Reflections on factors that influence access in a health region

Reflexões sobre fatores que influenciam o acesso em uma região de saúde

Reflexiones sobre factores que influyen en el acceso en una región sanitaria

RESUMO

Objetivo: analisar os fatores que influenciam o acesso à atenção cardiovascular. Método: estudo descritivo, abordagem qualitativa, a partir da entrevista de 41 gestores e reguladores de uma região de saúde do noroeste paulista. As entrevistas semiestruturadas foram transcritas, agrupadas por similaridade de conteúdo e categorizadas. Resultados: as categorias empíricas identificadas deflagraram que o acesso em saúde pode ser potencializado por meio da estruturação da rede de atenção, do fortalecimento da gestão, da qualificação da atenção, da melhoria da estrutura dos serviços e de um olhar sensível aos aspectos culturais da população assistida. Potencializar o acesso em um contexto de rede regionalizada pode trazer implicações tanto para a gestão, no que se refere ao planejamento e organização do sistema de saúde, quanto para a atenção, qualificando o cuidado na perspectiva da integralidade.

DESCRITORES: Acesso aos Serviços de Saúde; Regionalização; Sistema Único de Saúde; Doenças Cardiovasculares.

ABSTRACT

Abstract: This article analyzes the factors that influence regional access to cardiovascular care from the perspective of managers and those responsible for regulatory services. The results showed that health access can be enhanced through the structuring of the care network, the strengthening of management, the qualification of care, the improvement of the structure of services and a sensitive view of the cultural aspects of the assisted population. Potentializing access can have implications for both management, with regard to the planning and organization of the health system, and for care, qualifying care.

DESCRIPTORS: Health Services Accessibility; Regional Health Planning; Unified Health System; Cardiovascular Diseases.

RESUMEN

Resumen: Este artículo analiza los factores que influyen en el acceso regional a la atención cardiovascular desde la perspectiva de los gestores y responsables de los servicios regulatorios. Los resultados mostraron que el acceso a la salud se puede mejorar mediante la estructuración de la red de atención, el fortalecimiento de la gestión, la calificación de la atención, el mejoramiento de la estructura de los servicios y una visión sensible de los aspectos culturales de la población asistida. Potencializar el acceso puede tener implicaciones tanto para la gestión, con respecto a la planificación y organización del sistema de salud, como para la atención, calificando la atención.

DESCRIPTORES: Acceso a los servicios de salud; Regionalización; Sistema único de Salud; Enfermedades cardiovasculares.

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INTRODUCTION

The universality of access can be understood as a constitutional precept that still occurs in a selective, focused and exclusive manner. [1] The international experience suggests, as an innovative strategy for improving access, the organization of Health Care Networks (RAS) based on the coordination of Primary Health Care (PHC), through articulation with services of different technological densities. [2]

The implementation of regionalization as proposed by the federative model has positive effects that improve the efficiency of service delivery and the reduction of operating costs, optimizes human capital, technological resources, social and political resources, encouraging the sharing of responsibilities between management instances. [3]

A challenging aspect for the organization of the health system has been the increase in non-communicable chronic diseases (NCDs), causing a significant social and economic impact on the Unified Health System (SUS). [4] In this scenario, cardiovascular diseases stand out, representing an important public health problem in the world [5] and in Brazil. [6] Attention to these injuries requires the organization of the health system to provide comprehensive care to users. [7-9]

There are contributions in the literature from different studies about the importance of access to health care in the SUS. [1,10-11] There is a convergence regarding the idea that the end product of access is meeting the health needs of users, from the perspective of comprehensiveness and resolvability.

In this context, it is pertinent to understand the factors related to health access, in particular, to cardiovascular care, in order to provide subsidies for health planning, given the high contribution of resources that these conditions require. Based on these assumptions, this study sought to identify the factors that influence regional access to cardiovascular care from the perspective of health managers and those responsible for regulatory services.

