

HOME CARE IN THE STRUCTURING OF THE HEALTHCARE NETWORK: FOLLOWING THE PATHS OF COMPREHENSIVENESS

Atenção domiciliar na estruturação da rede de atenção à saúde: trilhando os caminhos da integralidade

Atención domiciliar en la estructuración de la red de salud: caminos de la integralidad

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ABSTRACT

Objective: to analyze Home Care as a tool for strengthening comprehensiveness of care in the context of the Health Care Network. **Methods:** A multiple case study with a qualitative nature undertaken through interviews with semi-structured scripts, between June and October 2012 in the health services of three municipalities in Minas Gerais. Thematic content analysis was used. **Results:** The results showed strengths and weaknesses of the Home Care in the context of the Health Care Network. The presence of meanings of comprehensiveness in the practices of the Home Care professionals was evidenced. Informational continuity as a management mechanism favors the articulation of the services in the perspective of comprehensiveness. The Home Visit, in the Family Health Strategy, is marked by challenges to be overcome with a view to its consolidation, and still has weak points. **Conclusion:** Home Care constitutes an important strategy for achieving practices grounded in comprehensiveness.

Keywords: Nursing; Comprehensive Health Care; Home Care Services; Health Systems.

RESUMO

Este estudo teve como objetivo analisar a Atenção Domiciliar como dispositivo para o fortalecimento da integralidade do cuidado no contexto da Rede de Atenção à Saúde. **Métodos:** Estudo de caso múltiplo, de natureza qualitativa, realizado por meio de entrevista com roteiro semiestruturado, entre junho e outubro de 2012, em serviços de saúde de três municípios de Minas Gerais. Utilizou-se a Análise de Conteúdo Temática. **Resultados:** Os resultados revelam potencialidades e fragilidades da Atenção Domiciliar no contexto da Rede de Atenção à Saúde. Evidenciou-se a presença de sentidos da integralidade nas práticas de profissionais da atenção domiciliar. A continuidade informacional como mecanismo de gestão favorece a articulação dos serviços na perspectiva de integralidade. A visita domiciliar na Estratégia de Saúde da Família é marcada por desafios a serem vencidos com vistas à sua consolidação e ainda apresenta fragilidades. **Conclusão:** A Atenção Domiciliar constitui importante estratégia para o alcance de práticas pautadas na integralidade.

Palavras-chave: Enfermagem; Assistência integral à saúde; Serviços de assistência domiciliar; Sistemas de saúde.

RESUMEN

Objetivo: Analizar el cuidado domiciliario como un mecanismo para fortalecer la atención integral en el contexto de la Red de Atención a la Salud. **Métodos:** Estudio de caso múltiple, cualitativo, realizado a través de entrevistas semiestructuradas entre junio y octubre de 2012, sobre los servicios de salud en tres municipios de Minas Gerais. **Resultados:** Se revelaron las fortalezas y debilidades en el contexto de la Red de Atención Domiciliar de Salud. Evidente la presencia de sensación de plenitud en la práctica de la atención domiciliar profesional. La gestión de la continuidad de información como mecanismo favorece la coordinación de los servicios relacionados a la integralidad. Las visitas a domicilio en la Estrategia Salud de la Familia están marcadas por los retos que hay que superar con el fin de obtener la consolidación, pero todavía presenta debilidades. **Conclusión:** La atención domiciliar es una estrategia importante para el logro de prácticas basadas en la integralidad.

Palabras-clave: Enfermería; Atención Integral de Salud; Servicios de Atención de Salud a Domicilio; Sistemas de Salud.

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INTRODUCTION

Home Care (HC) is an organizational and care tool which is propitious for putting into effect new modes of production of care and intervention at different points of the Health Care Network (HCN), assuming a care centered on the service user and her needs. In line with the current Brazilian health policy, HC integrates actions directed at the individual in her home, aiming for the humanization of care, avoiding inpatient treatment, and minimizing the risks of hospital infections through reducing the length of inpatient treatment, when necessary¹.

