IPS Instituto de Política Social

DOCUMENTOS DE POLÍTICA SOCIAL. HISTORIA, INVESTIGACIÓN Y DESARROLLO.

Número 13. Volumen II. Abril 2014.

ISSN 2340-7808.

THE TRIPOD GUIDING OF ATTENTION IN THE NATIONAL HEALTHCARE SERVICE (SUS) IN BRAZIL: INTEGRALITY, INTERDISCIPLINARY AND INTERSECTORIALITY.

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ABSTRACT: This article studies the tripod guiding of attention in the National Healthcare Service (SUS) in Brazil, represented by the three “I” (s) considered essential to the social rights to health effectiveness: integrality, interdisciplinary, and intersectoriality. In this perspective, at first glance, it is highlighted the attention to the National Healthcare Service (SUS), doctrinaire principle currently referenced as integrality, having as its historical moment the Brazilian Sanitary Reform. Following, it is presented a complete attention to the health care as an organically principle tied to notions of interdisciplinary and intersectoriality, ratifying its inseparability as essential meeting to the social needs of health, or access to the necessary conditions for the realization of the requirement social right to health.

KEY-WORDS: Integrality. Interdisciplinary, Intersectoriality. Healthcare. National Healthcare Service

INTRODUCTION

The so-called tripod guiding of attention in the National Healthcare Service (SUS) current in Brazil is represented by the three “I” (s) considered essential to the social rights to health effectiveness: integrality, interdisciplinary, and intersectoriality. The social needs service of healthcare or access to required conditions for effective social right to healthcare conditions - as a product to be achieved by the attention given in the different levels of the health system complexity - is linked to the continued promotion of the interface among the integrality, interdisciplinary and intersectoriality. Therefore, for integrality becomes a constant in the provided attention of the healthcare system ambit, the enlargement of the interface with interdisciplinary and intersectoriality should report in advances not only related to work processes of multidisciplinary teams, as well as to formation processes of the different professional groups in the healthcare field.

There are multiple sets of meanings attributed to the integral care by authors who are dedicated to the study of this thematic category and other presented in governmental texts. In this context, it is emphasized what conceives full attention as a doctrinal principle of the healthcare system, commonly referred as integrality. This meaning attributed to integral care has the Brazilian Sanitary Reform Movement as a historical moment, which played a unique role in the fight for public policies, the resizing of the relationship between the State and the civil society, and in the transformation of healthcare practices in the Country. With the advent of the Federal

Constitution of 1998 and the implementation of the National Healthcare System (SUS) in the 90s of 20th century, it was institutionalized the social security, and particularly the healthcare, as a social right, which the guarantee shall be recognized as a duty of the State.

Providing an integral care is assuming its recognition as an organically principle tied to notions of interdisciplinary and intersectoriality in the work processes of multidisciplinary healthcare teams. From European origin, the interdisciplinary is known in the country since the 70s of 20th century, and it presupposes the collective articulation seeking to break with the fragmentation of knowledge and practices. Through intersectoriality, it becomes possible to establish shared links between healthcare services and the set of public policies and/or social factors that contribute to the accomplishment of the social right to healthcare. Therefore, it is emphasized in this article, the inseparability among integrality, interdisciplinary and intersectoriality in attention, as an essential requirement to attending the social needs of healthcare, or for accessing to needed conditions for effective social right to healthcare.

1- THE INTEGRAL CARE IN THE BRAZILIAN NATIONAL HEALTHCARE SYSTEM (SUS)

The integral care is a polysemy expression fundamentally tied to notions of interdisciplinary and intersectoriality. In the Brazilian public healthcare system, the integral care, commonly referred as integrality, includes [1]"[...] everything that involves the health care of human beings, including the actions and services of promotion, prevention, rehabilitation and diseases treatment" (BRAZIL, 2009a, p. 40-41). According to the analysis proposed by Paim (2004), health care can be considered under two approaches. At first, as a social response, the health care "is part of the disciplinary field of health policy, especially when we analyze the actions and omissions of the State regarding the health of individuals and the collectivity"[2] (Paim, 2004, p. 15). Then, as a

[1] "[...] tudo que envolve o cuidado com a saúde do ser humano, incluindo as ações e serviços de promoção, prevenção, reabilitação e tratamento de doenças" (BRASIL, 2009a, p. 40-41).
[2] "insere-se no campo disciplinar da política de saúde, sobretudo quando são analisadas as ações e omissões do Estado no que tange à saúde dos indivíduos e da coletividade" (PAIM, 2004, p. 15).

service, the health care lies in the "tertiary sector of the economy, and it depends on the processes which permeate the spaces of the State and the market"[3] (Paim, 2004, p. 15).

