Urgent and Emergency Health Care
Network Policy in Brazil: influence and text production contexts

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Abstract: The article aims to analyze the contexts of influence and text production of the Urgent and Emergency Care Networks (RUE) policy in Brazil through the Policy Cycle Approach. Qualitative research was carried out through document analysis of legal texts, technical, and academic publications to analyze the contexts of influence and production of RUE texts, not being the object of this study the context of practice. The context of influences evidenced the dispute for the legitimacy of the SUS, neoliberalism, underfunding, managerialism, the hospital crisis, and the predominance of the health care network model. The texts, on the other hand, express values of citizenship, access, quality and comprehensiveness; purposes of nationalization and improvement of response time; influences from the previous policy of urgency and humanization, the area of hospital administration and concepts from the field of collective health. The plural and multifaceted character of the policy can bring challenges in the context of practice, to be researched in future studies, due to the need to develop and articulate different ideas and practices identified in the texts and resulting from multiple and diverse influences. Still, these can be resignified and crossed by vectors and disputes in fields of unique practices of decentralized and diverse management in the country, in the different services, municipalities and health regions.

➤ Keywords: Delivery of health care. Emergency medical services. Health Policy.

Introduction

The Brazilian Ministry of Health proposed the Urgent and Emergency Care Network (*Rede de Atenção às Urgências e Emergências* – RUE) as one of the thematic networks constituting the Health Care Networks (*Rede de Atenção à Saúde* – RAS) policy (Brasil, 2014) from 2011 to 2013, the first years of President Dilma Roussef's first term. This proposition introduced the polyarchic model when organizing health care, intending to provide better epidemiological results, comprehensiveness, and quality of care within the scope of the Brazilian Unified Health System (SUS) (Brasil, 2010).

The legal regulations that established the RUE proposed the articulation and integration of health equipment as objectives, aiming to expand and qualify access for users in urgent and emergency care situations in an agile and timely manner. The RUE was structured based on the following components: a) health promotion, prevention, and surveillance; b) basic health care services; c) Mobile Urgent Care Service (*Serviço de Atendimento Móvel de* Urgência – SAMU 192) and its medical regulation centers; d) stabilization Rooms; e) SUS national health care force; f) Emergency Care Units (*Unidade de Pronto Atendimento* – UPA 24h) and the set of 24-hour urgent care; g) hospital component; and h) home care services (Brasil, 2011a).

For Jorge *et al.* (2014), urgent care is a fundamental and priority issue, both for the federal government and for states and municipalities, given the magnitude of the problems in this area and the need for intervention to improve care. Most urgent care in the SUS has been marked by disorganization, overcrowding, and low integration with other points of care. At the urgent care doors, there is a mix of people with serious diagnostic hypotheses—such as cerebrovascular accident (CVA), acute myocardial infarction (AMI), victims of accidents and violence—and people with low-severity complaints, worsening overcrowding.

The thematic network of urgent care was chosen as the object of investigation due to its relevance and repercussions for the comprehensiveness and qualification of health care, the incipient academic production identified, and its contribution to the analysis and qualification of public health policies.

Implementing a policy like the RUE, which aims to organize and provide services at different network points, is challenging in itself; making it even more challenging

to take it as an object of investigation and analysis in the case of public policy. The Policy Cycle Model (Howlett; Ramesh, 1995) has been classically used to analyze public policies and subdivides the process into five phases: agenda setting, policy formulation, decision-making, implementation, and evaluation (Pinto *et al.*, 2015). However, criticism points to a fragmented understanding based on the predictability and supposed neutrality of the model, given the complexity of public policy processes that cannot be limited to stagnant and successive phases (Baptista; Rezende, 2015).

