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Training challenges for the network practice: evidence-based health care

Desafios formativos para a prática em redes: atenção à saúde baseada em evidências

Desafíos formativos para la práctica en redes: atención a la salud basada en evidencias

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The objective of this paper is to discuss the challenges for the critical training of health professionals to work in networks in the Unified Health System. It is a reflective essay whose theoretical and methodological framework was founded on the Social Critique Epidemiology, conducted from 2017. The discursive categories presented were: *The organization of Healthcare networks guided by evidence* and *The realistic review as evidence synthesis method for performance in networks*. In contemporary, the search for the commitment to universal health coverage emerges as a challenge, through the strengthening of professional training and development of human resources for health. It is essential the education of health professionals directed to the realization of health networks, so to allow an early approximation to the structures of the health system that dialog both with the scenario complexity, the diversity of the way of life of the communities and the practice based on evidences, in order that the realistic review shows itself as one of the methodological strategies to the incorporation of the evidences in the complex scenario experienced by the Primary Health Care.
Descriptors: Primary health care; Professional training; Evidence-based practice.

O objetivo deste artigo é refletir sobre os desafios para a formação crítica dos profissionais em saúde para atuação em redes no Sistema Único de Saúde. Trata-se de ensaio reflexivo cujo arcabouço teórico-metodológico foi pautado na Epidemiologia Crítica Social realizado a partir de 2017. Como categorias discursivas apresenta: *A organização de Redes de Atenção à Saúde pautadas em evidências e, A Revisão Realista como método de síntese de evidências para atuação em redes.* Na contemporaneidade emerge como desafio a busca pelo compromisso com a cobertura universal de saúde, por meio do fortalecimento da qualificação profissional e valorização dos recursos humanos para a saúde. Torna-se essencial a formação em saúde direcionada a efetivação das redes em saúde, de forma a permitir uma aproximação precoce às estruturas do sistema de saúde que dialoguem tanto com a complexidade dos cenários, a diversidade dos modos de vida das comunidades e a prática baseada em evidências, de modo que a revisão realista se mostra como uma das estratégias metodológicas para incorporação das evidências no cenário complexo vivido pela Atenção Primária.
Descritores: Atenção primária à saúde; Capacitação profissional; Prática clínica baseada em evidências.

El objetivo de este artículo es reflexionar sobre los desafíos para la formación crítica de los profesionales en salud para actuar en redes en el Sistema Único de Salud. Se trata de un ensayo reflexivo cuyo marco teórico-metodológico fue pautado en la Epidemiología Crítica Social realizado a partir de 2017. Como categorías discursivas presenta: *La organización de Redes de Atención de Salud pautadas en evidencias y, La Revisión realista como método de síntesis de evidencias para actuar en redes.* En la contemporaneidad emerge como desafío la búsqueda del compromiso con la cobertura universal de salud, a través del fortalecimiento de la cualificación profesional y valorización de los recursos humanos para la salud. La formación en materia de salud dirigida a la efectividad de las redes en materia de salud es esencial para permitir una aproximación temprana a las estructuras del sistema sanitario que dialoguen tanto con la complejidad de los escenarios, la diversidad de los modos de vida de las comunidades y la práctica basada en evidencias, de modo que la revisión realista se muestra como una de las estrategias metodológicas para la incorporación de las evidencias en el escenario complejo vivido por la Atención Primaria.
Descriptores: Atención primaria de salud; Capacitación profesional; Práctica clínica basada en la evidencia.

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INTRODUCTION

The Unified Health System in Brazil (SUS) is presented as a universal social protection policy, a citizen right expressed in the Constitution of 1988. As a result of social movement, especially the movement of health reform, it was consistent with the country process of redemocratization facing the governments of dictatorial recession, which lasted from 1964 to 1985[1,2].

The movement of the Brazilian Health Reform (RSB) consisting of health workers, teachers, academics and progressive political representatives had in its project the ordination of a health care system that would overcome the fragmentation of the hitherto instituted[3,4].

