the community[17].

Although not directly related to the transportation issue, the contributions of Silva[17] (p.2757) also emphasize the underfunding as a difficulty for the consolidation of regionalized networks and points to challenges to be overcome, such as: improvement in the relationship between the government and the clarity of its powers, improvement in the intergovernmental management, and the integration of a care model that favors the PHC.

As for the concerns of managers regarding the increased responsibility in guaranteeing the care to other municipalities, considerations are made in a study on the definition of allocation of funding resources, within the regionalization of the public structure in the network, considering that there will be an increase in the costs of the municipality where the SRC is referenced. Thus, funding resources should be increased to expand the access in a universal, equitable, and complete way to the citizens of the entire region[20].

We highlight that the Director Plan for Regionalizing Health Care (PDR) and the Negotiated and Integrated Programming (PPI) are the management planning instruments that guide the regionalizations of SUS health care services. And it is through them that the management seeks to ensure the access for users of a given municipality on another region that provides negotiated health care services[21,22].

CONCLUSION

The study represents a contribution towards bringing information from health managers of municipalities about advantages and disadvantages of the regionalization rehabilitation services, in accordance with the proposed for the deployment of the Health Care Network for Persons with Disabilities, having as reference the city of Três Rios to the Centro Sul Fluminense region.

Advantages were identified by the managers for the benefit of the citizens, mainly those related to ease of access to specialized services provision, including the deployment of the Network as a relevant initiative for users of the rehabilitation program. In the same line of reasoning, the managers highlighted in descending order the advantages of avoiding displacements, better quality of life, in addition to not identifying any disadvantage.

We pointed out as advantages for the administration: to guarantee quality services at a low cost, and the improvement in the management in the transportation sector, demonstrating both the involvement with the quality of services to be provided to the population and aiming an opportunity for improvements in the public management of health transportation.

Regarding the disadvantages for the citizens identified by the managers, we highlighted the responses to no disadvantage, followed by the difficulty in transportation, which is justified by the constant discontent of users of public health services, when the theme refers to the transportation. There were also those who mentioned a concern with the increase in demand.

This could also be observed regarding to what was considered a disadvantage to the administration, when most participants did not identify any, followed by difficulties in transportation and ending with responsibilities to guarantee the care to the users. Thus, we emphasize the managers' concern with the transportation of users, associated with the old insecurity regarding the guarantee of the care in the public service.