It is essential to consider that policies—understood in their complexity and characterized by unstable and ambivalent elements—are in permanent movement across time and space, outlining a trajectory and always maintaining a degree of uncertainty. Stephen Ball proposes a method for policy analysis that seeks to understand the unique movement of each policy by identifying its constituent elements and understanding the unique interaction of these elements in their specific historical situation (Rezende; Baptista, 2015). Thus, the Policy Cycle Approach (PCA), proposed by Ball (1994), considers policy as text and as discourse and studies the contexts of influence, text production, and practice. This article does not address the context of practice. The study aims to analyze the contexts of influence and production of texts of the Urgent and Emergency Care Network policy in Brazil based on the Policy Cycle Approach.

Methodology

The research has a qualitative and analytical design developed based on documentary analysis. The study period is initially between 2003 and 2014, comprising the first identified influences, the formulation, and the beginning of implementation of the RUE Policy in the country.

The main theoretical-methodological framework used is the PCA (Ball, 1994), which allows a non-linear and fragmented view of the policy under study. The idea of contexts offers a possible reading that is not unilateral but multidisciplinary and global, with the cycle stages not occurring in isolation but intertwining in a movement of interaction, completing each other (Jesus, 2014). This study adds other theoretical-conceptual frameworks as we come into contact with the empirical material. As Ball (Mainardes; Marcondes, 2009) states, developing a more coherent and articulated analysis of the world requires different types of theory, i.e., theoretical pluralism.

After researching published articles and analyzing official documents establishing the RUE policy, materials were also collected from other sources, such as websites, press reports, and other publications. The material was analyzed by adapting the guiding questions proposed by Mainardes (2006) for the context of influence and the context of text production, using PCA as a reference (Ball, 1994).

The study was funded by the National Council for Scientific and Technological Development (CNPq). It did not require approval by the Ethics Committee, as it did not involve human beings, having been developed from documents in the public domain and available virtually.

Results and Discussion

The results are presented and discussed in two sections: the context of influences and context of text production in the RUE, reconstituting the scenario at the time of decision and policy formulation, and the speech materialized in written form.

The context of influences on the formulation of the RUE

The context of influence is characterized by the beginning of public policy. This is when the first discourses emerge together with the interests of political groups, to influence the constitution and definition of policy. At this moment, the concepts and other base references gain legitimacy with the participation of different interest groups (Jesus, 2014).

When reconstituting the historical process that culminated in the RUE policy, it is essential to understand the implementation of the SUS in Brazil as a public policy. The SUS is defined as a universal health system consisting of a regionalized and hierarchical network of actions and services (Brasil, 1988), which is fundamental for implementing the constitutional right to health in the country.

In recent decades, the organizational guidelines of decentralization and regionalization have materialized and provided advances and challenges in structuring the system (Reis *et al*., 2017). For Viana *et al*. (2018), the political cycles of the SUS organization comprised two periods in which decentralization to subnational entities prevailed. The first, from 1988 to 2000, had as its main characteristic the protagonism of the municipal sphere; the second, from 2000 to 2016, had regionalization as its focus, culminating in the RAS model. The

construction of health networks in the SUS presupposes a regionalized organization along the lines of national health systems, with a theoretical framework referring to the Dawson Report, updated in the proposal of the Pan American Health Organization (Kuschnir; Chorny, 2010). In the Brazilian cooperative federalism model, Regional Intermanagerial Commissions (CIR) were established for health regions, which are instances of consensual agreement between federative entities to define the rules for shared management of the SUS (Brasil, 2011b). These collegiate bodies do not need regional health authorities. For Machado and Palotti (2015), there is a clear differentiation among the Union's powers regarding their capacity to control the agenda and induce support for federal programs that signal new financial resources.

The SUS has remained a counter-hegemonic project as a public and universal health system since it was created in the late 80s and early 90s, mainly following the growth of neoliberalism as a global economic trend and the consequent inflection of public investment into social policies, which continues to this day. It is essential to connect the economic, social, and ideological dimensions present in the construction and operationalization of a health policy to understand this context. Understanding the Brazilian insertion process in the globalized world, increasingly dependent on the financial market in the context of neoliberalism, allows us to understand the obstacles and challenges in implementing the SUS (Mendes, 2012).