RSB aimed at the implementation of a health system at the national level that would unify the financing of health actions by the public budget, and was no longer dependent on the financial range of taxpayers. Also, it would provide assistance to the different levels of care: from primary care to hospital services, in an integral way[3,4]. With innovations in planning and management of these services: to be standardized by the Ministry of Health, in which the verticality (up to down) in decision-making are replaced by a tripartite governance: state (union), state and municipal governments - being popular participation and participatory strategic planning decisive for the allocation of public resources to the health actions[1-4].

As guiding principles of SUS, there are: universality: as a right of citizens, free access provided by the state (government) aimed at promoting, protecting and recovering health; equity: actions and health services would be guaranteed according to the health needs of individuals and populations, in order to reduce inequality; and integrality: health actions cannot be compartmentalized, seeking to meet the broad health needs through a network of regionalized services, hierarchical and complementary[2,5]. These principles are regulated by the Organic Laws of Health 8080/90 and 8142/90[1,2,5,6]. In 2011, the presidency of Brazil decrees the regulation of the Health Organic Law 8080/90 - Decree 7508/2011, which provides for the organization of the Unified Health System - SUS, health planning, health assistance and coordination between federal states[5,6].

It is highlighted in this decree, the concept of Health Care Networks (HCN) as the originator order to be implemented for the realization of health services in the SUS, to ensure comprehensive care for a set of health actions and services articulated in increasing levels of complexity. In this perspective, a question emerges: *What are the challenges for inter/multidisciplinary training to work in the Health Care Networks?* Then, this work aims to reflect on the challenges for the critical training of health professionals to work in SUS networks.

METHOD

It is a reflection on the contemporary demands for multidisciplinary training in health. The starting point was collaborative action to the residence Multidisciplinary Integrated Health and Nursing Residence in Neonatology, both from Clinical Hospital of the Federal University of Triângulo Mineiro, since 2017.

The interest in discussing the multidisciplinary training relates to the UN document of September 2015, where world leaders reaffirm commitment to the Universal Health Insurance, through the strengthening of professional training and development of human resources for health[7,8]. Still, when analyzing the political-pedagogical projects of the Multidisciplinary Residency Programs in Health, research has revealed a heterogeneous scenario with regard to curricula, didactic and pedagogical organization, and studies that approximate the "live" curriculum of these programs[9].

The theoretical and methodological framework for the development of this reflection was the Social Critique Epidemiology - the act of searching, in this perspective, precedes the recognition of an interactive relationship between researcher and the phenomenon studied. It is intended, with this approach, a narrative construction that understands the reality in front of the dialectical perspective of the process[10,11].

RESULTS

The approach used in training to work in SUS networks along with the residents has been the active methodology - as a process of carrying out various mental operations, in an increasing complexity of thought, taking as its starting point the social practice.

Some challenges have been identified in this training process as:

a) need for transmutation of preventive-curative system to a model that reach range actions in the social determination context of the health-disease process;

b) interprofessional action that transforms the health services to eliminate discriminatory and class work, multidisciplinary relationships and service offerings;

c) overlapping relationships in the access that lead to consumption or health business productions, as well as the control of power inferring inequalities;

d) implementation of educational projects oriented to care networks with centrality in the primary care level, by the Family Health Strategy (FHS).

In the SUS context, the reorientation of vocational training requires foster teaching-service integration to ensure integral approach to the health care practices, such as improving the job skills in team, guide the case management, in addition to producing health practices of better quality for individuals and communities. From this perspective, the identified productions supported reflections on overcoming these challenges to work in health networks, with the prospect of structuring of an attention to evidence-based health.

DISCUSSION

The organization of Health Care Networks based on evidences

HCN are designed as polyarchic organizations of sets of health services, linked together by a single mission, common goals and a cooperative and interdependent action, which allow offering a continuous and comprehensive care to a given population, coordinated by primary health care given at the right time, in the right place, at the right cost, with the right quality and in a humane manner and with health and economic responsibility for this population[12].

It involves a continuous attention for primary, secondary and tertiary levels; by promotional, preventive, curative, caring, rehabilitative and palliative interventions. Appropriate care, in the right time and place are essential features of HCN[12] with coordinating action of the demand exerted by the primary health care.

The multidisciplinary primary care teams (AB)/FHS must recognize the extended health needs of the registered population, provide adequate diagnosis and identify local resources and equipment, or points (therapeutic and diagnostic) of HCN, or even intersectoral services to achieve resolutive answers to the demands[12,13].

