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HOSPITAL RESPONSIBILITIES IN HEALTHCARE NETWORKS: A SCOPE REVIEW

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SCOPE REVIEW

ARTICLE PROPOSAL

HOSPITAL RESPONSIBILITIES IN HEALTHCARE NETWORKS: A SCOPE REVIEW

ATRIBUIÇÕES DOS HOSPITAIS NAS REDES DE ATENÇÃO À SAÚDE: UMA REVISÃO DE ESCOPO

RESPONSABILIDADES HOSPITALARIAS EN LAS REDES DE ATENCIÓN SANITARIA: UNA REVISIÓN DEL ALCANCE

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ABSTRACT

The objective of this review was to map evidence and gaps in the literature regarding the roles that hospitals have played in healthcare networks in Brazil and worldwide. This is a scoping review that followed the recommendations of the Joanna Briggs Institute (JBI). Our study used the BVS, Medline via PubMed, Scopus, Web of Science, and Embase databases, applying the following keywords: Hospital Care, Community health networks, and Integrality in Health. A total of 86 publications were selected, presenting the following main roles of hospitals within the health networks: promoting coordination with services for continuity of care, permanent

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and/or continuing education, coordination with families and communities, health education, dissemination of innovations and health information, promoting responsible discharge, monitoring procedures in the territory when necessary, and the role of liaison professionals. Our results found that 49.41% of the selected publications were Brazilian. Brazil stood out in the number of publications and for advancing discussions in which hospitals act as co-responsible agents for therapeutic projects, working in a horizontal relationship with the health service network. The interconnection between hospitals and primary health care (PHC) continues to be a major challenge. The hospital, as an important component of the health network, was presented in this review as a dynamic facility that can assume a wide range of roles depending on the network in which it is inserted and the challenges to which it is exposed.

Keywords: Hospitals; Healthcare Models; Community Network.

RESUMO

O objetivo desta revisão foi mapear evidências e lacunas na literatura acerca das atribuições que os hospitais têm desempenhado nas redes de atenção à saúde no Brasil e no mundo. Trata-se de uma revisão de escopo que seguiu as recomendações do Joanna Briggs Institute -JBI. As bases de dados utilizadas foram a BVS, Medline via PubMed, Scopus, Web of Science e Embase e as palavras-chave *Hospital Care; Community health networks; Integrality in Health*. Foram selecionadas 86 publicações que apresentaram como principais atribuições dos hospitais nas redes: promoção da articulação com serviços para continuidade do cuidado; educação permanente e/ou continuada; articulação com as famílias e comunidades; educação em saúde; difusão de inovações e informação em saúde; promoção da alta responsável; acompanhamento de procedimentos no território quando necessário e atuação de profissionais de enlace. 49,41% das publicações selecionadas são brasileiras. O Brasil se destacou pelo número de publicações e por avançar em discussões nas quais os hospitais atuam como co-responsáveis pelos projetos terapêuticos, numa relação horizontal com a rede de serviços. A articulação entre os hospitais e a atenção primária à saúde segue como desafio de destaque. O hospital, como um componente importante da rede, apresentou-se nesta revisão como um equipamento dinâmico que pode assumir diversas atribuições a depender da rede na qual está inserido e dos desafios a que está exposto.

Palavras chave: Hospitais; Modelos de Assistência à Saúde; Redes Comunitárias.

RESUMEM

El objetivo de esta revisión fue mapear las evidencias y lagunas en la literatura sobre los roles que los hospitales han desempeñado en las redes de salud en Brasil y en el mundo. Esta es una revisión exploratoria que siguió las recomendaciones del Joanna Briggs Institute (JBI). Nuestro estudio utilizó las bases de datos BVS, Medline a través de PubMed, Scopus, Web of Science y Embase, aplicando las siguientes palabras clave: Atención hospitalaria, Redes de salud comunitaria e Integralidad en la salud. Se seleccionaron un total de 86 publicaciones, presentando los siguientes roles principales de los hospitales dentro de las redes de salud: promoción de la coordinación con los servicios para la continuidad de la atención, educación permanente y/o continua, coordinación con familias y comunidades, educación en salud, difusión de innovaciones e información sobre salud, promoción de un alta responsable, monitoreo de procedimientos en el territorio cuando sea necesario, y el rol de los profesionales de enlace. Nuestros resultados encontraron que el 49.41% de las publicaciones seleccionadas eran brasileñas. Brasil se destacó en el número de publicaciones y en avanzar en discusiones en

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las que los hospitales actúan como agentes corresponsables de los proyectos terapéuticos, trabajando en una relación horizontal con la red de servicios de salud. La interconexión entre los hospitales y la atención primaria de salud (APS) sigue siendo un gran desafío. El hospital, como un componente importante de la red de salud, se presentó en esta revisión como una instalación dinámica que puede asumir una amplia gama de roles dependiendo de la red en la que está insertado y los desafíos a los que se enfrenta.

