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Articles

Integrality in the Urgent and Emergency Health Care Network: care over services

Construção da integralidade na Rede de Atenção às Urgências e Emergências: o cuidado para além dos serviços (resumo: p. 16)

Construcción de la integralidad en la Red de Atención a Urgencias y Emergencias: el cuidado más allá de los servicios (resumen: p. 16)

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This research aims to analyze the dimensions of care and health needs reported by users of the Urgent and Emergency Care Network (RUE) in a health region. The qualitative study was conducted by collecting statements from health service users about their experiences with the illness process and the use of RUE. The analysis considered the references of the "Taxonomy of Health Needs" and the "Multiple Dimensions of Care Management". The statements emphasized the users search for autonomy and the action of family care. Understanding the health needs of users and the different dimensions of care management is essential to formulate health policies and organize networks towards comprehensiveness.

Keywords: Comprehensive health care. Health services needs and demand. Emergency medical services. Health systems.

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Introduction

Providing comprehensive health care for the Brazilian population has been a significant challenge for the Brazilian National Health System (SUS). The principle of comprehensiveness recognizes the complexity of individual and collective health needs, showing that the right to health in Brazil should not be restricted to a basic supply of services but contemplate the necessary for health care with dignity[1].

Comprehensiveness is described in the Organic Health Law[2] as the articulated and continuous set of preventive, curative, individual, and collective actions and services, required for each case at all levels of system complexity, and considered a principle of polysemic conception[1,3,4]. Understood either as an integrator axis of services or a holistic view of the subject of care, or even as actions of comprehensive care to demands and needs[4], the definitions of comprehensiveness express the access to different levels of care and the articulation of different health services, being often based on the reception and relationship between users and teams[1].

Mattos[3] identifies at least three sets of meanings of the concept of comprehensiveness: the first, applied to the characteristics of health policies or the scope of government responses, seeking to articulate preventive actions with care actions; the second, related to aspects of the organization of health services, which should ensure both access to care and continuity of care; and a third set, focused on attributes of health practices with an expanded look on the subjects. From other perspectives, Ayres[5] understands comprehensiveness from four axes, including: Needs, concerning reception and response to health demands; Purposes, including the relationship between promotion, prevention, care, and rehabilitation measures; Articulations, relevant to the actions of multidisciplinary teams, interdisciplinary knowledge, and intersectoral actions; and Interactions, which address the possibilities and strategies of intersubjective encounters.

In this study, we understand comprehensiveness as the connections between the multiple dimensions of care[6] operating to meet the different health needs[7] of the population and individuals. As Mattos[3] summarizes, what characterizes comprehensive health is the increased understanding of needs and the ability to adapt the offers to the specific context in which the subject meets with the team and where people's lives are concretely produced.

Considering that health needs are always historical, dynamic, and changing but also have a subjective and individual component, Cecílio and Matsumoto[7] formulated a taxonomy organized into four major axes of needs: 1) having good living conditions; 2) having access and ability to consume all health technology which can improve and prolong life; 3) creating and maintaining (a)effective relationships with health teams and professionals; and 4) having increased autonomy in the way of living. This classification summons an accessible and integrated health system which produces care and subjectivity.

Under the theoretical framework of symbolic interactionism, Utzumi *et al*.[8] understand health care as something concrete, a social object from the action of each individual involved in the process. In an inclusive conception, Cecílio[6] defines health care management as providing health technologies according to the necessities of each person, at different moments of their life, for their well-being, safety, and autonomy to maintain a productive and happy life. The author also proposes producing care in six dimensions – individual, family, professional, organizational, systemic, and societal – which, inherent to each other, present multiple connections, producing a complex network of contact points, shortcuts, collateral paths, and possibilities.

