


FAMILY HEALTH SUPPORT CENTER: AN INTERSECTION BETWEEN PRIMARY AND SECONDARY HEALTH CARE

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ABSTRACT

Objective: to identify the space in which the Family Health Support Center is structured in the services and how it works within the scope of the Unified Health System.

Method: a conceptual study based on partial results of a multicenter, descriptive-exploratory study with a qualitative approach, carried out in 2017, in the State of Santa Catarina, with managers and professionals from the Family Health Support Center. Content thematic analysis was used with the data from semi-structured interviews with professionals and individual interviews with managers, totalling 18 participants.

Results: the professionals of the Family Health Support Center are identified as specialists who work in or close interaction with Primary Health Care, in the context of matrix support, in order to assist in the planning of the Health Care Network, which strengthens the general practice in Family Health. In addition to primary health care, they can act in intercessory spaces and perform secondary health care; set forth possibilities for intervention and enhance inter-sectoriality and co-responsibility.

Conclusion: the Family Health Support Center was recognized as an important articulator of interdisciplinarity in health work, capable of promoting comprehensive and intersectoral care, in addition to its initial proposal of supporting the Family Health Strategy, which could help in the coordination and fulfillment of secondary health care in the Brazilian Unified Health Care System, thus being an intersecting space between primary and secondary health care.

DESCRIPTORS: Primary health care. Secondary health care. Family health strategy. Health policy. Health services accessibility.

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NÚCLEO AMPLIADO DE SAÚDE DA FAMÍLIA: ESPAÇO DE INTERSEÇÃO ENTRE ATENÇÃO PRIMÁRIA E SECUNDÁRIA

RESUMO

Objetivo: identificar o espaço em que o Núcleo de Apoio à Saúde da Família e Atenção Básica se estrutura nos serviços e como atua no âmbito do Sistema Único de Saúde.

Método: estudo de natureza conceitual, a partir de resultados parciais de um estudo multicêntrico, descritivo-exploratório, de abordagem qualitativa, realizado no ano de 2017, no Estado de Santa Catarina, com gestores e profissionais do Núcleo de Apoio à Saúde da Família. Os dados foram analisados por meio da análise temática de conteúdo, oriundos de entrevistas semiestruturadas em grupo com os profissionais e entrevistas individuais com os gestores, com o total de 18 participantes.

Resultados: identificam-se os profissionais do Núcleo Ampliado de Saúde da Família como especialistas que atuam na Atenção Primária à Saúde, em íntima interface com ela, em um contexto de apoio e matriciamento, de modo a auxiliar no ordenamento da Rede de Atenção à Saúde, o que fortalece a atuação generalista na Saúde da Família. Para além da Atenção Primária, podem atuar em espaços intercessores e exercerem a atenção secundária; anunciam possibilidades de intervenção e potencializam a intersectorialidade e a corresponsabilização.

Conclusão: O Núcleo de Apoio à Saúde da Família foi reconhecido como importante articulador da interdisciplinaridade no trabalho em saúde, potencializador da atenção integral e intersectorial, para além da inicial proposta de apoio à Estratégia Saúde da Família, podendo auxiliar na coordenação e realização da atenção secundária no Sistema único de Saúde, portanto, sendo um espaço de interseção entre atenção primária e secundária em saúde.

DESCRITORES: Atenção primária à saúde. Atenção secundária à saúde. Estratégia saúde da família. Política de saúde. Acesso aos serviços de saúde.

NÚCLEO AMPLIADO DE SALUD DE LA FAMILIA: ESPACIO DE INTERSIÓN ENTRE ATENCIÓN PRIMARIA Y SECUNDARIA

RESUMEN

Objetivo: identificar el espacio en que el Núcleo Ampliado de Salud de la Familia y Atención Básica se estructura en los servicios y como actúa en el ámbito del Sistema Único de Salud.

Método: estudio de naturaleza conceptual, a partir de resultados parciales de un estudio multicéntrico, descriptivo-exploratorio, de abordaje cualitativo, realizado en el año 2017, en el Estado de Santa Catarina, con gestores y profesionales del Núcleo Ampliado de Salud. Los datos fueron analizados por medio del análisis temático de contenido, oriundos de entrevistas semiestruturadas en grupo con los profesionales y entrevistas individuales con los gestores, con el total de 18 participantes.