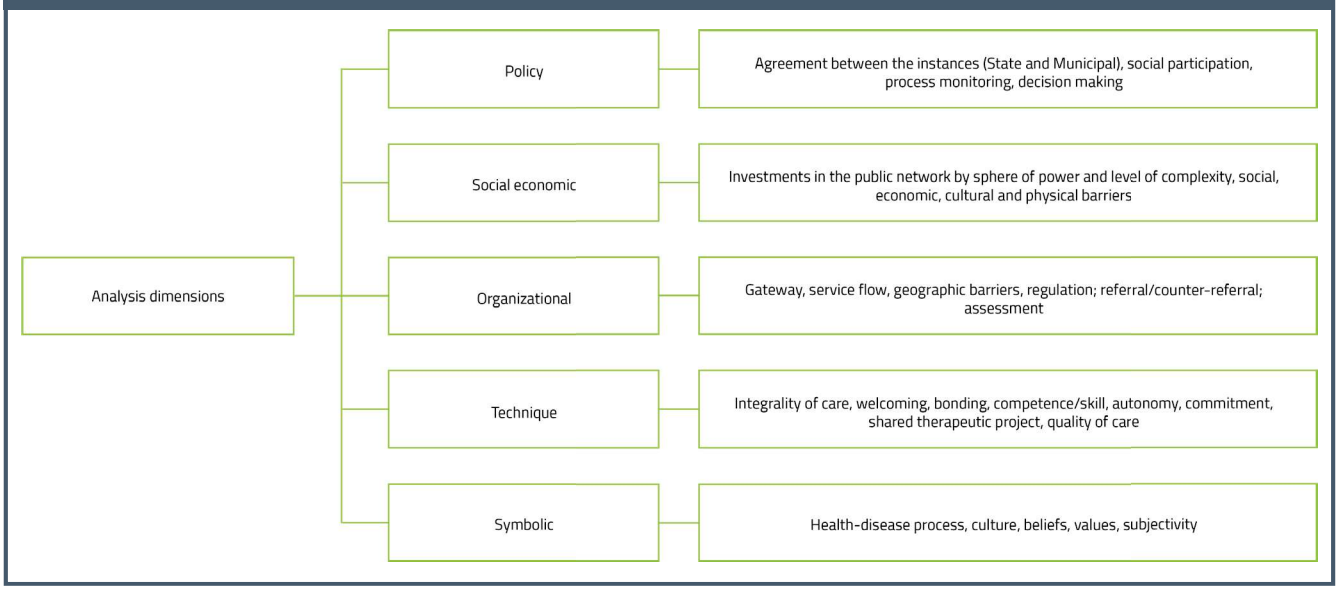
METHODS

Descriptive study, qualitative approach, carried out at the Regional Intermanagement Commission (CIR) of São José do Rio Preto, a health microregion inserted in the XV Regional Health Department (DRS XV). This CIR has approximately 710,663 inhabitants [12] and is located in the northwest region of the state of São Paulo. It comprises 20 municipalities, of which 50% have up to 10,000 inhabitants and 90% have less than 50,000 inhabitants. [13]

The study included health managers and those responsible for regulatory services who had worked for at least one year in the function, in the municipalities or in the DRS. For the semi-structured interview, a script consisting of five open questions related to access to cardiovascular care in the health region was used. The interviews were digitally recorded and later transcribed.

For each municipality, there was a random numeric identification that varied from "1" to "20". Participants who were managers were identified with the letter G and regulators with the letter R. In total, 41 participants were interviewed.

Figure 1 - Theoretical dimensions used to analyze access to cardiovascular care health services:



FONTE: Assis, Jesus 10 (adaptado)

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Data analysis involved vertical and exhaustive reading of the material followed by horizontal reading, in order to establish relationships between the testimonies, resulting in a grouping by content similarity. [14] Data categorization was carried out based on the dimensions of access proposed by Assis and Jesus. [10]

This article brings in the results the most representative fragments of the speeches, as well as narrative syntheses of the testimonies. The purpose was to understand processes that facilitate access to health through a representative scenario.

It was approved by the Ethics Committee of the Ribeirão Preto School of Nursing and developed to ensure compliance with ethical precepts.

