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ARTCILE

Difficulties in accessing services that are of medium complexity in small municipalities: a case study

Camila Ribeiro Silva [1]
Brigida Gimenez Carvalho [2]
Luiz Cordoni Júnior [2]
Elisabete de Fátima Pólo de Almeida Nunes [2]

Abstract *The study aimed to describe the specialized health services and to identify areas of greater difficulty of access to specialized consultations offered by SUS in small cities in the 18th Regional Health Area of Paraná State, Brazil, using case study methodology. The data were collected between January and April 2015. Managers, management teams and the board of directors of the CIS (Consórcio Intermunicipal de Saúde) were interviewed. The 21 studied specialist areas were rated like Sufficient Quota, Insufficient Quota, Inexistent Supply, and Assistance Gap. The services with more difficulty of access were Vascular Surgery, Proctology, Geriatrics, Endocrinology, and Neurology, considered Inexistent Supply/Assistance Gap, and Orthopedics, Neuro-pediatrics, Urology, Rheumatology, Ophthalmology, and Otorhinolaryngology, were considered Insufficient Share. Contribute to the magnitude of the problem: lack of specialist doctors, private sector dependence and de decrease of the Federal and State Governments in financing the Health Sistem. Therefore, the gap in specialized healthcare is complex and difficult to solve in the short-terms, proving that this services have become a "bottleneck" in the SUS.*

Key words *Health managing, Health managing services, Health assistance, Health assistance network, Health systems*

[1] Universidade Estadual do Norte do Paraná. Rodovia BR-369 Km 54, Vila Maria. 86360-000 Bandeirantes PR Brasil. camilarsilva@hotmail.com
[2] Universidade Estadual de Londrina. Londrina PR Brasil.

Introduction

Universal access to health services, as well as being a constitutional right, is a symbol of the fight waged by social movements in this area and it represents one of the most important fundamental rights of Brazilian citizenship[1]. The right of access is not just having the ability to use the health services, but it covers having the opportunity to use the services when they are needed, within an adequate timeframe in order to obtain the best health outcomes[2,3].

The process of decentralization and regionalization in the Brazilian Health System is complex due to the diverse realities and regional inequalities that exist and also because of the ratio of multiple agents at different levels with reference to the accessibility of the health services[4]. This question involves the fact that the Brazilian Health System, unlike the British system which is nationalized and the Canadian system which is provincial, opted for decentralization at the municipal level with a delegation of responsibilities being made to the municipalities for organizing and managing the health systems[5].

Historically, decentralization did not assume a priority with reference to universal access to health services. It had a strategic character of intervention in the economy with projects designed to cut superficial costs in the state in an effort to obtain economic stability[4]. This represented a strategy of the movement of responsibilities over social spending for the sub-national spheres that were not always in a position to take on the financial responsibilities[6].

In this way, the decentralization of the health system served as a way for the Federal Government to take a step back and to contain expenses rather than expanding, which its funders had hoped for[6]. This materialized into a heavy burden on the municipalities that in addition to taking on the Primary Health Care Network, had to also guarantee access to services of medium complexities (MC).

The specialist services are marked by different obstacles principally in relation to access. According to the Ministry of Health (MS) the difficulty in ensuring access to specialized services is due to: the way how the care model has been adopted, the resoluteness of the AB and the dimension and organization of the services on offer[7].

At this level the primary health model that was analyzed, became fragmented and disorganized in relation to the health services, owing to the existence of various local and isolated systems where the decisive spaces of the managers are permeated by local interests at the detriment of actions taken by the universality of the System[8]. Associated to this, the managers, especially those in the small municipalities need more representation at regional levels for taking decisions[9]. What exists is a lack of order in the process of decentralization of the System in spite of the expansion of the offer and the gains in autonomy on the part of the municipalities in the last few years[4].

Despite the growth in interest in the accessibility to specialist health care, little research exists on the reality of the small municipalities. Knowing the panorama of this type of assistance with reference to the access to services of MC and especially to the specialized consultations, permitted attention being placed on this question in an attempt to respond to the following: what is the dimension of the problem in relation to the difficulty of access of the users to the actions and health care services of MC in municipalities that are small (MPP)?

