International Medical Society
http://imedicalsociety.org

International Archives of Medicine
Section: Primary Care
ISSN: 1755-7682

2017
Vol. 10 No. 119
doi: 10.3823/2389

The Team of the Family Health Strategy and the Doctrinal Principles of the Unified Health System: Perceptions and Applicability

ORIGINAL

Woneska Rodrigues Pinheiro[1], Thais de Lima Felix da Silva[2], Isaac de Sousa Araújo[3], Kátia Monaisa de Sousa Figueiredo[4], Lorena Pereira Bernardo[5], Hermes Melo Teixeira Batista[5], Daisy Teixeira de Menezes[6], Rayane Moreira de Alencar[2], Marco Akerman[7]

Abstract

Introduction: The SUS, which was guaranteed by the brazilian constitution of 1988 and regulated by organic laws of health, offers a system governed of doctrinal principles (universality, fairness and completeness) concerning the philosophy of the system and extend the concept of health and the right to it. On the promotion of these principles, the municipalization of health is referred to as a policy of decentralization which incorporates basic health attention, permeated by the principles of the SUS, where inserts in this context the basic health units (UBS) that are entrance doors of the population to the system. When considering that the proposals brought by the family health strategy (FHS) are great potential to restructure the welfare model and the Organization of health services, and these proposals based on the principles governing the SUS, becomes essential, inter alia, that the worker member of this team have involvement and knowledge of the project, as well as on its goals and principles governing it.

Objective: Check the knowledge and promotion of doctrinal principles of the SUS by active team of FHS in the town of Juazeiro do Norte in the State of Ceará (CE), Brazil.

Method: This work deals with a transversal nature study exploratory, qualitative approach. The survey was conducted in the family health strategy of the city of Juazeiro do Norte-CE, with top level professionals (physician, nurses and dentists) who work on units during the collection period. The collection was performed through a semi structured interview and the data analyzed by means of the collective

1 PhD In Health Sciences. Professor of Nursing College Leão Sampaio. Juazeiro do Norte, Ceará, Brazil. Laboratory studies on social determinants and health member equity (LEDSES).
2 Laboratory studies member on social determinants and health equity (LEDSES).
3 Surgeon Dentist. Master In Endodontics By College São Leopoldo Mandic.
4 Professor of Nursing College Leão Sampaio. Juazeiro do Norte, Ceará, Brazil. Laboratory studies on social determinants and health member equity (LEDSES).
5 Estácio, FMJ, Juazeiro do Norte, Ceará.
6 Surgeon, Hospital Regional do Cariri (HRC).
7 Doctor specialist in Public Health and Social Medicine. PhD in Epidemiology and Public Health.Professor from the Department of Practice and Public Health of USP's. Sao Paulo, Brazil. Laboratory studies on social determinants and health member equity (LEDSES).

Contact information:

Woneska Rodrigues Pinheiro.

woneska@bol.com.br

subject discourse. This study was submitted to the ethics committee of the College Lion Sa, having the opinion of approved (nº: 1067638).

Results: The results showed that the professionals have demonstrated no knowledge of, nor promote some doctrinal principles of the SUS coherently. The knowledge that they have are fragmented and incipient, and Praxis (theory combined with practice) is still far from being achieved.

Conclusion: The findings of this research show gaps as the promotion of the principles of the SUS by professionals who act. The ineffective knowledge on how SUS is organized and on what basis rests, leads to improper practices, making deployment and consolidation process.

Keywords
Doctrinal Principles of the SUS; Unified Health System; the Family Health Strategy.

Introduction

The current health services in Brazil consolidated by the unified health system (SUS), is the result of a historical process of joint struggle of brazilian health movement struggles for democratization of concomitant society brazilian. The SUS, which was guaranteed by the brazilian constitution of 1988 and regulated by organic laws of health, offers a system governed of doctrinal principles (universality, fairness and completeness) concerning the philosophy of the system and extend the concept of health and the right to it [1]. These principles are today considered symbols of a social achievement. Because it is from them that the brazilian health system is organized in such a way as to offer a public health insurance to every citizen. About the principles that guide the SUS, the universality which guarantees the access of the entire population to health services at all levels of assistance, equity ensures that assistance consider the differences between groups and individuals, giving priority to those that present greater need, and completeness which is defined as a set of actions in health preventive and curative services hinged either individual or collective, are principles that should direct the democratization of health services and make it so the right of all citizens to access and participation in health policy [2]. From the concept of health through the federal constitution of 1988 as health being right and duty of the state and the consolidation and regulation of SUS through 8080 laws /90 and 8142 /90, emerged a new strand to the public health policies doctrinal and organizational principles consolidated the SUS [3]. The health reform experienced by the country with the aim of formation of SUS, established on the principles of universality, equity and comprehensiveness, has several strategies to continue this reform, including the adoption of the proposed family health (SF) by the Ministry of health in 1994, as a way of implementing the SUS [4]. On the promotion of the principles here referred to, the decentralization of health is referred to as a policy of decentralization which incorporates basic health attention, permeated by the principles of the SUS, where inserts in this context the basic health units (UBS) which are input ports of the population to the system [5]. The Family