Resultados: se identifican a los profesionales como especialistas que actúan en la Atención Primaria a la Salud, en íntima interfaz con ella, en un contexto de apoyo y matriciación, de modo a auxiliar en el ordenamiento de la Red de Atención a la Salud, lo que fortalece la actuación generalista en la Salud de la Familia. Además de la atención primaria, pueden actuar en espacios intercesores y ejercer la atención secundaria; anuncian posibilidades de intervención y potencian la intersectorialidad y la corresponsabilización.

Conclusión: El Núcleo Ampliado de Salud fue reconocido como importante articulador de la interdisciplinaridad en el trabajo en salud, potencializador de la atención integral e intersectorial, además de la inicial propuesta de apoyo a la Estrategia Salud de la Familia, pudiendo auxiliar en la coordinación y realización de la atención secundaria en el Sistema único de Salud, por lo tanto, siendo un espacio de intersección entre atención primaria y secundaria en salud.

DESCRIPTORES: Atención primaria de salud. Atención secundaria de salud. Estrategia de salud familiar. Política de salud. Accesibilidad a los servicios de salud.

INTRODUCTION

Primary Health Care (PHC) is, in essence, the basis of health care in countries that adopt universal health care systems. The International Conference on Primary Health Care, held in Alma Ata in 1978, highlighted that the success of a universal and resolute health care system depends on access, good coverage and quality care.¹

In Brazil, after almost 30 years of the Unified Health System (*Sistema Único de Saúde - SUS*), PHC, also called Basic Health Care (*Atenção Básica à Saúde - ABS*), is recognized as the principal entry to the health care system and is responsible for directing the Health Care Network (HCN). In order to do this, it must perform some specific functions that impose challenges, such as: be resolute and guide the organization of the various points of health care networks.²

The Family Health Strategy (FHS) is the main model for the reorientation of PHC services and extends qualified care through multiprofessional teams composed of professional generalists. This level of attention must develop actions aimed at the promotion, protection and recovery of health and the prevention of diseases, according to the attributes of humanization, comprehensiveness and longitudinality of care.¹⁻²

Regarding health promotion, the 1986 Ottawa Charter defined five fields of action: healthy public policies; health-friendly environments; reorientation of health services; reinforcement of community action (empowerment) and the development of personal skills.³ The document reinforces the influence of social factors on health and strengthens the possibility of change with a focus on the territory, being co-responsible for quality of life and health. Such proposals from the 1980s and 1990s occurred from a Canadian socio-institutional situation in which universal access to clinical care via PHC was relatively satisfactory as well as the socio-sanitary situation of the population.

In Brazil, the National Health Promotion Policy guides the involvement of health care teams with expanded health care measures in order to solve problems related to social determinants such as: basic sanitation, income distribution, democratization of power, formal education, safety and nutrition which remain very precarious.⁴ Obviously, handling these factors is well beyond the limits of PHC services.⁵⁻⁶ On the other hand, in the set of actions developed in the FHS, clinical care to users is undeniable, has clinical and epidemiological impact and reduces inequities, even though a significant percentage of users are referred to specialists.⁷ Faced with this, PHC professionals are committed to problematizing social determinants, in an individual, micro-social and community dimension, although they do not always do so, since they must integrate clinical care with disease prevention and health promotion. However, they cannot deprioritize the sick in favour of paying more attention to healthy ones.⁸

Thus, in the work of the FHS, health promotion implies an empowering expansion of the quality of care and extended clinical care to the sick/demanding individuals and prevention, since this is related to the solvability of PHC.⁹ This requires that health services provide accessibility with high resolution for the majority of the problems. When it is impossible to solve them, they coordinate and activate specialized care, which transcends the generalist, in order to materialize comprehensiveness within longitudinality.

