ACCESS AND CONTINUITY OF CARE FROM PRIMARY TO SPECIALIZED CARE IN THE BRAZILIAN UNIFIED HEALTH SYSTEM (SUS)

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INTRODUCTION

- ✓ One of the meanings of comprehensive healthcare: availability and linkage between different supplies of care to “respond” to diverse health demands and needs, with a given healthcare model as the reference.

- ✓ Access to actions and services as well as continuity and integration of care are some of the key points for production of comprehensive care, influenced by socio-spatial, personal/family, professional, organizational, and policy elements, besides the social production of demands and needs.

- ✓ Primary healthcare (PHC) is essential (but insufficient) for access and continuity of care, requiring support and resources from other modalities of healthcare services and inter-sector action for management of some situations.

OBJECTIVES OF THIS PRESENTATION

Address key elements in the interface between primary healthcare (PHC) and specialized care in Brazil.

Share some results from a study on an experience with regulation of access to specialized outpatient care via PHC in Brazil.

PRIMARY HEALTH CARE IN BRAZIL: CHARACTERISTICS AND GUIDELINES

Privileged space in the healthcare network for access and uptake of the entire population;

Organizational strategies of Brazil's PHC:

- territorialization,
- health accountability,
- assigned coverage of the clientele,
- core multidisciplinary teams (family health teams),
- and matrix support;

Assimilation of the spontaneous demand, continuing care, action in collective health problems (individual and collective care)

SPECIALIZED HEALTHCARE: CHARACTERISTICS AND SITUATION

The SUS has witnessed significant expansion of access to PHC in recent decades, but access to specialized care is still a challenge.

Specialized services with heterogeneous arrangements and important participation by private providers.

Access to specialized care generally mediated by central regulation desks.

Waiting times for specialized tests, appointments, and procedures are one of users' main complaints about the SUS.

With few exceptions, the interface is critical between PHC and specialized care (sharing of information and care and specialists' view of PHC).

Predominant financing model for specialized care: procedure-based and according to output.

SPECIALIZED OUTPATIENT CARE: NEEDS AND PROPOSALS

Technology density, temporary care, prolonged care.

Expansion of treatment strategies (consultations, groups, monitoring, treatment management).

New national policy for specialized care (currently in the implementation phase): financing of “packages” of integrated care (diagnostic and/or therapeutic) rather than stand-alone procedures.

Matrix support for PHC.

Financing and management consistent with logic of care and inclusion in regionalized networks.

INTEGRATION AND CONTINUITY OF CARE: DEVICES.

Lines of care

Electronic user files with clinical information, shared in network format

Matrix support and collaborative care

Clinical, referral, and discharge protocols

Co-management spaces involving administrators / professionals from different services

Regulation of access to tests, consultations, and procedures

REGULATION OF CARE (OR ACCESS) IN BRAZIL

Central directions of regulation of access, mediation between demand and supply, production of access with clinical indications - equity, timeliness, transparency.

Levels of regulation of access: outpatient (specialized tests and consultation), urgent care, and beds

Formal regulatory power over access steadily concentrated in Central Regulation Desks.

Patient care regulation as a field of tensions and disputes, permeated by different regimes (professional, governmental, paternalistic, lay, and judicial) (Cecílio et al., 2014)

Movement involving progressive recommendations to expand the attributions of PHC in healthcare regulation, conceptually expressing the notion of micro-regulation, and operationally in initiatives toward linkage between Tele-Health and regulation (Melo e cols, 2020)

BRIEF SHARING OF THE RESULTS OF A STUDY ON REGULATION OF ACCESS TO SPECIALIZED CARE VIA PHC IN THE CITY OF RIO DE JANEIRO, BRAZIL

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PROGRAMA INOVA FIOCRUZ

STUDY ON REGULATION OF ACCESS TO SPECIALIZED CARE VIA PHC IN THE CITY OF RIO DE JANEIRO, BRAZIL

Oportunidades, percalços e justificativas: a descentralização da regulação ambulatorial no município do Rio de Janeiro

Opportunities, drawbacks and justifications: outpatient care regulation's decentralization in the city of Rio de Janeiro

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A regulação do acesso à atenção especializada pela Atenção Primária à Saúde da cidade do Rio de Janeiro: coordenação ou competição?

