Regulatory process of the Family Health Strategy for specialized care

Processo regulatório da Estratégia Saúde da Família para a assistência especializada

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ABSTRACT It was aimed to know the regulatory process of the Family Health Strategy for specialized care in Campo Grande, Mato Grosso do Sul. Descriptive study, with 53 physicians, whose data collection used a structured and self-administered questionnaire. The professionals (50.9%) considered that the regulation contributes to the coordination of the care, that the return of the referrals is due to the lack of clarity of the test results (57.1%) and that the main measure to improve the access to the specialized care would be the increase of positions. A greater communication among the professionals involved in the regulatory process should be encouraged, in order to provide the full exercise of their functions.

KEYWORDS Health regulation and monitoring. Family Health Strategy. Health services accessibility.

RESUMO *Objetivou-se conhecer o processo regulatório da Estratégia Saúde da Família para a assistência especializada em Campo Grande, Mato Grosso do Sul. Estudo descritivo, com 53 médicos, cuja coleta de dados utilizou um questionário estruturado e autoaplicável. Os profissionais (50,9%) consideraram que a regulação contribui para a coordenação do cuidado, que a devolução dos encaminhamentos deve-se à falta de clareza dos resultados dos exames (57,1%) e que a principal medida para melhoria do acesso à atenção especializada seria o aumento de vagas. Uma maior comunicação entre os profissionais envolvidos no processo regulatório deve ser incentivada, de modo a possibilitar o exercício pleno de suas funções.*

PALAVRAS-CHAVE *Regulação e fiscalização em saúde. Estratégia Saúde da Família. Acesso aos serviços de saúde.*

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Introduction

Among the specific attributions of the medical professional who works in the Family Health Strategy (FHS) is to carry out referrals to other points of the care network, responsibility for the therapeutic plan in a shared manner, respecting the care flows, the appropriate registration of information and communication among professionals in a timely and appropriate manner, in a way that meets the needs of the user[1,2].

The FHS is, therefore, the starting point from which the flow of the health system starts, in which the professional must act with autonomy. However, the resoluteness of care depends not only on the performance of primary care professionals, but also on professionals from other levels of care[3].

In 2008, the Ministry of Health established the National Regulatory Policy, which contemplates three aspects: regulation of health systems; regulation of health care; and regulation of access to care, the latter being an important tool of public management, allowing its state, municipal and federal agencies to regulate the health care profile most appropriate to health needs[4,5].

Because it is a recent instrument in medical practice, the regulation of access can generate difficulties in its management, due to the reduced knowledge or inability of the professional, in order to delay or even prevent access of users to specialized health services, compromising the integrality of care.

For the adequate functioning of the networks of attention, aiming at the care in a timely and appropriate place, it is necessary that the various health sectors act in a coordinated and integrated way.

In this sense, given the relevance of this problem and the need for scientific productions that address the theme, especially, those associated with knowledge and good regulatory practice performed by the medical professional inserted in primary care, this study aims to know the regulatory process of FHS for specialized assistance in Campo Grande, Mato Grosso do Sul.

Methods

This is a cross-sectional, descriptive study, carried out in the Basic Family Health Units (UBSF) in Campo Grande, state of Mato Grosso do Sul.

The population was composed of 89 doctors, of both sexes, who were crammed into the 38 FHS units, three of them rural, with, at least, six months of activity in the FHS in activity, because a minimum time of experience is necessary in order to evaluate their insertion in the services.

Thus, before the collection, the professionals were questioned individually by the researcher regarding their time of operation, being excluded, in total, 36 (40%) participants, 10 of them (27.7%) because they did not meet this criterion, 7 (19.4%) for being on vacation and/or medical leave, 18 (50%) for refusal and 1 (2.7%) for being the researcher herself. At the end, the sample consisted of 53 doctors, from 35 Units, who were invited to participate in the study and who, after acceptance, signed the Informed Consent Form (ICF).

The primary data collection occurred during the months of June and July 2015, previously scheduled with the professionals, according to their availability.

For the collection, a self-administered questionnaire was developed by the researcher, composed of 18 closed questions, which approached the following variables: regarding the characterization of the medical professional (professional experience, type of employment relationship, education and training for the practice of the function); with respect to the regulation of access to specialized care (evaluation of the regulation and its practice, main reasons for return of referrals

and strategies to improve regulation).

The obtained data were organized in Excel® electronic spreadsheet, evaluated according to the descriptive statistical analysis and presented in the form of tables.

The study was approved by the Research Ethics Committee linked to the Federal University of Mato Grosso do Sul, under the opinion nº 1.045.233.