An understanding of this context will contribute to the strategy to tackle the question of guaranteeing access to these procedures in addition to the provision of support to the managers who are in the state and municipalities in the development of the Organizational Contract for Public Action (Contrato Organizativo da Ação Pública, COAP). This is an important instrument for the organization of the management of the Health Regions. In this way, this study had as its objective, the analysis of the offer of specialized services by SUS and looking at the specialized health services that present the most difficulties in accessing in MPP.

Material and methods

A single case study was conducted with various units of analysis with the objective of identifying areas/specialist services that present the most difficulties in ensuring access for users of that require services of MC.

The case study is characterized as an empirical investigation into the complex contemporary phenomenon in context, especially when the limits are between the phenomenon and the context, both of which are not clearly defined[10] and which applies to the object of this study.

The case that was studied was the 18th Regional Health Area (RS) located in the northern region of the State of Paraná. The analysis of

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heath units that were selected were the 18 municipalities with up to 20,000 inhabitants and they were considered to be small municipalities[11].

The data was obtained through interviews using structured questionnaires with the managers and the members of the management team responsible for the regulation of specialized procedures, and there was the filling in of an instrument for each one of the 18 municipalities that were studied. The script used in the interviews covered: a monthly offer of health consultations through a consortium, considerations as to whether the offer was sufficient or insufficient, if the specialist services were not offered by the Consortium but were offered by the municipality in this case as who would paid for them and which criteria to be used to guarantee access to the user.

Also, a semi-structured interview was conducted with the administrative board of the Inter-Municipal Health Consortium (Consórcio Intermunicipal de Saúde, CIS) in the region. Their interview focused on the following: if the number of vacancies offered by the CIS for the municipalities were considered sufficient for meeting demands, what criteria/parameter should be used for the distribution of the vacancies and what is your opinion on what causes the problems of a shortage of places for specialist consultations.

This instrument for obtaining the data from the municipal managers was valid in pilot studies conducted in a municipality in the region that was not a part of this study in September 2014. The interviews were conducted between January and April 2015.

The 21 specialist services that were analyzed were selected based on the National Relations of Actions and Health Services (Relação Nacional de Ações e Serviços de Saúde, RENASES)[12] and the COAP of the 18th Regional Health Area which is still in the process of being developed[13]. They are: Angiology, Cardiology, Dermatology, Gastroenterology, Infectology, Neurology, Neuro-Pediatrics, Nephrology, High Risk Obstetrics, Rheumatology, Orthopedics, Mastology, Ophthalmology, Psychiatry, Endocrinology, Nutrition, Urology, Otorhinolaryngology, Geriatrics, Proctology, and Vascular Diseases.

The offer for specialized consultations was categorized based on the information from the managers in one of the four possibilities: *Sufficient Quota*: the places for consultations on offer on a monthly basis by the Inter-Municipal Consortium in North Pioneiro (CISNOP) are sufficient to meet the monthly demand of the municipality. *Insufficient Quota*: the places for consultations on offer on a monthly basis by CISNOP are not sufficient to meet the monthly demand of the municipality and they act to ensure access to the users. *Non-existence Supply*: there are no offers of places for consultations for specific specialist services by the CISNOP in the monthly program of specialist consultations and as a result the municipalities act in other ways to ensure access to these services. *Assistance Gap*: there are no offers of places for consultations by the CISNOP and the municipalities cannot do anything in terms of guaranteeing access for the users to specialized services.

The data that was obtained was organized initially for each analysis unit separately so that a general panorama could be obtained of the situation of each municipality. What follows is the data from the municipalities grouped and placed in a database and which was placed in Excel® where tables were produced that showed the results considering the relative and absolute frequency of the responses as well as the weighted average of the analyzed results.