Regarding solvability, the possibility of new references in order to design clinics which are focused on the individual in the PHC is proposed, with the intention of creating responsibilities beyond the biological component, recognizing subjective and social dimensions of people and diseases.¹⁰

An expansion of the clinic is recommended, redefined based on the object, objective and work methods of care to individuals or groups. The expansion of the objective allows the individual care that generates health production through clinical care, rehabilitation and relief of suffering,

includes simultaneous effort to increase the coefficient of user autonomy, approaching the logic of health promotion. The expanded clinic must be positioned in the fight against hypermedicalization, institutionalization and excessive dependence on professionals or services.¹⁰ Thus; it confers on the use of active mechanisms of listening and dialogue that provide, to a certain extent, comprehensive care.¹¹

Faced with these challenges, in 2008, the Ministry of Health implemented the Family Health Support Centers (*Núcleo de Apoio à Saúde da Família - NASF*) in the framework of the PHC in order to increase the actions and the solvability of the FHS, in order to provide matrix support to the already existing teams in the territory and contribute to the resolution of cases and improved attention to the health needs of SUS users¹² The matrix support methodology promotes the activation of communication spaces and joint deliberation, which promotes the sharing of knowledge and organizes flows in the HCN. Formed by a multiprofessional team and different knowledge centers,¹² this support device was inspired by the Paideia model,^{10,13} with a methodology that reformulates the traditional management mechanisms and focuses on the education of people and social relations. Integrated action fosters discussion on clinical cases and enables shared care among professionals, both in the health unit and in home visits, which favours the joint construction of therapeutic projects.¹⁰⁻¹³

In this perspective, that it be called “nasfians” in this study. the NASF acts in the background and supports the FHS, through the needs and representations of the health-disease process of the individuals and families that use SUS, and as articulators and regulators of the access to the RAS, with organization, especially, in the referrals to medium complexity services. Such support is also focused on intersectoral actions, with a focus on disease prevention and health promotion. NASF conceptions are in line with the HCN proposal for non-hierarchical cooperativeness among health care points, in an interrelationship between levels of care and the sectors involved in health and disease.¹²⁻¹⁶

NASF is also considered a transforming device of the PHC work process by means of co-management aimed at improving HCN.¹⁴⁻¹⁷ This can mobilize and impact hegemonic health practices, immersed in scenarios of devaluation of public services, in addition to precariousness of working conditions, as a way of subverting the established power lines. However, few studies analyse the work process and discuss the scope of actions and the potential impact on services and care to the population. The objective of this study is to identify the space in which the Family Health Support Center is structured in the services and how it operates within the scope of the Unified Health System.

METHOD

A conceptual research on the meaning of NASF, based on the problematization of partial results of the multicenter study “Family Health Support Centers: permanent education movements for health promotion through the social reality of the territory.” The results are derived from the descriptive-exploratory section,¹⁸ of a research with a qualitative approach, carried out in four municipalities of the State of Santa Catarina, with NASF managers and professionals.

The information was collected from September to November 2017, through semi-structured group interviews with professionals and individual interviews with NASF managers, totalling 18 participants, that it will be called “nafians” in this study. The inclusion criteria of the participants were: to work in NASF teams in one of the selected municipalities; (as a professional or manager) for at least six months. Exclusion Criteria: Professionals who are on leave from work for any reason. The invitation to the participants was sent to all nasfians in the municipalities, selected by health macro-region of the State, and the group interviews occurred with those who were willing to participate.

The analysis of the data complied with the one recommended by the operational proposal of thematic content analysis,¹⁸ performed in three phases: pre-analysis performed through transcription and floating reading of the participants’ statements; exploration of the material and treatment of the

results obtained with a view to seeking the core meanings; inferences and interpretations from the theoretical construct on the theme, seeking to promote a theoretical/conceptual discussion with the empirical findings.¹⁸

The research was approved by the Human Research Ethics Committee, and respects all ethical precepts and Brazilian legislative guidelines in force. The details of the study were explained to all the participants, who then signed the informed consent form, while preserving their identities. The municipalities were identified as A, B, C and D, followed by the letters "G" (manager's statement) and "P" (professional statement), followed by cardinal numbers.

RESULTS

Among the 18 participants in the study, four are NASF managers and 14 are NASF professionals in the areas of Physical Education (1), Psychology (2), Nutrition (4), Social Work (4), Physiotherapy (2) and Pharmacy (1). The managers are experienced and trained in the following areas: Nursing (2), Psychology (1) and Medicine (1). The two thematic macro-categories that enable the objectives of the present study to be met are presented below.

