The multiple borders in the health care provided to foreigners in Corumbá, Brazil

As múltiplas fronteiras presentes no atendimento à saúde do estrangeiro em Corumbá, Brasil

Clarisse Mendes Pinto Gomes Ferreira
Universidade Federal de Mato Grosso do Sul. Campus do Pantanal. Masters in borderland studies Corumbá, MS, Brazil.
E-mail: clarisse_mp@yahoo.com.br

Milton Augusto Pasquotto Mariani
Universidade Federal de Mato Grosso do Sul. Campus do Pantanal. Masters in borderland studies Corumbá, MS, Brazil.
E-mail: miltmari@terra.com.br

Sergio Iván Braticevic
Universidade de Buenos Aires. Instituto de Ciências Antropológicas. Buenos Aires, Argentina.
E-mail: sergiobraticevic@gmail.com

Correspondence
Milton Augusto Pasquotto Mariani
Cidade Universitária s/n. Campo Grande, MS, Brazil. CEP 79070-900.

Abstract

Corumbá is the largest Brazilian city to border with Bolivia and has a better health infrastructure than its neighbor country and, associated with the fact that Bolivia does not provide free services to all its residents, the city of Corumbá has attracted a significant flow of borderland population who seek local free health services, making it a scenario of coexistent behaviors and identities, mostly controversial ones. This article presents some reflections on empirical data from interviews with health professionals in Corumbá and aims to analyze the multiple borders recognized from these speeches. For that purpose, theoretic contributions are used, with geographical and anthropological supplementation, to understand the different border approaches extracted from the perspective of health professionals about the population that lives at the border and also about Integrated Border Health System–SIS-Fronteiras, a project created by the Brazilian Ministry of Health, in 2005. The information obtained from qualitative field research shows that the high level of permeability with the political border between Brazil and Bolivia has favored the construction of ethnic and cultural boundaries, in which the foreigner, especially the Bolivian, is the "other" in a social interaction among health professionals and users inside health units. And yet they reveal many challenges in implementing the SIS-Fronteiras project in the border region, above all, health professional's lack of knowledge about the project and its objectives.

Keywords: Borders; Identities; Public Health Care.

Resumo

Corumbá é o maior município brasileiro limítrofe com a Bolívia e está dotado de melhor infraestrutura de saúde que seu país vizinho e, aliado ao fato deste não dispor de serviços gratuitos a todos os seus habitantes, tem atraído um fluxo significativo de fronteiriços para atendimento ao serviço de saúde público, tornando-se palco de coexistência de comportamentos e identidades, muitas vezes controversos. Este trabalho apresenta algumas reflexões sobre os dados empíricos oriundos das entrevistas realizadas junto a profissionais de saúde atuantes em Corumbá e tem como objetivo analisar as múltiplas fronteiras reconhecidas a partir dos discursos proferidos por eles. Para tanto, faz-se uso de contribuições teóricas, com aportes geográficos e antropológicos, para compreender as diferentes abordagens de fronteira extraídas a partir da perspectiva dos agentes de saúde sobre o atendimento aos fronteiriços e também sobre o Sistema Integrado de Saúde das Fronteiras – SIS-Fronteiras, projeto criado pelo Ministério da Saúde do Brasil, em 2005. As informações obtidas a partir da pesquisa de campo, dotada de caráter qualitativo, evidenciam que o elevado grau de permeabilidade com a fronteira política entre Brasil-Bolívia tem favorecido a construção de fronteiras étnicas e culturais, em que o estrangeiro, especialmente o boliviano, é o "outro" na interação social entre profissional de saúde e usuário dentro das unidades de saúde. E ainda revelam inúmeros desafios na concretização do projeto SIS-Fronteiras nessa região fronteiriça, sobretudo o desconhecimento dos profissionais de saúde quanto ao projeto e seus objetivos.

Palavras-chave: Fronteiras; Identidades; Atendimento à Saúde.

Introduction

At the borders, there are multiple dimensions, and each one allows a particular process of identity creation. Far beyond representing a limit separating two or more nation-states, borders also represent the convergence of different relationships where there is a social, cultural and political exchange that provides a process of ambivalence between the "self" and the "other", contributing to the construction and reconstruction of identity.

Situated on the international border between Brazil and Bolivia, the city of Corumbá has about 107 thousand inhabitants[1] and, despite the scarce settlement, it has a striking connection with the Bolivian cities of Puerto Suarez and Puerto Quijarro, which together add up to 37 thousand inhabitants, and with the Brazilian city of Ladário, of only 20 thousand inhabitants. With better health infrastructure than its neighbor country and considering the fact that this country does not offer free services for all its inhabitants, Corumbá has attracted a significant flow of heterogeneous population to serve with the local public, free and universal health service, characteristic of the Brazilian National Health System [*Sistema Único de Saúde*] - SUS, making it a setting for coexisting behaviors and identities often controversial among those involved.

Worried about better understanding the needs and health problems in border areas, the Brazilian government created the Integrated Border Health System - SIS-Fronteiras, on July 6, 2005, with the goal of increasing the operational capacity through a financial compensation system, 121 border cities located up to 10 km from the border and that attract regular visits of patients from the neighbor country. Corumbá joined the SIS-Fronteiras officially on December 29, 2005, and since then no study has been done on the understanding and perception of the project among health professionals working in the city.