Cecílio[6] argues that the logic of the first dimension – individual dimension – is the need of self-care, autonomy, the right to choose. The second dimension, family, is composed of family members and also friends, neighbors, affective relationships, and the network of caregivers which surrounds the individual. The logic of this dimension is support, proximity, and all the elements present in the world of life. In the third dimension, the professional one, the actors are health workers and the constitutive elements are technical preparation, acquaintance, and ethics. In the fourth dimension, the organizational one, health teams and managers are the protagonists, coordinating care in the service. The fifth dimension, systemic, is the field of administrators and the locus of production of health policies, organization, financing, and system coordination. The state and society operate in the sixth and final dimension, the societal one, which must guarantee the basic conditions of existence and reproduction of life[6].

Comprehensive care still causes dispute and tension within SUS since, despite bringing advances and innovations, care practices are still strongly related to the biomedical, curative paradigm. Such paradigm expresses a more mechanized, controlling, and normatizing assistance, focusing on pathology over human beings[9]. Santos and Giovanella[10] analyzed the conformation of comprehensive care management at the political-institutional and organizational levels and in health practices in a health region, identifying challenges for municipal and between-municipality coordination of essential care for users. One of these challenges are the devices for integration and regulation of care because of fragmented care points of the system and a communication disruption in the network.

To overcome this intense fragmentation of health actions and services and qualify care management, since 2010, the Ministry of Health proposes health care networks (RAS) as an organizational model for SUS[11]. The constitution of RAS was strongly marked by the federal induction to implement thematic networks in health regions. These networks include the Stork Network, the Urgent And Emergency Care Network, the Psychosocial Care Network, the Network for Health of People with Disabilities, and the Chronic Diseases Care Network[11].

Regardless of the organizational model, many countries have been investing in emergency services to meet the growing demand of cases and resolve hospital overcrowding[12]. Considered a priority agenda for the population, health workers, and administrators, urgent and emergency care in Brazil affects society's assessment of the guarantee of the right to health, the care offered, and the legitimacy of SUS[13]. Since 2011, the Urgent And Emergency Care Network (RUE) is implemented to articulate and integrate all health equipment, aiming to expand and qualify humanized and comprehensive access to users in an emergency situation swiftly and conveniently. RUE guidelines include territorial action organized from the population's health needs, risks, and vulnerabilities and professional and management practice aimed at improving the quality of care by developing coordinated, continuous actions for comprehensiveness and longitudinality of health care[14].

Considering the multiple dimensions of care management and the different health needs, our question is: How is RUE, as a health policy, effectively built by users who seek to fulfill their needs and gain assistance to their illness processes? Although the knowledge of users of the health system should be considered valid for being an "assessing knowledge", it is often disregarded by professionals, managers, and researchers[15]. This study thus aims to analyze the multiple dimensions of care and health needs reported by RUE users in a health region.

Method

This qualitative study used the statements of eight SUS users about their experiences with RUE. The users were interviewed openly and in depth, narrating their illness processes and their experiences using RUE. The interviews were dialogical and started from the invitation "tell me...", with potential to apprehend feelings, understandings, interpretations, and factual and objective information[16].

The field survey was conducted in two medium-sized municipalities in a health region in the state of São Paulo in March 2019, both chosen by convenience. Interviewees were selected based on information collected in the regulatory centers of the municipalities. The inclusion criterion were having used, in the last month, the health network for urgent or emergency situations in one of the three lines of care of the RUE: cardiovascular, cerebrovascular, and traumatological[14]. From the listings provided by the municipalities, users were contacted by telephone to be explained about the research objectives and invited to participate. All users who could be reached and who consented to participate were included, totaling eight interviewees.

The interviews had an average duration of 40 minutes and were conducted in households and health services with participants who consented to participate and signed an informed consent form. The participation of family members and caregivers as mediators was allowed to expand the detailing of information and complement the reports[17]. The content was recorded and transcribed and the identities were encrypted to ensure confidentiality and anonymity. The observations recorded by the interviewers in field notes were also included as empirical material.