Health Strategy (FHS), is composed of a multidisciplinary team, with medium-high level professionals including doctors, nurses and dentists, this team that has gradually as the consolidated program as primary form of health care in the country, thus increasing the demand of these professionals [3]. We can say, therefore, that the multidisciplinary team that integrates the FHS, is responsible not only for the direct way of conducting the service, but also are these professionals who have the responsibility to put into practice the theory that the SUS offers for its functioning. When considering that the proposals brought by the FHS are great potential to restructure the welfare model and the organization of health services, and these proposals based on the principles governing the SUS, becomes essential, inter alia, that the worker member of this team have involvement and knowledge of the project, as well as on its goals and principles governing it [4]. Leaving this context, this research study left of the following questions: How the FHS professionals conceptualize the doctrinal principles of the SUS. As these professionals put these principles into practice in the exercise of their profession? This research is relevant, considering that demonstrates the professional design of basic attention to doctrinal principles governing the brazilian health system, as well as the way in which these professionals apply these principles in his professional practice, contributing factor directly on how to organize the service and assistance provided to the population. By virtue of that form, to manage create a service and watch the people are influenced by concepts and professional practices and thus, the demotic assembly studied theories on the subject, who claim that the professionals operating in the FHS often form teams uncommitted and unlinked with the objectives of the system, it can be affirmed that these professionals do not have the adequate knowledge about the doctrinal principles that govern the health system and the services provided in the units they work, which is the hypothesis assumed in this research project. Therefore, the present study was carried out in order to allow a better understanding of the doctrinal principles of health unic system and also to evaluate and delineate the profile of the services and the care organization, which may or may not consolidate the system's objectives.

Method

The present work it is a transversal nature exploratory research with qualitative approach. The cross-sectional survey is one in which the data are collected and analyzed in a given time space, based on a sample selected through established criteria, allowing to inform the existing situation at the time of data collection [6]. Exploratory research is used when there is little knowledge about the subject, making it thus clearer. This type of search further on issues hitherto little discussed, contributing to clarify matters superficially studied [7]. Qualitative research is an important tool for understanding of values and representations of a particular group about different themes. This is research that worries about a reality that cannot be quantified and covers aspects such as conceptions, perceptions, values and activities [8]. The survey was conducted in the family health strategy of the city of Juazeiro do Norte, Ceará, Brazil. The sample of this study was composed of nineteen [19] FHS professionals (nurses, physicians and dentists). The data collection was conducted in the months of february and march 2015, through interview using a script previously structured. The semi-structured interview is a medium where the researcher obtains information through the talks participants, combining open and closed questions where the interviewee can address specific theme without being influenced by the researcher [8]. The semi-structured interview follows a previous script and is indicated to study phenomena with specific populations, where there must be flexibility in questions and the interviewer can ask supplementary questions for better understanding of the pheno-

menon [9]. A pilot test was conducted for analysis and confirmation of the data collection instrument. The interviews were recorded and subsequently transcribed in full, respecting the ethical and legal aspects of research and maintaining the confidentiality of the interviewee. The qualitative data were analyzed by the Collective Subject Discourse method (CSD), which consists in implementing speech in the collective, as if it were only one individual through discourses of similar meaning extracted from the depositions and focusing on the central ideas and expressions. It still implies in the presence of social research a collective thought as empirical reality, describing the social representations. The speeches can be organized according to the questions asked to the participants [10]. This study was submitted to the ethics committee of the College Lion Sa, having the opinion of approved (nº: 1067638).