Palabras clave: Hospitales; Modelos de Atención de Salud; Redes Comunitarias.

INTRODUTION

The contemporary hospital is a complex sphere. It is socially recognized as being strategic for health care and is replete with diverse interests that unfold in health care, technological incorporation, training processes for health professionals, and the production of new knowledge. Its organization is also criss-crossed by intense political, economic and social disputes[1,2]. In recent decades, hospitals worldwide have undergone changes in their care profiles, in the supply and regulation of hospital beds, in the size and number of these institutions, in their clinical approaches, and in the interaction of these facilities with health systems[3]. Hospitals can play different roles depending on their classification, insertion in the health system, and relationship with other services. In the 21st century, hospitals continue to be the final reference in the flow of care for serious health conditions, even though there is a diversification of emergency care facilities[4]. Greater hospital bed turnover and care for an increasingly aging population required a reconfiguration of hospital teams, with an increase in the number of professionals to manage elderly users with multiple morbidities who return to the territory with care needs that, if not met in facilities with different levels of complexity, lead to frequent hospital readmissions.

In view of these challenges, the role of hospitals in health networks is considered essential, as a reference for training and improving health practices in the territory, mediated by the shared construction of health teams[5]. Demands are marked by the need to overcome historically fragmented care in an attempt to produce comprehensive health care[4].

In the Brazilian case, Health Care Networks (*Redes de Atenção à Saúde* – RAS) were provided for in the Federal Constitution of 1988[6] as an articulated set of actions and services organized in a hierarchical and regionalized manner. In 2010, the Ministry of Health defined the RAS as arrangements that encompass different technological densities and seek to guarantee comprehensive health care[7].

Networks in current health systems refer to organizational arrangements with different configurations. In countries such as the United States (USA), with market-oriented health

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policies, networks are vertical, as they configure aggregations of service/input providers. In countries with universal systems, networks refer to the integration between services to provide health care with equity and with a view to comprehensiveness. In any case, networks presuppose interdependence, organizational structure, and actors in negotiation[4,8]. To expand knowledge concerning the dynamics of relationships established by hospitals and contribute to the production of more in-depth reflections on the directions they can produce in health systems, we decided to conduct a scoping review that explores how these connections have been established. The objective was to map evidence and gaps in the literature about the roles that hospitals have played in healthcare networks in Brazil and worldwide.

METHODOLOGY

This review followed the recommendations of the Joanna Briggs Institute (JBI) Reviewers Manual[9]. After defining the research question, a protocol was drafted and subsequently registered in the Open Science Framework under https://doi.org/10.17605/OSF.IO/97865. The method presented in the protocol contributed to mapping the performance of contemporary hospitals in the construction of comprehensive health care within the network.

The research question was defined with the support of the PCC mnemonic (population, concept, and context). The defined **P**opulation were users of healthcare services around the world who, at some point, required hospitalization. The key **C**oncept refers to the attributions of hospitals in healthcare networks. The **C**ontext concerns hospitals in healthcare systems around the world. Thus, the guiding question was: what scientific evidence is there concerning the attributions that hospitals have exercised in healthcare networks around the world? Searches for references were performed in the databases of the BVS (Virtual Health Library), Medline via PubMed, Scopus, Web of Science, and Embase via CAPES portal. The keywords used were: Hospital Care, Community health networks, and Integrality in Health. The search strategy was planned in such a way as to retrieve studies that contain the term hospitals or care network, and was individualized for each database with their respective keywords, descriptors, and combinations (Table 1). Works published in the last ten years in English, Spanish, or Portuguese were considered. Searches were conducted in March 2024, and the results were sent to the EndNote software (https://access.clarivate.com/login?app=endnote) for the selection of titles and abstracts.