Being attentive to health care with aiming at integrality, means conceiving the citizen as a social, political and historical subject in its completeness. For its effectiveness, it is necessary to integrate the actions of health promotion, diseases prevention, treatment and rehabilitation through the development of work processes which prioritize the interdisciplinary and the intersectoriality, for the reason that the isolated action of one or another public and/or social policy is not sufficient to meet the healthcare needs (BRAZIL, 2001). Those, in turn, are social reproduction needs, i.e., classes needs that differ "[...] in different social groups defined by its insertion in the social division of labor that determines different ways of living"[4] (CAMPOS, Mishima, 2005, p.v1261). The healthcare needs inform, therefore, different ways in which social groups participate in the social production and reproduction process.

Mattos (2011) works with enumeration of three sets to rescue the senses of integrality. The first set of integrality senses goes back to the criticism of integral fragmentary medical practice regarding to the patients, associating it with the attitude, as good medical practice. The second set of senses of integrality comprehends the services organization and healthcare practices, in which the integrality can only be an attitude instead of a brand in the organization of working processes way. The third set of senses of integrality turns to specific groups, relating it to the so-called special policies. For the author, understanding the polysemy notion which surrounds the integrality, refers to the understanding of the Brazilian Sanitary Reform specificity, and to the corporate project in which it is bound (Mattos, 2011).

Despite Brazilian's economic development historically marked by social inequalities, having the neoliberal presuppositions as guiding of the hegemonic corporate project in the contemporary scene, in the political and social spheres is observed along the historical process the presence of social resistance strategies that give indicative of collective coexistence and individual counter-hegemonic projects. In societies based on the capitalist mode of production, as Brazil's case, despite other

[3] "setor terciário da economia e depende de processos que perpassam os espaços do Estado e do mercado" (PAIM, 2004, p. 15).

[4] "[...] nos diferentes grupos sociais, definidos pela sua inserção na divisão social do trabalho que determina os diferentes modos de viver" (CAMPOS; MISHIMA, 2005, p. 1261).

determinations, the corporate projects are required and the class projects simultaneously (Netto, 2006), having the embryonic locus, therefore, the contradictory social relationship between capital and labor. The corporate projects are "[...] collective projects, although their unique feature is the fact that they constitute as macroscopic projects such as proposals for the whole society"[5] (Netto, 2006 p.142). The essential question to be considered for thinking about the social projects in class societies is the political character that pervades the practice (Teixeira; BRAZ, 2009).

Before the contemporary crisis in the late 70s of the twentieth century and changes in capitalist production, understood as determinants of corporate change in progress (MOTA, 2009), there was significant declining trend recessive of the economy in Latin American countries, exacerbating the inflationary process, external debt, structural unemployment and the fiscal deficit. In Brazil, the levels of population health have been negatively affected, requiring a position before sanitary problems. In parallel, the social resistance to sanitary problems was gaining strength, requiring a new construction theoretical-discursive directed to [6]"[...] the reorientation of the medical care system, with the privileging of the actions developed to public sector level" (FELIPE, 1987, p. 489). As a consequence of the 30th Annual World Health Assembly promoted by the World Health Organization (WHO) in 1977, it was adopted the goal "Health for all by 2000", highlighting the social determinants of health.