According to Lima (2010), from the 1990s onwards, Brazil moved toward a broad neoliberal consensus favorable to the implementation of the stabilization, adjustment, and institutional reform program of the International Monetary Fund (IMF) and the World Bank, obeying their guidelines for unrestricted opening of the economy, commercial and financial deregulation, deregulation of the labor market, and downsizing of the State. From a social point of view, we are witnessing the privatization of financing and production of services, the precariousness of public policies with cuts to social spending, and the focusing of investments toward the most vulnerable groups.

For Mendes (2012), the SUS financing crisis takes place over a long process of conflicts and clashes between actors in the social field of public health who defend social security and health as a right for all and a duty of the State, and actors who advocate a restrictive economic policy supported by the principle of containing public expenses. In the governmental field, constant tensions are identified between

health managers and the economic and planning areas as a scenario of disputes over resources for the SUS. This underfunding scenario constitutes an essential national influence on health policy in Brazil.

The growth of neoliberal discourse and practices was not restricted only to economics but also impacted public administration, including Brazilian administration, using managerialism (Pereira, 1999). Constitutional Amendment No. 19 of 1998 included the principle of efficiency and proposed the transition from bureaucratic public administration to managerial administration, whose main characteristic is the control by results and not by processes (Tofani; Sguarezi, 2016).

As a global influence, New Public Management, also called managerialism, in addition to expanding the import of techniques typical of private management into the public sector (Menezes; Leite, 2016), proposes with great emphasis the elimination, privatization, and outsourcing of public services, having as operational prescriptions: disaggregation of the public service into specialized units and cost centers; competition between public and private organizations; attention to discipline and parsimony; entrepreneurial administrators with autonomy; performance evaluation; and evaluation focused on results and productivity (Secchi, 2009).

The formulation and institution of the RUE (Brasil, 2011a) took place in the first year of Dilma Rousseff's term as president of Brazil. Her administration established its own style, with a technical emphasis on results and greater monitoring of goals (Ihohara; Rocha, 2011). This conception of public administration was also repeated as a sectoral influence in the health area. In his inauguration speech, Health Minister Alexandre Padilha committed, among other priorities, to implementing a national quality assurance and access indicator as a permanent goal for each sphere of government (Padilha, 2011). Therefore, the search for results in the area of health—access, quality, and timeliness—under the monitoring of indicators and goals was present as an influence in the period of formulating the RUE policy.

The persistent crisis of overcrowding in SUS hospitals and urgent care doors, especially in Rio de Janeiro, also characterized the scenario at the time (Sá; Azevedo, 2010). Overcrowding in urgent care is a worldwide phenomenon. It is characterized by having all beds in the service occupied in the same space and period, bedridden patients in corridors, waiting times for care of over an hour, high tension in the care team, and tremendous pressure for new services (Bittencourt; Hortale, 2009). In Brazil, this phenomenon points to a disproportion between the demand of users who

reach the services and the capacity to provide care and the insufficient management of services (Coutinho, 2010). This crisis in urgent care is also understood as influencing the political decision to structure the RUE due to society's demand for solutions, its visibility in the media, and the exploration of the topic in the electoral process.

As for international influences, the Pan American Health Organization (PAHO, 2010) recommendations for organizing health systems in Integrated Health Service Networks are followed. This model was proposed to face the complex scenario of health needs and to end the fragmentation that weakens most of the world's health systems. It was adapted for the SUS as Health Care Networks (*Rede de Atenção à Saúde – RAS*) in Brazil, whose theoretical-conceptual development occurred with a partnership between the Ministry of Health, PAHO, and the National Council of Health Secretaries (*Conselho de Secretários de* Saúde – CONASS). The experience in the State of Minas Gerais, as described by Mendes (2011), was used as reference, which was decisive in the formulation of the policy, and which defines the RAS as networks made up of different health care points, with primary care centrality, logistical systems, and support.