Family Health Support Centers work: primary health care or beyond?

Nasfians are not convinced in relation to the space they occupy in the HCN, as expressed in the following statement: *We still do not understand each other well [...] not only about the NASF, in relation to all primary care. Here we have the Basic Health Units and the Regional Units; we do not have an intermediate unit, so there is no understanding of what primary health care should be, which also includes the Support Centers. It is a very limited thing: either it is the hospital center or it is Primary Health Care, and the intermediary demands usually come here [...]* (CG).

It was mentioned that health care professionals are generally unaware of the work of the NASF, and it is necessary to carry out Permanent Health Education (PHE) actions to understand the work process shared with the NASF. *We always have new professionals in the network, [...] most professionals do not know how the NASF works, we always have to explain the NASF's function, present the ordinances, do the education process and show what our work is like* (B_{p2}).

The work of the NASF flows in an intermediate direction, leaning towards PHC, or in an intermediate space, whose federal regulations sometimes restrict and confuse it. The study highlights the matrix support of the NASF teams, especially at a higher frequency for NASF linked to a larger number of FHS teams. On the other hand, those who attend a smaller number of FHS teams, end up performing more specialized activities, directly to the user of the service, as the statement illustrates:

[...] We end up having a smaller amount of speciality referrals and counter referrals, because we have a professional there trying to do this, which is supposed to be the logic of the NASF, but still happens to have referral as a specialty [within the specialties that the NASF offers]. [...] we sometimes question: the patient in a psychological crisis, the psychologist ends up attending. That's because we do not have a home visit service; and the NASF is there, so he ends up in the emergency room (A_G).

It is understood that NASF is a point of advice for family health teams in clinical cases that are not resolved or referenced:

[...] We will start to attend the people in queue that is coming now to do this triage: before going to the physiotherapy clinic, the NASF physiotherapist evaluates the case and then he says whether or not to go to SISReg [Health regulation system]. We intend to do this with a

nutritionist and speech therapist as well, but we do not have enough professionals. Both the speech therapist and the nutritionist have their workload divided between the NASF and the outpatient clinic [...]. With secondary health care, we file a request, but this is another problem: for the management to understand the need and show the impact that will occur in the queue with this triage! (D_G).

[...] There are cases that we have followed for a longer period of time, the patient ends up having a reference in the unit, so those who had me as a reference still come to me; I still do this job, but much less. I work more with orientation: a situation occurred which we perceived that the child had suffered some violence or harm, I orientate: we refer them to the CRAS [Social Work Reference Center], for CREAS [Social Work], we will pay a visit with the family health team. [...] we perform shared care, there are situations where I need the presence of the psychologist, we define a schedule that the two professional are available to attend together (C_{P1}).

What spaces reach the work process of the “nasfians”?

The NASF's different possibilities include the participation in the regulation, evaluation and reduction of queues for specialties up until the total fusion of the NASF team's identity as a reference service, which has shown to be more advanced in mental health matrix support as shown in the following statement: *I cannot imagine what the mental health demands would be like without having the NASF. What was done with this demand? So, thinking about this NASF idea, we were able to accept a mental health demand in primary health care, I think it's a very good progress, a quality indicator that is very evident because we absorb a demand that until that moment had nowhere else to go (A^{P5}).*

The institutional performance of the NASF professionals is linked to the specialist center, which acts based on its specific competence; interdisciplinary requirements and also the necessary articulation between services in order coordinate the care of the PHC through the EHS. This broadens the potential of their contributions to the qualification of care, while at the same time enhancing their educating and supportive effect, as expressed in the statements:

[...] From the beginning we kept the focus of weekly matrix support in all units, a fixed day in the month [...] the Basic Health Units organizes the cases for us to evaluate, to see if there is a need for shared care, if there are any cases that can be matrix support, if there are cases in which the treatment is individual; we talk about groups, about NASF demands [...] actually, the nurse and some other professionals participate, we have units where we are able to include the pediatrician, the gynecologist, there is one unit with good participation, that the NASF things are flowing well and we have support to organize groups and waiting rooms (D^{P4}).