Table 1: Record of search strategies

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BASE	STRATEGY
BVS*	((hospital OR hospitais OR hospitals OR hospitales OR hôpitaux OR "Assistência Hospitalar" OR "Hospital Care" OR "Atención Hospitalaria" OR "Soins Hospitaliers")) AND (("Modelos de Assistência à Saúde" OR "Healthcare Models" OR "Modelos de Atención de Salud" OR "Modèles de Santé" OR "Integralidade em Saúde" OR "Integrality in Health" OR "Integralidad en Salud" OR "Intégralité en Santé" OR "Redes Comunitárias" OR "Community Networks" OR "Redes Comunitarias" OR "Réseaux communautaires" OR "Rede de Saúde Comunitária")) AND (db:("LILACS" OR "BDENF" OR "IBECS" OR "MINSAPERU" OR "BINACIS" OR "SES-SP" OR "INDEXPSI" OR "BBO" OR "colecionaSUS"))
MEDLINE VIA PUBMED	(Hospital OR Hospitals OR "Hospital Care") AND ("Healthcare Models" OR "Integrality in Health" OR "Community Networks")
SCOPUS (Via Portal Capes)	(Hospital OR Hospitals OR "Hospital Care") AND ("Healthcare Models" OR "Integrality in Health" OR "Community Networks")
WEB OF SCIENCE (Via Portal Capes)	(Hospital OR Hospitals OR "Hospital Care") AND ("Healthcare Models" OR "Integrality in Health" OR "Community Networks")
EMBASE (Via Portal Capes)	(Hospital OR "Hospital Care") AND ("Healthcare Models" OR "Integrality in Health")

* MEDLINE results were excluded from the VHL, as they will be analyzed via PubMed, thus excluding duplications. ** Source: Baeta Vianna Library (Campus Saúde – UFMG).

Studies that addressed hospitals' connections with institutionalized networks and/or produced by family members and/or users were selected for full reading. Duplicate articles, those restricted to paying patients, and those that, even addressing hospitals and healthcare networks, did not mention articulation between these services were excluded. Five independent reviewers read the titles and abstracts. One of the reviewers read all the results attached to EndNote, while the others were divided to read all the results from the same database. All titles and abstracts were selected by pairs of reviewers. Discrepancies were resolved by a third independent reviewer.

After this stage, a table was created in Microsoft Excel 365 software with the titles of the studies eligible for full reading. For each study, data regarding the authors, year of publication, journal/publisher, country of research, objective of the article, methodology, main findings, discussion, and role of the hospital in health networks were extracted. After reading the articles in full, the articles that did not address the responsibilities of hospitals in the networks were excluded. At this stage, two researchers selected the articles, and any disagreements were analyzed by a third researcher.

RESULTS AND DISCUSSION

Database searches yielded 1,662 potentially relevant publications. After removing duplicate results, 1,280 remained. Selection by titles and abstracts led to the removal of 1,080

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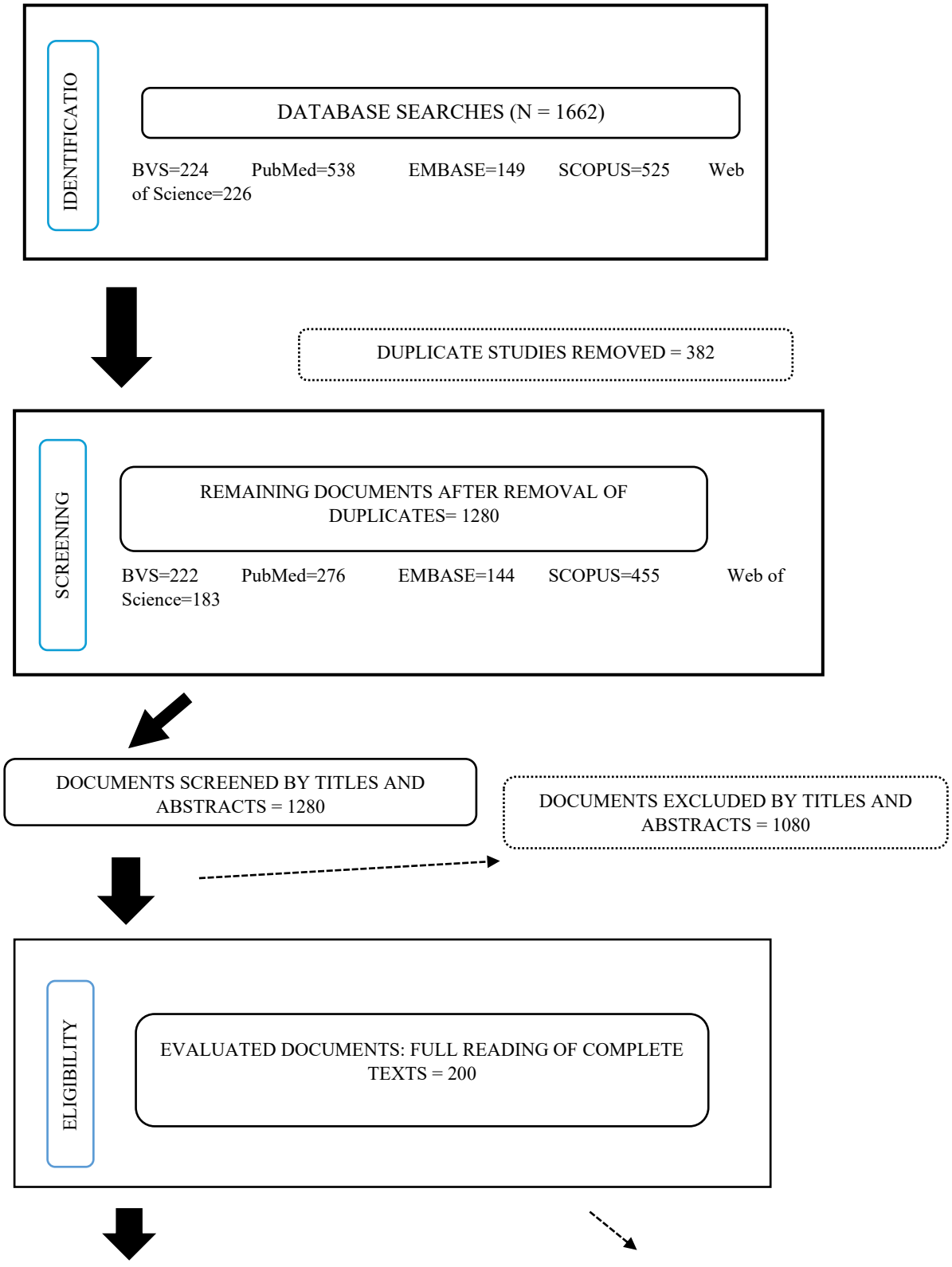
articles. Of the remaining 200 publications, 114 were excluded, as they did not meet the inclusion criteria.