Thus, when proposing a genealogy for the historical construction of the RUE Policy in the SUS, global, national, and local influences that made it emerge are identified: the context of a dispute over the implementation and legitimization of the SUS, including its organizational process; the economic scenario of neoliberalism and underfunding of public health policy; the strengthening of managerialism and the search for results in public administration; the need for a political response from the actors who took over leadership of the federal government that was beginning to respond to the social demand for a solution to the crisis in public hospitals and urgent care doors; and, the international and national influences on the organization of the health system based on the RAS conceptual model.

Context of production of RUE texts

The context of producing the text of a given public policy comprises the result of the disputes and political agreements established for it to be formulated. The linguistically materialized speeches reveal the power games and interests of the different actors involved in and with the policy formulation process (Jesus, 2014).

Regarding the analysis of the context of RUE text production, nine legal regulations, two technical publications from the Ministry of Health, and two articles

published by authors who were strategic actors in its formulation and implementation were defined as scope (Table 1). Its contents were analyzed, including introductions, considerations, notes, prefaces, and annexes.

Table 1. Documents analyzed to reconstruct the context of RUE text production

Document	Author/year	Modality	Description
GM-MS Ordinance No. 4,279 of December 30, 2010	Brasil. Ministério da Saúde, 2010	Legal Regulation	*Establishes guidelines for the organization of the Health Care Network within the Unified Health System (SUS) scope.*
Decree No. 7,508 of June 28, 2011	Brasil, 2011	Legal Regulation	*Regulates Law No. 8,080, of September 19, 1990, to provide for the organization of the Unified Health System-SUS, health planning, health care, and inter-federative coordination, and provides other measures.*
GM-MS Ordinance No. 1,600, of July 7, 2011	Brasil. Ministério da Saúde, 2011	Legal Regulation	*Reformulates the National Urgent Care Policy and establishes the Urgent Care Network in the Unified Health System (SUS).*
GM-MS Ordinance No. 1,601, of July 7, 2011	Brasil. Ministério da Saúde, 2011	Legal Regulation	*Establishes guidelines for implementing the Emergency Care Units (UPA 24h) component and the Urgent Care Network's set of 24-hour urgent care, per the National Urgent Care Policy.*
GM-MS Ordinance No. 2,395, of October 11, 2011	Brasil. Ministério da Saúde, 2011	Legal Regulation	*Organizes the Urgent Care Network Hospital Component within the Unified Health System (SUS) scope.*
GM-MS Ordinance No. 2,994 of December 13, 2011	Brasil. Ministério da Saúde, 2011	Legal Regulation	*Approves the Acute Myocardial Infarction Care Line and the Acute Coronary Syndromes Protocol, creates and changes procedures in the SUS Table of Procedures, Drugs, Orthoses, Prostheses, and Special Materials.*
GM-MS Ordinance No. 665, of April 12, 2012	Brasil. Ministério da Saúde, 2012	Legal Regulation	*Provides for the criteria for qualifying hospital establishments as Urgent Care Centers for Patients with Stroke within the Unified Health System (SUS) scope, establishes the respective financial incentive, and approves the Stroke Care Line.*
GM-MS Ordinance No. 1,010, of May 21, 2012	Brasil. Ministério da Saúde, 2012	Legal Regulation	*Redefines the guidelines for implementing the Mobile Urgent Care Service (SAMU 192) and its Medical Regulation Center, a component of the Urgent Care Network.*