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A regulação do acesso à atenção especializada e a Atenção Primária à Saúde nas políticas nacionais do SUS

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A regulação ambulatorial na Atenção Primária do Município do Rio de Janeiro, Brasil, a partir dos médicos reguladores locais

Outpatient regulation in Primary Care in the municipality of Rio de Janeiro, Brazil, based on the local regulatory doctors

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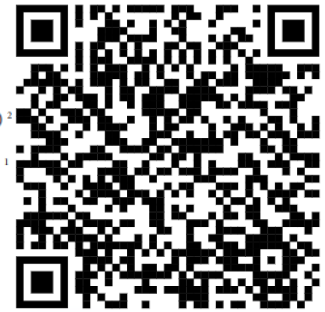

STUDY ON REGULATION OF ACCESS TO SPECIALIZED CARE VIA PHC IN THE CITY OF RIO DE JANEIRO, BRAZIL

Incipient regulation via PHC in the SUS (regulatory power concentrated in central regulation desks), with distance and weak communication between regulation desks (where the regulating physicians are located) and requesting physicians in PHC.

2012: Beginning of partial decentralization of outpatient regulating power in the city of Rio de Janeiro to physicians in PHC, based on limits and supplies determined by the Central Municipal Regulation Desk, aimed at expanding the capacity for coordination of care by PHC.

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Unique experience in Brazil's healthcare system.

Questions: What are the arrangement's repercussions on the work process for healthcare professionals in PHC? What repercussion does it have on the capacity for coordination of care in PHC and on access to specialized care?

Overall study objective: Analyze the experience with regulation of specialized outpatient access via primary care in the city of Rio de Janeiro, considering the period from 2012 to 2019.

STUDY ON REGULATION OF ACCESS TO SPECIALIZED CARE VIA PHC IN THE CITY OF RIO DE JANEIRO, BRAZIL

OBJECTIVE	RESEARCH TECHNIQUE
1) Identify the way regulation can be conducted in PHC has been conceived in national documents.	Document analysis
2) Analyze the policy-making and decision-making process of outpatient regulation via primary care in the city of Rio de Janeiro.	Document analysis Interviews with administrators
3) Characterize the design of regulation of outpatient care in the city of Rio de Janeiro.	Interviews with administrators Visit to services Document analysis
4) Characterize the regulation process conducted in PHC units, including the work process of professionals in charge of local regulation.	Interviews with health professionals Visit to services Online questionnaires
5) Analyze local effects of decentralized regulation on health professionals' work process and on requests for outpatient consultations, tests, and procedures.	Interviews with health professionals Interviews with administrators Visit to services

METHODOLOGICAL ASPECTS OF THE STUDY

Study scenario: Central administrative and regulatory area and Programmatic Area 3.1 in the city of Rio de Janeiro.

Two PHC units were selected and studied in this area (3.1).

Visits were conducted and 11 health professionals were interviewed in the two units.

Fieldwork lasted 7 months (July 2019 to January 2020).

OVERALL DATA ON THE NETWORK IN THE CITY OF RIO DE JANEIRO

Population	Estimated population: 6,718,903 in 2019.
Administrative Division	The Municipal Health Network is organized in 10 regions called Programmatic Areas (APs). Each AP has a Programmatic Area Coordinating Body (CAP).
Primary care	As of late 2020, the city reported approximately 49% population coverage, estimated by Family Health teams.
Specialized care	Specialized outpatient care is connected to hospitals or polyclinics and specialized centers. Among outpatient procedures (tests and consultations) under municipal regulation, an estimated 60.1% are municipal, 24.2% are by private providers, 7.4% are by federal hospitals and institutes under contract, and 8.3% are by university hospitals.
Hospital Network	The installed state and municipal hospital network in the city shows a predominantly general care profile, while the federal and university network has a high-complexity profile.