With this in mind, the objective of this study is to analyze the multiple recognized borders from the discourse of these health professionals, when asked about access and demands by foreigners and

1 Data obtained from IBGE. *Departamento de Atenção Básica* (DAB)/Ministry of Health, 2013.

Brazilians that do not reside in the country for local service and about the SIS-Fronteiras program. This study did not include interviews with users of the service, despite their importance, because it is a partial result of an ongoing investigation, that is part of the Master's project entitled "O SIS-Fronteiras na fronteira Brasil-Bolívia: o caso de Corumbá."[2]

The article is structured in two parts. In the first part we use theoretical contributions, essentially bibliographic ones, with preferential geographical and anthropological augmentation, to understand the different approaches that focus on the term border. Then, aiming to present how these approaches relate at the moment of service to the border population, we will present the results and reflections of the field research, in which we interviewed—through a semi-structured script that guaranteed a enriching freedom and spontaneity—10 Brazilian health professionals from different specialties (physicians, nurses, social workers and psychologists) working in the City Emergency Unit, Santa Casa de Misericordia, Health Centers and Basic Health Units, all situated in the city of Corumbá.

The types of borders in the view of social studies

There are several approaches to the analysis of borders, stimulated by multiple approaches to their designs and the myriad of interpretations in the social sciences (geography, history, sociology, economics and anthropology, among others).

In classical geopolitics, Friedrich Ratzel,[3] in his book *Politische geographie*, wrote the first notable systematization of the border (Ratzel apud Benedetti, 2014), developing his theory from an evolutionary and organismic proposal, with features related to the national level and universal types usually arranged in opposite pairs always mobilized by the State's role, calling the border metaphorically as the "State's epidermis."

It is a traditionally political conception, associated with the very formation of Nation States, which in the process of consolidation during the eighteenth and nineteenth centuries had, and still have, to clearly demarcate their borders to enforce the limit of order, standard and of the established power. The border is thus understood as a territorial limit between Nation States, as sovereignties divider (Nogueira, 2007).

In the same nineteenth century, another exponent stands out in the analysis of border, the historian Frederick Jackson Turner, whose studies developed on the American expansionist movement to the west allowed the establishment of an economic conception of the border, in which it's presented as fluid, mobile, in constant progress and setback. In Brazil, this concept was assimilated during the Vargas government in the 1930s, associated with the internal territorial expansion process and the incorporation of areas to productive activity (Nogueira, 2007).

In Latin America as a whole, the Turner model of border based on the process of advancement influenced countless historical, social and structural conflicts, such as the expulsion of the natives in the case of the Mapuche people in Patagonia and of the "march to the West" replicated in Brazil, reinforcing the myth of free and unexplored lands. This takes us back to an approach of border as a pioneer front, a 'limit' area, marginal, representative of unstructured spaces, bringing out the distinction between the terms *border* and *frontier*:

> La primera refleja el límite territorial entre la jurisdicción de distintos Estados-Nación. Por su parte, el segundo remite a la articulación entre dos sistemas socio-espaciales diferentes y "donde un frente de inversiones capitalistas y estatales tiene una tendencia a expandirse sobre una zona marginal" (Gordillo; Leguizamón apud Braticevic, 2013, p. 109).

In Anthropology, the concept of liminality emerges from the studies of rites of passage performed by Arnold van Gennep and ritual processes developed by Victor Turner. The first states that during the pas-

2 The purpose of this Master's project is to evaluate the progress, setbacks and difficulties of the SIS-Fronteiras in the city of Corumbá since it relates to the current health status in the city.

3 Ratzel (1988).

sage between two territories there is a region called margin that has, on occasion, a certain autonomy. These areas, in a way, "float between two worlds," containing the idea that a person, through rites of passage, leaves a "former world" to enter a new world (Van Gennep, 1978, p. 36).

In relational terms, to cross boundaries or limits implies to pass from one situation to another. Considering the first ritual phase studied by Victor Turner (1974), by moving from one country to another, the national becomes foreign. In this transition, the ritual subject ceases to step on home soil, drifting away from their social structure and at the moment of liminality, with the bond already broken, they don't get another, incorporated only at the time of reinstatement, even if as a foreigner. According to the author, after the passage, the individual remains in a relatively stable state, only from that moment does the individual enjoy the rights and duties established by the new group (Turner, 1974, p. 116-117).

The construction of the border between Nation States evokes an internalization of the imagery related to a nation-building process, after all, this scheme of rites of passage contributes to the association of the border and its residents to a region that, in certain aspects, lives in a state of ambiguity, a threshold, between two or more political, economic, symbolic contexts, and so on.

On another view, the German anthropologist Fredrik Barth (1998), in his book entitled "Ethnic Groups and their borders", makes an ethnographic approach to the border to understand the group dynamics and the interests involved in the identity process. Causing a paradigm review, especially by the functionalist (stability, adaptation, consensus) and modernization theorists, the author replaces a static, essentialist conception of ethnic identity by a dynamic and constructivist design where this identity, like any other collective identity is built and transformed in the interaction of social groups through processes of exclusion and inclusion that create boundaries between such groups, determining which are in and which are not. Social actors manifest themselves in order to categorize the "I" and the "other", attributing identity based on objective factors, often not corresponding to the actual characteristics. However, in inter-ethnic interaction, the defining valuating patterns of behavior in front of other groups are not fixed and can be transformed and have new meaning in another given social context.

Using Barth as reference, Maria Cristina Bari (2002) clarifies that the ethnic group can be defined as "a local social organization characterized from standards of self-inclusion and awards by others, guided by a value system" and adds that this system of values "becomes dynamic by practices of production and reproduction of material and social life, which drive internal and external relations by defining their ethnic boundaries" (Bari, 2002, p. 4).

According to Philippe Poutignat and Jocelyne Streiff-Fenart (1998), for Barth "the best use of the term ethnicity is a concept of social organization that allows us to describe the boundaries and relations of social groups in terms of highly selective contrasts, which are used in an emblematic way to organize the identities and interactions" (Barth apud Poutignat; Streiff-Fenart 1998, p. 184). The inter-ethnic articulation happens, therefore, across the border, the ethnic border, where feelings of alterity and the figure of the "other" are created, and the identity of the "I" and the "we" are consolidated and confronted with what is "different." An important Barth (1998) legacy is to present borders as places that reveal identities.