It was designed a full movement for the reform of health systems, which became known as the Brazilian Sanitary Reform Movement[7]. Besides the contestation to the dictatorial regime, the Sanitary Reform Movement contained proposals for strengthening the public sector, as opposed to the private, and the construction of a new agenda in the healthcare field, with references made from a close dialogue between the Marxism and Structuralism tendencies. In the early years of struggle for the Sanitary Reform, the strategy of occupying all the spaces of possible discussion focused on finding manufacturing guidelines of the healthcare system. Amid the transition to the

[5] "[...] projetos coletivos; mas seu traço peculiar reside no fato de se constituírem como projetos *macroscópicos,* como propostas para o *conjunto* da sociedade[5]" (NETTO, 2006, p.142).
[6] "[...] a reorientação do sistema médico-assistencial, com o privilegiamento das ações desenvolvidas ao nível do setor público" (FELIPE, 1987, p. 489).
[7] Arouca (1976) *apud* Carvalho (1995) characterized the Sanitary Reform on three levels: a- the theoretical and practical, that is, as knowledge construction; b- ideological practice, that is, transformation of consciousness; c- political practice, that is, the transformation of social relations.

process of democratization of the country, and simultaneously to the economic crisis of the state, the Sanitary Reform Movement gained force (BRAZIL, 2007 apud CAMARGO, 2009).

With the government's announcement of the economic crisis[8] and its inability to fund it, increased the social mobilization for the formulation of a new concept of healthcare with significant changes in its organization and management form, a promising effort to equip it to the condition of public liability policy of the State. Being overcome the Brazilian military dictatorship period, issues such as the change of the constitutional norm, the change of the framework of institutional practices, the living conditions, and the population health, they took over on a political dimension. Two striking features of this historic moment: political democratization surpassing the dictatorial regime and the outbreak of a deep and prolonged economic crisis (BRAVO, 2006; CAMARGO, 2009). While the first "[...] came gradually mining the available resources for social spending"[9] (DRAIBE, 1993, p. 22), the second "[...] impelled generous reforms movements of its protection system"[10] (DRAIBE, 1993, p. 22). The decade of overcoming the dictatorial regime was marked by political democratization of the country and, concomitantly, by the worsening of the living conditions of the population and coincides with the decade considered "lost" in economic terms, marked by the spread of so-called *culture of crisis*[11].

During the 8th National Health Conference (CNS) held in 1986 in Brasília / DF, were widely discussed topics such as the design of the health condition as the social right, and State duty, the universal and equal access to healthcare, participation and social control. Part of these guidelines, as well as the demands of the Sanitary Reform movement, they were served with the Constitution in 1988 and, after several political

[8] Two vectors are considered backdrop of the economic crisis: "the changes in the labor world (productive restructuring and replacement of the Fordist-Keynesian model by flexible accumulation) and changes in State intervention (Keynesianism crisis and neoliberaism emergence)" (CAMARGO, 2009, p. 44). Under the discourse of measures to overcome the economic crisis, the country became a signatory to the agreement signed with international organizations like the World Bank and International Monetary Fund (IMF) through the guidelines laid out in the Washington Consensus (COUTO, 2004).

[9] "[...] veio gradativamente minando os recursos disponíveis para o gasto social" (DRAIBE, 1993, p. 22)

[10] "[...] impulsionou movimentos generosos de reformas do seu sistema de proteção" (DRAIBE, 1993, p. 22).

[11] Its predominant trace is the spread of the idea that the crisis affects identically throughout society, regardless of social class status of the subject, so that the 'exit' requires consensus and sacrifices of everyone (MOTA, 2005).

agreements (CAMARGO, 2009). As consequences of this process, it has the social status achievement of the healthcare law, as well as a range of other rights by the citizenship; the acceptance that the guarantee of healthcare as a duty of the State; the agreement of this chapter relating to the Federal Constitution of 1988; the integration of social security beside the political assistance and welfare.

The sanitary politicization allowed following decisive ways towards the welfare institutionalization. In accordance with this, the National Healthcare Service (SUS) was implemented in 1990, based on the named Organic Law of Health (LOS) and composed by the Laws n. 8.080 and 8.142[12] (BRAZIL, 1990a; BRAZIL, 1990b). According to the constitution, the SUS covers a "[...] set of actions and health services provided by federal, state, and municipal agencies and institutions, direct and indirect administration, and foundations maintained by the Public Power" [13] (BRAZIL, 1990a, p. 02). It is organized into three levels of attention: primary, secondary, or tertiary and medium complexity, or high complexity, and is governed by the so-called doctrinal principles: universality, equity and integrality and organizational: regionalization and hierarchy, decentralization and unique command, and popular participation. This way of organization of the health system intends to ensure more efficient use of resources, universal access and equity in attention.