In view of the different terms referent to this issue, this study adopted the theoretical framework of Home Care which conceptualizes it as a "generic term which involves actions for health promotion, the prevention and treatment of illnesses, and rehabilitation, undertaken at home"^{2:90}. The mode of Home Care encompasses, therefore, the attendance, the inpatient treatment, and the home visit².

In this mode, the interventions are undertaken in the patient's home by a multiprofessional team, knowledge of the context in which the patient is inserted being fundamental, and aiming for the promotion, maintenance and recuperation of health². Emphasis must be placed on the need for mutual responsabilization between patient and health team, highlighting the patient's protagonism in her health-illness process. In this perspective, home care allows the patient and her family to actively participate in the process of planning, organizing, implanting and controlling the care necessary. Home care is a health intervention strategy which makes possible practices which are closer to the concept of comprehensiveness.

Comprehensiveness has been generally used to designate one of the doctrinal principles of the Unified Health System (SUS). However, its understanding goes beyond the organizational perspective, as comprehensiveness reveals the ideological framework of the Brazilian Health Sector Reforms, being understood as the ideal which is hoped to be reached in health practices and in the design of the new care model under construction³.

In this perspective, conceptualizing comprehensiveness is a great challenge, given its multiple meanings, it being necessary, therefore, to highlight these³. The first is that of comprehensiveness in its vertical meaning, which presupposes the search for the service users' needs through a comprehensive, broadened, view, seeking to capture holistically what can benefit their health in their contacts with the different points of the system. The second is that of horizontal comprehensiveness, in which it is evidenced that the responses to the service users' needs are not generally obtained through a first or single contact with the health system, it being necessary for there to be sequential contacts with different services and monitoring

of the therapeutic itinerary between them. The third relates to the interaction between public policies and, therefore, to intersectoriality, conferring a transversal character on comprehensiveness. In addition to this, comprehensiveness translates into the characteristics of the health practices which refer to the comprehensive view of the health worker who, in addition to identifying needs, needs to capture the service users' health needs - these often being concealed and hidden by the traditional language of the illness.

The formatting of the HCN is based on the principle of comprehensiveness, as its objective is the integration of the health services and the interdependence of the actors and organizations, understanding that no service has available all the resources and competences necessary to solve the population's health problems in the various points of their life cycles⁴.

The HCN is being designed at different points of attention through distinct equipments, with different technological densities distributed in them so as to result in quality, efficiency, efficacy and resolute capacity⁵.

In contrast with the perspective of comprehensiveness, the Brazilian health system is characterized by the predominance of fragmented practices and points of care which do not communicate with each other, weakening the consolidation of this principle in the services' routine, as well as the strategies foreseen for putting into action, among these, HC.

Bearing in mind the above, one may ask: what are the strengths and weaknesses of Home Care for achieving comprehensiveness in the context of the HCN? It is aimed, therefore, to analyze Home Care as a strategy for strengthening comprehensiveness in the context of the Health Care Network.

METHODOLOGY

This is a multiple case study with a qualitative character. This approach was chosen because qualitative research is oriented more to the analysis of concrete cases in their specific characteristics of time and place, based on the expressions and activities of the people in their local contexts. The multiple case study method is viable when there are various studies which are conducted simultaneously, with different subjects or institutions⁶.

The present study's universe was made up of three municipalities located in the State of Minas Gerais, specifically, Ipatinga, Betim and Belo Horizonte. To this end, the following were analyzed: the Home Hospitalization Program (HHP) located in Ipatinga, an Immediate Care Unit (ICU) in the municipality of Betim, which has a HC team, and seven Family Health Strategy (FHS) Primary Care Centers in a health district in Belo Horizonte. It is stressed that each case in particular consists of a "complete" study, in which the authors sought convergent or divergent evidence regarding the facts and the conclusions for the case⁶.

The decision to use the three cases mentioned is based on evidence resulting from multiple case studies, in which it is possible to make use of direct replication. Furthermore, the analytical conclusions which appear independently become more striking than those originating from a single case⁶.