Also, secondary data was accessed covering: populations, actions and health services offered by SUS and financing public health. This information was obtained from the national databases (CNES, IBGE, SIOPS). This information was used to contextualize the case study and to add to the analysis of primary data.

The work was part of a larger study called: "The management of the work in SUS in small municipalities in Paraná through looking at the Management Team" supported by PPSUS/2013 (Fundação Araucária-PR / SESA-PR / MS-DECIT/CNPq) and it was approved by the Ethics Committee on Research (CEP) at the university where the researchers were based.

Aside from the approval of the CEP, the project was presented at the meeting of the Regional Inter-Management Commission (CIR) in November 2014, having its execution done by the board. The carrying out of the interview in the municipalities was proceeded by explanations on the objectives and characteristics of the research, clearing up any doubts and signing a research consent form.

Results

The context

The 18th Regional Health Area has 404 health establishments and 126 of them being

directly administered by the government, 42 by non-profit private bodies and 236 by profit making private establishments[14]. The center of the municipality has the majority of health establishments, offering specialized services of MC in SUS with emphasis being placed on Regional Hospitals and the Regional Center for Specialties[13]. The division of the procedures carried out by SUS in relation to the public and private service providers is shown in Table 1.

On analyzing the presented table, checked in relation to outpatient production, it can be seen that the MC procedures are carried out predominantly by the private sector (Figure 1).

In relation to the organization of health care, all 18 MPPs adhered to the Family Health Strategy whose coverage in the population in these areas was 85.4%[15]. Aside from this, all the municipalities have, as a minimum, primary health care and 14 of them have hospitals[16].

Offer of specialized consultations

The 21 municipalities that make up the 18th Regional Health Area make up the Inter-Municipal Health Consortium in the North of Paraná (CISNOP) responsible for the offer of the majority of the specialist health services available from SUS in the region.

The monthly places for specialist services are available in the municipalities according to the percentage of the population for each one in relation to the total population in the region. Table 2 shows the quantity of specialized consultations offered to MPPs in the month of March 2015 and the rate per capita to which this value corresponds.

Table 1. Distribution of the outpatients` procedures carried out by SUS by type of provider, 18th Regional Health Area 2013.

Procedures	Public		Private		Total	
	N	%	N	%	N	%
Medium Complexity	222.433	20,7	854.180	79,3	1.076.613	100,0
High Complexity	1.261.097	96,6	43.895	3,4	1.304.972	100,0
Primary Health Care	3.618.602	100,0	-	-	3.618.602	100,0
Others	-	-	219.890	100,0	219.890	100,0
Total	5.102.132	82,1	1.117.965	17,9	6.220.097	100,0

Source: Region and Network, 2013.

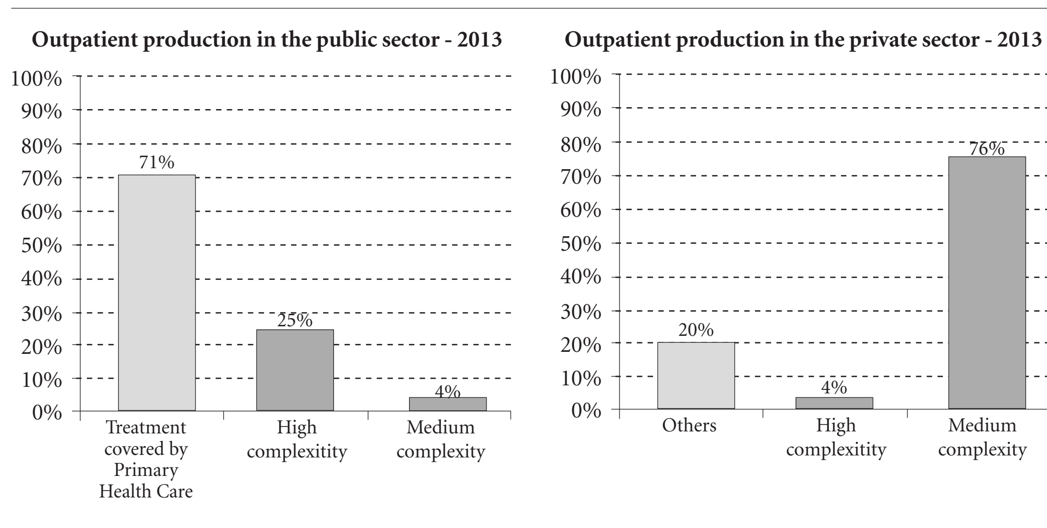

Figure 1. Comparison of the Outpatient Production by Provider, 18th Regional Health Area, 2013.