To Mattos (2006), in a close estimate, one can say that the integrality constitutes one of the basic guidelines of SUS established in the Constitution of 1988, aspect in which, since the implementation of SUS, differentiates the Brazilian public healthcare system from the global trend. In the Article 198 of the Federal Constitution of 1988, in fact, given the integration of actions and public healthcare services through a regionalized and hierarchical network into a single system, having as one of its guidelines the "[...] full service with priority to preventive activities without prejudicing

[12] The Law n. 8.080/1990 provides for "[...] the conditions for the promotion, protection and recovery of health, organization and functioning of relevant services" (CAMARGO, 2009, p. 37). The Law n. 8.142/1990 provides for "[...] the community participation (social control) in the management of the Unified Health System (SUS) and intergovernmental transfers of financial resources in the health sector" (CAMARGO, 2009, p 37).

[13] "[...] conjunto de ações e serviços de saúde, prestados por órgãos e instituições públicas federais, estaduais e municipais, da Administração direta e indireta e das fundações mantidas pelo Poder Público" (BRASIL, 1990a, p. 02)

care services [...]”[14] (Article 198, Item II in BRAZIL, 1988, p. 81). The integrality term has been commonly used to designate this guideline because “[...] in any of these meanings, and many others that this term can acquire, the integrality represents, above all, escape from the reductionism. Behind all these senses, it must be the principle of the universal right to health care needs” [15] (MATTOS, 2011, p. 01).

Because it is a demarcating element of the health system, the fact of the integrality does not have a single meaning or a single definition, it can be considered at the same time, a weakness and a potentiality (SANTOS *et al*., 2011). In the experiment, the integrality assumes the meaning of its legal definition “[...] as a social action resulting from democratic interaction among the actors in their everyday practice, the provision of health care, and the different levels of health care system”[16] (PINHEIRO, 2009, p. 01). Considering the actions, integrality is “[...] a concrete strategy to make collective and accomplished by individuals in defense of the life”[17] (PINHEIRO, 2009, p. 01). Thus, presupposes the overcoming clippings actions and focusing on diseases, assuming full attention to the social subject, including his family and the community in which it operates, from a broad concept of health.

The current Brazilian legislation considers the healthcare the result of a set of determinants and conditioning as, [18]“[...] food, abode, basic sanitation, environment, labor, income, education, transportation, recreation, access to essential goods and services” (BRAZIL, 1990a, p 01; BRAZIL, 2009a, p. 337-338). This broad concept of healthcare surpasses the minimalist notion of access to services and medical treatments or to medicalization[19], comprehending the social health needs and giving evidences of the necessary recognition of the repercussions of corporate transformations in that field

[14] [...] atendimento integral, com prioridade para as atividades preventivas, sem prejuízo dos serviços assistenciais [...] (Art. 198, Item II *in* BRASIL, 1988, p. 81).
[15] “[...] em qualquer desses significados, e em muitos outros que esse termo pode adquirir, a integralidade representa, acima de tudo, a fga do reducionismo. E, por trás de todos esses sentidos, deve estar o princípio do direito universal ao atendimento das necessidades de saúde” (MATTOS, 2011, p. 01).
[16] “[...] como uma ação social que resulta da interação democrática entre os atores no cotidiano de suas práticas, na oferta do cuidado de saúde, nos diferentes níveis de atenção do sistema” (PINHEIRO, 2009, p. 01).
[17] “[...] na estratégia concreta de um fazer coletivo e realizado por indivíduos em defesa da vida” (PINHEIRO, 2009, p. 01).
[18] “[...] alimentação, moradia, saneamento básico, meio ambiente, trabalho, renda, educação, transporte, lazer, acesso a bens e serviços essenciais” (BRASIL, 1990a, p. 01; BRASIL, 2009a, p. 337-338).
[19] Bravo (2000) uses the term to refer to the emphasis in clinical practice through actions focused on curative medical assistance, individual, with the devaluation of preventive and collective actions preconized by the public health.