The AB/FHS teams are responsible for the information and follow-up of people in different services, to provide continuity of care and its rear by active search, guidance, referrals, information sharing and health monitoring.

The FHS communication center presents itself by the care coordination in the ABS/FHS - to be a coordinating space of flow and counterflow, because health systems with greater focus on the primary care level have a higher resolution of the health demands of the population[13], with highlights to: reduction of more expensive procedures unduly required; emphasis on health promotion and disease prevention and; especially have better recognition of the epidemiological and socio-sanitary situation to which different populations are subjected.

Therefore, they undertake more skilled management of health risks and vulnerabilities to which people are subject. However, when considering the effectiveness of HCN as the organizer of the health care system, one of the biggest problems internationally recognized touch upon inconsistencies between clinical practices provided in health services - including primary care level, the social and epidemiological situation of the population registered, technological knowledge made possible by scientific research and their

incorporation into clinical practice. These gaps impact the health system with increasing costs[12-15].

In universal protection in health, the issue gains greater relevance by imposing the government to pay equitable and universal attention. Facing this situation has required prudence to health professionals as they make decisions (especially physicians) on health systems as a whole on hospitalizations, medications to be prescribed, what exams to be ordered. There is a universal tendency that the most significant part of the costs of health care systems are related to requests and medical authorizations - The Law of the doctor's pen[12-16].

It happens that most of the health professions are trained under the Hippocratic tradition of offering all kinds of interventions to all people. This individual or Hippocratic ethics conflicts with a social ethic that derives from the need to only offer necessary services and proven effectiveness and safety to those who will most benefit with the scarce resources of the health care system.

Nevertheless, the cumulative effect of clinical micro-decisions is an important aspect that leads to lack of health care costs. For example, the introduction of a new diagnostic method or technology treatment, which often do not have robust scientific evidence that they do more good than harm; however, their prescription entails reasonable costs to the system[14-16].

Addressing this problem has required a new decision-making logic to health care that is expressed by the Evidence-Based Practice (EBP). Historically, the term PBE originated by the Evidence-Based Medicine. Despite being a concept discussed by Clinical Epidemiological since the 1970s, the first publications occurred in the 1990s, with Guyatt and colleagues, at McMaster University and Sackett, in an editorial in the British Medical Journal[17-19].

The Institute of Medicine of the United States in its report "*Crossing the Quality Chasm*: *a New Health System for the 21st Century*" points to the mandatory teaching of this practice in health education. This initiative emerges against the number of errors of health professionals, with emphasis on medical errors having an impact on the death of people[17-19].

The evidence-based practice in evidence would interfere in greater patient safety. In general, clinical decisions are made based on values present in a society, contexts of ideological expressions and available resources. Lobbyists, pressure groups and consultants strongly influence this decision-making process.

To this, one also should add influencing factors as: the media, the information easily accessible available on the Internet and other interest groups. On the other hand, inducing the decisions in the health system anchored by EBP enables a more harmonious relationship between the cost-effectiveness of this system[19].

However, EBP presupposes: the production of scientific evidences – by rigorous studies, and is, therefore, essential the investment in front of the definition of research thematic areas and technological development that are presented as crucial to SUS operations[15,19].

The availability of evidences is presented as another crucial aspect. This practice is essential to health services in ensuring access to scientific publications, journals, mainly on electronic scientific database. There shall be added the expertise, the competence of the health professional to use evidence in his practice: it requires constant updating[15,19].

Therefore, the health system should dismiss risk control instances, patient safety and reviews of the incorporation, adequacy or replacement of technologies. So, observing that the evidence does more harm than good, it should not be introduced or, in case it has already been introduced, it should be stopped. The transferring of knowledge produced by researchers in due course is also presented as a challenge for the health professionals. Usually, the knowledge generated has slow traffic to everyday health practices[15,19,20].

The realistic review as evidence synthesis method to work in networks

The realistic Review has been presented as a systematic review method designed for

synthesis of evidences on interventions that can support complex political demands - such as performance in HCN.

It has usually been used in different fields such as social sciences, psychology and economics. For health care, the use of this method is still new, with few international publications[21-25]. It corresponds to qualitative synthesis of the scientific production to support the development of theoretical models, policies and intervention practices. Above all, realistic review discusses the evidence synthesis to understand mechanisms on how complex programs works on specific contexts[21,22].