Source: Region e Network, 2013.

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The total population of the 18th RS is 230,949[17] inhabitants and the population of the MPPs is 128,285 inhabitants which represents 55% of the population of the region. According to the criteria used for the distribution of places, 55.79% of the places available per month were available through the CIS. They were made available to the inhabitants in the municipalities that had a population of up to 20,000 inhabitants. This worked out to be, on average, 0.27 consultations/inhabitant/year.

On questioning the municipal manager on the offer of places by the Consortium and its adequacy to meet the needs/ demands of the municipalities, we noted that half of the specialist services that were researched did not meet the needs/ demands for all of the municipalities. It is worth emphasizing that for RENASES and COAP, there were specialist services that were researched that were not being offered by the Consortium. They are: Neurology, Neuro-Pediatrics, Endocrinology, Nutrition, Geriatrics, Proctology, and Vascular Related services.

This situation according to the managers of the MPPs was such that even though there was no agreement on the action services of MC, they assumed the expenditure for the provision of services in this area for example: the monthly payments to maintain the Consortium, the purchase and complementary contracting services to carry out consultations and support services for diagnosis and therapy (SADT), raising the percentage of municipal budgetary spending in health care.

Table 3 shows the classification of the specialist services according to the following areas: sufficient quota, insufficient quota, inexistent supply and assistance gap. The numbers that are shown on the lines represent the number of municipals that the managers considered as a classification of the specialist services inside of each category.

Of the 21 specialist areas that were analyzed, the CIS offered places for 14. For the other seven specialist services, – Vascular, Proctology, Geriatrics, Nutrition, Endocrinology, Neurology e Neuro-Pediatrics – there were no offers as they were considered as Inexistent Supply or Assistance Gap by the municipalities. Of the 14 specialist services offered on a monthly basis, for nine of these the offer was considered insufficient for the majority of the municipalities, (Cardiology, Dermatology, Gastroenterology, Rheumatology, Orthopedics, Ophthalmology, Psychiatry, Urology e Otolaryngology). Based on the data presented in Table 3 it is possible to detect which are the specialist services that present the most difficulty in obtaining access to specialist consultations in the 18th Regional Health Area in the state of Paraná shown in Figure 2.

The specialist services mentioned by the managers that presented the most amount of difficulties in terms of access to the MPP in the 18th RS were: Vascular related services, Proctology, Geriatrics, Endocrinology and Neurology for not being offered by the CISNOP. The specialist services of Orthopedics, Neuro-pediatrics, Urology, Rheumatology, Ophthalmology and Otorhinolaryngology, in spite of being regularly offered by the consortium, they were considered by the majority of the municipalities as insufficient which generates greater repressed demand for these types of services.

In an interview the board of the CIS admitted that the monthly vacancies for consultations are generally insufficient to meet the demand for this type of service. However, it did not attribute this insufficiency to the quantity of consultations offered but to other factors principally a lack of resoluteness in the Primary Health Care Network in the municipalities and the lack of articulation between the levels in the Primary Health Care system.

The COAP, which is the instrument designated to tackle this problem in an inter-federative way, is according to the managers, in the process of development in the 18th Regional Health Area however it is incipient in that it does not have a date for an agreement between the managers and the public. The negotiations still have not been developed and the necessary agreements need to be reviewed. They affirm that the participation of the state in the effective allocation of resources, needs to be greater and the CIR needs greater decision making powers.

Table 2. Monthly offer of Specialized Consultations by CISNOP at the 18 MPPs in the 18th Regional Health Areas in the State of Paraná, March 2015.