(CAMARGO, 2009). Cecilio (2001) equates the determining factors for the health needs of health, classifying them into four groups: 1 - the good living conditions; 2 - the access to major technologies that improve or prolong life; 3 – the effective creation of linkages between users and professional/health team; 4 – the increasing degrees of autonomy that each person has in their way of conducting life aspect, that goes beyond information and education.

Providing an integral care in meeting the social needs of health, or in access to needed conditions for the effective social right to health, requires the collective articulation for the sake of integrality, aspect by which it becomes essential recognizing it as a principle organically tied to the interdisciplinary and intersectoriality notions. It is necessary to restore the senses of integrality as described in the conceptual foundations of the Sanitary Reform: a- an integration of actions at different levels of the healthcare system complexity; b- the way of professional activities comprehending the set of determinant and conditioning factors of health; c- the assurance of attention continuity at different complexity levels of healthcare system; and d- the articulation of public policies related to changing projects (PAIM, 2008). Therefore, the integrality needs to be the product of the collective construction, having senses and scopes built in the plural space composed by different social actors involved in the production process of health care.

2- INTERDISCIPLINARY, INTERSECTORIALITY AND THE INTEGRAL ATTENTION TO THE HEALTHCAERE

Starting from the understanding of interdisciplinary as an epistemological constant Minayo (1994) it was problematized it from the point of view of its functionality and utopia to support the discussions in the healthcare sector, affirming that is a term covered in controversies and a plurality of meanings. When it deals with interdisciplinary, as a pursuit for the entire knowledge, among others, the author names the Brazilian researcher Japiassú (1974), and the French philosopher and scientist

Castoriadis (1987)[20], which strongly criticized the knowledge fragmentation, the institutional knowledge and the modern science obscurantism. In the theoretical review by the author, it is still found the position of authors which characterize the interdisciplinary as a feature of science and technology, and other authors who characterize it as communicative reason, confirming the impossibility of consensus in conceptualizing interdisciplinary:

> As mentioned in the introduction, it becomes practically impossible to conceptualize interdisciplinary by consensus. On one hand, there is an ‘implicit interdisciplinary’ unspoken, internal, own of the scientific rationale that, by the advance of knowledge, ends up creating subjects. On the other hand, there is an interdisciplinary use constituted externally via operating fields that link science, craft and politics, mainly through social interventions such as the health care. [...] (MINAYO, 1994, p. 61) [21].

It has been conveying in Brazil since the 70s of 20th century that the interdisciplinary had as pioneers Japiassú and Fazenda. The first, considers the term under the epistemological approach, realizing that “the interdisciplinary distinguishes itself from the other concepts for do not limit the methodologies of just one science” [22] (JAPIASSU, 1976, p. 74). The second, discusses it under the pedagogical approach, stating that interdisciplinary emerged in Europe, especially in France and Italy, in the 60s of 20th century, done by the student movement, which demanded a new university status and school as opposed to excessive specialization of knowledge that caused the gap between education and the daily problems (FAZENDA, 2002). Despite the different approaches of approach, these authors corroborate the recognition of interdisciplinary practice as a solution to the problem of disciplinary and, consequently, as a strategy to overcome the knowledge fragmentation (ALVES; BRAZILIAN; BRITO, 2004; SANTOS *et al*., 2011).

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[20] Both authors are considered disciples of Gusdorf Georges (1912-2000), French philosopher and epistemologist who studied interdisciplinary as the search for totality of knowledge (MINAYO, 1994).

[21] Como se menciona na introdução, torna-se praticamente impossível conceituar consensualmente a interdisciplinaridade. De um lado há uma ‘interdisciplinaridade implícita’ não dita, interna, própria da racionalidade científica que, pelo avanço de conhecimentos acaba criando disciplinas. Por outro lado há um uso interdisciplinar constituído externamente através de campos operativos que articulam ciência, técnica e política, sobretudo através de intervenções sociais como é o caso da saúde. [...] (MINAYO, 1994, p. 61).

[22] “a interdisciplinaridade se distingue dos demais conceitos por não se limitar as metodologias de apenas uma ciência” (JAPIASSU, 1976, p. 74).