TABLE 1 - Theoretical dimensions used to analyze access to cardiovascular care services in DRS XV, empirical categories and identified strategies:

Dimensions	Categories	Strategies
Organizational	Care Network Structuring	Primary Care empowerment and strengthening
		Organization of service flows
		Strengthening local and regional regulation
		Reduction of geographic access barriers
		Strengthening the evaluation of health services
Political	Strengthening of SUS management	Qualification and continuity of municipal management
		Commitment and cooperation of state management
Economic and social	Qualification of attention	Institutionalization of health education
		Guarantee of resolvability of attention
Econômico-social	Improved service structure	Provision of necessary resources for health care.
Simbólica	Cultural aspects related to the health-disease process	Not reported

Source: own authors (2021)

RESULTS

From the political, economic-social, technical, organizational and symbolic dimensions of access to health 10 the empirical categories were established: structuring the care network, strengthening management, qualifying care, improving the structure of services and cultural aspects related to the health-disease process. Within each category, access-facilitating strategies were identified.

Structuring of the care network

In the organizational dimension of access, the category "structuring the care network" emerged, whose strategies were "empowering and strengthening Primary Care (PC)", "organization of care flows", "strengthening local and regional regulation", "reducing geographic access barriers" and "strengthening the evaluation of health services".

The "empowerment and strengthening of PC" strategy includes the relevance of technical support from articulators and matrix support, for its qualification:

"There are primary care articulators who work together with the municipalities in order to organize health care, primary care within each municipality and according to each reality". RM1-1 "We are working on qualified discharge (...) the hospital has a matrix proposal with primary care (...), there are two representatives from each municipality, the hospital has contact with these professionals to advance in the actions related to discharge." RM1-2 "The gateway is primary care, which has to be specialized, has to be trained. If you don't have this training, bury the whole network" RM1-2.

In the "organization of service flows" strategy, the statements highlight the

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relevance of technical guidelines and care protocols, as well as reference and counter-reference: "Cities have tried to adapt to the implementation of care lines, adopting protocols for requesting tests ". RM1-1 "At DRS, what was very positive was the protocol that AME developed. Before, the patient would go to the AME, he would skip the first appointment and, after he went, he would come back to do the exams. Now it is only referred according to some criteria and with a list of exams". GM18-1 "AME doctors send counter-references to municipalities, and our doctors see what was done, everything saved in the patient's record." RM11-2

In the strategy "strengthening local and regional regulation", the importance of implementing these services to enhance access is identified: "As soon as regulation was mentioned, they were already implemented in the system here, so it made the service a lot easier, it made it a lot easier" RM20-2 "We did work to implement a municipal regulation group to minimize the real queue. Because they often had 200 patients, but of those 200 patients, many had already been treated, many no longer needed it, wrong referrals too". RM1-2 "Every month a spreadsheet is made with the municipality's pent-up demand. Regulation sends the repressed demand of each specialty for them to make an assessment, see what is left, to see if they can change" GM8-1

From the perspective of the "reduction of geographic access barriers" strategy, considering the distance for the reference agreement process can be understood as an action to reduce these barriers: "If suddenly we could get the exams closer together, it would be better, because sometimes you find a patient who has the resistance to go to a farther city." GM7-1

In the strategy "strengthening the evaluation of health services", the relevance of evaluation and monitoring for access to health was identified: "Action to enhance is monitoring and evaluation. We know the actions that work, but if you don't monitor and evaluate them, they won't happen." GM12-1

Management strengthening

In the political dimension, the category "strengthening management" emerged, whose strategies were "qualification and continuity of management" and "commitment of state management".

Regarding the "management qualification and continuity" strategy, the relevance of technical and qualified management was identified: "A lot of training is lacking... The manager changes and often they are not managers of the area. When they learn what health is, what SUS is, they are exchanged again. So the difficulty here in the region is to create networks with this change of manager, low managerial training." RM1-2

Regarding the "commitment of state management" strategy, the role of coordination of the DRS in the organization of the regional network was evidenced, mainly with regard to the management of providers: "The DRS has done a good job with the providers! It has a good survey of the region's difficulties to take to providers. Including, in a CIR meeting, the AME came to account for what it has done. That was a big win." GM4-1"In the DRS they try to help us and that's what's positive about it". RM2-2

Qualification of attention

In the technical dimension of access, the category "qualification of care" emerged, whose strategies were: "institutionalization of education for health" and "guarantee of resolvability of care".