Nº. MPP	Population of the MPP	Nº. Monthly Offered Consultations	% of Consultations for MPPs in relation to the total offer	No. Average consultations/hab./year
18 MPP	128.285	2.895	55,79	0,27

Source: Small Municipalities in the 18th Regional Health Area in Paraná and CISNOP, 2015.

Table 3. Characterization of the specialist services according to the indication of the Management Teams of the MPP of the 18th Regional Health Area in Paraná, 2015.

Specialty	Sufficient quota	Insufficient quota	Inexistent Supply	Assistance Gap
Angiology	12	6	0	0
Cardiology	8	10	0	0
Dermatology	8	10	0	0
Gastroenterology	8	10	0	0
Infectology	15	3	0	0
Neurology	0	0	15	3
Neuro-Pediatrics	0	0	18	0
Nephrology	9	9	0	0
Obst. High Risk	16	1	1	0
Rheumatology	3	15	0	0
Orthopedics	0	18	0	0
Mastology	11	6	1	0
Ophthalmology	5	13	0	0
Psychiatry	4	14	0	0
Endocrinology	0	0	4	14
Nutrition	0	0	11	7
Urology	2	16	0	0
Otolaryngology	5	13	0	0
Geriatrics	0	0	2	16
Proctology	0	0	1	17
Vascular	0	0	0	18

Source: Municipal Secretaries of Health of the MPP, January to April, 2015.

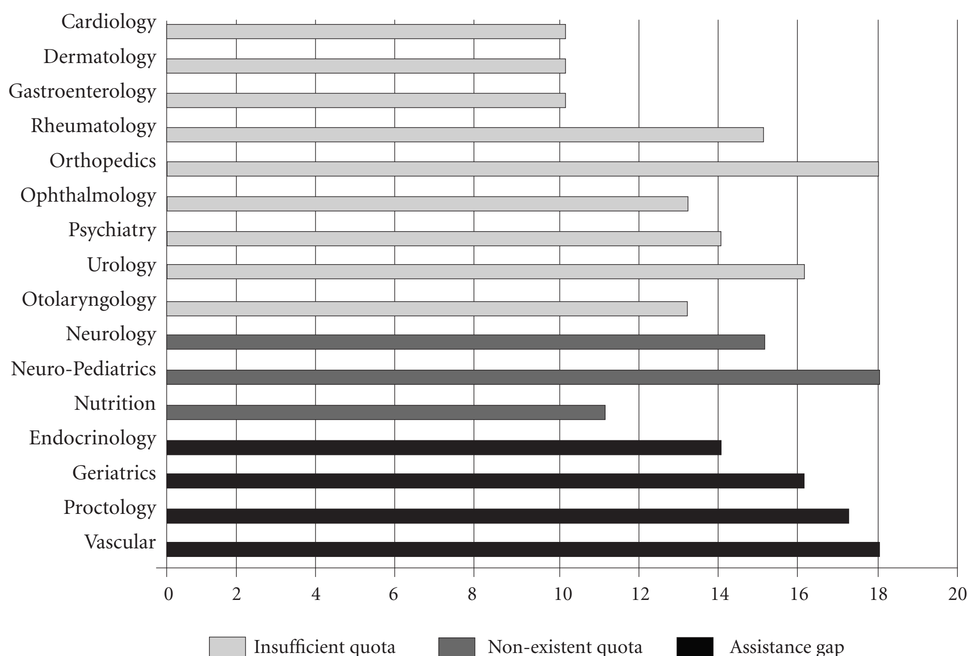

Figure 2. Specialist services that present the most difficulties for people to access according to the classification given by the management teams of the MPPs in the 18th Regional Health Area in the State of Paraná, 2015.

Source: Municipal Secretaries of Health of the MPP, January to April, 2015.

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Discussion

The insufficient offer or the inexistence of the consultations in many specialist areas meant that the managers encountered many difficulties in guaranteeing access to these services in their municipalities. When there are difficulties, the health needs of the users or the demands for health services are not met. This was confirmed in the municipalities of the regions that were studied.