More than evaluate the effects of a particular intervention, realistic review has as object of analysis the circumstances that lead a given intervention or program to achieve its results. Effective implementation of an intervention or program – so that it increasingly can match in practice to the expected pattern – it depends on environmental factors such as available infrastructure, engagement of the process legitimizers, interpersonal relationships and the expectations of those to whom the intervention is aimed at[23-25]. In this sense, the realistic review is presented as a method that proposes to capture in the particularities of different contexts points of contention and influencers aspects to the outcome of implemmentation[21].

It is based on the ontological assumption that reality exists, but could only be understood through the senses and perceptions of people. Is, thus, represents the recognition of a fact or phenomenon by a impregnated interpretation of the subjectivity[21]. Thus, it denotes the intervention as interference on a process or a phenomenon in order to modify it, and considers the complex social context as a scenario possessing properties that cannot be reduced to its constituent elements in isolation. Thus, the results of realistic review aims at contributing to the transforming action of the research, even minimally, through the reality researched[21-25].

The procedures for realistic review comprise steps with correspondence to other review methods. Although the steps are to be displayed sequentially, they may overlap or interact with the process development. It begins by identifying the subject of the study; therefore, denoting the nature of the intervention and its conceptual or theoretical assumptions, as well as the operating structure expected or, policies, guidelines, objectives and targets to be achieved. The search for evidence comprises a non-linear analysis of primary studies, in which it can be supplemented at any time of the research development[21-23].

The primary studies included in the realistic review make up an intentional sample, up to the point the researcher identifies a point of saturation. Distinguished scientific literature niches can be delimited. The extraction of data from primary studies implies the use of existing scripts or development of specific forms. However, the proposition is that findings of different designs and types of scientific production can be extracted, to contribute to an analytical scheme in generating evidences[21-23].

In this method, the quality of evidence diverges from the hierarchical evaluation proposed for systematic reviews. Relevance and methodological rigor of the primary studies are aspects to be considered from the researcher denotation, which allows the inclusion of primary studies that are methodologically sufficient to ensure its contribution to the analysis of the intervention characteristics. The analysis of the primary studies does not intend to discriminate the effectiveness of a program or intervention, but provide procedural explanations and unveilings of situations, on how programs and interventions are understood in specific circumstances[21-23].

Above all, results from realistic review culminate in a general theoretical model or conjectures, or even rationalization of how a given intervention works. So, it is possible to formalize hypotheses or explanations of the analyzed object. In the conduction process of the realistic review the researcher does not meet with people or groups to the development of a qualitative research. In the methodological approach mentioned the

researcher meets the scientific productions[23-25].

The realistic review purposes integrate evidence synthesis that include: review of the integrity of the program or intervention; review for evaluation between theories of programs or rival interventions; review to compare conceptual structures of programs or interventions developed in different contexts; revision of the official expectations of programs or interventions regarding the real practice[21-25].

CONCLUSION

In everyday life, the implementation of evidence-based HCN to healthcare professionals should consider that, apart from the contextual characteristics of the network territory and scientifically valid studies, the professional expertise itself and preferences of assisted persons are taken into account. In this sense, it is increasingly important to invest in methods that allow the approach in the use of the research as effective supporter in decision-making.

Considering this reality in interprofessional education for SUS, partnerships with universities - which have in their composition consolidated research groups, or even the provision of specialized technical advisory services to guide how to use research in practice - is essential. Above all, investing in the expansion of the professionals skills to action based on evidence should be set up as a liability, in addition to academic education, but also the health system itself.

Through composition of methods for the evidence synthesis that support decision-making, the Realistic Review - still little known in Brazil, is presented as a potential to support the action based on evidence in the HCN/SUS.

This, therefore, allows critical evaluation of initiatives, interventions or programs and the circumstances that led to the results achieved. With that, it is increasingly essential training for this new logic, which allows an early approach to the SUS structures and dialogue both with the complexity of the scenarios, the diversity of the communities ways of life, and practice-based evidence. These issues are leading to accomplish the SUS - in defense of citizenship.

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CONTRIBUTIONS

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