Results

Regarding the characterization of the medical professional of the FHS, it was verified that the average time of operation was of 6.2 years old, and standard deviation of 4.9, with predominance (49%) of experience in the area of up to four (4) years, with employment, relationship, in the majority, of the statutory regime, 47.2%.

To act in primary care, 54.7% did not have any training. The other 45.3% participated in specialization courses in Family and Community Medicine (FCM) and/or Family Health (*sensulato* and *sensustricto* courses). Only 7.5% had medical residency in FCM.

For the introductory course, the results were close. 47.2% reported participating, and 49.1% did not. As for continuing and/or permanent education courses, the majority (83%) reported having performed, with most of the courses (69.8%) being offered by municipal management.

Regarding the regulation of access to the specialized service by the FHS doctors, 50.9% considered that this process contributes to the coordination of care, however, 34% stated that they interfere negatively (*table 1*).

As for the frequency of authorization of referrals for specialized care, 94.4% stated that they were always, or most of the time, authorized, and, regarding access to referrals returned, 24.5% reported receiving them weekly, 22, 6% were informed by the patient and 18.9% did not know to inform (*table 1*).

For most participants, the waiting time for specialized consultations was considered very unsatisfactory (43.4%) and unsatisfactory to 34%, which together represented 77.4% (*table 1*).

On the degree of difficulty in obtaining a vacancy for a patient in need of specialized consultation, 50.9% considered it difficult, being the main motive (to 58.5%) the reduced offer of vacancies for specialties (*table 1*).

Table 1. Evaluation of the regulation of access by the doctorof the FHS. Campo Grande, MS, 2015. (N=53)

Variables	n	%
Regulation		
Contributes to the coordination of care	27	50,9
Interferes negatively in the coordination of care	18	34,0
Does not know how to inform	4	7,5
No information	4	7,5
Frequency of referrals authorization		
Always	2	17,0
Most of the time	41	77,4
Never	1	1,9
Does not know how to inform	2	3,8

Table 1. (cont.)

Frequency of referrals returned		
Weekly	13	24,5
Bimonthly	5	9,4
Monthly	12	22,6
Users themselves report the return	12	22,6
Does not know how to inform	10	18,9
No information	1	1,9
Waiting time for consultation with a specialist		
Satisfactory		3,8
Little satisfactory	9	17,0
Unsatisfactory		34,0
Very unsatisfactory	23	43,4
Does not know how to inform	1	1,9
Degree of difficulty for specialized consultation		
Difficult		50,9
Moderate	23	43,4
Easy	1	1,9
No information	1	1,9
Difficulties		
Reduced offer of vacancies for the specialty	31	58,5
Low malleability of regulation	10	18,9
Difficulty in meeting the requirements demanded by the protocol	4	7,5
No information		1,9

Regarding the regulatory practice by the FHSdoctors, the results can be observed in *table 2*.

Among those interviewed, 86.8% reported knowing the protocol for referring primary care to specialized care, accessing it and using it most of the time. However, when asked about receiving training for handling, the majority (69.8%) stated that they did not do it and that it would be important to do so.

In addition to the referral registered in the Regulatory Information System (Sisreg), telephone communication by the management of the health unit represented 45.3%, and only two professionals (3.8%) reported direct contact with the central, via telephone.

In situations in which the referred case was a health priority, 64.2% stated that, in addition to meeting the minimum requirements of the protocol, they expressed the need for urgency and justified it by reporting with clinical data. As for the use of personal influence to achieve quick access without passing through regulation, only 5.7% reported performing.

Table 2. Regulatory practice by the doctor of the FHS. Campo Grande, MS, 2015. (N=53)

Variables	n	%
Knowledge of protocol		
Does not know	3	5,7
Know, have access and use it most of the time	46	86,8
Know, have access, but do not use it	2	3,8
No information	2	3,8
Performance of the training on protocol management		
Yes, it helps to improve the work process	3	5,7
Yes, however, it was not useful in the work process	4	7,5
No, but considers that it would be important to do so	37	69,8
No, because it would not improve the work process	9	17
Means of communication with the Regulation Center (RC)[a]		
By phone, via management	24	45,3
By e-mail	5	9,4
By telephone, with direct communication with the medical regulator	2	3,8
Never had other forms of communication	18	34,0
No information	1	1,9
In case of priority[a]		
Meets minimum requirements and reports on urgency	34	64,2
Notifies RC, by e-mail or phone	18	34,0
Follows the protocol and prioritizes regulation	10	18,9
Uses the risk classification in the request form	7	13,2
Uses personal influence	3	5,7
No information	1	1,9

[a] More than one alternative could be signaled.

Among the reasons for returning referrals to the Regulation Center (RC) for adjustments, there was a predominance of improvement of the description of the results of mandatory basic exams in the access protocols (57.1%), followed by a better description of the clinical picture, 31.4% (*table 3*).