This problem is not just exclusive to the MPPs nor to SUS. Studies carried out in countries belonging to the European Union in 2008, showed that the wait for specialist care and for elective surgery is one of the main public health problems and directly interferes in the state of health of the population. It affirmed that in the United Kingdom even though there has been investment and financial incentives in the last few years, this problem persists in some areas[18].

Access to the health services is connected to the principles of equality, integrality, and the universality of SUS and it establishes actions connected to social justice. To guarantee access to health services is to ensure that the user is a part of the system in conditions that allow for their needs to be met. The availability of the services is influenced by factors such as: structure, type, quantity, resources, capacity to pay and accessibility[2,3,19].

The possible causes of the problem of access to specialized consultations are: the offers of places for consultations are below the acceptable norm, the number of doctors is insufficient, difficulties in persuading doctors to work in outer regions, a reduction in the participation of the Union and the State in offering such services and the financing of the services.

In relation to the offer for consultations, we noted that the monthly availability of places for specialist services through the CIS is less than what is set out in Official Government Notice number 1101/2002. The distribution parameter for the consultations according to the Official Government Notice is two to three consultations per year for each inhabitant. These specialist services should correspond to 22% of the total consultations that are scheduled[20].

If the parameters recommended by the official government organ were applied, the average use would be 2.5 consultations/ inhabitant /year. What would be recommended would be the offer of 0.55 specialist consultations/ inhabitant /year. In this way 5,879 consultations per month would be made available to the municipalities. Thus, it can be affirmed that the vacancies for specialized consultations that are being officially made available to the municipalities corresponds to half of what is considered to be the norm (0.27 consultations/ inhabitant /year). This fact has been used to justify the situation of insufficiency/inexistence of many specialized consultations in the region and which in a certain way goes contrary to the affirmation from the board of the Consortium on the cause of the problem.

On analyzing the context of the region, based on the information that was obtained in relation to the installed capacity, the offer of services, spending on health care and the budget, we noted that concerning the guarantee of access to services of the MC goes beyond the limits related to the articulation of the AB with the rest of the primary health care levels and the supposed low level of resoluteness.

Huber et al.[18] affirmed that in relation to the reduction of demand being repressed by the elective appointments, it is necessary that there is equal access to health services. This includes the policy of providing primary health care access to all citizens that is of high quality and a time limit needs to be established for obtaining access to medium complex services, if necessary.

The MS has been proposing some strategies for the resolution of problems related to access to health services such as: the Family Health Strategy (this is the primary health model proposed for the reorganization of the primary health care), the implementation of Primary Health Care Networks, the implementation of Clinical Protocols for Primary Health care and the implementation of Tele-health and it supporting material. Also, this could impact the resoluteness of the primary health care increasing the clinical capacity of the teams and the articulation between the different primary health care levels[7].

On the other hand, we observed that in an attempt to guarantee access to specialist care, the municipal managers have taken on the development of measures for the offer of services of MC that extrapolate those that have been agreed with a term of commitment and management under a Health Agreement[21]. As a consequence of this, these municipalities have invested more than what is advocated in the Law 141/2012 for spending on health. On average, 23.9% of the municipal budgets for the MPP studied are directed to the sector[22]. In 2014 the average spending with the municipalities own resources for health in relation to the total in this sector corresponded to 69.7%[23], varying between 57.2% and 81.8%. The

high percentage of resources of the municipalities budget invested in health, demonstrated the great weight of the responsibility that has fallen on the municipalities.

The services of MC are more expensive for the municipalities in relation to the primary health care. In addition to this, there is a great demand that is repressed for specialized services with which the managers of the municipalities have to live with on a routine basis, without being able to respond in a satisfactory way. Dealing with this issue means that a considerable part of the public resources is concentrated on health[24].