Document	Author/year	Modality	Description
GM-MS Ordinance No. 1,365, of July 8, 2013	Brasil. Ministério da Saúde, 2013	Legal Regulation	*Approves and establishes the Trauma Care Line in the Urgent and Emergency Care Network.*
Instructional manual for the Urgent and Emergency Care Network in the Unified Health System (SUS)	Brasil. Ministério da Saúde, 2013	Technical Material	*Presents, clarifies, and guides managers, workers, and users on the principal regulations and guidelines for implementing RUE in the territories.*
Implementation of Health Care Networks and other SAS strategies	Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde, 2014	Technical Material	*Presents the process of implementing the thematic networks agreed on a tripartite basis for the years 2011 to 2013: Stork Network (*Rede Cegonha*), Urgent and Emergency Care Network, Psychosocial Care Network, Care Network for People with Disabilities, and the Health Care Network of People with Chronic Illnesses.*
Entendendo os desafios para a implementação da Rede de Atenção às Urgências e Emergências no Brasil: uma análise crítica.	Jorge *et al.*, 2014	Article	This article describes and analyzes the Urgent and Emergency Care Network (RUE) implementation process in Brazilian health regions, seeking to identify the factors that facilitate and hinder its implementation to contribute to evaluating this policy.
Fragilidade na governança regional durante implementação da Rede de Urgência e Emergência em Região Metropolitana.	Padilha *et al.*, 2018	Article	This article analyzes the implementation of the Urgent and Emergency Care Network and its regional inter-federative arrangements for policy agreement and management in the Metropolitan Region of São Paulo from 2011 to 2016.

Source: own elaboration.

The RUE was formulated and established in 2011 as a thematic network in the context of the RAS, which is one of the priorities established by the federal government (Brasil, 2013a). Its primary legal framework was Ordinance GM-MS no. 1,600, of July 7, 2011 (Brasil, 2011a), which reformulated the National Urgent

Care Policy, which reformulated the National Urgent Care Policy, defining the components of this network and the incentives to be made available to states and municipalities for its implementation (Jorge *et al.*, 2014). The RUE was formulated by the team from the Hospital Care and Emergency Department of the Health Care Secretariat of the Ministry of Health, composed mainly of technical-political staff with expertise in management and coming mainly from the states of Rio de Janeiro and Minas Gerais (JORGE *et al.*, 2014), from where they brought their experiences and contributions. It was agreed upon in the Tripartite Intermanagerial Commission (CIT) with the representations of State (CONASS) and municipal (CONASEMS) managers (Padilha *et al.*, 2018) through a process of negotiation and consensus formulation, following the SUS interfederative management flows in the country (Brasil, 2011b).

When formulated, the policy was initially called the Urgent Care Network (*rede de Atenção às* Urgências – RAU) (Brasil, 2011a). In 2012, the RAU began to be officially called, through redefinition in an ordinance, the Urgent and Emergency Care Network (*Rede de Atenção às Urgências e* Emergências – RUE) (Brasil, 2012a), adapting the legal regulations to the most common terminology among SUS managers and workers. In the documents analyzed, the primary values expressed in the policy were citizenship, access, quality, and comprehensiveness.

Citizenship is declared as an understanding of the concept of health as a social right resulting from the population's living conditions and guaranteed through social and economic policies that aim to reduce the risk of disease and other injuries (Brasil, 2011a). This conception runs through all texts as a premise formed by the triad: health, law, and citizenship.

Access is a value present in texts with great intensity and literal frequency. The RUE policy considers that care for users with acute conditions must be provided across all entry points to health services (Brasil, 2014), expanding access and reception, taking into account risk classification and necessary intervention to different health problems (Brasil, 2011a), uninterruptedly 24 hours a day, every day of the week (Brasil, 2011c), being offered to the entire Brazilian population (Brasil, 2012b).