The Brazilian anthropologist Roberto Cardoso de Oliveira (2000) comes very close to the Barthian theory by presenting the ethnic identity as a *contrastive identity*, which declares itself by "denying" the other identity, viewed ethnocentrically. And he adds that, specifically in relation to the population of a border between countries, in other words, groups acting within common social contexts - therefore border areas (such as areas of inter-ethnic friction[4]) - there is a degree of ethnic diversity which, along with the nationality of either side of the border, gives rise to an overly complex socio-cultural situation. Hence, the author called borders a "cultural bound-

4 "Inter-ethnic friction" is defined as "a situation of contact between two populations 'dialectically unified' through diametrically opposed interests, although interdependent" (Oliveira, 1963, p. 127-129).

ary" absconding the then usual "cultural divide" or *boundaries*, to assimilate the meaning of the term assigned to it by Barth (Oliveira, 2000).

Cardia (2009) already used the term "social boundaries" to refer to relations between groups who live within the geographical limits of States and adds that social interaction sets other limits, not necessarily coinciding with the political and administrative divisions.

We can see, therefore, that the word *border* takes on a polysemy. For Nogueira (2007), despite the different conceptions of border, they all converge to the reference of a place where its inhabitants live and exist, a place of demarcation of differences.

Health at the border and its dilemmas

As the place its inhabitants live and relate, through the reproduction of their economic, cultural and everyday social practices, the border has routinely been object of instrumentalization by the local population due to concrete and particular interests, from which they reaffirm or deny the political-administrative demarcations through different practices and representations.

In health care, this dynamism proves to be more frequent, especially when asymmetrical health systems coexist, such as those of Brazil and Bolivia, being an attraction factor for population mobility in this border (Marques, 2012).

The Brazilian health system includes the Brazilian National Health System - SUS, whose characteristic is universality, equity and integrality of actions and health services, and also allows for assistance as an activity free to the private initiative, incorporating a hybrid between public and private in the financing of health care.

In contrast, the free National Health System [*Sistema Nacional de Saúde*] - SNS of Bolivia is a segmental care system with unequal and unfair distribution of health care in which most of the population is forced to pay a price for health care in public or private establishments since free services are directed only to vulnerable groups - pregnant women, children under 5 years of age and seniors over 60 years of age (OPS, 2008).

This duality has accentuated the demand for care in the health service of Corumbá by Bolivian nationals, fact also observed by Marques (2012) in his thesis "Mobility, access to health and border space: the case of Corumbá-MS, Puerto Quijarro and Puerto Suárez-Bolivia", leading thus to rising costs of domestic services, with no prospect of compensation, since this itinerant population is not considered for the purposes of financial transfers from the Federal Government.

The calculation of the amount received by Brazilian cities and directed to the financing of its procedures and actions of Primary Health Care is based on a *per capita*[5] value. Consequently, cities located in the border region do not have the budget to take all the demand of Brazilians who do not reside in the country, nor that of border foreigners, and end up assuming alone the cost of this service without the respective contribution of the Union, whose patient identification system used for the financial transfer uses a national resident base.[6]

Given this situation, local managers and health professionals routinely face the ethical and professional dilemma of, albeit with scarce transfer of funds for local demand, not "ignoring the problems that refers to human life nor withholding care to foreigners" (Silva, 2010, p. 16), after all the phrase "health is everyone's right and a duty of the State" is enshrined in the Constitution of the Federative Republic of Brazil in 1988, in his art. 196, and Law No. 8,080 of 1990 while regulating the text, ratifies that "health is a fundamental human right, and the State is responsible for providing the necessary conditions for its full exercise" both ensuring universal

5 The Basic Health Care (*Piso de Atenção Básica*, PAB), established in 1997, implemented in 1998 and expanded in 2001, is a financing mechanism of the Brazilian National Health System (SUS), which changes the logic of payment by production. The city health funds receive directly from the National Health Fund (FNS), by a fund to fund transfer, an amount calculated on the basis of a value *per capita*, and the local administration takes responsibility for primary health care of its territory (Brazil, 2002a).

6 Art. 3 The National Health Card System, valid nationwide and with territorial attachment base founded in the residential address of the holder, is coordinated by the Ministry of Health and allows registration of users and health professionals and the continuous monitoring of health care provided to the population. (Brasil, 2002b)

and equal access to health actions and services for its promotion, protection, and recovery:

Inevitably, some doubts are imposed in this normative context, ones which are also shared by Marisa Lucena Branco (2009) in her thesis "The Brazilian Health System (SUS) in the Border and the Law: to what extent the foreigner is entitled to SUS," does the words "all" present in the Constitution include only Brazilian citizens or all people who seek health care? Does it cover all Brazilian-born and naturalized, or also foreigners? And the foreigners that live close to the border, do they deserve differential treatment for their condition of foreigners? And to what extent should the service to foreigners be provided, urgent and emergency or elective visits also?

Even without conclusive official answer to these questions, the Brazilian government, to better understand the needs and health problems in border areas, created the project Integrated Border Health System - SIS-Fronteiras in 2005, aiming to expand the operational capacity of border cities that attract regular visits by patients from the neighboring country. Corumbá joined the project, still in 2005, pledging to make their 3 stages of implementation, which also corresponds to the creation of financial incentives.

The first refers to a diagnosis of the health situation and the available infrastructure, as well as characterization, quantification and identification of clientele and presentation of an operational plan for local management, in partnership with the Federal University of the respective state. The second phase involves the qualification of management, services and actions and the implementation of the health services network in the border cities. The third phase is the implementation and consolidation of services and actions in the border cities (Brazil, 2010).