The article selection process is described in Figure 01.



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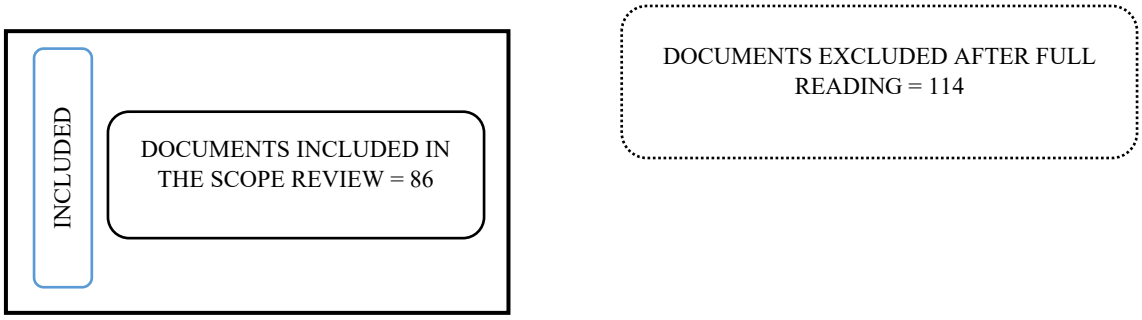

Figure 1: PRISMA-ScR flowchart for the selection of evidence sources.

During the reading, records of attributions that hospitals have exercised in some formally or informally established network were identified. Sixty-four of these publications were original articles, two Master's theses, two Doctoral dissertations, one residency completion paper, seven literature reviews, two conference abstracts, one book, one editorial letter, and six comments in journals.

The attributions were mainly described in the discussions of the articles. Only one article, found in the BVS, presented the act of seeking a specific role of the hospital in the health network as one of its objectives. In the article, the hospital appears as a key point for different thematic networks[10].

In 86 publications, descriptions of the role attributed to the hospital in a health network were found, with a wide range of designs that did not always correspond to the configuration presented by the RAS in Brazil.

Four publications described integrations between hospitals. The articles from Spain and Germany presented the experience of articulations between hospitals aimed at training professionals[11,12], and two English articles presented vertical integrations between hospitals to improve coordination between services, as well as reduce unplanned hospitalizations and hospital readmissions[13,14,15]. One article presented the idea of central hospitals and intermediate hospitals, especially when there are serious crises in situations of advanced chronicity[16]. Pinter et al.[17] argued that the integration of health care constitutes a response to the challenges faced by the need to provide health services over the long term.

Countries such as Spain and China presented networks with several facilities, in addition to considering community actions in the implementation of this network[16,18]. Sweden[19], the USA[20,21], and India[22] demonstrated networks in collaborative care models between different public and/or private organizations. Singapore[23], Argentina[24,25], Israel[26], the United States[20], and France[27] showed fragmented networks with activities in some programs. There are selected

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publications that, when addressing specific aspects of the networks in which hospitals are inserted, did not describe the characteristics of these networks.