What can be seen is the gain in autonomy for the municipalities. This was accompanied by an increase in the responsibility for the financing of actions and health services, owning to the gradual reduction in the participation of the state government and the Union in the management of the system. In the last seven years, the public expenditure of the Federal Government on health has increased by only 40.4% while the states and the municipalities increased their expenditure on health by 49.4% and 71.6%, respectively[25].

This information corroborates what Teixeira et al.[26] affirmed that in spite of the municipalities having benefited from the 1988 Constitution with the process of decentralization, they still continue to present major fiscal vulnerabilities. If on one side there was an increase in the sources for resources, on the other side the process of decentralization of public functions has been having a major impact on the finances of the federal entities.

In addition to the question of financing, another question that affects the guarantee of access to specialist consultations is the lack of continuity of the services inside of the Consortium. This may be due to absences owing to holidays, removals or dismissals, and to the quantity that is insufficient in relation to medical professionals as well as the difficulties of getting professionals to work in places that are far from the main cities.

On analyzing the rate of doctors per thousand inhabitants in the 18th Regional Health Area in 2013[14] (0.93) in relation to the rates in the state of Paraná (1.96) and Brazil (2.11), for 2015[27] we noted that the rate in the 18th RS was very much below the state and the country. The southern region is considered, jointly with the central-western region, the area with the best balance between the proportion of doctors and inhabitants[27]. From this one can infer that the situation of the MPPs in other regions of the country is even worse.

The World Health Organization (WHO) and the Pan-American Health Organization (PAHO) do not recommend having a rate for the number of doctors per inhabitant because the establishment of this rate depends on regional, socioeconomic, cultural and epidemiological factors[27]. What should be considered are the following: the type of doctor, the specialty, the ease of access by the population to services, existing resources, distance travelled, the availability of technology and the type of population that is referred to when there is the establishment of this type of rate[28]. However, it is evident that the insufficient number of doctors is directly reflected in the availability of health care assistance at all levels of the primary health care network and this situation exists due to a lack of policies to resolve the problem[29].

According to Ney and Rodrigues[30], there are critical factors for the placement of doctors in the outer regions of the country principally doctors earmarked for primary care connected to SUS such as: inadequate municipal policies on human resources, the precarious nature of employment ties, being overloaded at work, the high turnover of professionals, dissatisfaction with the work environment and a lack of career plans and salaries in the municipalities.

The difficulties found by the managers in finding professional doctors are partially determined by the low offer of training courses in specialist areas[31]. Also, according to the medical demographic report for 2015 only 5% of specialist doctors work in SUS. It is the scarcity that, without a doubt, contributes to the long waits for consultations, exams and elective surgeries[27].

In a study conducted in 2005 covering the CIS in the State of Paraná, it was shown that the main offer of specialist services was in the areas: of orthopedics, cardiology, ophthalmology and neurology. According to 64.8% of the directors of the CIS interviewed in this study, it is necessary to contact more specialist doctors that are not offered to be a part of medical teams[32].

The search for vacancies in medical residences has been following the logic in the market meaning that specialist services that are most sought after are those that present a better financial rate of return. The professionals also have been searching for lesser work roles. The specialist services dermatology, otorhinolaryngology and ophthalmology are sought after the most[31-33].

It was shown that the number of specialized professionals that have the greatest difficulty in access is small in relation to the rest, and its representation in the total number of specialist

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services is less than 5%[27]. This makes the municipalities have to depend, to some extent, on the private sector to meet the demand of the specialist services in which the number of specialist services is reduced.

The situation is even worse because: "the strong presence of specialists in private consultations in contrast with the low presence in outpatient services in SUS. It is a major obstacle to the widening of the public network as well as the offer of specialized medical assistance"[27]. Thus, in relation to the private sector in health that was before SUS, it has gained strength and stability, principally at the levels of primary care where there is the possibility of profit as is the case for specialist primary care[34].

The question of availability of medical professionals acting through SUS worsened the situation of the MPPs in the area of the quantity of consultations and the question of the maintenance of specialized services. This is a situation that, theoretically speaking, can be overcome with a meeting of the municipalities with the CIS.