Despite already having received the funds corresponding to Phases I to III, and carried out some actions, such as the preparation of the Local Diagnosis and Operating Plan[7], the purchase of equipment, training of health professionals and restoration of the Emergency Room, the expansion of a Basic Health Unit, as well as the acquisition of vehicles for health surveillance, no study has been done on understanding and perception of the project among active health professionals. It is only known that the Ministry of Health issued the Ordinance No. 622, of April 23, 2014 (Brazil, 2014), establishing the deadline until July 31, 2014 for completion of the actions foreseen in the respective Operational Plans of cities that already received the resources for Phase III.

Reflections on the empirical work

The data presented relates to the issues that made up a semi-structured interview script, applied in the first quarter of 2014 with a non-probabilistic sample of 10 Brazilian healthcare professionals, the vast majority of them were women, of different backgrounds (doctor, nurse, social worker and psychologist), of which 4 work in the City Emergency Room, 4 in the Basic Health Units - UBA / Corumbá Health Centers of the Corumbá Health Department, the first reference in the search for primary care services, and 2 in the philanthropic Hospital that has a partnership with SUS - the "Santa Casa de Corumbá" direct and agreed reference hospital for the city of Ladário and indirect and not agreed reference hospital for the Bolivian cities of Puerto Quijarro and Puerto Suarez.

Among the Basic Health Units - UBA / Corumbá Health Centers, the different specialties were adopted as selection criteria (Basic Family Health Unit, Woman's Health Center, Psychosocial Center for Children and Youth etc.), proximity to the Brazil-Bolivia border and active time, in which service experience was more consolidated.

All interviews were recorded, fully transcribed and then analyzed in order to consolidate the information obtained in regards to the proposed objective. For a description and interpretation of messages, indicators and the conditions of production of discourses, some of the content analysis techniques proposed by Bardin (2011) were used.

The first stage of analysis was the full reading of the interviews and coding of the material by

7 In the Operational Plan of Corumbá, the need to improve the local Healthcare Units with respect to their physical structure and the services offered to the community was pointed out, also was raising funds for efficient coverage of the border region (Corumbá, 2008).

numbers for easy identification of each element of the sample with sequential numbers (E1, E2 .... E10), once assured to respondents, by ethical principles, the protection of anonymity. Then the data were submitted to step "unitarization", in order to establish the unit of analysis, established from the set of information with its own meaning, based on the nature of the issues presented and the purpose of the study.

Thus, the texts were submitted, in the synthesis plan, to operations of breaking-up into categories, according to analog regroupings. Thematic analysis was adopted for categorization in which the material analyzed was separated in subjects that, according to Berelson (1971 apud Bardin, 2011, p. 135). can be "a statement about a subject. This means a sentence, or a composite phrase, usually a summary or a condensed phrase, under the influence of which a wide range of natural of singular formulations may be affected." In each answer, the sentence and/or speech excerpt was highlighted, that is, what was designated by Bardin (2011, p. 135) as the "nucleus of the meaning" of communication, that which responds more objectively to the question asked, regarding the theme.

For each of the categories, a text-synthesis was produced describing and exposing the set of meanings present in multiple units of analysis evident in each of them, using direct quotations from the original data. Finally, we sought the interpretation of both the expressed content and the underlying ones, through a dialogic relationship with the theoretical foundation.

Initially, the healthcare professionals were asked to expose how the city of Corumbá operates in the health care of foreigners or Brazilians living abroad. According to respondents, the gateway for foreigners' search for SUS health care in the city of Corumbá is the City Emergency Room, where the service is performed equally, without distinction of any kind, in cases of emergency care. Even with the usual procedure of asking for identification documents, the National Health Card - SUS Card[8] and proof of residence in the country for registration purposes or registration in the chart, these are not considered mandatory for urgent and emergency situations, only for elective consultations.

When non-existent in the city the health expertise necessary or when there is progress in the level of complexity of care of foreigners, the guideline is to return him to his country of origin because the nearest Brazilian referral center, the city of Campo Grande, located 430 km from Corumbá, does not accept the transfer of foreigners, at which point, according to some participants, the Bolivians are desperate because they cannot afford to continue the treatment in their home country, whose reference center is at least 650 km from the border. The fact that it is free is appointed as the greatest motive for Bolivians to seek the Brazilian health system:

> *So we see that they come here and, depending on the case, if we do not have the specialty here, when we instruct them to go back to Santa Cruz, they become desperate because they have neither the condition nor the transport, which is paid, let alone money to pay for treatment itself. But when they come here too, depending on the case, I would say more specifically, for example, in the case of neuro, right, neurology or even neurosurgery: in the city we do not have such expertise and Campo Grande does not accept them, so patients are referred there or we end up losing this patient here* (E3).

> *Campo Grande does not accept transfer of foreign patients. So, they end up staying here until they are stabilized, and the Bolivians have to transport them to Santa Cruz or La Paz and Cochabamba* (E4).

> *The Foreign patient can be treated at the border, when the patient worsens, which is usually what happens, from Corumbá we transfer them to Campo Grande, but foreign patients cannot go to Campo Grande ... because Campo Grande does not accept them. Then you have to return to the reference hospital in Santa Cruz* (E9).

8 The National Health Card [*Cartão Nacional de Saúde*], established by Ordinance/GM No. 1,560, of August 29, 2002 (Brazil, 2002b), allows you to link the procedures performed under SUS to the user, to the health professional who performed the procedure and to the health care unit, from a national identification number provided after registration. Since proof of residence is necessary to request the card, this instrument has brought, in some ways, limitations to the care of foreigners and Brazilian non-residents.

Benedetti and Salizzi (2014) point out that "*en las fronteras se articula un sistema de continuidades y descontinuidades*" (Benedetti; Salizzi, 2014, p. 132). The international borders of Brazil with neighboring countries establish discontinuities in laws and health systems policy, while continuity is observed in the practices of the border population of reaffirming or denying the political-administrative demarcations through the recurrent search for health services in neighboring cities.