The publications that made some contribution to the description of the role of hospitals in the network were distributed in the databases, according to the countries where the research was conducted, as follows:

Table 2– Distribution of publications with contributions on the role of hospitals in the network by database and country of research, period

Base de dados/país	BVS	EMBASE	Web of Science	PubMed	SCOPUS	Total of publications
Brazil	38	01	01	00	03	**42**
United States	00	00	01	02	05	**08**
Canada	00	01	01	02	02	**06**
Spain	03	01	00	00	02	**06**
China	00	00	00	00	02	**02**
Argentina	02	00	00	00	00	**02**
India	00	00	00	00	02	**02**
Norway	00	01	00	00	01	**02**
United Kingdom	00	01	01	00	00	**02**
Singapore	00	01	00	01	00	**02**
Other countries	00	06	00	02	03	**11**
Total of publications	**43**	**12**	**04**	**07**	**20**	**86**

Source: Created by the author

Brazil appeared in this review with the greatest contribution to the topic. Forty-three texts were selected. There shows evidence of integration between services and hospitals in Brazil. Considering that the choice of descriptors was highly affected by the Brazilian context, it is possible to identify the influence of a public and universal health system in the country with legislation that established its organization in networks[7], together with a national hospital care policy[28] that seeks to induce hospitals in the SUS as members of these networks.

The second country with the most selected publications was the USA, with eight articles, which presented: health network involving the participation of hospitals in specific programs[20,21,29,30]; transfer of information, especially during the transition of care from the hospital to the community in order to avoid hospital readmissions[15,29,31]; the production of health care and the training of professionals with shared responsibilities between institutions and the community[30,32,33]; and the management of patients in the community[29,34]. In addition, the articles presented hospitals seeking partnerships with various institutions to reduce costs[34] and improve quality indicators[32].

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Brazilian publications also cited the transfer of information[10, 35,36,37,38,39,40,41,42;] the training of professionals in a network[36,42,43,44]; the production of shared care[10,36,45,46,47,48,49,50,51]; the hospital in the health network as co-responsible for therapeutic projects in a horizontal relationship with other services[47,49,52]; participation in the organization of flows in the network[50] and in the regulation of access to hospital beds[37,41,50,53,54,55]; a substitute tool for mental health care within a health network[56]; a provider of health professionals as links in the network[36,40,41,43,45,50,57]; and the support of Emergency Care Units[58]. Some studies have mentioned the hospital as a promoter of responsible discharge for the continuity of care[38,40,42,47,55]; its participation in a computerized system integrated into the network[40], and the nationwide strength of the Unified Health System (SUS) in dealing with emergencies in cases of major catastrophes[59].

Nine Brazilian publications addressed responsible discharge[36,40,45,47,50,51,52,55,60] associated with the transformation of professional practices that are subsequently focused on the user[47,51] and highlighted as a process that involves the entire period of hospitalization[55] and diminishes patient abandonment of treatment for diseases, such as tuberculosis[45].

The National Regulatory Policy[61] stands out as a Brazilian benchmark that has reduced distortions in care, in turn increasing equity and co-accountability of the providers[5]. This is a logic based on horizontal relationships of agreement and commitments[4] for the exercise of monitoring, evaluation, auditing, and surveillance with the implementation of rules for prioritizing access and organizing assistance flows, as well as the creation of regulatory centers[61].

Four Brazilian publications highlighted the importance of regionalization in the organization of services. They present articulations between municipalities, aiming to expand access and improve the quality of services[53], thereby contributing to the improvement of management tools that monitor the paths of users in the networks[2].

Jorge et al.[53] highlighted the impasses in the relationships between managers concerning the operation of the emergency and urgency network. Righi et al.[59] highlighted the regional organization of SUS as relevant in dealing with disasters. Brandão, Lanzonib, and Pinto[54] cited regionalization as a technology for improving networks.

In 12 Brazilian publications, hospitals were presented in concepts that involve comprehensive care[10,35,37,42,44,50,51,52,56,58,63,63]. Neri and Pinto[64] highlighted the RAS in Brazil as a governance model, which has been advancing in the processes of collective decision-making and the objective of providing equitable and comprehensive care. Comprehensiveness as a doctrinal principle of SUS and the role of network governance are explicit in articles about

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SUS. The possibility of social participation and interaction of various actors in the RAS, with shared decision-making and responsibilities, makes the Brazilian governance system distinct and important in the enabling of user-centered care[64].

In Brazil, there is an effort to make this model available, which is still counter-hegemonic in most hospitals and municipalities. This is also why publications have emerged in Brazil that refer to disputes between therapeutic projects and care models[48,49,57]. These articles are produced in an attempt to help overcome the legacy of a fragmented system, with limited capacity to respond to the health needs of the population. Four articles pointed out obstacles between the hospital-centric model and the creation of networks[10,48,49,56], and one highlighted the "family-oriented" model of family responsibility and the omission of social protection by the State[46].