The empirical material was analyzed based on the theoretical-operational references of the Taxonomy of Health Needs[7] and the Multiple Dimensions of Care Management[6]. After exhaustive reading of the full transcribed interviews, excerpts from statements which expressed health needs and dimensions of care management were selected. These excerpts were categorized according to the proposed analytical framework and organized in summary tables.

The results were interpreted based on the meanings and recurrences observed[16] and questions evidenced were expanded by the inductive method – that is, other concepts and added new theoretical references were researched from the empirical material.

The research was approved by the Research Ethics Committee in accordance with Resolution No. 466/2013 of the National Health Council by opinion no. 2.447.067/2017 and funded by the National Council for Scientific and Technologic Development – CNPq.

Results

The eight SUS users interviewed had a history of recent health episodes which required care in the RUE. Participants were four men and four women and their age ranged from 46 to 75 years. Of the eight interviewees, three were diagnosed with stroke, two with acute myocardial infarction (AMI), and three had orthopedic traumas.

All statements expressed health needs (Frame 1) and dimensions of care management (Frame 2).

Frame 1. Health needs* expressed by the interviewees.

Interviewee	Living conditions	Access to services	Acquaintance	Autonomy
F-H-t (46 years old)	Lives on the street and does informal work as a bricklayer and street vendor. Awaits social security benefits.	Use of SAMU, Municipal Hospital, and Regional Hospital. Previous one-off visits at the emergency care unit (ECU) and basic health unit (BHU) (access to medicines).	Staff of the Municipal Hospital (hospitalized for three months).	After accident, reports needing to recover autonomy for hospital discharge and to return to work.
V-H-a (47 years old)	Lives with family. Reports having financial difficulties.	Received care in two hospitals (municipal and university hospital). Accompanied by BHU. Awaits physical therapy.	Acquainted with the doctor of the BHU who accompanies her.	Loss of autonomy for self-care and work after stroke.
M-H-i (49 years old)	Good family interaction and intense social activity.	Emergency care in Municipal Hospital. After a long wait, underwent catheterization via private health sector. Accompanied by BHU.	No reports	Loss of temporary autonomy for three months after AMI. Total autonomy for life and work after catheterization.
O-I-a (74 years old)	Good social condition, with intense professional, sports, and social activity before stroke.	Rescue care and philanthropic hospital by SUS. Family-funded home care and outpatient care.	Prior acquaintance with physicians and health professionals.	Loss of autonomy after stroke. Inability to work.
MV-I-a (65 years old)	Older adult who lives with family members	Care at the ECU and Philanthropic Hospital. Follow-up at the BHU.	No reports	Loss of autonomy after stroke.
A-I-i (67 years old)	Retired. Had intense physical and social activity before AMI. Reports careful eating. Smoker.	Emergency care in Philanthropic Hospital. Rapid catheterization scheduling in the regional referral service	No reports	Desires regaining autonomy to return to physical and social activities.
P-I-t (62 years old)	Active merchant	Care at the ECU and Philanthropic Hospital. In outpatient follow-up, awaiting a decision on the indication of surgery or physiotherapy.	No reports	Reports needing to recover to return to work after the accident (trauma).
L-I-t (75 years old)	Reports good living, economic, and family conditions	Care at the ECU and Philanthropic Hospital, where he underwent surgery. In outpatient follow-up after surgery. Awaits physical therapy.	Reports being acquainted with some medical professionals she knew beforehand.	Immobilized. Needs assistance for daily activities.

*Taxonomy of Health Needs[8].

Frame 2. Dimensions of care management* reported by interviewees.