Considering that it is in the plane of the routine practices that the construction of comprehensiveness with its various interpretations occurs, it was decided in this study to include the following subjects: four professionals from a multiprofessional home care team from a hospital in Ipatinga (nurses, doctor, nursing technician and physiotherapist); three professionals from an Immediate Care Unit (ICU) in Betim, in administrative and technical management positions (coordinator of the medical team, and coordinator of the nursing team) and twelve degree-level professionals (nurses, doctors, and social workers) and; seven Family Health Strategy nurses from seven health centers from a health district of Belo Horizonte, making a total of 26 subjects. It is emphasized that the choice of the three cases mentioned above had as its objective to encompass the analysis of Home Care in three distinct points of attention of the care given by the Health Care Network, these being: primary, secondary and tertiary care.

Data collection took place during June - October 2012, through interviews with a semi-structured script, undertaken after the signing of two copies of the Terms of Free and Informed Consent, in line with Resolution 196/96 of the National Health Council. The analysis of the data was guided by thematic content analysis which was carried out, therefore, around three chronological poles, these being: pre-analysis, the exploration of the material, and the treatment of the results⁷.

In presenting the results, the use of codes was adopted to safeguard the subjects' confidentiality. The codes "ICU-M" and "ICU-P" were used for managers and health professionals from Betim, respectively, "HHP-P" for health professionals from Ipatinga and "FHS-N" for the nurses from Belo Horizonte, after the quotations from the accounts corresponding to the interviews, followed by the number attributed which referenced it in the study's database.

This study was approved on 2nd December 2009, by the Research Ethics Committee of the Federal University of Minas Gerais, under nº CAAE 04941012.0.0000.5149.

RESULTS AND DISCUSSION

The results presented in this article relate to the congruencies regarding the three cases studied in relation to the strategies which strengthen home care in the construction of the actions' comprehensiveness, as well as this type of care's weak points, thus constituting two categories of analysis.

Strengths of Home Care: following paths to comprehensiveness and continuity of care

The meanings of comprehensiveness were evidenced in the routine of the services studied, especially in the municipalities of Ipatinga and Betim³. It was observed that Home Care contributes to comprehensiveness in the three meanings. In the vertical meaning, which assumes the search for the service users' needs based on a comprehensive, broad view, professionals from the HHP in Ipatinga and from the ICU in Betim make it clear that the HHP can contribute to a holistic and humanized view in care in the home, understood as a "new" place for undertaking health care.

[...] it's a great comfort for the patient, because I don't take (the patient) from the domestic responsibilities which she carries out at home, she carries on doing them. For example, X [patient] was a seamstress, so she was here (in hospital) - she wasn't working. She was treated at home, she carried on working, sewing (ICU-P10).

[...] we always study that the patient, or the client, must be treated as a whole. In the HHP, principally, you have to treat him as a whole, because that includes the problems not only of the illness, the pathology, but sometimes of the family, of the coexistence within the family which isn't good, we have to be there, acting directly and indirectly in this (HHP-P2).

The HHP's aim is dehospitalization, because it is known that the patient treated at home has conditions to recuperate faster, given that we are avoiding the complications resulting from hospital infections, from the mental situation itself, the patient's psychological situation, when he is in hospital for a long time. Home is an excellent place for treatment because the person is surrounded by family and friends, you know? It's very gratifying and I think it's interesting, this view that we health professionals have inside the person's home, it's another view of the patient. So, it's one thing for you to attend the patient in an impersonal way, you know? And in the hospital, in a consultation office, in an outpatient center... and when you are in the patient's home, you get another view, of the patient's needs, of the shortcomings, of the patient's suffering, so, in their home, the view becomes much broader (HHP-P3).

Comprehensiveness in the horizontal sense, evidencing that the responses to the service users' needs are generally not obtained through the first or only contact with the health system, was observed in this study. The HHP "facilitates" the link between the service user and the health service.