Health care quality in the RUE is declared imperative due to the necessary gain in resolution sought (Brasil, 2011a; 2012b). Creating lines of care (Brasil, 2011a) for the most prevalent conditions in urgent and emergency care situations expresses this value. In addition to structuring and organizing flows, the lines of care for

acute myocardial infarction, stroke, and trauma (Brasil, 2011d; 2012a; 2013b) seek to induce changes in the way care is produced through the institution of clinical practices qualified (Brasil, 2013a). Creating and qualifying specialized hospital centers, such as Coronary Care Units, Stroke Emergency Care Centers, and Trauma Centers (Brasil, 2011d; 2012a; 2013b), allocate new financial resources to services. They also introduce new procedures (Brasil, 2011d), induce the implementation of arrangements (Brasil, 2011c; 2011e), and Hospital Access and Quality Centers (Brasil, 2011e). The formulation and adoption of clinical protocols (Brasil, 2012a; 2011d; 2011e), associated with the necessary training processes and ongoing education of health teams (Brasil, 2011a; 2013a), are placed as mandatory conditions for the qualification of care points (Brasil, 2011c; 2012b) and aggregation of new financing amounts, referring to quality certification and hospital accreditation processes.

Comprehensiveness is a value expressed in policy texts under various conceptions. From the perspective of the broad concept of health, it is understood that coping with urgent and emergencies and their causes requires not only immediate assistance but also includes actions to promote health and prevent diseases and injuries, continuous treatment of chronic diseases, rehabilitation, and palliative care (Brasil, 2013a). It is also understood as the articulation and integration of different health services and equipment, constituting health networks with connectivity between different points of care (Brasil, 2011a). This is expressed in the proposal for articulating basic health units, SAMU 192, urgent care doors, hospital units, diagnostic and therapeutic support units, and other health care services, building coherent and effective referral and counter-referral flows ordered by regulatory centers and regulatory complexes installed in health regions (Brasil, 2011c). Furthermore, concerning comprehensive health care, the work of multidisciplinary teams is proposed to be organized horizontally, using a single medical record shared by the entire team, the implementation of clinic management mechanisms, the reorganization of flows, work processes, and the implementation of reference teams for accountability and monitoring of cases (Brasil, 2011e).

As for intentions and purposes, the texts of the RUE policy indicate the objectives of national policy implementation and improvement of response time to urgent health conditions. It is indicated that the RUE must be implemented gradually throughout the national territory, respecting epidemiological and population density criteria (Brasil, 2011a), with each health region having to prepare and agree on its

Regional Action Plan (Brasil, 2013a). Furthermore, access to the health system for users in urgent and emergency care situations is proposed to occur in an agile and timely manner (Brasil, 2011a; 2013a), as access in a manner non-compatible with the needs of the first care can increase deaths, length of hospital stay and sequelae resulting from the absence of help (Brasil, 2014).

Previous experiences in urgent and emergency areas, such as the implementation of SAMU 192 (Brasil, 2004) and UPA 24h (Brasil, 2009; Konder; O'Dwyer, 2015), are incorporated and reoriented in the context of RUE, as well as the previous Urgent Care policy (Brasil, 2003), which already provided for the organization of loco-regional networks for comprehensive urgent care. Elements of the SUS National Humanization Policy are also identified in aspects linked to work processes in hospital services, reception guidelines, expanded clinics, and the implementation of devices that trigger transformations in hospital realities (Brasil, 2011f). Such actions seek to ensure the implementation of a user-centered model based on their health needs (Brasil, 2011a).

As for a solid theoretical influence, the conceptual model of RAS is identified (Brasil, 2010; OPAS, 2011). In Brazil, the production of publications through partnerships between PAHO, the Ministry of Health, CONASS, and CONASEMS (Silva, 2008; Mendes, 2011) moved strategic actors and shaped guidelines later included in the RUE policy: a regulated hierarchical system, organized in regional urgent care networks as links in a life maintenance network at increasing levels of complexity and responsibility (Brasil, 2011a).

Another theoretical and instrumental influence observed concerns hospital management and its administrative practices (Farias; Araújo, 2017). Elements of managed care are identified in the guidelines that indicate a better definition of work processes and institution of clinical care practices based on the management of lines of care (Brasil, 2013a), standardization of routines, and adoption of protocols (Brasil, 2012a; 2012b; 2013b), in addition to the development of quality certification processes for RUE components (Brasil, 2011c; 2012b; 2011e). The incorporation of the project management methodology is also noted, expressed in the guideline for institutionalizing the practice of monitoring and evaluation through process, performance, and result indicators that allow evaluating and qualifying the care provided.