The interdisciplinary is convened to promote the break with the knowledge fragmentation that is established by modern science under the protection of the capital, conveyed in the training process and reproduced in the world of labor (PEREIRA, 2009). In the healthcare scope, it contemplates the "[...] operative articulation of knowledge and practices, seeking to break the isolation of the body of knowledge and each health professions performance, resulting in a fragmentation of health care" (SANTOS *et al*. 2011, 65)[23]. The training processes, as well as the processes of health work, should aim at promoting continuous enlargement of the interface between interdisciplinary, the integrality and intersectoriality, in the perspective of expanding healthcare as a citizenship right impelling new rights. On the contrary, if it incurs in the risk of reproducing the fragmentation of attention, markedly characteristic presented in "old" health practices, offered by various professional groups as a condition to be overcome. In this sense, the process of health work emerges as human action through which:

> The workers tend to adopt a particular type of work organization: a specific course of action to relate each other, the users, and establishing specific rules on division of labor in the provision of care. In the work process, the workers "use of themselves" for themselves. For every situation that arises, the worker prepares strategies that reveal the intelligence that is inherent in every human work. Therefore, the employee is also a manager and producer of knowledge and innovations (BRAZIL, 2009, p. 372)[24].

The maintenance or break with the "old" health practices are related to the models of care, contradictory and complementary, along the historical process. The models of care, attendant models or intervention ways in health are "[...] technology combinations structured according to health problems (damage and risks) that compose the epidemiological profile of a given population that express social and health needs

[23] "[...] articulação operativa de saberes e práticas buscando a ruptura do isolamento do corpo do conhecimento e da atuação de cada uma das profissões da saúde e decorrente fragmentação da atenção em saúde" (SANTOS *et al.,* 2011, p. 65).

[24] Os trabalhadores costumam adotar um determinado tipo de organização do trabalho: uma forma específica de agir, de se relacionar entre si e com os usuários, e de estabelecer regras específicas na divisão do trabalho na prestação dos cuidados. No processo de trabalho, os trabalhadores "usam de si" por si. A cada situação que se coloca, o trabalhador elabora estratégias que revelam a inteligência que é própria de todo trabalho humano. Portanto, o trabalhador também é gestor e produtor de saberes e novidades (BRASIL, 2009, p. 372).

historically defined" (PAIM, 1998, p. 568)[25]. In the contemporary scene, it is dominated by models of assistance in medical-care privatizing health and Sanitary Reform. The first, essentially healing, focuses on the disease, on the individual, palliative and fragmentation of subjects, and for these reasons, tends to undermine the integral attending (PAIM, 2003). The second is guided in health as a social right and State duty, "[...] the democratization of access to units and health services [...] democratic access to information and encouraging citizen participation" (BRAVO; MATOS, 2006, p. 36)[26].

Conforming with the model of health care in the Sanitary Reform, the interdisciplinary involves working collectively, *ie*, to manage the production process of care cooperatively with professionals which integrate the multidisciplinary teams, both in the health system, as in the set of public policies and/or social related to it. Managing implies creating, *ie*, constantly trying to exchange theoretical knowledge and practice with the multidisciplinary professional teams of the health system and the set of public and/or social policies related to it, as well as users of the health system, to build through teamwork, different ways to produce an attention aiming at integrality. In this context, teamwork comprises "[...] the action of a group of people to achieve common goals, with shared responsibility and commitment, open communication and effective. [...]" (GRISCI, 2011, p. 453)[27].

The work, while "the exercise of vital activity capable of shaping their own production and reproduction of humanity [...]" (ANTUNES, 2011, p. 433)[28], emerges as a central element to unravel the processes of production[29] and social reproduction of health. In health care, the integrality depends on how much work "[...] articulates breaking the fragmentation between knowledge and practice" (MOTA; AGUIAR, 2007, p. 366), *ie*, in the light of interdisciplinary. The living and working conditions of the

[25] "[...] combinações tecnológicas estruturadas em função de problemas de saúde (danos e riscos) que compõem o perfil epidemiológico de uma dada população e que expressam necessidades sociais de saúde, historicamente definidas" (PAIM, 1998, p. 568).