Source: Prepared by the authors based on data from municipal documents.

Population	Estimated population: 886,551 in 2019.
Administrative Division	Includes a Programmatic Area Coordinating Body (CAP), with an Internal Regulation Center (NIR).
Primary care	The region had 32 PHC units with 196 Family Health teams, covering approximately 66% of the population.
Specialized and hospital care	Medium and high complexity care included 1 state hospital, 3 municipal hospitals, 2 federal hospitals (1 of which was part of a university), 5 Urgent Care Units (UPAs), 2 municipal polyclinics, and 6 Centers for Psychosocial Care (CPHC).

Characteristics of the SUS network in the Programmatic Area in the study in the city of Rio de Janeiro, Brazil, 2020.

Source: Prepared by the authors based on data from municipal documents.

Characteristics of the PHC units in the study

Health unit	Population covered	Number of teams	Interviewees	Units' specific characteristics	Characteristics common to both units
A	46,600	14	- 1 regulating physician; - 1 requesting physician; - 1 PHC manager; - 2 community-based health workers.	• High number of physicians (27), including supervisors and residents in Family and Community Medicine; • Covered population is predominantly low-income; • The unit supplies tests, such as sample collection (blood, stool and urine), ECG and ultrasound.	• Both lack a Family Health Support Group (NASF). • Infrastructure with climatized consulting rooms, computers, and connectivity; • Difficulties in recent years involve salary delays, inconstant supply of medicines, and maintenance problems.
B	24,000	6	- 2 regulating physicians; - 1 requesting physician; - 1 PHC manager; - 1 community-based health worker; - 1 administrative assistant.	• Two incomplete teams without an MD or nurse, besides limited number of community-based health workers; • Physicians in the unit lack training in family and community health; • Presence of medical interns, but no residents; • Covered population is low and middle-income.	

PHC MEMBERS IN THE PROCESS OF REGULATING ACCESS IN RIO DE JANEIRO

DEMANDS

Regulation in PHC

Requesting physician:
enters the request in the SISREG with risk classification: red, yellow, green, and blue.

Regulating physician:
analyzes the request and chooses between authorizing, leaving as pending, returning, and rejecting.

Community-based health worker:
informs the user.

Manager:
evaluates and manages the process.

Administrative assistant:
organizes the scheduling forms.

Family health and NASF* teams:
manage the waiting list.

* Varies according to the PHC unit.

SPECIALIZED CARE

REGIONAL REGULATION CENTER

MUNICIPAL REGULATION CENTER

Principal findings

Advances:

- More participation by PHC in the regulation process and greater knowledge within PHC concerning the services network;
- Closer collaboration between the requesting physician and the regulating physician: increase in clinical skills.
- Proximity for the regulating physician: regulation with greater knowledge of users' needs.
- Partial expansion of the capacity to coordinate care.

Limits:

- Competition for places in tests and medical consultations, with an overload of associated work;
- Low interaction between PHC and specialized care;
- Weak (intra-municipal) regionalization of the network;
- Tension between real-world conditions for access and comprehensive care, requirement of efficient performance by regulating physicians

FINALLY, AN IMPOSSIBLE REFERENCE SITUATION FOR MANAGEMENT OF ACCESS TO SPECIALIZED CARE

- Production of needs and demands;
- Clinical and patient care capacity in PHC;
- Organization and functioning of specialized care (regionalized networks, installed capacity, providers, and contractualization);
- Balance in direct access flows between PHC and specialized care versus flows conditioned on prior evaluation and authorization.
- Targets of regulation of access (stand-alone procedures versus integrated sets of tests, consultations, and procedures);
- Guaranteed access with equity versus rationalization of resources in the face of budget constraints and supply capacity.

MUITO OBRIGADO

MERCI BEAUCOUP

THANK YOU

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