From the data of the interviews, it is possible to identify a *continuity* in foreigner's visits, mainly of Bolivians, to the local public, universal and free health system, which, in turn, has faced legal and procedural restrictions on more complex treatments situations, transferred, mostly to the centers of distant references to hundreds of kilometers from the border.

In turn, to provide health care of foreigners or Brazilians living abroad in the Basic Health Units - UBA / Healthcare Centers and in the Santa Casa de Misericordia de Corumbá, it is required the presentation of identification, proof of residence and SUS card, but many foreigners make use of illegal subterfuges to get them. In these service points, there are rules with few exceptions, depending on the patient's condition.

One of the health professionals interviewed justified this practice by the fear that foreigners, especially Bolivians, are not being treated and in the complication of their financial situation:

> *Although many foreigners, especially Bolivians, are afraid of not being treated. So, they falsify addresses, and they become known in the city. They bring water or energy bills, and we know that they do not live here, but they are scared of not being treated.* [...]*Their financial situation is very complicated* (E3).

Despite respondents having exposed the constant foreigners search for SUS and also the practice of documents request to provide service to foreigners in the city of Corumbá for registration purposes or records, many say there is no system that allows the quantification of these foreigners, this is, demand is not formally scaled.

Only one participant mentioned the existence of the SIS-Reg, Health Regulation System[9], a Health Ministry system that regulates exams and consultations, fed with data from SUS Card carriers. However, SUS card is highlighted as one of the impediments to the reliability of this accounting for SIS-Reg, due to the fact that foreign patients do not have such a document or have used false data to get it.

Some respondents had only a monthly estimate of foreigners who consulted, which varies: in the Emergency Room, 50 visits from the 300 daily average; at the Santa Casa de Misericordia, up to 10%; the Woman's Health Center, estimates between 5 and 10 cases.

The flow of patients at the border to the neighboring city which has a better offer and the use of prevarication by foreigners to evade the imposed bureaucratic barriers to access SUS reinforcing the idea that the border is a liminal area where particular modes of life are generated, in that constitute social dynamics border cities understood from those living in these regions. This specificity can also be designated *border condition*, understood as a *savoir passer* [learn to pass] acquired by the inhabitants of the border, used to trigger differences and national, linguistic, legal, ethnic, economic, and religious similarities, which now account for advantages, why the restriction of transit or rights" (Dorfman, 2013, p. 10).

As for Brazilians living abroad, participants say there are no major difficulties in meeting because they have national documents. However, some obstacles to access by non-residents of the city, both Brazilians and foreigners, have been identified in the form of notices fixed at the front desk of some units and health center visited, demanding the presentation "of RG [personal Identity], CPF [National taxpayer registry], proof of residence (utility bill) and the SUS card".

9 *online* system developed by DATASUS - SUS Department of Information Technology/MS and provided by the Ministry of Health to manage the entire Regulatory complex, ranging from the basic care to the hospital, aimed at humanizing services, better controlling the flow and optimizing the use of resources, in addition to integrating the regulation with the areas of assessment, control and audit. Source: Coordination of Development Health Systems/CGAM SUS Department of information technology Available at http://www.datasus.gov.br/DATASUS/index.php?acao=11&id=30430. Accessed on: 21 may. 2014.

When asked about the existence of uniformity among health professionals in the understanding of the right to health at the time of consultation to the foreigner in the SUS, what stands out is the restriction of that right to domestic users, and in almost all responses, expressions of prejudices in themselves and other colleagues in speeches and attitudes of intolerance, discrimination and hostility:

> *Look, so ... There are some, some professionals ... that hum, hum* [...] *do not understand, okay? If I say that all hum, accept it ... They treat them. They treat them, but sometimes with some restrictions, with some questions, okay?* [...] *Yes, they question the professionals, for being foreigners: "hum..., Bolivian, hum... came here, right? Problem. Not Brazilian* (E1).

> *Yes, they understand, but they get stressed out. They get stressed with the arrival of an ambulance from Bolivia.* [...] *Look, there are times that we should not treat. A Bolivian here is a problem. They only bring us trouble. I might even be cruel, but that's the truth* (E2).

> *We try to have, okay. There are some professionals that, sometimes I speak, there are moments of greater exaltations, either because of the stress of the moment, depending on the case, sometimes they talk, right, that they will not treat or that, in the case it becomes an admission at the hospital or if it is no longer a SUS case and becomes a private, but most of the time, I always think it's when the situation calms down, that they see they cannot fail to treat* (E3).

> [...] *But, we always notice that sometimes we have: "Oh, this Bolivian woman comes here and wants to be treated." There always, always is a bit of discrimination not only by the nursing staff, but by doctors, you know? Even we sometimes lose our temper and say something, but they have to ... if it were the other way around, they would not want to treat us there in Bolivia, but when they come over here they want to be treated regardless and sometimes we end sinning, you know, sometimes, sometimes from disturb our judgment so much, we sometimes end up discriminating a little* (E8).

> *I think there is a lot of prejudice. A barrier is formed that way as well, it's ... in the treatment of the foreigner. I don't say in the emergency, right, because in the emergency, the SAMU, as long as it is within our territory, we treat, but I see that some professionals see this with some discrimination* (E9).

What has prevailed in these speeches is, therefore, a social representation that fragments users of the local health system in Brazil on one side and Bolivia on the other, reinforcing the existence of an "invisible wall" located at the border. This negative construction of alterity in the border present in the transcribed interviews is what reinforces Brazil's own identity, a way to ratify the hegemonic identity with the country itself and the notion of identity by opposition. And this reference of the "other" acquires peculiar contours in the Brazil-Bolivia border when the health professionals themselves associate Bolivia and Bolivians to symbols of delay and poverty and, above all, the binomial dirt/disease:

> [...] *I will speak for myself, but there are professionals, that, for them, they could be held at the border. Even because of existing conditions that are not appropriately treated there in Bolivia, which end up being brought to Brazil, right.* [...] *Bolivia, what I see more, I know little about Bolivia, but what we see closer to the border is a very financially needy population, right. Their financial situation is very complicated* (E3).