[26] "[...] democratização do acesso às unidades e aos serviços de saúde [...] acesso democrático às informações e estímulo à participação cidadã" (BRAVO; MATOS, 2006, p. 36).

[27] "[...] a ação de um conjunto de pessoas a fim de atingir objetivos comuns, com responsabilidade e compromisso compartilhados, comunicação aberta e efetiva. [...]" (GRISCI, 2011, p. 453).

[28] "exercício de uma atividade vital capaz de plasmar a própria produção e a reprodução da humanidade [...]" (ANTUNES, 2011, p. 433),

[29] O processo de produção em saúde consiste na "articulação social dos diferentes processos de trabalho nesse campo, tem como finalidade responder às necessidades sociais da saúde. Necessidades de saúde são necessidades de reprodução social, dadas nas diversas realidades sociais em que estão inseridos os sujeitos" (CAMARGO, 2007, p. 82).

population also occupy centrality in the design of social determinants of health adopted by the National Commission for the Social Determinants of Health (CNDSS)[30] in 2006, in which the socioeconomic, cultural and environmental conditions are included, and related to the life condition and work of social subjects, including social and community networks (COMISSÃO NACIONAL SOBRE OS DETERMINANTES SOCIAIS DA SAÚDE, 2006).

In order that the integral attention is achievable, it is necessary provision of continuous and coordinated set of actions, preventive services and individual and collective healing, required for individual or universal, in all complexity levels of healthcare system (BRASIL, 2003). In the continuity of preventive and healing actions, it is highlighted the importance of interdisciplinary in the work processes since the health care field is not private in any professional category, while one or another professional category is not enough to meet the social health needs. In the services articulation, it is highlighted the importance of intersectoriality in work processes since the realization of the social right to health depends on a set of determinants, conditioning and one or other public and/or social policy, singly, it is not enough to deal with social health needs .

As the health effectiveness, in the quality of social law is coupled with guaranteed access to the set of determinants and conditioning factors, the integral attention effectiveness is tied to the interface with interdisciplinary and intersectorial in work processes, with qualitative impact on formation processes for healthcare field. In this terms, it is worth noting that in the specific Curricular Guidelines for undergraduate programs in health care field[31], published in 2001, the curricular flexibility, as opposed to curriculum rigidity, was highlighted as essential to meet social demands of the contemporary globalized world in the 21st century, as well as human needs related to creativity and freedom (CREUTZBERG; LOPES; DOCKHORN, 2011).

[30] A comissão equivalente da Organização Mundial da Saúde (OMS), criada em 2005, que leva o mesmo nome da brasileira – *Commission on Social Determinants of Health* (CSDH) – define os determinantes sociais da saúde como as condições sociais em que as pessoas vivem e trabalham (BUSS; PELLEGRINI FILHO, 2007).

[31] It is a wide range of professional groups belonging to health field. According to the Resolution of the National Health Council (CNS), n. 287 of October 8, 1998, are considered professional health categories top level: social workers; biologists; biomedical professionals; physical education professionals; nurses; pharmacists; physiotherapists, speech therapists, physicians, veterinarians, nutritionists, dentists, psychologists, and occupational therapists (BRASIL, 1998).

The *status* of social rights is asserted to health as a duty of the State "[...] through social and economic policies that aim at reducing the risk of disease and other health problems, and the universal equal access to actions and services for its promotion, protection and recovery" (Art. 196 in BRASIL, 1988, p. 81)[32]. The joint action between the managements of different spheres of health policy: municipal, state and federal, articulately with other government sectors and the set of public policies and/or social must "[...] contribute, directly or indirectly, to promote better conditions of life and health for the population"[33] (BRASIL, 2009a, p. 337-338), *ie*, having scoped intersectoriality. From this perspective, intersectoriality emerges as a strategy aimed at overcoming the fragmentation of the set of policies in areas where these are operationalized, whose equation involves the integration of action by virtue of which:

> The social policies, even the universal nature, have difficulty in promoting equity and integrality of attending. Despite the social problems, they manifest themselves in sectors that their solution is dependent on the action of more than one policy. They are part of a whole complex and require an integrated way to solve them, hence the need to sort the power structures of public policies (JUNQUEIRA, 1997, p. 32)[34].