[...] those doctors who are more participative in the matrix support meetings, those cases that sometimes cannot be referred, we discuss that case there at the time, they bring the need of that patient to the discussion there. So, they already have this conviviality with us, this vision of matrix support, they are already used to it, they already have a vision of the NASF, it is not so much communicating the needs while passing each other in the corridor, 'I need the nutritionist!' Or 'I'm going to make the referral with the NASF psychologist [...] we have tried to work so that it is not that way, just by referral, just a hand over of cases, but when that occurs, they call us to have this discussion, this conversation (B^{P1}).

The statements show that the NASF work process interrelates the activities of primary and secondary health care, thus, it acts at the intersection of these spaces of health care production in the logic of comprehensive care.

DISCUSSION

The core of knowing and competence demarcates an area of knowledge and practices unique to a profession or specialty, which has variable limitations related to the context and, to a certain extent, are porous. On the other hand, the field of knowledge and competence refers to a space of imprecise limitations in which each discipline and profession seeks support from others and with them shares common actions in order to fulfill their theoretical and practical tasks.¹⁰ In this perspective, the results of the present study show that the work of the NASF professionals has been oriented towards a type of borderline action, in which such workers must act in their own core of knowledge and practice and in the boundaries between their core and the core competence and expertise of the FHS team, which obviously encompasses their common area of care.

This is a possible interpretation of matrix support: simultaneously putting one's knowledge and competence (field and core, as applicable) at the service of the users (selected or referenced) and the FHS team, to empower it, increase solvability and provide PHE.¹¹ PHE is seen as a transversal practice that supports matrix support offers valuable elements and a general philosophical-political, technical-pedagogical vision for the training/qualification process of professionals, in view of the challenges of the work.¹⁹⁻²⁰

Within the discussion of the core of knowledge and skills, the need to clarify the role of specialists in a health system focused on PHC is highlighted. Their insertion occurs through brief consultations; timely interventions for which PHC professionals do not have the necessary technologies or knowledge; providing care through guidance to the FHS teams regarding emerging issues in the cases; or, in partnership with the teams, assuming the specialized care of certain users (with or without prior shared consultation or discussion of the case). The most appropriate assignment of the specialists in this interdisciplinary proposal would be that of consultants, without excluding the possibility of periodic visits to the services in order to evaluate certain groups of users.^{10,12}

Thus, through the concepts of field and core, matrix support is perceived as the commitment of different cores of knowledge, which dialogue and exchange knowledge among each other to construct certain therapeutic projects. It should be stressed that this therapeutic project, constructed in an interdisciplinary manner, with one or more specialists, was considered important and necessary by the PHC/ FHS generalists.²¹

In a pioneering article on matrix support published in 1999,²² the performance of specialized care was fully assumed, since it already existed, with the proposal of adding the support function and PHE of the FHS reference teams, so that both constituted matrix support,²² support to the teams and exercise of the specialized clinic. In later writings,^{11,13,21-23} such assumption was subtly relativized and less thematized, although never denied, but rather emphasized and hypertrophied the support function.

Based on the ministerial work proposal for the NASF, this should prioritize: (a) shared clinical actions for an interdisciplinary intervention, with emphasis on study and discussion of cases and situations, joint attendance, implementation of a singular therapeutic project, meetings, as well as support via telephone, e-mail, among other resources; (b) specific interventions of the NASF professional with the users and/or families, with discussion and prior negotiation with the professionals of the family health team responsible for the case, so that the individualized care of the NASF occurs only in extremely necessary situations; (c) shared actions in the territories of its responsibility, developed in an articulated way with the family health teams and other sectors.¹²

For the organization and development of this process, some tools can be listed, such as: matrix support, the expanded clinic, the singular therapeutic project, the health project in the territory and the agreement of support.¹² It should be noted that (b) restricts specialized care to something called situations of extreme necessity, without any specification of what this type of situation would be, but

effectively indicates that this aspect is not a desirable or routine action of the NASF professionals; and that (c) is defined in such a way that it involves the whole scope of territorial prevention and promotional actions, conventionally attributed to PHC as a whole, and, at least part of them, attributed to the FHS staff teams.