> [...] *The situation in Bolivia is poor, you know, they do not have the structure that Brazil has. Despite being a very small structure close to them we are the "must"* (E6).

> *There the ... the socio-economic and cultural power is very small. That place is the line, there are areas below the poverty line, like misery really. So, there is no sewage, no clean water, no sanitation. So the diseases that Brazil fight for years and still exists, being a country with the eighth world economy, we have this barrier and have a very poor border, which like it or not the infectious diseases that exist there come here, and vice versa, I'm not saying we're 100% sanitation, which is far from true, but since we have these active fairs here, the cities receives these foreigners very often, daily, we*

have a contact with them, so It is ... a very close contact. So the food they bring from there have no inspection. Here we have ... health surveillance that covers that, there they don't (E9).

Infectious diseases presented as problems not adequately addressed in the Bolivian side has fueled the border idea inherent to the contamination area, where the disease sets "a sign of physical and moral corruption, a sign of lack of civilization" (Hardt, Negri, 2000 p. 132). There is thus a cultural border, or rather a "cultural limit", in the words of Oliveira (2000), associated with a social context of stigmatization, categorization from the production of alterity, strongly linked to the political border.

As a result, the 10 health professionals interviewed were asked to assess, according to their perceptions and experience, the possibility of integration of health systems in Brazil and Bolivia at the border, where only 3 said to exist or believe possible an integration between the two health systems at the border, but stressed the need for political will.

In contrast, the majority of respondents replied that it would be very difficult or would not be any integration at all of health systems between Brazil and Bolivia, under argumentation of scarce resources, or complicated financial situation and a precarious health system in Bolivia, where the service is private, while in Brazil it is free, and also cultural differences. One of these professionals also medical student in Bolivia, said in Bolivia "medicine is good, but there is no infrastructure." It is also remembered by one of the participants that integration exists only in the area of health surveillance, especially in the prevention of dengue, but reinforces the cultural difference and the imbalance of structures in this border:

Paradoxically, it was cited that some healthcare specialties were sought out by Brazilians residing in Corumbá in Bolivia, such as ophthalmology, traumatology, rheumatology, clinic, pharmacy, ultrasound exams and mammograms and blood tests, provided by the experiment of Cuban doctors in Cuban Medical Brigade[10] in Puerto Suarez and the gratuity of some services in this health unit, as well as speed in getting the results of laboratory tests, quick service (no queue) and cheaper medication in Bolivian pharmacies.

Asked about "how health professionals understand the SIS-Fronteiras and the role of the City of Corumbá in the SIS-Fronteiras", the most frequent response among respondents was that the service providers are unaware of what is the SIS-Fronteiras. Among the reasons given are: lack of project dissemination on the job and most of health professionals in exercise come from other cities and therefore not understand what it is to work in a border city. Two participants confessed to never having heard of the project.

It is interesting to note that of the 10 respondents, 2 were born in Corumbá, 1 in Campo Grande, 3 in São Paulo, 2 in Rio de Janeiro and other 2 the first to be interviewed, did not report because the item "place of birth" was not yet in the script used for the interview. They all began to practice their profession in the city of Corumbá between the years of 1998 and 2010.

It is worth clarifying that Corumbá does not yet offer university courses in higher education such as Medicine, Physiotherapy, Social Care, Nutrition, Dentistry, although the city has already suffered with a dengue outbreak and reflex of a rabies outbreak from Bolivia, which can be inferred as a rationale for the multiple origins among health professionals working in Corumba. The nursing course only opened in 2008 and is taught online.[12]

Half of the subjects, in an attempt to explain what the SIS-Fronteiras is, presented laconic answers or confused it with the literal sense of integration between the two countries, with the initiative and participation of both sides:

10 The Cuban Medical Brigade in Bolivia is the product of an international cooperation agreement reached in December 2005 with Cuba, where Cuban specialists provide free medical care for a population deprived of resources. Despite the Brigade's mission to provide free care, the San Juan de Dios Hospital located in Puerto Suárez taxes some services within the scope of their regiments (Espírito Santo, N. P. Unidades de Saúde na Bolívia: a Realidade na Fronteira com o Brasil em Mato Grosso Do Sul. Thesis submitted to the Graduate Program in Border Studies - Federal University of Mato Grosso do Sul-UFMS, Corumbá, 2013, p. 63).

11 according to data from the Ministry of Education. Available at: http://emec.mec.gov.br/.

[...] *Then I have to explain to them that there is such SIS-Fronteiras program, you know, this, this, this ... for them to understand why they have to treat them because it is their right that we need to give, right?* [...] *Others question even more... they question the country having this agreement with the neighboring country* (E1).

About the SIS-Fronteiras, I remember that would be an agreement, right, of treatment, which would be one, hum ... some actions that we could be doing, you know, but ... I don't recall, hum, that we could, like, go there and stuff ... And, and some incentive, something, I do not remember (E7).

Yeah, I know it's a program that exists at the federal level, for service for both Brazilians, right, and Bolivians, and vice versa. Both for their treatment here, and ours, and us there in their country. [...] *I know the basics of what the program is, it is an integration program between the two, you know, the two countries* (E8).

Understanding is totally wrong by health professionals because the SIS-Fronteiras is an interaction between the border, the treatment, right, both here and there, but it was seen as if there was a need for personal resources for this. [...]*It would be a friendly manner, for both the Brazilian to be treated there, and them here* (E9).