It is important to note that Brazil has instituted a policy that guides hospitals to carry out actions that consider the epidemiological and demographic profile of the population[28], and lines of care have been structured in SUS with the challenge of articulating elements that go beyond the medical and technological care offered by a hospital[49]. Hospital workers must work as a team and even in an inter-institutional manner to cope with the complexity of demands. Constructing therapeutic projects negotiated with the health network, containing the maximum number of elements referent to the lives of users, is of utmost importance in the attempt to transform the health model in favor of comprehensive care, with the hospital serving as a care observatory within this network[51]

Furthermore, Brazil, together with the participation of hospitals, has adopted network care mechanisms as strategies that position them as care stations. Responsible hospital discharge; hospital contact with other points in the health network; the construction of dehospitalization; home care[28]; as well as the implementation of unique therapeutic projects with a shared construction of care involving different professionals, equipment, and sectors to better meet the needs of users are all examples of mechanisms that help to overcome gaps in health care. Negotiations between workers, users and family members, when supported by protagonism and social inclusion, produce sustainable changes that directly impact people's lives[49]. The roles of hospitals in the health network described in the selected publications were grouped in Table 3 according to the database and country of origin of the description. Some publications presented more than one function for the hospital in the health network; consequently, the number of times the attributions appear does not correspond to the number of publications, but rather to the number of times they were reported.

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Table 3 – Hospital assignments in networks by database and country of origin, period

Database/Assignments	**BVS**	**EMBASE**	**Web of Science**	**PubMed**	**Scopus**	Number of times assignments appear
Promote coordination with the various services in the health network for access and continuity of care	Brazil (20); Espanha (1); Argentina (2)	Taiwan (1); Irlanda (1); Holanda (1); Sweden (1)	United States (1); Canada (1).	France (1); Canada (1)	Brazil (2); United States (1); Spain (1); Norway (1); China (1)	37
Participate in Permanent and/or Continuing Education processes for the network	Brazil (6)	Taiwan (1); Norway (1); New Zealand (1); Singapore (1); Spain (1)	Brazil (1); Israel (1)	United States (1)	Brazil (2); China (2); Spain (1); Norway (1)	20
Participate in discussions with family and/or community	Brazil (5)	New Zealand (1)	Canada (1)	France (1); USA (1)	USA (1); China (2)	12
Promote health education for the general population	Brazil (3)	Holanda (1)	United States (1);	Canadá (2); Singapore (1); United States (1)	United States (2)	11
Participate in the dissemination of innovations and information in health	Brazil (2); Spain (1)			Singapore (1); France (1)	Brazil (1); Germany (1); Pacific countries (1); USA (1); Norway (1); Spain (1)	11
Promote responsible discharge (interconnected with the territory)	Brazil (9)					09
Monitor procedures in the sphere when necessary (shared care)	Brazil (5) Spain (1)	Canada (1)			Canada (1)	08
Work with liaison professionals	Brazil (7); Spain (1)					08
Participate in health network projects or programs	Brazil (1); Spain (1)				China (1); United States (1)	04
Manage access regulation between the hospital and other components of the network	Brazil (4)					04
Coordinate with other hospitals		United Kingdom (1); Spain (1)	United Kingdom (1)		Germany (1)	04
Participate in the organization of network flows	Brazil (3)					03

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Participate in patient management in the community					United States (2); Germany (1)	03
Build a Singular Therapeutic Project with other components of the network	Brazil (2)					02
Exert political influence to support network projects			Israel (1)		United States (1)	02
Use Telehealth in a health network					Canada (1); India (1)	02
Act as a RAPS care device	Brazil (1)					01

Source: Created by the author.

The main role identified for hospitals in the context of networks was to promote coordination with other services for access and continuity of care. The justifications described include: home and community support for users and families after discharge[27,47,48,52,65]; cooperation and solidarity within the network[24,38,47,50]; technical improvement based on critical thinking[52] and expanded care aimed at comprehensiveness[10,51]; promoting regulated, equitable, and pertinent access[11,37]; reducing mortality after discharge, the search for emergency care, hospital readmissions[27,31], and overall healthcare costs[24]; and promoting protection and secondary prevention mechanisms to improve the quality of life of users[18,20].

This attribute is intertwined with the dynamics of the health systems in which these services are inserted and constitutes a relevant movement in the transformation of health care. By promoting coordination that takes into account the needs of users and seeks expanded and shared care, the hospital encourages dialogue and collaborates in the production of network links that redefine the way the hospital and other points of the network are viewed, enhancing a more flexible and participatory healthcare model. Different systems recognize this responsibility, from those with liberal models to those that opted for social security or countries with universal systems.