In the field of working micro processes, it is expected that the official regulations of the NASF will perform actions that support health care promotion, at least at the local and municipal level, spaces that deal with the social reality and need to be constantly evaluated, since these actions also require action in the territory, community focus and approach problems in partnerships with users and other sectors.¹² This set is involved in most of the assignments common to all FHS staff professionals, therefore, it guides NASF work, if they are considered part of the PHC.

Emphasis is given to the fact that official NASF legislation has transformed a significant part of the spectrum of PHC knowledge and practice into a common field of the various professions (including NASF professionals), and it does not recognize practically any core specific knowledge or competence of the generalists of FHS teams, related to territorial action, planning, disease prevention and health promotion.

However, if most of the problems of the users are solved by the FHS and the rest are sent to professionals/specialized services, which are not the NASF, this seems to remain, in the SUS service network as a whole, the advice for doubtful cases, Border-line, (still) not forwarded. It is also possible to support other more complex ones, whose follow-up is done in an interdisciplinary and presential way, supposedly, an even more complex fraction of cases that, in addition to be being referenced for specialized services, deserve shared care, with a face-to-face interface, between PHC and specialists: the NASF.

From a point of view of classical references,^{1,24} observing the regulations, the NASF are not from PHC, since they do not work with direct access; however, in practice, the results of this study, like other researches in the field,^{14-17,25} confirm that professionals perform clinical, preventive, planning and health promotion work. From this point of view, nowadays, it is a partly secondary health care (specialized care) and partly articulation-intermediation and EPS, located in the intercession between PHC and secondary care, and also assists in the management of the priority analysis (exercised by generalists) and referrals, i.e., in the management and regulation of specialized care.

At the same time, the problem of inadequate specialized health services in SUS is highlighted, which can lead to a misleading performance of the NASF,²³ when it assumes the role of a specialized service in order to respond to the demand of the community. There is a common dispute in the service environment regarding the NASF implementation mode: the defense of specialized assistance versus team support, while in theory, matrix support encompasses both actions.²²

The ministerial instructions are not explicit in this respect, and they leave behind a discussion that is intended to deepen the specialized performance of the NASF, although the latter, institutionally in Brazil, is considered a service of the PHC.¹² It is known that in other countries, similar initiatives position the teams as supporters,²¹ without leaving their secondary care position and clinical performance in the space of the PHC, i.e., approaching these spaces, when it is necessary for the therapeutic project of the user.

Another issue to be considered lies in the scope of PHC, in which NASF can emerge as a resource to face the failures of this level of care. It is dangerous to legitimize situations in which the nasfians prioritize generalist services, which are essentially from the SF. They must encourage and contribute to the qualification of the practices and act together with the generalist groups in a timely manner, when their core competencies are required. But, above all, they must support these groups and help their implementation. However, it is fundamental to leave these groups, progressively, in the

hands of the FHS, except for occasional participation, which involves specific issues for which their specialist performance is required or justified.

On the other hand, the complexity of the challenges in health production is also contextualized, which has required the construction of new models of work organization, since PHC alone is not enough.^{1,24} The possible interfaces through relationship between PHC and specialties, signals greater user satisfaction with shared care, which has repercussions on the reduction of exams and procedures. Such resolution in PHC in the United Kingdom is due to the possibility of easy communication between generalists and specialists.^{1,26}

Thus, it is understood that the work of the NASF can and should be seen as a source of new forms of intervention, not restricted to an environment or level of health care system (such as PHC or specialized service). It expresses itself in intercessory spaces between the core knowledge and practice of its professionals (specialists) and the core field of knowledge of the generalists, which is must be highlighted and respected. In light of the ideas presented and the partial results of the research, we elaborated a summary of the routine actions of the nasfians (Table 1), in addition to the occasional ones, developed in partnership with PHC professional generalists.

Considering the listing of actions in Table 1, Figure 1 maps out the institutional sites or spaces in which NASF professionals work

Table 1 – Summary of Family Health Support Centers actions by characterization of their practices.