The HHP [Home Hospitalization Program] functions better the moment he goes, the team communicates with the HCP team. So, the staff at the clinic already know that that patient has a discharge date, that is, from then on it'll be the HCP which will give continuity, the PHC will give continuity, so these patients which go to the HHP, we manage to give continuity, in conjunction with Primary Care (ICU-M1).

The HHP is like a link between the hospital and the health clinics, you know? We manage to work undertaking the dehospitalization of the patient, but we have the hospital at hand should anything happen. And with the health clinics, we get involved mainly when the patient is discharged, which is when we refer him or her to the health clinic, get it? (HHP-P1).

The third meaning refers to the incorporation of a transversal character into the comprehensiveness. This is presented in the statement from a professional of the HHP in Ipatinga.

[...] the objective, when we get there, when we enter and are by the person's side, our objective is above all to prepare the family to care for this patient. Because, for example, a person's healthy and all of a sudden they have a CVA, an acute one you know? He goes to bed, he doesn't speak, he can't walk, what is it like to be fed through a nasogastric tube or a gastrostomy, or even to use a relief catheter. When the patient is discharged, the family becomes very troubled, they arrive completely stressed! So the program has this aim, of giving support to this family in that first period, so we go to the person's home, and there, we teach them to care for the patient. [...] when the family receives this training, they take on the responsibility for this patient in everything, so we also drop in, but of course we steadily reduce these visits, we leave gradually. We transfer the care to the family member, this functions very well, because they learn very easily, you know? (HHP-P3).

It is shown, through this statement, that HC provides care directed at conditions which are not, at times, valued in the hospital ambit. It is recognized that HC allows innovative and individualized care in health, as the work in this mode of care is associated with the use of different knowledges beyond the scientific, allowing closer relationships with service users and their family members assisted in their daily lives⁸. Thus, the professionals can "face complex and polemical cultural and social universes". In this

specific element of home care, there appears the possibility of "interaction, overcoming of prejudices, the invention of solutions and the rescuing of networks of solidarity"^{9:183}.

HC is perceived as an effort for change in the organization of the health services, seeking to overcome the model of care centered on hospital care, although the same is essential in specific situations¹⁰.

One of the strengths observed in the study was the continuity of care as an attribute to achieve comprehensiveness. The continuity of the care is related to a specific health problem and to the succession of events with a view to resolving it; in this way, it was observed that the HHP has this character of "resolving and continuing" in the home the treatment initiated in the ICU and in the hospital¹¹. In this study, the HHP is shown as a potential strategy for achieving continuity of care, thus contributing to the comprehensiveness.

One of the best tools for the continuity is the HHP, our HHP was the most effective, our HHP started functioning this year, it managed to take many patients out of the center and managed to get a referral for that patient, I can finish his treatment at home, for him, the HHP will be better (ICU-G2).

Because to give continuity in the patient's treatment, total recovery, the HHP has a big influence, because sometimes the patient leaves hospital and has a wound, so he leaves hospital and goes home, then what will happen? The caregiver will be trained by the HHP to care for this wound, to rehabilitate the patient anew. And when you have to discharge the patient, [...] from then on, he'll be embraced by the Family Health Program [FHP] (HHP-P2).

The literature indicates various types of continuity, among which informational continuity stands out, which is in relation to access to information on the previously-given care, being understood as a connection which links the care from one professional to another professional and one event which happened with the individual to another¹¹. One can observe, therefore, in the routine of the HHP, the exchanging of information between the professionals and the services with a view to achieving continuity.

The HHP has direct contact with the FHP, so everything the patient needs is there: the referral from the HHP to the FHP, the FHP doctor monitors the case too (ICU-M2).

It exists. There is always that referral and counter-referral, always the Counter-referral. There is a link, we contact, we communicate with the people in other sectors,

I've never had any problems. Sometimes they contact us and we answer. At least, in my sector we have this counter-referral (HHP-P1).