The second most frequent assignment in hospitals in the network, present in 23.26% of the texts in this review, concerns participation in permanent and continuing education processes in the networks. Bertussi and Feuerwerker[66] described permanent education as a service-learning movement that favors the continuity of care, which is a powerful device for network production. Inserted in movements of transformation of the hegemonic model, it subsidizes the training of professionals marked by the experience of producing consensus, connections, and affections. Workers acquire elements that help them to problematize situations, question established truths, and, in this light, contribute to thinking about and implementing new

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possibilities for the continuity of health care. The hospital is widely recognized as a place for learning and professional technical development in partnership with the health network[18,26,33,41,44,67,68], in addition to being a relevant space for discussing health practices[12,43,69,70,71,72]. Moreover, continuing education is considered a cross-cutting device for the implementation of networks[50]. The approach of Lara et al.[70] stands out, discussing continuing education as a tool for sharing knowledge in the health network, avoiding unnecessary referrals to hospitals and the isolation of workers.

The dialogue between the hospital and families, the third most cited attribute in the publications, is present in several health systems around the world. Differences highlighted in this review are related to the financial and cultural resources of these families and a greater or lesser capillarity of access by families to healthcare tools.

Komene[69], in New Zealand, highlighted the importance of hospitals working together with families and communities to provide healthcare models that recognize and respect the cultural diversity of the territories. Clarke et al.[14] highlighted the importance of hospital/family/community collaborations to encourage collective actions that sustain hope for users in vulnerable situations, such as mothers of newborns who abuse drugs. Cao et al.[18] highlighted the relevance of this participation to support care for people with chronic diseases. Li et al.[72] supported this type of connection to make the end of life less difficult.

In the USA, this collaboration involves the hospital providing information about the care needed after discharge and services available to patients[29]. In general, North American publications showed a hospital that informs and holds those who received the information accountable.

The families are held responsible for the continuity of care[37,46,66,68] and are undervalued in decisions regarding care[49,65]. The hospital coordinates care processes with families that could be coordinated with the health network. Furthermore, families in vulnerable situations are held responsible for care; however, without being able to assume the leading role in care processes.

In addition to this idea of creating networks with families, Belga, Jorge, and Silva[50] and Hermida et al.[58] presented informal flows between workers as facilitators of users' paths in the network. From this perspective, these dialogues facilitate paths in formal flows.

Health education is the fourth most cited hospital role in the network. The authors argued that hospitals can provide important reflections on the way of thinking about health[43], expanding, for example, the conception of the use of medications[30,73]; encouraging the social and political participation of users in the territories[62]; in addition to providing learning about self-care and one’s self-management of life[20,39,74]. Some articles addressed the need for

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adequate clarifications in the transition to discharge as a contribution of the hospital in the education of patients and family members[23,29,75].

Four of the eight North American publications addressed this topic. There is, however, no detailed description of what is considered health education in this country. Furthermore, the centrality of hospitals in the USA is evident. In countries with universal systems, due to the diversity of equipment in the territories, health education is more widespread and is not restricted to the hospital area.

In the same position as health education, in terms of frequency of citation in articles, is the dissemination of innovation and information, with emphasis on the development of systems and sharing of health information[11,21,27,35,40,41,71,75]. New information technologies are recognized as one of the key elements in the face of current health challenges, especially with regard to continuity of care[17]. It is important to note that seven publications related the disconnection of hospitals and other services to failures in hospital/network communication[37,38,45,47,63,73].

By leading the dissemination of technologies to the network, the hospital serves several interests, whether related to the medical-industrial complex 2 or to protecting health in the community[18]. There are attributions identified in this review that, when analyzed, may overlap others, such as the use of networked telehealth, which contributes to sharing knowledge in education.

Two attributions found in this review were present only in countries with a universal system. These are: monitoring, by hospital workers, of users in the territory when necessary, and the existence of liaison professionals. Costa et al.[15] defined liaison professionals as those who establish coordination between the hospital and teams from other facilities distributed throughout the territories for continuity of care.

Eight publications mentioned monitoring by hospital professionals in the territory in response to the need for care. For example, situations of care for children who require mechanical ventilation as life support[48] and for patients who have undergone myocardial revascularization[57] were mentioned. The lack of adequate monitoring, with greater involvement of multidisciplinary teams and alignment between services, were highlighted as gaps in the implementation of this proposal[55,57,60,76].

The work of liaison professionals was reported in eight publications, demonstrating the relevance of this health professional in care management and in planning the transition to hospital discharge[15]. Hospital liaison nurses have a shared responsibility with nurses from other

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points in the health networks[45] and are considered essential for the production of care in these networks[40,41,43,50].