Support to ESF teams	<ol style="list-style-type: none"> 1. Joint/shared consultation; 2. Possible participation in groups performed by FHS professionals; 3. Meetings for technical and pedagogical support to the teams (PHE, studies/discussion of case, elaboration of therapeutic projects); 4. Actions in schools relating to the specialty of the Nasfian professional; 5. Conversations, scheduled or not, in person or with different information technologies, with trained professionals; 6. Meetings with FHS teams when applicable; 7. Participation in the FHS team meetings, when invited for some specific reason that demands its core professional;
User care	<ol style="list-style-type: none"> 8. Individual consultation/service of users; 9. Home visit; 10. Group performed according to core knowledge/practice;
Coordination and regulation of care	<ol style="list-style-type: none"> 11. NASF Team Meetings; 12. User referral (and evaluation of the FHS teams referrals) to other secondary and tertiary care services (flow regulation); 13. Study/discussion of cases among nasfians when necessary

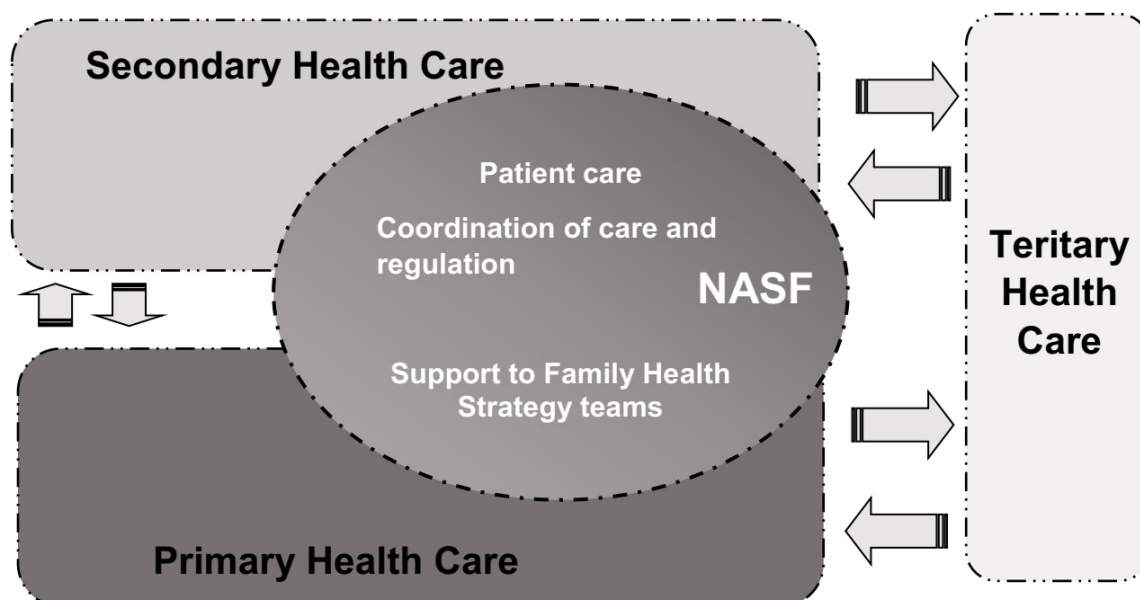


Figure 1 – NASF area of action: intersection between primary care and secondary health care.

Figure 1 shows that work in the NASF is part of the secondary level of health care (specialized care to users) and part of the articulation-intermediation and EPS between primary care and specialized services, and also helps in the management of specialized care. In this context, the NASF establishes itself in a promising direction for the construction of service networks coordinated by PHC. Within limits and when possible, it is argued that the NASF is configured as secondary care, i.e., performs specialized care, but also supports, and assumes its two faces; and that, on the other hand, symmetrically, every specialized service makes personalized training to as far as possible.

Supported by the relative expansion of diffuse municipal experiences in the country, which are still scarcely analysed and thematized (in addition to their condemnation based on official guidelines), the potential of these NASF professionals to be active in the construction of PHC articulation and communication with the specialized services and even to act as specialized references in the spaces they support.