In this way, the comprehensiveness is configured as a space for intersubjectivity, favoring the dialog between the health professionals, with strengthening of the communication between the different health services¹². It is emphasized that, in the municipality of Betim, the Home Care Program (HCP) is linked to Primary Health Care (PHC), characterizing the mode AD1 described in the legislation currently in force¹. In relation to the HC, it can be seen that, given the diversity of possibilities of this mode of care, its understanding in the network is more complex as the organization of its technological set depends on its interface with the different services. Thus, when organized using the logic of home care, it tends to be closer to the primary care services; when organized for home hospitalization it tends to greater articulation with the hospital services⁸.

In this regard, the localization of the HHP in the HCN in Ipatinga seems to be a facilitating factor for the articulation between the services. According to the interviewees, the integration with the hospital, where the HHP is located, occurs in a harmonious and simplified way. In addition to this, the integration with other services is benefitted through communication strategies, strengthening the informational continuity.

For example, the case of a patient who needs inpatient treatment, he was being treated under the HHP, and had a complication, and has to go back to hospital. So, because of the HHP being here in the hospital, this process of re-hospitalizing is much easier. And, also, with the Family Health, in cases of discharge, you always have to pass it on to the FHP. I think it's a good way of communicating, people have to arrive and tell us. [...] In writing, and verbally too (HHP-P2).

In the case of Ipatinga, in relation to the analysis of the HC in tertiary care, it was observed that the articulation in the network made cooperation and solidarity possible between the services, creating benefits for meeting the requirements of the HC service users. The need for integration of the HC with the tertiary level of health care was evidenced, as there is difficulty in re-admission to hospital, a lack of strategies for support and continuity for the care, and problems relating to the referral and counter-referral systems¹³.

Contact via telephone has become a significant communication strategy for the articulation of the HHP with other health services, strengthening the informational continuity, as evidenced by P03.

What favors the articulation is this - dialog. We ring the health center. We make ourselves available for guidance, for clarification, you know? (HHP-P3).

It is emphasized that telephone contact was used for articulation with different municipal sectors and services, being most frequent with the PHC service¹⁴. Another aspect evidenced in the study in Ipatinga relates to the issuing of reports in writing for discharge from the HHP. Such reports are issued by the health professionals and delivered to the service users or caregivers who take them to the health center with the objective of giving continuity to the care.

When I'm going to discharge somebody, if the patient is going to continue with the care, most of the time we refer him, produce a discharge report, the doctor does too. (HHP-P1).

Thus, even though the issuance and delivery of the report constitute a relevant practice for the articulation of the network, this does not always take place systematically, existing only in cases considered priority, with the need for discharge linked to the health teams and families¹⁰.

It is evidenced, therefore, that the HC is configured as an important strategy for achieving comprehensiveness, incorporating practices of integration with other services. The home care, in this way, represents an important space in the re-ordering of the health work and in the re-organizing of the health care.

The Home Visit in the Family Health Strategy: a challenge to be overcome for comprehensiveness to be achieved.

In the case of Belo Horizonte, the home visits of the FHS teams were analyzed, considering PHC. It is emphasized that the Home Visit (HV) is one of the modes of Home Care². In this regard, this category discusses how the HV occurs in the FHS in a health district of Belo Horizonte. Nevertheless, it presents reports from subjects from the context of hospital care, who indicate the possible difficulties for operationalizing the HV based on the PHC.

In relation to HC in Primary Care, the study showed important weak points in regard to the consolidation of the modality of HV. The accounts relate this weakness to the FHS work routine, which is characterized by organizational and assistential conflicts, which affect its work process and the undertaking of its activities.

So, the same nurse who is here for giving care is the same one who has to go out to do visits. The same one, who doesn't have time to sit down with the Community Health Worker to be scheduling, organizing things, you know? (FHS-N5).

Among these conflicts, emphasis should be placed on the ambiguity of having to take responsibility for the set of activities which make up the dynamic of the functioning of the health center, and the specific work of the FHS. The demands imposed on these nurses are not proportional to the conditions which they are given to respond - with quality - to the FHS' prerogatives and to meeting the spontaneous requirements. This being the case, there is always the conflict of taking decisions, recognizing that some activity or another will be neglected in order for another to be undertaken.