It is important to note that, among the 37 publications that demonstrated the relevance of hospital/network interaction aimed at a continuity of care, 18 showed gaps in the health systems related to weaknesses in the connections between hospitals and health networks. Without a specific network, children tend to be hospitalized for longer periods of time[48]; frail elderly individuals are transferred from one hospital to another, with no clear therapeutic plan for continuity of care[38]; patients with heart failure, without adequate transitional care, tend to have their treatments discontinued after being released from the hospital[75].

Freitas[63] highlighted that the hospital has been a reference for care in health networks, but he criticized the fragility of PHC, which makes it difficult to overcome the hospital-centric model. A hospital that operates in a network in a user-centric health system needs to establish fluid, problem-solving connections, in interface with the specific network, especially PHC. Hospitals should act as "technical support for the matrixing and co-management of cases"[2], not as a preferential link for the user throughout their journey in the health system. In ten publications, the interaction between PHC and hospitals continues to be a major challenge[35,37,40,42,45,57,60,63].

Kahl et al.[77] highlighted that, given the difficulties in interaction between hospital and PHC, the network actions have been carried out by families. Pichelli[46] showed how difficult it is for families to face the difficulty of PHC assuming the coordination of care in the territory, which calls on SUS managers to think about the role that the PHC has really played in people's daily lives. Implementing the model proposed by SUS involves expanding PHC in terms of financial resources and qualified workers, as well as providing elements that enable an effective coordination of care. Furthermore, strengthening ties between PHC and hospitals means investing in the hospital as a reference facility in the territory and in connectivity among SUS managers, workers, and users[5]. Disconnection in the network directly affects the lives of users.

The set of functions presented in this review, as well as the singularities of the interactions that hospitals perform in different countries, bring to the forefront possibilities to produce more effective health care and overcome obstacles to the continuity of care. They constitute strategies to be considered when pondering possible paths for contemporary hospitals in health systems, especially when considering comprehensive care in a health network.

This review did not intend to conduct an in-depth discussion of each of the identified functions. Further research should be directed toward this goal.

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The results of this work are directly related to the understanding of how each function of a hospital in a given network is experienced in each country in which it was identified, since these functions are highly dependent on the type and model of social and health protection adopted. It is therefore necessary to contextualize these roles based on the existing social protection models.

It is important to highlight that if other descriptors had been used, the results would perhaps have shown a greater number of publications from other countries. The use of the descriptor “integrality in health” allowed many Brazilian articles to appear in the searches.

Furthermore, there was no intention to seek a causal relationship between the identified attributions and the format of the established networks. However, the results provided clues about the relationship between the functions that hospitals perform in the given networks and the health systems in which they are inserted. A future study that explores this relationship can highlight new directions for the functioning of hospitals in health networks and help to evaluate the effectiveness of these interactions.

The mapping carried out in the present study showed that there are complexities involving the connections that hospitals establish, be they with other health facilities or with communities. An approach to the daily routine of these connections can reveal significant interferences of these network actions with a certain degree of caring processes in the health systems.

FINAL CONSIDERATIONS

The distribution of functions identified for hospitals in the networks, based on this review, revealed the power of SUS in terms of developing devices for the operation of hospitals in a health network. Within the limits of the search carried out in the databases, it was not possible to identify another country similar to Brazil that invested so much in academic production on hospitals, focused on a diverse set of health equipment and with an intense interaction with users and families.

There is an effort in Brazilian universities to produce research that subsidizes the development of the SUS in a way that is committed to comprehensive care and the improvement of the guidelines proposed for the system. Moreover, the hospital, as an important component of the RAS, can act as a network observatory, and can present itself as a type of dynamic equipment that can assume various responsibilities depending on the network in which it is inserted and the challenges to which it is exposed.

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One example of this is the role of health education, whether for the general population or in the ongoing education of professionals. In a network, hospitals fulfill this role beyond their walls, establishing various connections with other facilities and the community.
The network operation has also led hospitals to offer new possibilities for connection, such as when they provide liaison professionals to improve care within the given territory.

The role identified as most widespread for contemporary hospitals, related to the idea of the need for a succession of care actions after hospital discharge, demonstrated that this concept is widespread in health systems around the world.

It is important to note that the strength of this review lies in the convergence of descriptions of hospital actions in networks in a single academic work. By mapping the attributions of hospitals in different network formats, with greater or lesser operational power, whether formally established or not, it was possible to observe the strengths and weaknesses that exist in different types of networks, despite the concentration of efforts to produce broader care in universal systems.

Networked hospitals worldwide contribute to the consolidation of the systems in which they are inserted and expose necessary changes. They are capable of attributing responsibilities, for example, to families, without considering broader contexts, but they also contribute to the production of living networks that rely on the creativity and collective responsibility of the various actors involved in healthcare processes.

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