Results

This section of the study was used to analyze the knowledge of nineteen [19] professionals about the doctrinal principles of the SUS, through the speeches of the participants. After thorough and comprehensive reading and transcription of all the interviews, key expressions were dropped lines, and the central ideas that are similar have been allies in order to compose the collective subject discourse. For better layout, analysis and understanding of the results, divided the discourses based on inquiries made to the participants of the study during the interview.

Question 1: Which the doctrinal principles of the SUS, you know?

In this question, respondents who were asked to cite the doctrinal principles of the SUS that knew each other, and after examining the key expressions were taken from the answers, and so two speeches were identified, arranged as follows:

> *Universality, fairness and completeness.*
>
> DSC1.

Note that in most of the interviewees DSC1 cited the universality, fairness and completeness as doctrinal principles. Leaving this speech, it can be said that the speech of professionals is consistent with the literature. This can be stated as the universality, equity and comprehensiveness are willing in the organic law of 8,080/90 health as doctrinal principles of the SUS, and these principles are laid out in the federal constitution as guidelines of the unified health system [11]. This speech, therefore, takes the understanding that professionals active in the existence of the FHS doctrinal principles of the SUS, as well as know what are these principles. However, another idea about the doctrinal principles of the SUS emerged between the answers of the participants of the study, as you can see in the DSC 2 willing to low:

> *Equality and accessibility.*
>
> DSC2.

In this speech, we can observe the existence of professionals made allusion to other words and quoted as doctrinal principle. The federal constitution, as well as the organic laws of not mentioning the equality and accessibility as doctrinal principles. However, in the literature, there are some authors that define equality as a doctrinal principle, often replacing the principle of equity. The actions and health services, associated or not, that make up the health system, are governed by the principles of universality, access the integrality and equality in assistance [12]. Therefore, we can say that what is said by the interviewees in DSC2, is in part according to the literature, since there are authors that define equality as a doctrinal principle.

Question 2: I wish you conceptuses the principles mentioned above

This question respondent defined the terms cited as doctrinal principles of the SUS. So, for better organization and understanding, the DSC was formed for each principle.

Universality

The participants defined the Universality as "universal access to health services, without discrimination or distinction." Is what is observed in the following speech:

> *The universality is you promote universal access to health services offered by SUS. Everyone has the right to care, regardless of race, gender, belief, income, without discrimination of any kind.*
> DSC3.

Before the talk, it was possible to notice that the participants defined the universality, such as the right of all citizens to access to health services offered by SUS, so that this access is extended to all people regardless of their ethnic differences, religious, financial, or any other species. These data are consistent with the definition of this principle both in literature and in law. From the principle of universality health became a right of all citizens, and the duty of the State, causing all individuals, regardless of their differences of any kind, have access to health actions and services offered by SUS [13]. This fact is confirmed in the federal constitution of 1988, which States that universality is the constitutional guarantee of access of all persons, actions and health services, in any level of assistance, without prejudice or privileges of any kind. Therefore, being in the exposed, the subject of this research demonstrated to meet the principle of Universality, in its full definition.

Equity

With regard to equity, the subjects have cited two central ideas as a definition. The first with the idea that fairness is "offer service according to the needs", and a second, which alludes to equity as a synonym for "equality". Is what can be seen below:

> *Equity is dispensing care and assistance according to the needs of the patient, giving more to those who have less and who need more.*
> DSC4.

This DSC noted that equity was defined by the participants in the form of dispensing assistance taking into account the needs of individuals, so that the actions and services are offered to those who need it most.

> *Equity is to guarantee equality to all people the care and health actions.*
> DSC5.

On the other hand, what is observed at DSC5, is a divergent of the idea first speech, in which study participants consider equity as synonymous with equality in assistance. In this way, we realize that they are distinct ideas, once in DSC4 equity is defined as a way to consider the differences in level of need, therefore, would not be offer care and assistance of egalitarian way, as what is stated in DSC5. However, we can say that the two ideas, although distinct allude to the right direction of equity. What happens is that this is a principle still very complex in its definition. Equity is the assurance of health actions and services, at all levels of assistance, taking into account the complexity of each case, without privileges or barriers [14]. The law 8080/90, in turn, says equity ensures that the provision of health services take into consideration the differences between groups and individuals, giving priority to those which have greatest need, considering the situations of risk and vulnerability. Therefore, we can say, is that professionals, when defining equity, have cited this definition in different ways, so that literature itself, or even the laws, do not bring a unified definition of this principle. This is

a factor that may hinder the promotion of fairness in the system, since different concepts, leading to different practices.