Table 3. Main reason for return of the referral, according to the doctor of the FHS. Campo Grande, MS, 2015. (N=53)

Reason for return	Opinion of the FHS doctor				
	1	2	3	4	5
	n(%)	n(%)	n(%)	n(%)	n(%)
Improve clinical state description	9(25,7)	11(31,4)	5(14,3)	5(14,3)	5(14,3)
Improve description of required basic exams	20(57,1)	7(20,0)	1(2,9)	5(14,3)	2(5,7)
Correct the ICD-10 informed	1(2,9)	7(20,0)	14(40,0)	9(25,7)	4(11,4)
Modify requested specialty	1(2,9)	8(22,9)	10(28,5)	12(34,3)	4(11,4)
Correct typing error	4(11,4)	2(5,7)	5(14,3)	4(11,4)	20(57,2)
No information	18	18	18	18	18

Note: Arranged on a scale of 1 to 5, with 1 being the most frequent and 5 being the least frequent.

As for the strategies to improve the regulation of access to specialized care, the increase in the number of places for specialists was the most cited, 50%, followed by the revision of access protocols by medical specialists, regulators and basic care, 36.8%. Improving the management of the clinic in the FHS was the least relevant strategy, 52.6% (*table 4*).

Table 4. Strategy to improve the regulation of access to specialized care. Campo Grande, MS, 2015. (N=53)

Strategy	Opinion of the FHS doctor				
	1	2	3	4	5
	n(%)	n(%)	n(%)	n(%)	n(%)
Conduct review of protocols by specialist doctors, regulators and the FHS	14(36,8)	8(21,1)	5(13,2)	3(7,9)	8(21,1)
Improve communication between the RC and the FHS	3(7,9)	8(21,1)	18(47,4)	16(15,8)	3(7,9)
Improve the management of the clinic at FHS	0(0,0)	3(7,9)	6(15,8)	9(23,7)	20(52,6)
Improve the management of the clinic in the RC	2(5,3)	8(21,1)	4(10,5)	18(47,4)	6(15,8)
Increase the number of vacancies for specialists	19(50,0)	11(28,9)	5(13,2)	2(5,3)	1(2,6)
No information	15	15	15	15	15

Note: Arranged on a scale of 1 to 5, with 1 being the most important and 5 being the least important.

Discussion

The average time of medical professionals in this study was higher than the national average (3.9) and the Center-West region (4.5), as well as the employment status of the statutory regime (47.2%)[6].

The Brazilian Society of Family and Community Medicine (SBMFC) considers the Family and Community Medicine (FCM) residence to be the gold standard for the training of a specialist in Primary Health Care (PHC). However, in view of the need to increase the qualification of this professional and the still limited access to medical residency programs, the SBMFC recognizes postgraduate courses as a provisional alternative[7].

The low demand for the specialty, observed in this study, can be explained, in part, by low remuneration, excessive workload, precarious employment ties, low professional and social status[8]. Also, to work at the FHS, it is not mandatory to reside or specialize in FCM. It suffices that it is a general practitioner, with no salary distinction between those with and without medical residency. These are possibly some of the factors that contribute to non-training in this area, including in countries with more structured primary care, such as Canada, Cuba and England[8,9].

For the introductory course, it can be observed that there was greater adherence among professionals when compared to the Damno study[10], in which 33% of the FHS doctors reported having done so. Even though it is a course recommended by the Ministry of Health, its fulfillment is still below the desired level, with a promising collaborator of Telehealth, with potential for its expansion and professional practices, through tele-education[11].

To improve primary care, it is necessary to develop in the family doctor specific technical skills with a high degree of qualification[12], a concern evidenced by the management of Campo Grande, which offered training courses to its professionals, which may contribute to more resilient teams and to improve the coordination of care[13].

One positive aspect is the fact that more

than half of doctors considered that regulation contributes to the coordination of care. Coordinating care means being, among others, responsible for the flow of care in the Health Care Network (HCN). In this perspective, primary care has the power to interfere directly in the performance of specialized care, since it is from the first level of care that most of the demand for other levels of care is generated, depending on its degree of resolution[2].

However, about 1/3 of professionals felt that regulation negatively interferes with care. This may mean difficulties in understanding the principles of the National Regulatory Policy and its role of collaborator in the process of coordinating care[4], or, furthermore, that regulation is not fulfilling its role in acting as a supporter of the FHS, since some doctors pointed to the low malleability of regulation as an obstacle to access to specialized care.