Interviewee	Individual	Familiar	Professional	Organizational	Systemic	Societal
F-H-t (46 years old)	Takes walks at the Hospital.	No family ties.	Social Assistant of the Municipal Hospital.	"Heroic" care from SAMU. Prolonged hospitalization.	Health care services from SAMU, Municipal Hospital, Regional Hospital, ECU, and BHU.	No reports
V-H-a (47 years old)	Loss of autonomy after stroke.	Family members, neighbors, and church members take turns providing home care and transportation by private vehicle.	Follow-up by physician and physiotherapist at home.	Did not describe care from any specific service provider.	Care at the University Hospital and the BHU and Home Care.	No reports
M-H-i (49 years old)	Self-care due to hypertension before and after AMI: medication, walking, and diet.	Daughter provided first aid. The family drove them to the hospital in their own car and helped pay for catheterization in a private hospital.	Reports good care from physicians and nurses in the hospital.	Reports good emergency care at the Municipal Hospital.	Received emergency care at the Municipal Hospital, but waited three months for catheterization. Medicine supply and follow-up of SAH in a BHU.	No reports
O-I-a (74 years old)	Loss of autonomy after stroke.	Wife caregiver. Family authorization for risk procedure. Family members take turns providing home care. Family members drive them for consultations and exams. Home visits by a neighbor who is a doctor and family friend. Family funds home care by health professionals.	Follow-up with cardiologist. Home visits by a neurologist. Physiotherapist and Speech Therapist services in home care. Positive evaluation of medical professionals.	Philanthropic Hospital: urgent care (procedure for blood clot removal). Hospitalization in ICU and infirmary: positive assessment of care.	Rescue help. Emergency care and hospitalization in Philanthropic Hospital. Delay for vacancy in the ICU. Physiotherapy in Rehabilitation Clinic.	No reports
MV-I-a (65 years old)	Loss of autonomy after stroke. Did not participate in follow-up of hypertension before the event.	Daughter and granddaughters provide home care. Family members took her to the hospital when she had a stroke and did not authorize a risky surgical procedure.	Home care by a BHU physician, a physiotherapist, and a nutritionist.	In visits to the philanthropic hospital during the week, health professionals did not identify the stroke. After diagnosis, she remained hospitalized.	Emergency care in Philanthropic Hospital. Follow-up by the BHU in home care. Receives medicines, diapers, and enteral nutrition food from SUS.	No reports
A-I-i (67 years old)	Reports previous care with diet and physical activity. Self-controls medication. Quit smoking.	Family members took them to the hospital when they had the AMI. Son made the administrative procedures for exam scheduling and catheterization.	Reports good care from physicians and nurses in the hospital.	Emergency care in Philanthropic Hospital (AMI): fast and efficient.	Emergency Care: at the Philanthropic Hospital. Reference for catheterization in another municipality.	No reports
P-I-t (62 years old)	No reports	Neighbor drove him to the ECU at the time of the accident. Wife helps in daily care.	No reports	Emergency care at the ECU (trauma) and referred to Philanthropic Hospital (orthopedics). Reports receiving good care in both services.	First care received at the ECU. Transfer (ambulance) to a Philanthropic Hospital. Outpatient follow-up (Orthopedics). Awaits medical decision on need for surgery and/or physiotherapy.	No reports
L-I-t. (75 years old)	Controls and administers their own medicines. Admits "needing to be more careful" due to age.	Son helped at the time of the accident and took them to the ECU. Son helps in daily care.	Names the medical professionals who assisted them.	ECU: fast service. Philanthropic Hospital: very organized assistance.	Clinical follow-up for years at a BHU. First emergency care in the ECU: emergency (trauma). Transfer (ambulance) to a Philanthropic Hospital. Surgery and outpatient follow-up (orthopedics). Awaits the start of physical therapy.	No reports

*Multiple Dimensions of Care Management[10].