Not only can this be highly beneficial, contrary to current criticism in public health, but it can also put the NASF in a prominent position in structuring the HCN :as a simultaneous instrument of PHC, to increase the comprehensiveness and solvability of PHC; as a specialized care resource; as a construction of the articulation of other services with PHC, i.e., construction and feasibility of care coordination that leaves the role and is structured in practice, advancing in overcoming the precarious situation of specialized outpatient care in SUS. The NASF seeks to realize its specialized clinical function, intended for matrix support, progressively forgotten and/or undervalued. However, one of the risks of this proposal is for these professionals to slip into the common isolation of specialized outpatient services in relation to PHC, which should be actively and carefully avoided.

On the other hand, the renunciation that sometimes occurs (for some, desired) by the nasfians to perform specialized clinical care (individual or collective) to the “filtered” users sometimes has significant adverse effects. It is important to highlight the loss of their identity, their need and their effectiveness as an advisor and institutional intercessor, resulting from their distancing from the pressure of PHC care restricted to the family health team. This may compromise the commitment and partnership required for effective technical-pedagogical support with an educating effect and promoting the capacity of care services.^{7,11,13}

It should be noted that the professional who provides matrix support emerges together with the FHS as desirable when participation is deemed adequate and/or necessary, when there is a demand/approach for specialized content/practices. It may also coordinate/lead a group, according to its core activity, characterized as collective specialized care or participate in the generalist team meeting, and called for specific reasons related to its core competence when necessary.²

“Nasfians” need to be aware of their own limits in order to welcome the contributions of other specialties and FHS generalists in order to mediate and support, when requested, the wide range of practices and decisions that primarily define user assistance in HCN.¹³ In the PHC context, always in a field of dispute and permeated by changes in the political, social and economic context, the work of the NASF emerges as a promoter of this level of care and articulator of secondary care with PHC, which is closely articulated with the FHS teams.

One of the limitations of this debate lies in the lack of discussion and data on the concrete working conditions offered to the NASF for activity development, taking into account the precarious structural and economic characteristics that permeate Brazilian PHC, and especially its role in the health care system. It is considered, due to the unequal distribution of the proposal in the Brazilian territory, that NASF’s actions and work process requires in-depth and continuous studies on the effectiveness of this device.

CONCLUSION

By making greater interdisciplinarity feasible through their performance, the nasfians need openness for integrated collaboration with different specialists and with other generalists, in order to avoid looking fragmented and uncommitted to the patient. Their complexity and uniqueness are revealed in their performance as specialists who foment a greater solvability of the generalists; and also part of an articulated secondary care coordinated by PHC, including tertiary/hospital care.

If properly articulated with the PHC, the NASF professionals promote, support and strengthen the performance of the FHS generalists in the context of matrix support. They also appear as specialists who work with their core knowledge and assist in the planning of the HCN, since they begin to assist the FHS teams in the planning and care coordination, in addition to exercising their professional activities.

Thus, they can contribute in part, to the reduction of PHC bottlenecks. In order to do so, they need to stay in a space that is not totally PHC, but that supports this level and articulates with the others, besides exercising specialized care. The NASF can be recognized as an important articulator of care coordination, intersectoriality, interdisciplinarity and the various RAS services in health work, as already defined by official regulations in the PHC context, but also beyond it.

Care is advised to ensure that nasfians do not identify themselves as PHC professionals, which should be reserved for FHS generalists, except for exceptions such as dentists. They must identify with two emerging and innovative institutional roles: on the one hand, acting on the transition, articulation and connection between PHC and the other HCN devices, which involves care coordination and regulation and intersectoral articulation.

They must also identify as a new specialized attention, characterized by collaborative work and closely articulated to PHC as well as coordinated by it. Being heterodox and innovative for the Brazilian institutional realities, the nasfians must exercise specialized care to the users, support and give feedback to the PHC teams, in such a way that exercises the PHE all the time. This materialises matrix support, expands PHC solvability and explores the potential of the NASF, but implies building and legitimizing a role or function still in progress. It should be emphasized that if NASF is not a clearly delineated strategy in relation to its purposes, guidelines and structural and performance possibilities, it runs the risk of functioning as a team with no clear identity in the RAS context, with little effectiveness

and sustainability. This would be a waste of a decade of innovative public investment and institutional experimentation in matrix support performed by the NASF.

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NOTES

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CONFLICT OF INTEREST

There is no conflict of interest.

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