Completeness

To conceptualize the completeness, the participants have to treat the patient as a whole, "but" without defining what "all" mentioned, besides making a certain redundancy to the beginning, when they claim to completeness is "offer full assistance".

> *Completeness is you can offer integral assistance, treating the patient as a whole.*
>
> DSC6.

Have the participants of the study a very vague definition of the principle of completeness. The completeness has two senses. The first, with a horizontal dimension, where the actions and health services must occur in an orderly manner at all levels of attention, with links between reference services and reference counter, elective and solving way [15]. In the second sense, referred to by the author above, completeness has a vertical dimension, where the subject must be viewed as a whole, one and indivisible, going far beyond the merely biological aspect, where it must be considered the social, spiritual and emotional aspects of individuals. This definition coincides with the cited by study subjects, however, the professionals have cited very superficially, showing don't know in full its full meaning.

Equality and accessibility

As already seen, accessibility and equality are not among the doctrinal principles of the SUS, however it is important to know which sense the respondents gave to the terms, since these were cited. In reading the speeches, the professionals have defined equality as "equal assistance to all" and accessibility as the idea of promoting "access to the actions and services."

> *Equality is to provide care equally for everyone. The SUS is equal for everyone. Everybody's got a right.*
>
> DSC7.

> *Accessibility is you promote access to every group that requires the attendance of the SUS. Offering the closest access to the service. People have a right to access, so we have to facilitate such access.*
>
> DSC8.

In the speeches above, individuals define equality and accessibility, alluding to the principle of Universality. By saying that " *the SUS is equal for all*", "*everyone has the right*" and "*access to every group that requires the attendance of the SUS*" these professionals mistook the principles of the SUS, not having legitimate knowledge about the same.

Question 3: As you upgrade each principle in your professional practice? quote examples

In the third question, the goal is to know how the professionals promote the principles cited. Asked if then, that cite practical examples for a better understanding.

Universality

In the speeches of the participants observed two ideas about the promotion of universality. The first DSC professionals stated that promote universality since all people without distinction, in another idea point to difficulties in promoting the principle. In this way, the DSC obtained with these lines, are prepared and analyzed below:

> *I offer service to everyone who comes, since everyone has the same right, got it all evenly, without distinguishing and without any discrimination.*
>
> DSC9.

In the speech above, note that the subjects apply universality in order to meet any person, equally and without distinction. Comparing with the definition of the term given by them, on the second question of the questionnaire, we can say that the design is in accordance with the promotion, in this case, thus obtaining the *Praxis* (practice and theory aligned).

> *We feel difficulty to be promoting this principle because the demand is very great, so here we watch out everyone within the programs and who gets there first will have. However, in the case of medical emergencies, we also attend and these cases will be seated.*
>
> DSC10.

In the second speech in the universality, the professionals they had a difficulty facing for promoting the principle, where they cited the wide demand for patients. These data corroborate with the studies of literature, who claim that there are difficulties that impede the universality in its entirety, as the excess of people to be serviced, which involve the formation of queues and the need to arrive at dawn to the service to be served [13]. Still in the analysis, DSC10 cited scheduling queries as main form of care, which can be considered a form of corruption from the top. However, the subject claim that to the emergency room, there is a fitting within this schedule. This, however, alludes to the principle of equity, where once again note that the professionals do between the two principles. However, this is an erroneous idea, because even though interlinked, universality and equity are not synonymous. Fairness is characterized as an offshoot of the principle of universality, where ensures that the differences among groups and individuals are taken into account in the allocation of resources and assistance where the needs are greater [13].

Equity

When asked about the promotion of equity, the participants of this study reported promotes it in two ways, as follows:

> *Always I'll be a little more careful with that patient that demand more care and offer individually, identifying those that we can ta doing docking and ensuring the query also. So I try to see to the needs of each patient, to meet according to this need. For example: has an urgency in front of everyone you're on record, we put that patient in front, elderly patient, pregnant woman, takes precedence.*
>
> DSC11.

> *We serve everyone equally, offering the same assistance to everyone, not making a difference from person to person.*
>
> DSC12.