Only one subject describes the SIS-Fronteiras in line with the proposal of the Ministry of Health:

[...] *In fact, the SIS-Fronteira is a system where the government gives greater attention funding than the city itself sends to the Ministry, it is approved that this money will be sent because this is a border region, and that is not to serve the Bolivian or, foreigners, right. So people have a lot of confusion about what, how the SIS-Fronteira works* (E4).

Health professionals have exposed at this time some criticism of the SIS-Fronteiras such as: the lack of dissemination of the project, the lack of financial transfers, questioning about the treatment to the foreigner himself and the existence of an integration agreement that supports this service, without a counterpart in the neighboring country.

When asked: "What are the results achieved in your work station after the implementation of SIS-Fronteiras", most said no positive result was observed in their work stations after the implementation of the SIS-Fronteiras. Two respondents added that the proposition of the SIS-Fronteiras has not been achieved, highlighting again that it is a project that was "only on paper". Only one respondent identified improvements in their work station after the implementation of SIS-Fronteiras, illustrating with the modification of the profile of the staff more focused on urgent and emergency care and in the emergency room because of new equipment.

Thus, in the case of health care in Corumbá, you can identify a plurality of territoriality, that is, collective and subjective manifestations of social actors on the territory (Saquet, 2009): the Brazilian State, with the examples of the SUS and the SIS-Fronteiras; the Bolivian border population, crossing the international border to be treated in Corumbá; and the Brazilian users, legal and formal owners of the right to health guaranteed by the Constitution and often also use the *border condition* to seek care and medicine in Bolivia, among others. Thus, there are different forms of the same territorialization of a space by different social actors, who have to live with the differences marked by political and administrative border. As Cardia (2009) already pointed out:

> A same space, in this case a border, is regionalized in different ways, for different political norms, cultural references, ways of understanding and ownership is taken by different social groups, different socio-political realities (Cardia, 2009 p. 117).

These territorialities coexist in the same space occupied by heterogeneous population, resulting in territories with different settings, time frames and goals. Inevitably, they are related in complex ways and conflicted with other territoriality, according to the socio-cultural, economic and political dynamics that induce social actors that exert them.

Indeed, Brenna (2010, p. 272) adds that the borders are "*Interculturales espacios, inter-ethnic and inter-societal en los que hay un cruce dynamic y Complejo several territorialities visiones y del mundo*". And it is through the co-existence of all these logics that the border becomes a "limita-

tion" in health care of foreigners in the city of Corumbá, each enabling a particular process of identity construction and reinforcing the thought that the border should not be reduced only a space between two or more States, since this too can "separate territories within the same national space and form in the minds of individuals when they are identified in distinct settings" (Vidal, 2008, p. 102).

Final remarks

This work proposes to analyze the multiple recognized borders from the talks by health workers operating in compliance with border population in Corumbá. The demand for local health services by foreigners, especially Bolivians, is recurrent in the city, favored by the high degree of permeability with Bolivia and the gratuitousness of SUS Health System, but the health care of the floating population has faced some setbacks, such as restrictive understanding of the right to health at the time of treatment abroad in the SUS and the expression of prejudice among professionals responsible for this attention.

The field research allowed, thus, to demonstrate the existence of some types of correlated borders, each with particular characteristics that allow identification: the political border, formed as a limit between nation states, for example Brazil-Bolivia; Barth's (1998) ethnic border or the "cultural boundaries" of Roberto Cardoso de Oliveira (2000), linked to the relationship between national Brazilians and foreigners, Bolivians, where is present the difference between the "I" and the "other", considering the identities and differences as much on one side as the other, reflecting the principles of nationalism; and social border Cardia (2009), recognized from the different social relations that are configured in this border area.

It is interesting to note that all these boundaries overlap and clash in health care in Corumbá The Bolivia-Brazil political border proved often denied from the *continuity* undertaken by the constant visits of Bolivians to health centers in Corumbá and sometimes stated as a *discontinuity* by health professionals, to the extent that ethnic, social and cultural divide emanating from the social interaction that surpasses state demarcation.

Despite the search, by the authorities, for solutions to improve the conditions of service to local health national and non-nationals by adhering to the SIS-Fronteiras, there are still many challenges and difficulties to integrate these actions in the Brazil-Bolivia border, specifically in Corumbá, such as the predominance of a critical perspective on the integration between the two health systems at the border and the lack of knowledge of health professionals regarding the SIS-Fronteiras project and its goals, making it necessary to train for the assimilation of the importance of the project for the city and, above all, to provide a continuous, humanized and appropriate service to the border community.

Finally, policy actions at the border must be developed in a setting of tolerance and respect for the different. One can thus consider that the perspective of health professionals on in the SIS-Fronteiras serve to consolidate the need to recognize the border territory as a conflict area in which the "other" can and must be transformed into actor, not only through public policy, but even more pretentiously with joint meetings of health councils, universities, professional advice and implementation of bi-national events co-financed in health, taking an important step in deciding the particulars of a border community that shares a common destiny.

References

BARDIN, L. *Análise de conteúdo*. São Paulo: Edições 70, 2011.

BARI, M. C. La cuestión étnica: aproximación a los conceptos de grupo étnico, identidad étnica, etnicidad y relaciones interétnicas. *Cuadernos de Antropología Social*, Buenos Aires, n. 16, p. 149-163, jul. 2002.

BARTH, F. Grupos étnicos e suas fronteiras. In: POUTIGNAT, P.; STREIFF-FENART, J. *Teorias da etnicidade*. São Paulo: Edunesp, 1998. p. 187-227.

BENEDETTI, A. Espacios fronterizos del sur sudamericano: propuesta de un modelo conceptual

para su estudio, estudios fronterizos. *Revista de Ciencias Sociales y Humanidades*, Mexicali, v. 15, n. 29, p. 11-47, 2014.