One of the main health needs reported was the search for autonomy, especially for work:

> If I get the benefit, then I can afford to rent a room, I even have a place. [...] With money, I pay a month in advance and get in. Then I buy a bachelor bed, a stove, a cooking gas cylinder. That I can arrange. Then there are people who give me [things], lend them to me. Then I'll go back to making my food, eating, drinking, and sleeping. Until I heal for good and go back to work. (F-H)

> Before I had this problem, I worked for a cleaning company. Then I got sick, I had the first stroke which made get hospitalized. I did things at home by myself. I'd do some of them, but I did them. Now I can't do them anymore. Because [when] I stand up, the pain starts down here and if I don't sustain myself, I fall, I go to the ground [...] it's too bad to depend on others. Being dependent on others for everything, depending on them to take a bath, to climb stairs, it's very bad, it's humiliating. (V-H)

> I was away for a month from work, because I had been working. The INSS gave me a leave of absence and in this short one month of absence, which the INSS gave me, I saw that I was unwell to go back to work. Then I had to quit my job. Because there was no way I could work. I stopped working and went after my health. (M-H)

> I'm home, there's nothing I can do! I'm waiting for my recovery, to be able to do something [...] the other time, after the surgery, I did a little over a month of physiotherapy and that's when my hand got better and I started working. (P-I)

Among the dimensions of care management mentioned, the societal dimension was not directly mentioned. Interviewees did not report on the importance of the organization of the Brazilian state and the promotion of public policies such as SUS. Some statements mentioned public social security policies by reporting on social benefits, pensions, and sick leave benefits, which refer to the societal dimension. The statements show strong family care, including the support of neighbors and friends:

> After leaving, I was brought to my mother's house. But I gave her more trouble than a child. I wouldn't even sit up in bed. I started walking with a walker. The walker had no tassel on its feet, [it] seemed like a horse walking indoors, with horseshoe: "clop, clop, clop, clop..." that bothered me, I passed by the rooms, in the hallway, by my sister's room, my mother's. They couldn't sleep because of me. (F-H-t)

> Then, suddenly, my mouth began to warp, my hand started "thinking", it was my daughter who saw: mom, your mouth is getting crooked [...] then, I called the neighbor, a colleague of ours who is always here with us, here we're like a family, then she arrived, that's when she immediately took us to the hospital. Because my car cannot pass by there because it has no license plate [...] at the time of the birthday (of her daughter), I still joked around with everyone, [saying] they took my picture with my mouth more crooked than it is. The guys gathered everyone here, for support, then they made her birthday while I was all bent here. (V-H)

> I lay down and woke up with shortness of breath and pain, a lot of chest pain. My daughter, since she's doing nursing, I called her and asked: daughter, where are you? She said, I'm coming. I said, I'm not okay. She came in and saw it was a myocardial infarction. Then she woke up my husband. He took me right away and when I got there it really was [an infarction] [...] and it was taking months for me to get catheterization. And this is urgent. So I chose to pay for a private service. The whole family helped. (M-H)

> We need to set up a special room, 24-hour nurse monitoring [...] and now, it's been a month without a nurse, just me and my family. I have a niece who helps during the day [...] the one who comes to visit is the doctor who is [our] neighbor. He's coming today. He always comes by. Such a friend, right? (O-I)

> So much pain! I got cold sweats, the sweat was pouring. Then my son put me in the car, took me to the hospital [...] I left the hospital and my son took care of it, he went after it and went to the SUS, scheduled the catheterization. (A-I)

Discussion

Understanding what guides users' actions across the health system could significantly help build comprehensiveness in SUS. For Cecílio *et al.*[18], with their action, users produce care maps that indicate a multiplicity of arrangements which escape the standardization of systems. By listening to them we can identify multiple health systems, created from a complex tessitura, in which distinct and interweaving flows of knowledge and actions produce circuits and short circuits that open new flows and paths to produce health care[15].

This study thus identified dimensions of care present – or absent – in the care of the different health needs expressed. Similarly to Hadad and Jorge's[19] study with guide users, this study showed moments of enunciation of living and powerful networks, but also moments of insufficiency or lack of network. It also showed the protagonism of users and their families in their combined use of SUS and private services, the 'public-private mix'[18]. Also similarly to the research of Fausto *et al.*[20] conducted in an interstate region of Northeastern Brazil, our study found several forms of access to services and of service offerings. Despite the guarantee of hospital care, networks were fragmented, with no integration of primary care with other points of the system and with low access to rehabilitation actions.