The two speeches are according to the definitions cited about fairness by the interviewees. Where defined promote the principle of fairness as "meet according to the needs" and "serve all equally". In the first speech, it can be affirmed that the subject not only has the proper notion of what fairness means, but also to promote according to his conceptions. Supply and dispensing services must be made individually, based on the needs and priorities in order to be fair. Equity allows the unequal service to those who are not equal, giving priority to those most in need [16]. In the second speech, the subject stated apply equity given to all equally, again referring to equity as synonymous with equality. However, although some authors also define equity in this way, there is disagreement in the literature about it. It is through the principle of equity which reduces inequalities, however, this does not mean to say that she be synonymous with equality, because even though all have the right to access, regardless of color, race, sex, religion and have

no privilege, people are not equal, and thus have different needs [13].

Completeness

As a way to promote the entirety the respondents claimed to practice from the point of view of completeness between networks and services, and of completeness on multi professionalism.

> *I offer, patient care fully, treating the patient as a whole, not just its pathology and offering him all kinds of service that is needed, and that the SUS offers.*
>
> DSC13.

In this speech, study participants point to promotion of completeness both with a view to consider the patient as a biopsychosocial being, as in the perspective of giving and direct the user to the actions and services that exist at any level of attention of the system. The professional participants of the study promote completeness by noting the patient beyond his illness. The SUS server is much more than a carrier of a disease or health problem, he is a human being before that, inserted into a society, cultures, habits, financial conditions and different beliefs, and all these factors can interfere directly or indirectly on health. The completeness is beyond sight of a fragmented health attention, focused only on the biological factor. Assuming that there is a look at the affective factors, biological, sociocultural and spiritual of each person [15]. Completeness guarantees the entire population access to various levels of attention, seeking to promote, prevent and restore health, as well as rehabilitating the individual in your social environment. The professionals also mentioned promoting completeness multi discipliner.

> *In completeness we search for, if necessary, other professionals that can integrate this care, both from the dental, medical and nursing.*
>
> DSC14.

However, if we consider the allied theory and practice with regard to completeness, it is possible to observe a disharmony of ideas on the part of respondents. The same conceptualized this principle as "*make offer integral assistance, treating the patient as a whole*", but this is a very sparse and shallow definition of completeness. The professionals were more goals in time to explain the way we promote the principle, giving more extensive and profound answers about the practice, unlike the concept, which does not contemplate the true meaning of completeness in its entirety.

Conclusion

The family health strategy, is the gateway of the population to SUS, in addition to being an important instrument for the implementation and consolidation of the system, once ruled by their doctrinal principles. The team of professionals specialized in these units, is responsible for the organization and management of direct service, as well as on the way to attend the population. Therefore, it is essential that these professionals meet the objectives and principles governing the SUS. Demographic characterization of professionals was drawn initially, so that they could meet the profile of the participants of the study. The data pointed to a sample essentially feminine, composed of young adults, both recent college graduates, as formed and working in an average time of FHS 6 months to 5 years. As regards the design of the professionals on the doctrinal principles of the SUS, you could say that most of these, know what are these principles correctly, citing the universality, fairness and completeness in their speeches. However, other terms like "equality and accessibility" were cited by respondents, showing that there are still professionals who don't know the subject consistently with what they say the laws and literature. With regard to universality, the defined properly. Universality ensures that all citizens have the right to access the actions and health services offered by SUS, without distinction

of any kind, and the definition given by the respondents, corroborates with this reality. Already with regard to equity, the pros have shown in part the meaning of this principle. Equity is the way to offer and dismiss actions and services fairly, giving priority to those most in need. The definition given by the respondents is partially consistent with the real meaning of equality. However, much of the sample associated with equity as synonymous with equality, and sometimes confused with the definition of the principle of universality. In defining the principle of completeness, the description given by professionals proved scarce and subjective, conceptualizing it only as offering fully assistance, whereas the patient as a whole, where the professionals have demonstrated no knowledge of the breadth of meaning of this principle. Regarding the promotion of principles, one of the three doctrinal principles, only on the tangent of universality, the praxis of professionals. In addition to its definition to be according to the literature, the way to promote the principle in professional practice, also proved in accordance, where participants, showed combining theory and practice consistently. However, there was still a mixture or confusion in practice, where some professionals, gave practical examples related to equity as a way to promote universality, showing once again the erroneous Association that makes between the two principles. The data showed that, in the practice of equity, when the participants claimed to promote considering all equally and without distinction, strengthening again this Association. As the promotion of integrality, professionals demonstrated conceptualizing it very superficially, but claimed to promote it in a way that goes far beyond the definition given by them. Fragmentally respondents promote the completeness of the multi professional point of view and also considering the multi sectoral user as a biopsychosocial being. Finally, what can be said is that the initial hypothesis of this study was confirmed, since professionals have demonstrated no knowledge and promote all the doctrinal principles of the SUS coherently. The knowledge is still very fledgling and fragmented, and the praxis (theory combined with practice) is still far from being achieved. The results indicate a certain fragility in the knowledge of these professionals regarding the doctrinal principles of SUS. This fragility can arise from the training process during graduation or even from the lack of training and continuing education on the part of them. What we can say is that this is a negative point which must be taken into account by professionals and managers, since they are the doctrinal principles of the SUS, governing the entire system, as well as their way to organize. And ineffective knowledge, leads to erroneous practices, hindering the process of implementation and consolidation of the SUS.