For "institutionalization of education for health", professional improvement was evidenced: "We have been trying to expand the training of these professionals more and more, to guarantee follow-up. "GM9-1

Regarding the "guarantee of the resolvability of care", having resolving services was highly highlighted by the participants: "The patient of the family strategy is very well assisted" RM12-2 "It has an EB that works". GM6-1 "The speed of the cardiac emergency is very great." RM10-2

Improved service structure

In the economic-social dimension of access, the category "improvement of the structure of services" emerged, which included the strategy "provision of resources necessary for health care", which included physical resources, such as services and health information systems ; human capital, in particular the importance of securing professionals and necessary material resources/equipment. "I believe that the service offer in the region also collaborates to better organize the network" RM1-5 "Today everything is forwarded via the system, it makes it much easier because in the past you had to go via the folder, sometimes you came back without scheduling. RM7-1 "The municipality is trying to recruit professionals" RM1-5 "What makes it easier is having an emergency room that is very well set up". GM16-1

Cultural aspects related to the health-disease process

In the symbolic dimension of access, the category "cultural aspects related to the health-disease process" emerged, based on the recognition of the implication of cultural factors in access to health, according to the statements: "We have some difficulties in changing habits. We have groups of hypertensive people and we realize that it's a paradigm shift to have a healthy diet, exercise... I think this is the biggest complicating factor".GM4-1"The man doesn't want to take the medicine because he wants to go to the bar. Usually what happens most is that these people have a stroke, one of the biggest causes in the unit". RM14-2

For this dimension, there were no elements in the participants' statements that could indicate strategies or even propositional actions. Even so,

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it is considered that the result can encourage reflection, which permeates the perception and perspective of care and comprehensiveness in health. The hypotheses for the absence of propositions may come from the characteristics of the participants in this study – professionals with a focus on management, who often have little interface with user assistance. But they can also come from a concept of care that does not value the centrality and autonomy of the subjects.

DISCUSSION

In the Brazilian health system, the term "Basic Care" (AB) is used as a synonym for Primary Health Care, being understood as an essential element for the organization and articulation of the RAS, acting as a preferential gateway to the system, favoring access , bonding and ongoing care centered on the person rather than the disease. [2]

The expansion and qualification of PHC services favors the expansion of access as it promotes the detection of health conditions that require coordination and organization of the entire care network 2, a challenging situation for the health system, considering that there is still a fragility of the PHC both in constituting itself as a preferential entry point in the system, and in offering resolute health care. [7-8]

PHC empowerment is intrinsically related to increasing its resolving capacity15, so that the inequality of access and quality at this point of care creates numerous difficulties for the development of the rest of the system[16].

The PHC's resolving capacity can be enhanced through qualifying care actions. Among these actions, one can highlight the work of primary care articulators, professionals linked to the SES-SP, whose attribution is to help municipal managers in the qualification of services [17] and also the matrix support, a tool that favors the construction of knowledge of the PHC team through support from the support team.[18]

The organization of care flows can also influence access to health. The arrangement of care flows is directly related to health care processes, with emphasis on the inadequate care model for the local reality, the lack of prioritization of risks, definition of protocols and implementation of lines of care, as well as poor monitoring of chronic conditions. [16]

[...] é pertinente compreender os fatores relacionados ao acesso em saúde, em especial, para a atenção cardiovascular, a fim de fornecer subsídios para o planejamento em saúde, dado o elevado aporte de recursos que esses agravos requerem.

With regard to health care, the work process should be aimed at establishing care management and not the fragmentation of care, which can have negative implications for access. [2] In addition, it is considered that comprehensive care does not end in a single health service or region. The main element for the integration of health services and/or networks is an effective referral and counter-referral system. [8]

The strategy of strengthening local and regional regulation is also well established for organizing the care network. Care regulation involves processes such as planning the provision of actions and services based on the health needs of the population. [19]

The regionalization of health is an organizational guideline of the SUS that seeks to expand access and reduce inequalities, in order to enable the use of the most appropriate technology, in any part of the territory, guided by a systemic rationality. [20]

This "rationality" related to the health area is inserted in a macro context within public administration, the principle of efficiency, which provides for the allocation of resources that maximize results and minimize costs, to guarantee the sustainability of the public health system. [11]