It was observed in this study a high number of professionals who reported having their referrals authorized, however, it was observed, for these same professionals, a reduced systematization of their referrals to specialized care. To guarantee the integrality of access, changes in the forms of production of care, using all the resources available in the health system through directed flows and guided by the therapeutic project of the patient, in order to guarantee the safe access to the technologies necessary for their assistance, are necessary[14].

The waiting time, associated with the high difficulty for specialized consultations, especially the low number of vacancies, are some of the limiting factors for the regulation of access. However, in countries of the Organization for Economic Cooperation and Development (OECD), with high levels of spending, with beds or doctors, there is still a long waiting period[15].

A considerable portion of referrals from primary to specialized care could be resolved with primary care. The low resolution of PHC raises, among other factors, increased queues for specialized care[16], which may hinder and delay access to priority cases.

The use of protocols constitutes important instruments for both clinical and regulatory practice, since it promotes continuity and completeness of care[17]. In this study, it can be verified that the knowledge and the use of the access protocols are present in the regulatory practice of the FHS professionals, although they have not received training for their handling and considered that it would be important to do so.

The fact that there is no direct communication between the professionals involved in the regulation process, which is limited to completing the referral form, may suggest little integration between services, and information exchange is essential for the strengthening of primary care as an authorizing officer of care[18].

In the priority cases, which require greater agility in the authorization of specialized consultation, the majority of physicians stated that they met the minimum requirements and informed the necessity of urgency, presenting justification with clinical data. According to Ferreira et al.[19], incomplete informations about the clinical condition of the referenced patient was identified as the most damaging problem in the regulatory action, since they make the referral analysis process difficult, as well as impede the identification of conditions that could be resolved at the primary level, in addition to being unfavorable to evaluate the resolving potential of HCN.

Few professionals reported using personal influence to achieve faster access without going through regulation. Cecílio[20] considers this way of referring to a form of regulation, called informal, which, although generating parallel flows and seems to disorder regulation, has its value when it is recognized that, in special situations, it shows itself as a highly caring act.

However, considering the recommended

way to refer the user, when a referral is regulated by the RC of Campo Grande, a number of criteria for authorization are observed, including clinical data, results of exams (altered or not) recommended by protocol and International Statistical Classification of Diseases and Related Health Problems (ICD-10), consistent with clinical history[21].

Although they did not collaborate in their elaboration, the participation of the family health doctors in the review of the protocols was considered by the participants an important strategy to improve the regulation of access to specialized care in Campo Grande, surpassed only by the increase of vacancies for specialists.

With a view to guarantee integrality and equity in health care, the participation of primary healthcare professionals in the elaboration and revision of access protocols is essential, as they are confused with clinical protocols, not considering the position of the user in the different points of the network[17].

However, the simple increase in the number of openings of places for specialties and procedures does not reduce the difficulty of access to them, since, over time, the referrals become less critical, without precise indication, not motivating improvement in the quality of care[22]. On the other hand, when the use of procedures through regulation is accompanied by remodeling of the care system, with responsibility for care, avoids wasting resources, improves the resolution and decreases the queues[23].

The study also reveals that, for the professionals, improving the management of the clinic in the FHS would be the last measure to be taken, which shows their difficulties in understanding it as an important instrument for the coordination of care. According to Mendes[24], this management is based on micro-management technologies, the main one being evidence-based clinical guidelines and people-centered care, at the appropriate time and place, in a humanized way, causing the least harm to users and professionals, with the lowest possible cost.

Final considerations

The study evidenced that there are weaknesses in the regulation of access by the doctor of the FHS, which, although contributing to the coordination of care, has not yet been used as a clinic management tool. Investing in professional qualification and qualification under the PHC and health regulation can promote greater resolve with better management of care, as well as the rational use of available resources.

As a component of HCN with a wide and privileged vision of the available resources and the dynamics of services, it should be considered as a great ally for the professionals inserted in the FHS units, since it will contribute to the coordination of care and, thus, to enable more accessible, equitable and integral assistance. In order to do so, it is necessary a better communication between the professionals of the regulatory centers and the FHS.

However, decentralizing the regulatory process, making the doctor of the FHS directly responsible for the scheduling of some procedures and consultations, once he/she knows the needs of the user, their clinical and social context and articulates their flow in the care network, it is shown as alternative to the optimization of the regulation of vacancies.

As a limitation of this study, investigating counter-referrals could fill gaps in the regulation of specialty care physicians for primary care, in order to identify critical nodes in the resolution of the requested demands.

Finally, the FHS, as the authorizing officer and coordinator of care, must cease to be a theoretical discourse of public policies and, in fact, play its role in HCN. ■

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Received on 11/12/2017
Approved on 01/05/2018
Conflict of interests: non-existent
Financial support: non-existent