The texts analyzed also identified some concepts and premises from the Public Health field, such as epidemiology, health promotion, and basic/primary health care.

Barata (2013) recognizes that epidemiology did not develop separately from public health as a scientific discipline or a field of practice. This relationship between epidemiology and public health is identified by incorporating epidemiological knowledge in formulating, implementing, and evaluating public policies. The RUE policy is influenced by epidemiology, and organizing a network that meets the main health problems of users in the urgent care area requires considering the epidemiological profile in Brazil. In other words, a high morbidity and mortality related to violence and traffic accidents up to forty years of age and, above this range, a high morbidity and mortality related to diseases of the circulatory system (Brasil, 2011a). The policy is, therefore, based on an epidemiological diagnosis that justifies, supports, and directs it.

Health promotion is linked to the conception expressed in the Ottawa Charter, defining health actions that aim to reduce inequities, guaranteeing the opportunity for all citizens to make choices that are more favorable to health, being protagonists in the health production process and improving quality of life (WHO, 1986). In the text that regulates the RUE, the health promotion, prevention, and surveillance component is included with the express objectives of stimulating and promoting the development of health actions aimed at monitoring and preventing violence and accidents, injuries and deaths in traffic, and chronic non-communicable diseases, in addition to intersectoral actions, participation and mobilization of society aimed at health promotion, disease prevention, and health surveillance (2011a). Starting from the concept of social determination of the health-disease process, for Malta *et al.* (2016), health promotion, as a set of strategies and ways of producing health at the individual and collective level, emerges marked by its own tensions in defending the right to health produced by the disputes of subjects who aim to place specific interests and needs on the agenda of public policies. Health promotion in the RUE includes intersectoral and social mobilization actions on the social determinants of accidents, violence, and chronic conditions, often opposing economic and market interests that override supposed healthy individual choices.

In the normative texts that regulate the RUE, the basic care component aims to expand access, strengthen the link, accountability, and first care for urgencies and emergencies in an appropriate environment, up to transfer to other points of care when necessary, providing for the implementation of patient reception with risk and vulnerability assessment (Brasil, 2011a).

For Cecílio and Reis (2018), the use of the terms primary health care and basic health care, in addition to a semantic issue, implies the dispute between different projects for the SUS: while the concept of basic health care is not a pure reproduction of international experiences and formulations, but the result of a political process that finds its roots in the history of the Brazilian Health Movement and the construction of Collective Health thinking, primary health care would take place in health systems based on supposedly universal coverage, but fragmented and restrictive, which operate a basic basket that would fit into the budget of poor countries, leaving the rest to the market, as recommended by the World Bank and the IMF. In the RUE texts, the terminology basic care is exclusively observed, to the detriment of primary care, reiterating the already declared values of citizenship and comprehensiveness. The second question that emerges is the role of the Basic Care component in RUE. According to the regulations, its primary mission would be to provide access and referral to other points of care. The hegemonic discourse of coordination of networks through basic (or primary) care, expressed in the standardization of RAS (Brasil, 2010) and in the texts that support them (Mendes, 2011; OPAS, 2011), was not reproduced. This position envisaged for basic care in the RUE, in which coordinating action is not provided, similar to what occurs in other thematic networks, leads to reflections on the organizational model of networks for urgent and emergency care situations, as well as the concept itself of RAS (Mendes, 2011) for expressing a different conception of how it should be structured.