The intersectoriality has as primary challenge "[...] articulating different sectors in solving problems of everyday management and it becomes strategic to guarantee the right to health since health is the output from multiple social policies to promote quality of life"[35] (BRASIL, 2008, p. 01). Through the intersectoriality, it can be possible establish links between different public and/or social policies, with potential impact on the population health conditions. On one hand, the movements of intersectoriality imply changes in the system, services, actions and processes of health care work. On the other

[32] "[...] mediante políticas sociais e econômicas que visem à redução do risco de doença e de outros agravos e ao acesso universal igualitário às ações e serviços para sua promoção, proteção e recuperação" (Art. 196 *in* BRASIL, 1988, p. 81).

[33] "[...] contribuir, direta ou indiretamente, para a promoção de melhores condições de vida e de saúde para a população" (BRASIL, 2009a, p. 337-338)

[34] As políticas sociais, mesmo as de caráter universal têm dificuldade em promover a equidade e a integralidade do atendimento. Apesar dos problemas sociais manifestarem-se setorialmente, sua solução está na dependência da ação de mais de uma política. São parte de um todo complexo e demandam uma maneira integrada para resolvê-los, daí a necessidade de ordenar as estruturas de poder das políticas públicas (JUNQUEIRA, 1997, p. 32).

[35] "[...] articular diferentes setores na resolução de problemas no cotidiano da gestão e torna-se estratégica para a garantia do direito à saúde, já que saúde é produção resultante de múltiplas políticas sociais de promoção de qualidade de vida" (BRASIL, 2008, p. 01).

hand, it requires the constant review of the formation of different types about health professionals' process. Thus, the multidisciplinary teams begin to operate as sets of knowledge, overcoming the fragmented forms of health care (JUNQUEIRA, 2000).

From the point of view of networking, the power of intersectoriality is to give to the multidisciplinary professionals health teams "[...] new opportunities to provide assistance more integral and in a resolute way, increasing new paradigmatic views to these professionals" (PAULA; STRAW; PROTTI, 2004, p 332). The Networking refers precisely to work processes in health that require joints, linkages, complementary actions, horizontal relations between different social subjects and interdependence of actions and services, with a view to ensuring comprehensive care. It is a process of "[...] learning and determining the subject, which also results in the integrated management of social policies, to respond effectively to the problems of the population of a given territory" (JUNQUEIRA, 1997, p. 36)[36].

The intersectoriality is this "articulation among subjects of different social sectors and, therefore, of knowledge, power and many wills in order to approach a theme or situation as a whole"[37] (BRASIL, 2009b, p. 18). Working towards the intersectoriality favors the overcoming of fragmentation not only of knowledge, but also social structures mediators of attention of social health needs. At last, the intersectoriality requires mechanisms for collective involvement in the form of networks production health. These networks production health must be built collectively, aiming at promoting continuous enlargement of the interface between the integrality, interdisciplinary and intersectoriality in health care, with the encouragement of social participation as a precondition to democratize and qualify the public space and strategies of social control, and, accordingly, contribute to the construction of one more just and egalitarian social order.

Finally, it is emphasized that to meet the complex range of social health needs that cross everyday lives of different levels of complexity of health system, the professionals of multidisciplinary teams are challenged to build better ways to organize

[36] "[...] aprendizagem e de determinação dos sujeitos, que resulta também na gestão integrada das políticas sociais, para responder com eficácia aos problemas da população de um determinado território" (JUNQUEIRA, 1997, p. 36).
[37] "articulação entre sujeitos de setores sociais diversos e, portanto, de saberes, poderes e vontades diversos, a fim de abordar um tema ou situação em conjunto" (BRASIL, 2009b, p. 18).

and pay attention, coordinating resources, especially: a- theoretical-practical: knowledge and experience; b- institutional: services, institutions, industries, and public policy and/or social; and c- socio- political: subjects, movements and social structures; considering that promoting health is to improve the ways of interpretation and also construction of responses to social reality. Thus, it confirms the inseparability of integrality, interdisciplinary and intersectoriality in attention, as essential to meet the social needs of health, or access to needed conditions for the social right health effectiveness.

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