Thus, the FHS nurses report that the HV is one of the activities put in second place so as to enable them to respond to spontaneous demands. This troubled context of the work process which is organized with priority given to the spontaneous demand causes actions which are fundamental to the FHS to be relegated to the background. Thus, it is not unusual for there to be situations in which the nurses do not manage to leave the Health Center to intervene directly in the community and get to know the territory where the subjects' processes of being healthy or becoming ill are produced, along with their emotions, the meanings they apply to life, their relationships, culture and ways of living.

It is possible to observe that the HV, although it is very important to achieve the family health objectives, worsens the upsets caused in the health center, because of the high demands:

In the afternoon, there's me, an auxiliary nurse, and an administrator, who stays in the pharmacy until three o'clock and then goes home. So, we have to take over the pharmacy to keep it open too. Because of this, I reduce the number of visits (FHS-N5).

I manage to do some home visits, I don't manage to go to all of them. I think it's possible to do them, but it's all very rushed you know. I would have to leave a whole load of stuff here to do it, and off I go to do the visit, there's always some demand (FHS-N7).

So we have the timetable, the supervision, we have other issues which take up a lot of time. So, we don't have such an intense visiting schedule, home visits, as the people who are only from the family health, like in the countryside. Because Belo Horizonte is a metropolis, it really is another program. (FHS-N3).

One can observe the influence of the organization of the work process in primary care, with bureaucratic activities related to structural issues being prioritized to the detriment of actions directed at the comprehensiveness of

the care. It may be inferred that the technical questions have priority over those which are subjective or relational, which permeate the routine in health.

In this way, a distancing between theory and practice is evidenced, as it is established by the legislation currently in force that the HV is a strategy for achieving comprehensiveness, although in the routine work exercised by the professionals, fragmented and isolated attitudes predominate, even though the undertaking of pre-arranged visits is established as a norm, as is the case in the FHS¹.

The HV is revealed as a privileged locus for strengthening the link and the construction of more effective channels for dialog between the health professional and the service user, as well as for the production of new knowledge¹⁵. In addition to this, the home visit aims to give assistance to those individuals who do not have the conditions to go to the health center; neglecting or postponing it in the name of other demands can mean an important contradiction in the health practices: the person with the greatest need cannot gain access, due to her physical limitations - and the service keeps this need hidden, as the person is unable to knock on the service's door demanding her right to health. It is therefore necessary to reorganize primary care with a view to the universality of access to comprehensive services and actions¹⁶.

Besides the democratization of access afforded by the HV, one can emphasize its potential to recognize the nurse's professional competence, in addition to broadening the view of the community and its life context, which allows the construction of more effective and coherent care plans:

And I think that when you have the opportunity to get out of the health clinic, when you make a visit, you do an activity in the locus in the community, you create a space, for attendance within the community, your work is more recognized, becomes better-known, and you end up being more valued professionally too. So, I understand that doing these activities, I think, you gain. And also, when you are recognized, this is clear, all of us want to be well-treated, recognized, when you are well recognized in your population, you feel good, don't you? Now, when you are not seen well, badly-recognized, this impacts on your activities. When you carry out activities in loco, you have the opportunity to exchange this experience with the person, the person has more freedom, you're going to get to know the area she lives in, what she does, her environment that she experiences, what she does, and there you have the opportunity to organize your work, whether it is in health promotion, the prevention of ill-health or in advice, for you to be able to attend the patient,

you are going to know what it is like there, everything there that the people experience in their day-to-day. So, the opportunity for you to be in loco, within your area of coverage, getting to know it, it's very important, and family health gives you this opportunity (FHS-N2).

It must be stressed that the routine of the FHS is impacted by the organization of the HC at the tertiary point of care, as the lack of HV overloads the functions of the HHP team.