Statements did not mention directly or understand the societal dimension of health care. The broadest dimension of care management, the societal dimension is how society and the state produce citizenship, the right to life, and access to every form of consumption that contributes to a better life[6]. Realizing the right to health in Brazil necessarily involves defending SUS and public policies that incorporate this dimension. For this perception, other methodological instruments may be needed to help approach this theme. According to Padilha[13], the RUE does not consolidate itself without public debate, without new interactions between government action and the spaces of society where perceptions about health, values, and consensus are constructed.

The interview statements show people's need for access to health services, actions, and technologies, the action of professional, organizational, or systemic care dimensions, and the search for autonomy, especially to work. The strong action and importance of family care during and after urgent and emergency health situations also stands out.

Family care

In a systematic review on therapeutic itineraries, Demétrio *et al*.[21] identified the family and health services as the main support networks to realize, assess, and select care. The family dimension of care management is located in the world of life, that is, its privileged actors are family members, friends, neighbors, and other affective relationships. This dimension has been increasingly significant due to the accelerated aging of the Brazilian population[6].

A study with users submitted to cardiac revascularization surgery after AMI[22] identified that health care processes often make invisible the family members and significant personal relationships who are co-responsible for caring for patients and favoring their protagonism. Maldonado *et al*.[23] observed that in the social network of older adults, in case of limitation and loss of autonomy, care is usually delegated to an informal female family member. For Cecílio[6], family care is not a world without difficulties: it includes conflicting relationships, especially those caused by the complexity of family ties, the absence of affective relationships, work overload for caregivers, and permanent requirements of the patient in care.

The relationship between health professionals and family members must also be strengthened. In a study conducted with patients hospitalized in intensive care beds[24], family members reported that the sensitivity of the health professionals was essential to answer their information needs. Moreover, knowledge of the real and potential needs of the family is determinant in the professional practice of nurses**.** In home care, information was necessary to develop care competencies for eating, turning around, and moving, facilitating the construction and application of educational technology for family caregivers[25]. Health care teams should therefore always include family caregivers in the formulation and implementation of therapeutic projects.

This study values and gives visibility to the family dimension, focusing on the importance of including this affective network in the care process, which could significantly affect the production or not of a living network that allows more qualified care. Besides the health workers, the care team should also open themselves to people's socio-affective network, caring 'with' and 'for' the caregiver.

The need for autonomy for life and work

Considering that humans are motivated by the desire to meet multiple needs, Maslow[26] structured his theory of human motivation considering as basic human needs the physiological, security, social, esteem, and self-realization needs. The author believes that human beings need means for existence and survival, individual protection, social life and affection, self-satisfaction, and personal accomplishment. As a necessity, autonomy can be transversal to all of them. For Cecílio and Matsumoto[7], the need for increasing degrees of autonomy in the 'way of leading life' implies that subjects can reconstruct the meanings of their life. This resignification would significantly affect their way of living, including the struggle for the satisfaction of their needs in the broadest possible way.

Severe health situations such as AMI, stroke, and trauma can affect living conditions and self-care by temporarily or permanently limiting autonomy. For Cecílio[6], the individual dimension of health care management is 'taking care of oneself', meaning that each of us can or has the power to produce a singular way of life, a nonlinear process often hindered by multiple relationships and social conditions of life that go beyond individual choices.