REFERENCES

1. Malfitano APS, Ferreira AP. Saúde pública e terapia ocupacional: apontamentos sobre relações históricas e atuais. Rev Ter Ocup Univ São Paulo. 2011;22(2):102-9. http://dx.doi.org/10.11606/issn.2238-6149.v22i2p102-109.
2. Almeida MC, Campos GWS. Políticas e modelos assistenciais em saúde e reabilitação de pessoas portadoras de deficiência no Brasil: análise de proposições desenvolvidas nas últimas duas décadas. Rev Ter Ocup Univ São Paulo. 2002;13(3):118-26. http://dx.doi.org/10.11606/issn.2238-6149.v13i3p118-126.
3. Mitre SM, Andrade EIG, Cotta RMM. O acolhimento e as transformações na práxis da reabilitação: um estudo dos Centros de Referência em Reabilitação da Rede do Sistema Único de Saúde em Belo Horizonte, MG, Brasil. Ciênc Saúde Coletiva. 2013;18(7):1893-902. http://dx.doi.org/10.1590/S1413-81232013000700004.
4. Mendes EV. As redes de atenção à saúde. Ciênc Saúde Coletiva. 2010;15(5):2297-305. http://dx.doi.org/10.1590/S1413-81232010000500005.
5. Machado WCA, Figueiredo NMA, Pereira J de S, Rezende KR, Silva RA, Silva VM. Capacidade funcional de idosos usuários de unidade dia: resgatando autonomia através das Atividades de Vida Diária. Gest Saúde. 2014;5(5):3068. Available from: http://gestaoesaude.bce.unb.br/index.php/gestaoesaude/article/viewFile/1130/pdf. Access date:
6. Castro SS, Lefèvre F, Lefèvre AMC, Cesar CLG. Acessibilidade aos serviços de saúde por pessoas com deficiência. Rev Saude Publica. 2011;45(1):99-105. http://dx.doi.org/10.1590/S0034-89102010005000048.
7. Lima MLLT, Lima MLC. Avaliação da implantação de uma Rede Estadual de Reabilitação Física em Pernambuco na perspectiva da Política Nacional de Redução da Morbimortalidade por Acidentes e Violência, 2009. Epidemiol Serv Saúde. 2013;22(4):597-607. http://dx.doi.org/10.5123/S1679-49742013000400006.
8. Melo E. Análise diagnóstica da política nacional de saúde para redução de acidentes e violências. Cad Saúde Pública. 2008;24(7):1717-8. http://dx.doi.org/10.1590/S0102-311X2008000700029.
9. Brasil. 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). Brasília; 2010. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2010/prt4279_30_12_2010.html. Access date:
10. Brasil. Portaria nº. 793, de 24 de abril de 2012 Institui a Rede de Cuidados à Pessoa com Deficiência no âmbito do Sistema Único de Saúde. [Internet]. 2012. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt0793_24_04_2012.html. Access date:
11. Lefevre F, Lefevre AMC. Pesquisa de representação social: um enfoque qualiquantitativo: a metodologia do discurso do sujeito coletivo. 2a ed. Brasília: Liber Livro Editora; 2012.
12. Lefevre F, Lefevre AMC. Depoimentos e Discursos: uma proposta de análise em pesquisa social. Brasília: Liber Livro Editora; 2005.
13. Travassos C, Martins M. Uma revisão sobre os conceitos de acesso e utilização de serviços de saúde. Cad Saúde Pública. 2004;20(Supl. 2):S190-8. http://dx.doi.org/10.1590/S0102-311X2004000800014.
14. Aguilera S, França BHS, Moysés ST, Moysés SJ. Articulação entre os níveis de atenção dos serviços de saúde na região metropolitana de Curitiba: desafios para os gestores. Rev Adm Pública. 2013;47(7):1021-39. http://dx.doi.org/10.1590/S0034-76122013000400010.
15. Almeida MAB, Gutierrez GL, Marques R. Qualidade de vida: definição, conceitos e interfaces com outras áreas, de pesquisa. São Paulo: Escola de Artes, Ciências e Humanidades – EACHUSP; 2012. Available from: http://each.uspnet.usp.br/edicoes-each/qualidade_vida.pdf. Access date:
16. Silva MA, Santos MLM, Bonilha LAS. Fisioterapia ambulatorial na rede publica de saúde de Campo Grande (MS, Brasil) na percepção dos usuários: resolutividade e barreiras. Interface comum. Saúde Educ. 2014;18(48):75-86. http://dx.DOI: 10.1590/1807-57622013.0264.
17. Silva SF. Organização de redes regionalizadas e integradas de atenção à saúde: desafios do Sistema Único de Saúde (Brasil). Ciênc Saúde Coletiva. 2011;16(6):2753-62. http://dx.doi.org/10.1590/S1413-81232011000600014.
18. Machado MC, Medina FM, Kara-José N. Percepção dos usuários, profissionais de saúde e gestores sobre o modelo de atendimento oftalmológico no Hospital Regional de Divinolândia-São Paulo. Arq. Bras Oftalmol. 2010;73(3):276-81. http://dx.doi.org/10.1590/S0004-27492010000300013.
19. Andrade AM, Brito MJM, Silva KL, Montenegro LC, Caçador BS, Cota Freitas LF. Organização das redes de atenção à saúde na perspectiva de profissionais da atenção domiciliar. Rev Gaucha Enferm. 2013;34(2):111-7. http://dx.doi.org/10.1590/S1983-14472013000200014.
20. Shimizu HE. Percepção dos gestores do Sistema Único de Saúde acerca dos desafios da formação das Redes de Atenção à Saúde no Brasil. Physis (Rio J.). 2013;23(4):1101-22. http://dx.doi.org/10.1590/S0103-73312013000400005.

21. Souza AS, Chebli ICF, Jacometti EJ, Paiva MG. Regionalização sob a ótica dos gestores: uma abordagem dialética. Rev APS. 2010;13(supl. 1). Available from: http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/?IsisScript=iah/iah.xis&src=google&base=LILACS&lang=p&nextAction=lnk&exprSearch=574562&indexSearch=ID. Access date:

22. Ianni AMZ, Monteiro PHN, Alves OSF, Barboza R. Metrópole e região: dilemas da pactuação da saúde. O caso da Região Metropolitana da Baixada Santista, São Paulo, Brasil. Cad Saude Publica. 2012;28(5):925-34. http://dx.doi.org/10.1590/S0102-311X2012000500011.

Received: March 26, 2015
Accepted: August 25, 2015