The CISs can be considered important tools in guaranteeing the integrality and universality of health care assistance. They came about in the attempt to overcome the difficulties in guaranteeing access to health services, principally for the small municipalities with the objective of consolidating, in an effective way, the regionalization of the management of SUS. However, the conception of the CIS as a management tool does not tackle the questions related to a context that is wider: "in that the public policies are influenced by the neo-liberal model installed that guides the system and weakens the provision of services as well as the control of the State in the field of Health"[35]. Such a fact came out of a study on the effectiveness of the CIS in the state of Santa Catarina in 2012 and is corroborated by the data from this study.

The municipalities through the monthly payments to the CIS and through the high investments in health, contributed to the feasibility of the services and they are dependent on the possibility of the offer of specialist services having the power of limited control for the actions that are carried out. It seems that the power to take decisions from the municipalities in the Regional Inter-Management Commission (CIR) has been inferior to the State Secretary for Health (SESA). This fact is confirmed by the study carried out in the northern region of Paraná[9] in that the CIR is configured in the space to re-pass information rather than take decisions with reference to the health policies in the region.

The main consequences of this situation are: highly repressed demand for specialist consultations (producing as a consequence, long waiting times between consultation, diagnosis and interventions) high levels of overloading of responsibilities and attributions for the municipalities (both in guaranteeing access to services that go beyond what primary care offers and financing). Also, there are discrepancies in relation to: the situation of the large municipalities, with a greater number of health establishments, technological density, the capacity for financing, the management of systems and the situation of the smaller municipalities that have lower capacities that have been installed and that are fiscally overloaded in the management of the system[36]. While the small municipalities (MPP) with a population of up to 20,000 inhabitants cover up to 80% of the costs on health in 2014, a large municipality in a macro-region (with a population of over 500,000 inhabitants) for example covers 41.42% of the total costs in health[22].

Final consideration

This case study on the access to specialized services reinforces the thesis that services of MC in the primary care network acts as a hindrance to SUS.

The medical specialist services that present the greatest difficulties for people to access are: Neuro-pediatrics, Vascular Related Services, Proctology, Geriatrics, Endocrinology and Neurology.

Some characteristics of the Brazilian Health System contribute to the difficulty in guaranteeing access to services of MC care in SUS. Above all of them are: the characteristics relative to the organization of the system, health financing and the availability of medical doctors and its relation with the private sector. In the studied region, the overload in the finances that was taken on by the municipalities related to: the total expenditure in health, the shortage of specialist professionals and as a consequence insufficiency/inexistence in the offer of consultations in various specialist services as well as a dependency on the private sector. This is evident and they all contribute to the magnitude of the problem.

Another factor that contributes to the problem is the growth in the distancing between the Federal bodies and the State (with its attributions). This is the case both for financing as well as the management of the system, especially in relation to regionalization. This contributes in

such a way that the problem of access to specialized services does not bring out any solutions in the short term. This is because the COAP which is an important instrument in management for tackling these problems, is still incipient without any pre-set publication date in the region.

The organization of the municipalities into Inter-Municipal Health Consortiums has been providing effective solutions for the problems due to the external factors that influence its structure and capacity to offer services such as: the adopted care model, the difficulty in providing a sufficient number of medical doctors, the capacity of the government and the limited decision making powers of municipal managers.

Thus, the situation extrapolates the established limits for the Consortium and brings consequences that push the managers into having to find other strategies for resolving problems in order to guarantee access to services that are of medium complexity.

Although light has been shed on the problem, this study does not completely solve all the problems. New studies will be necessary that provide more information of what responses the municipalities have been giving to deal with the demands for specialist services. This means what strategies have been adopted for these municipalities to ensure access to services that are of medium complexity.

Collaborations

The authors CR Silva and BG Carvalho equally participated in: the drafting of this paper, its conception, discussion, draft and the revision of the text. The authors EFPA Nunes and L Cordoni Junior participated in: the revision of the bibliography, the discussion section and the revision of the text.

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