The relationship between need for autonomy and work capacity was greatly significant in the statements collected in this study. The fulfillment of basic human needs, including subsistence, affects the world of work. Work is often studied in the field of social sciences as a form of exploitation and productive accumulation in capitalism[27] and in the field of collective health as a risk and cause of illness and death[28]. However, the understanding of work as a social value has gained new meaning. Affective labor, as a dimension of immaterial labor, can produce subjectivity, values, self-realization, sociability, and life[29]. Although most respondents in this research do not practice immaterial labor, according to their statements, they understand that being healthy, among other things, is having autonomy and capacity to work and to guarantee different self needs, including self-valorization. Considering the large social inequality and different social conditions, the possibility of access to work is also essential to produce life and guarantee access to basic conditions of survival. This study reinforces that the process of care should focus more on the search for autonomy and the suffering from the lack of it.

Our findings show the complexity of comprehensiveness as a principle of SUS, indicating the observance of health needs and different dimensions of care as a path to construct comprehensive care. This research, however, has limitations, including: 1) the collection of exclusive statements of SUS users who survived severe health risk situations and obtained access to urgent and emergency care services; 2) the possible 'gratitude bias'[30] of the users who obtained care in the various services of the RUE, expressed by their lack of criticisms; and 3) the cognitive and communication difficulties of some of the interviewees as after-effects of the illness processes they experienced. Future studies should further research questions on the need for autonomy and family care, exploring other health needs and dimensions of care management.

Final considerations

Formulators, managers, workers, and researchers of public policies may not always perceive and consider the emotions, rationalities, and senses from urgent and emergency situations. This study observed that users of RUE produced different care maps in their search for maintaining and improving their health and their lives. Understanding and including health needs of SUS users in urgent and emergency care situations and recognizing the different dimensions of care management is essential to formulate health policies and organize networks, services, and care processes as a fundamental strategy for comprehensiveness in health care networks.

This study thus shows the centrality of health needs and dimensions that are often disregarded, such as the autonomy to care for oneself and to work and family care. These refer to looking beyond the care arrangements restricted to health services and emphasizing the importance of being guided by the concept of health connected to and inseparable from the concrete production of life.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

The authors have no conflict of interest to declare.

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A pesquisa tem por objetivo analisar as dimensões do cuidado e as necessidades em saúde relatadas por usuários da Rede de Atenção às Urgências e Emergências (RUE) em uma Região de Saúde. O estudo tem caráter qualitativo e foi realizado por meio da coleta de narrativas de usuários de serviços sobre suas experiências com o processo de adoecimento e a utilização da RUE. A análise considerou os referenciais da Taxonomia das Necessidades em Saúde e das Múltiplas Dimensões da Gestão do Cuidado. Observou-se nos relatos especial ênfase à busca dos usuários por autonomia e a ação do cuidado familiar. A compreensão das necessidades em saúde dos usuários e das diferentes dimensões da gestão do cuidado em ação devem ser consideradas para formulação de políticas de saúde e para a organização de redes rumo à integralidade.

Palavras-chave: Assistência integral à saúde. Necessidades e demandas de serviços de saúde. Serviços médicos de emergência. Sistemas de saúde.

El objetivo de la investigación fue analizar las dimensiones del cuidado y las necesidades de salud relatadas por usuarios de la Red de Atención a Urgencias y Emergencias (RUE) en una región de salud. El estudio tiene carácter cualitativo y se realizó por medio de la colecta de narrativas de usuarios de servicios sobre sus experiencias con el proceso de enfermarse y de la utilización de la RUE. El análisis considera los factores referenciales de la "Taxonomía de las Necesidades de Salud" y de las "Múltiples Dimensiones de la Gestión del Cuidado". Se observó en los relatos un énfasis especial a la búsqueda de los usuarios por autonomía y la acción del cuidado familiar. La comprensión de las necesidades de salud de los usuarios y de las diferentes dimensiones de la gestión del cuidado en acción deben considerarse para la formulación de políticas de salud y para la organización de redes hacia la integralidad.

Palabras clave: Asistencia integral de la salud. Necesidades y demandas de los servicios de salud. Servicios médicos de emergencia. Sistemas de salud.