As for a discursive construction, the texts formulated for the RUE policy are pretty prescriptive. For Mainardes (2006), a readerly (or prescriptive) text limits the reader's involvement, while a writerly (or writable) text invites the reader to be a co-author of the text, encouraging them to participate more actively in the interpretation of the text. Thus, a writerly text would be more reflective and inductive of the production of new practices by the actors involved in implementing the policy. In the RUE policy, its texts regulate and guide it, defining conditions for the qualification and qualification of its components (Brasil, 2011c; 2012b; 2011e), implementation of priority lines of care (Brasil, 2012a; 2011d; 2013b), in addition to standardization planning, agreement, and financing processes (Brasil, 2011a). As for less prescriptive content, the regulations provide guidelines for their implementation that can and should be given new meanings in local-regional contexts for their materialization. For Ball (1994), it is vital to recognize that

these two styles of texts are a product of the policy formulation process, a process that takes place in continuous relationships with various contexts, including the possibility of using both writing styles in the same text.

The broad and complex context in which the RUE texts were formulated was materialized in regulations and technical documents that express values of citizenship, access, quality, and comprehensiveness; purposes of expanding and nationalizing policy and improving response time; influences from the previous emergency policy (implemented in 2003 and which resulted in the creation of SAMU and UPAs), the humanization policy, the conceptual model of RAS and the area of hospital administration; in addition to concepts and practices from the field of Public Health such as epidemiology, health promotion and primary care. In short, it is a plural and multifaceted production.

Final considerations

The texts of the RUE policy are dense, complex, diverse, and predominantly prescriptive, expressing the possible consensus among the actors who formulated and influenced it, adding different values, intentions, influences, frameworks, concepts, and discursive forms. The construction of the RUE policy took place in a context influenced by technical, political, economic, and social vectors as a proposed model for improving the SUS, aiming for greater access and quality in response to the demands of the population. This normativity and plurality regulate, deepen, and enrich the RUE policy. However, they can bring objective challenges in the context of practice, which will be investigated in future studies due to the need to develop and articulate different ideas and practices identified in the texts and resulting from multiple and diverse influences. Furthermore, these can be given new meanings and crossed by vectors and disputes in fields of unique practices of decentralized and diverse management in the country, in different health services, municipalities, and regions.[1]

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Note

[1] L. F. N. Tofani and A. Chioro: project design and data analysis and interpretation; article writing; approval of the version to be published; responsible for all aspects of the work in ensuring the accuracy and integrity of any part. L. A. C. Furtado and R. Andreazza: data analysis and interpretation; relevant critical review of intellectual content; approval of the version to be published; responsible for all aspects of the work in ensuring the accuracy and integrity of any part.

Resumo

A política de Redes de Atenção às Urgências e Emergências no Brasil: contextos de influência e de produção de textos

O artigo tem por objetivo analisar os contextos de influência e de produção de textos da política de Redes de Atenção às Urgências e Emergências (RUE) no Brasil através da Abordagem do Ciclo de Políticas. Empreendeu-se pesquisa qualitativa através da análise documental de textos legais, publicações técnicas e acadêmicas para análise dos contextos de influência e de produção dos textos da RUE, não sendo objeto deste estudo o contexto da prática. O contexto de influências evidenciou a disputa pela legitimação do SUS, o neoliberalismo, o subfinanciamento, o gerencialismo, a crise dos hospitais e o predomínio do modelo de Redes de Atenção à Saúde. Já os textos expressam valores de cidadania, acesso, qualidade e integralidade; propósitos de nacionalização e melhoria do tempo-resposta; influências da política anterior de urgência e de humanização, da área de administração hospitalar e de conceitos do campo da Saúde Coletiva. O caráter plural e multifacetado da política pode trazer desafios no contexto da prática, a serem pesquisados em estudos futuros, devido à necessidade de desenvolvimento e articulação de distintas ideias e práticas identificadas nos textos e resultantes das múltiplas e diversas influências. Ainda, estas podem ser ressignificadas e atravessadas por vetores e disputas em campos de práticas singulares da gestão descentralizada e diversa no país, nos diferentes serviços, municípios e regiões de saúde.

➤ **Palavras-chave:** Assistência à saúde. Serviços de urgência. Política de saúde.