BENEDETTI, A.; SALIZZI, E. Fronteras en la construcción del territorio argentino. *Cuadernos de Geografía: Revista Colombiana de Geografía*, Bogotá, v. 23, n. 2, p. 121-138, 2014.

BRANCO, M. L. *O SUS na fronteira e o direito*: em que medida o estrangeiro tem direito ao SUS. 2009. Monografia (Curso de Especialização em Direito Sanitário) - Fundação Oswaldo Cruz, Brasília, DF, 2009.

BRASIL. Ministério da Saúde. Secretaria Executiva. *Programa Atenção Básica (PAB)*: parte fixa. Brasília, DF, 2002a. (Série C).

BRASIL. Ministério da Saúde. Portaria n. 1.560, de 29 de agosto de 2002. Institui o Cartão Nacional de Saúde - CARTÃO SUS e dá outras providências. *Diário Oficial da União*, Brasília, DF, 30 ago. 2002b. Seção 1, p. 84.

BRASIL. Ministério da Saúde. Secretaria Executiva. Sistema Integrado de Saúde das Fronteiras. *Relatório de desempenho do Projeto SIS-Fronteiras*. Brasília, DF, 2010.

BRASIL. Ministério da Saúde. Portaria nº 622, de 23 de abril de 2014. Dispõe sobre os prazos para conclusão da implementação das ações previstas no Sistema Integrado de Saúde das Fronteiras (SIS Fronteiras) e sobre o repasse de incentivo financeiro. *Diário Oficial da União*, Brasília, DF, 24 abr. 2014. Seção 1, p. 77. Disponível em: <http://bvsms.saude.gov.br/bvs/saudelegis/gm/2014/prt0622_23_04_2014.html>. Acesso em: 24 maio 2014.

BRATICEVIC, S. Aportes a los estudios de frontera a partir del avance productivo en el norte argentino con dos casos testigo. *Revista Transporte y Territorio*, Buenos Aires, n. 9, p. 105-122, 2. sem. 2013.

BRENNA, B. J. E. De la frontera nacional a la frontera pluricultural. *Frontera norte*, Tijuana, v. 22, n. 44, p. 265-276, 2010.

CARDIA, L. M. Espaços e culturas de fronteira na Amazônia Ocidental. *Ateliê Geográfico*, Goiânia, v. 3, n. 2, p. 108-125, 2009.

CORUMBÁ. Secretaria Municipal de Saúde. *Plano Operacional do Município de Corumbá*. Sistema Integrado de Saúde das Fronteiras, 2008.

DORFMAN, A. A condição fronteiriça diante da securitização das fronteiras do Brasil. In: NASCIMENTO, D. M.; PORTO, J. L. R. *Fronteiras em perspectiva comparada e temas de defesa da Amazônia*. Belém: EDUFPA, 2013. v. 1, p. 96-124.

ESPÍRITO SANTO, N. P. do. *Unidades de saúde na Bolívia*: a realidade na fronteira com o Brasil em Mato Grosso do Sul. 2013. Dissertação (Mestrado em Estudos Fronteiriços) - Universidade Federal de Mato Grosso do Sul, Corumbá, 2013.

HARDT, M.; NEGRI, A. *Imperio*. Buenos Aires: Paidos, 2000.

MARQUES, A. M. *Mobilidade, acesso à saúde e espaço de fronteira*: o caso de Corumbá-MS, Puerto Quijarro e Puerto Suárez-Bolivia. 2012. Tese (Doutorado em Demografia) - Universidade Estadual de Campinas, Campinas, 2012.

NOGUEIRA, R. J. B. Fronteira: espaço de referência identitária? *Ateliê Geográfico*, Goiânia, v. 1, n. 2, p. 27-41, 2007.

OLIVEIRA, R. C. Aculturaçao e fricção interétnica. *América Latina*, Rio de Janeiro, v. 6, n. 3, p. 33-46, 1963.

OLIVEIRA, R. C. Os (des)caminhos da identidade. *Revista Brasileira de Ciências Sociais*, São Paulo, v. 15, n. 42, p. 7-21, 2000. Disponível em: <http://dx.doi.org/10.1590/S0102-69092000000100001>. Acesso em: 28 maio 2014.

OPS - ORGANIZACIÓN PANAMERICANA DE LA SALUD. *Perfil del Sistema de Salud de Bolivia*. Washington, DC, 2008.

POUTIGNAT, P.; STREIFF-FENART, J. *Teorias da etnicidade*. São Paulo: UNESP, 1998.

RATZEL, F. *Géographie politique*. Paris: Editions Economica, 1988.

SAQUET, M. A. Por uma abordagem territorial. In: SAQUET, M. A.; SPOSITO, E. S. *Territórios e territorialidades*: teorias, processos e conflitos. São Paulo: Expressão Popular, 2009. p. 73-94.

SILVA, W. A. da. *Fronteira e regionalização da saúde*: os dilemas da microrregião de Corumbá-MS. 2010. Dissertação (Mestrado em Estudos Fronteiriços) - Universidade Federal de Mato Grosso do Sul, Corumbá, 2010.

TURNER, V. W. *O processo ritual*: estrutura e antiestrutura. Petrópolis: Vozes, 1974.

VAN GENNEP, A. *Os ritos de passagem*. Petrópolis: Vozes, 1978.

VIDAL, D. Vivre sur fond de frontières: les migrants du Mozambique à Johannesburg. *Cultures & Conflits*, Paris, n. 72, p. 101-117, hiver 2008.

Authors' contribution

Ferreira and Mariani were responsible for designing and revising the article. Braticevic made methodological contributions to the work.

Received: 08/07/2014
Resubmitted: 23/10/2014
Approved: 19/11/2014