[...] but what happens... there are things which are the health unit's job and they pass them on to us. So we should go to the health center to speak with them, as we don't provide some services which they should do, for example, changing a catheter which they could do. But no! If the patient is bed-ridden, it's the HHP which does it, so it overloads our service (HHP-P4).

In this regard, it should be noted that health professionals from Ipatinga and Betim recognize the infra-structure difficulties in the PHC which directly influence the work undertaken in the HHP. Some subjects described the challenges referent to material and human resources and, also, to the demand for attendance as aspects which make it difficult to ensure a comprehensive and thorough PHC:

[...] in the case of the FHP itself, sometimes there is a shortage of material, sometimes there isn't a car to take you to the home visits, or even a lack of professionals, there's this shortage, all this interferes, you know? I don't know, generally it might be because of the lack of material, in general. Sometimes it can also reflect the lack of transport, because the nurse has to go there, she goes, she has to go to the person's house to do the visit, and sometimes there isn't a car for going, I think that all this influences matters, or there's an obstacle, isn't there? (HHP- P2).

[...] but this unit doesn't always have the technical and material conditions to continue providing care to a certain patient, so various patients complain about this, they don't find the necessary materials, for example, the relief catheter, dressings, you know? They can't even manage a doctor's visit [...]. (HHP-P3).

[...] the service users complain a lot... 'ah the HHP comes here every week, they (the professionals from the PHC) don't come', the care, it's very different... maybe because

of the volume of people who they treat, you know? We have to see their limitations too, because we have a fixed number of 70 patients per month, physiotherapy has a fixed number too, and I respect the schedule if it's time to discharge someone, for them to receive discharge, it's rare for me to extend the treatment (HHP-P4).

In some clinics, we have a lot of difficulty, there's no doctor, I don't know enough to tell you, if it's a lack of number of doctors, or their quality (ICU-P2).

Aspects such as shortcomings concerning the availability of transport, equipment and professionals in the PHC indicate obstacles related to the articulation of home care with the municipal health network, being related to the continuity of the care in the PHC units¹⁰. One should emphasize, therefore, the existence of weak points in the concretization of the comprehensiveness, which create gaps in the setting of the work of the PHC which impact directly on the services of other points of health care.

FINAL CONSIDERATIONS

Home care in the ambit of the SUS is a mode of health care characterized by a set of actions for promoting health, preventing and treating ill-health, and rehabilitation, provided in the home. From the study, it is possible to infer that this mode of care has led to important advances in the continuity of care and in the materialization of comprehensiveness.

The HC reveals its importance in the health setting by allowing new modes of production of care and intervention at different points of the HCN and, above all, by transforming the home into another care space. Thus, HC participates in the structuring of the HCN and affords new modes of intervention which can contribute to overcoming the model of health care which remains hegemonic.

The HV in the FHS constitutes one of the modes of HC, being a strategic tool in PHC by making it possible for nurses and other professionals in the team to get to know the life context of the subjects, so that their therapeutic projects may be possible to put into practice and may be coherent with their respective contexts. The HV is perceived of as an important space for recognition and, therefore, for reinforcing the identity, also being recognized as a space for exercising autonomy and concretization of activities in conjunction with the community.

The present study allows one to infer that the structuring of the HCN is still a process under construction, presenting important gaps in relation to the capacity to overcome fragmented healthcare practices. The HCN

constitutes, in this form, an organizational strategy not yet consolidated in the services' routine, which still presents weaknesses to be confronted, principally related to the services' complementarity and the interdependence between them. Working in a network depends on how each sector acts on its areas of responsibility, as this clearly causes impacts on the other's actions and can create or not the continuity of the care. In this context, it is necessary to rethink and propose strategies for overcoming the gaps existing, so that the HC may present significant advances in the construction of services and practices which are closer to comprehensiveness.

In relation to this study's limitations, it is emphasized that although it considers primary, secondary and tertiary health care, it was undertaken in three municipalities, which may not express the context in other localities. Thus, further studies must be undertaken for greater generalization of the results found here.

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