Geographical accessibility can also be understood as a guide for access, especially in very distant regions, with implications both for user care and for the efficient management of financial resources, impacting on expenses with the health transport of users. [11]

The incorporation of evaluation as a systematic practice in the various health services provides managers with the information required to define means of intervention. [9] Monitoring refers to the routine follow-up of relevant information, in a timely manner, to support decision-making, forwarding a solution,

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reducing problems and correcting courses; its operationalization is foreseen in the SUS. [21]

The qualification of managers has been a recurring challenge, influenced by the very complexity of the health sector and also by political and ideological disputes. The turnover of municipal health managers, low autonomy in executive decisions, insufficient qualification and the influence of party politics in decision-making processes in public policies are factors that obstruct the strengthening of SUS management. [20] The health manager must have the preparation and time to develop the strategic functions that involve putting the SUS principles into practice. [22]

The debate on regionalization in health has gained depth, both due to the consistency of international experiences and the legal direction of the legal framework of the SUS. The formation of regions and health networks in Brazil have become strategies to deal with the territorial dimension, with the universalization of access to health and for the planning and management of the system. [23]

The establishment of the CIR as an instance of co-management in the regional space builds a permanent and continuous channel of negotiation and decision between managers, a mechanism to affirm relationships of co-responsibility in the health region. Institutional learning strengthens management and is an important component for building a regionalized network. [20]

Incorporating education into health services is one of the focuses of the National Policy on Permanent Education in Health, whose central focus is the workers' experience, using the reality of each service. [24] Another strategy for professional improvement is continuing education, which acts to review and recover knowledge and skills, in addition to monitoring the changes brought about by scientific and technological progress, in order to qualify the care provided. [25]

The lack of training and insufficient number of health workers is a limitation of access, [1] as well as issues related to the provision of human capital, in particular, the hiring of doctors in small municipalities and in those furthest away from large centers.[16]

Despite this, the diagnosis of chronic underfunding of the SUS [26] the presentation of studies that point to the mismanagement of the use of public resources is recurrent [27], a condition that directly impacts the allocation of resources and services and, consequently, user access. In addition to these issues, it is worth mentioning the current political and economic situation, which converges to a fiscal austerity policy, which will certainly impact access. [26]

Finally, it is believed that health services need to promote a user-centered intervention that is capable of allowing the autonomy of individuals. Autonomy, in this context, is not simple freedom of choice, but a conscious, dialogued and shared choice. In this sense, co-responsibility is triggered, that is, the ability to perceive singularities and to invest in the individual capacity to make choices that promote care. [1]

CONCLUSION

It is understood, from the results, that access to health is a complex and multifaceted theme, which can be enhanced by structuring the care network, the strengthening of management, the qualification of care, the improvement of the structure of services and a sensitive look at the cultural aspects of the population.

In the region studied, a series of factors are superimposed that impact on access to health, among which we can highlight the resolvability of PHC, the organization of care flows, local and regional regulation, geographic barriers and also the need to strengthen the evaluation of health services. In addition, it also denotes the relevance of aspects such as the qualification of managers and the continuity of management, the strengthening of management instances, the qualification of professionals, the resolvability of care and the provision of the necessary resources for health care.

It is understood to be a limitation of the study not having the participation of care professionals and users with cardiovascular diseases, as they are actors who could contribute to the outcome of the investigation, especially with regard to the symbolic dimension of access. However, it should be noted that the findings obtained contribute to highlight aspects that can enhance regionalization.

As a contribution, it is understood that investigating the aspects involved in access in contexts of regionalized networks brings indications for the formulation or readjustment of health policies, in particular, with regard to the planning and organization of the health system, helping decision-making by managers in different instances, which can be especially relevant in unfavorable economic scenarios, such as the one that is now unfolding. Optimizing resources that can enhance access becomes, therefore, a virtuous and necessary task.

Finally, it is seen that the results of this study also bring contributions in the field of health care, both for managers and professionals who work in care, urging them to reflect on possible intervention strategies that can qualify access at different points in the regional network. It is understood that qualified access can re-signify care and improve service to users' health needs, amplifying propositions that favor integrality.

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