References

1. Roncalli, A.G. O desenvolvimento das políticas públicas de saúde no Brasil e a construção do Sistema Únicode Saúde. In: Antonio Carlos Pereira (Org.). *Odontologia em Saúde Coletiva*: planejando ações e promovendosaúde. Porto Alegre: ARTMED, Cap. 2. p. 28-49, 2003.
2. Aguiar, Z.N. *SUS: Antecedentes, percurso, perspectivas e desafios*. 1º Ed. São Paulo. Martinari, 2011.
3. Santos, M.A.M; Cutolo, L.R.A. A interdisciplinaridade e o trabalho em equipe no programa de saúde da família. *Arquivos Catarinenses de Medicina*. v. 33, n. 3, p. 31-40, 2004.
4. Bernardes, E.H. *Princípios Doutrinários do Sistema Único de Saúde: concepções dos enfermeiros da Estratégia de Saúde da Família de uma cidade do Estado de Minas Gerais*. 193f. Dissertação (Mestrado em Enfermagem em Saúde Pública) – Universidade de São Paulo, Ribeirão Preto, 2005.
5. Passos, J.P; Ciosak, S.I. A concepção dos enfermeiros no processo gerencial em Unidade Básica de Saúde. *Revista Escola de Enfermagem*.v. 40, n. 4, p. 464-468, São Paulo, 2006.
6. Richardson, R. J. *Pesquisa social*: métodos e técnicas. 3ª Ed. 14ª reimp. São Paulo, Atlas, 2012.
7. Raupp, M.P; Beuren, I.M. *Metodologia da Pesquisa Aplicável às Ciências Sociais*. São Paulo: ATTLAS, Cap. 3, p. 76-77, 2008.
8. Minayo, M.C.S. *Pesquisa Social: teoria método e criatividade*. 33ª Ed. Petrópolis, Editora Vozes, 2010.
9. Manzini, E.J. Uso da Entrevista em Dissertações e Tezes Produzidas em um Programa de Pós-Graduação em Educação. *Revista Percurso*. Maringá, v. 4, n.2, p. 149-171, 2012.

10. Lefèvre, F.; Lefèvre, A. M. C.; Marques, M. C. C. Discurso do sujeito coletivo, complexidade e auto-organização. *Ciência e Saúde Coletiva*. Rio de Janeiro, v. 14, n. 4, p. 1193-1204, 2009.
11. Mattos, R.A. Princípios do Sistema Único de Saúde e a humanização das práticas de saúde. *Revista Interface*. v.10, n.2, p.275-286, 2009.
12. Linard, A.G; Chaves, E.S; Rolim, I.L.T.P; Aguiar, M.I.F. Princípios do Sistema Único de Saúde: compreensão dos enfermeiros da Estratégia de Saúde da Família. *Revista Gaúcha de Enfermagem*. Porto Alegre, v. 32, n.1, p. 114-120, 2011.
13. Pontes, A.P.M; Cesso, R.G.D; Oliveira, D.C. : A Universalidade no SUS: Pensamento dos usuários. *Escola Anna Nery Revista de Enfermagem*. v.13, n.3, p. 500-507, 2009.
14. PINHEIRO, W.R. et al. Equity in health: conception of professionals in the primary network of the Unified Health System. *International Archives of Medicine*, Vol. 8 (110), 2015.
15. Carvalho, G. Os governos trincam e truncam o conceito de integralidade. *Radis*. v.49, n.6, p.234-241, 2006.
16. Paim, J.S; Silva, L.M.V. Universalidade, integralidade, equidade e SUS. *Boletim do Instituto de Saúde*. V.12, n.2, p.116-121, 2010.