ACCESSIBILITY TO SPEECH THERAPY CARE IN SERVICE OF MEAN COMPLEXITY

Acessibilidade à atenção fonoaudiológica em serviço de média complexidade

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ABSTRACT

Purpose: to evaluate the accessibility to speech-language pathologist in service of medium complexity of Recife. **Methods:** evaluative study with triangulation of information sources conducted in February-October2011. Participants were 38 children less than ten years old, the speech-language pathologist and two employees from the Department of Medical Archive (DMA). The three questionnaires used (adults accompanying children, professional and DMA employees) were prepared based on the referential of Donabedian. The children were compared to Family Health Unit registration using chi-square and Fisher's exact test. **Results:** the professional attended three times per week during shift. DMA offered 17 vacancies to the population of the district between January-October2011. A systematically rejection of demand occurred, according to the professional and employees. Of all children, 73.7% were boys, 73.7% were 5-9 years old and 94.7% were diagnosed at polyclinic. First consultation, 89.5% were conducted by a physician; 76.3% had appointments by DMA, 63.9% arrived at dawn; 83.3% had appointments at first attempt, 22.2 % had difficulties and 76.3% waited until 15 days for attendance. A trend of great difficulty for appointments for registered ones (p=0.069), causing dissatisfaction. Professional set a return date. Geographic accessibility, 68.4% were satisfactory and had greater dissatisfaction when registered. **Conclusions:** despite the limitations in the offers of consulting, making appointments and coordinating actions most children did not find it difficult to be attended by speech-language pathologist. The disparity between organizational conditions and absence of major barriers to entry suggests that this behavior represent no pattern of organizational accessibility in the assessed service.

KEYWORDS: Health Services Accessibility; Health Systems; Communication; Speech, Language and Hearing Sciences

INTRODUCTION

The accessibility is related to the concept of health as a right of citizenship and represents a priority action for the effect on the comprehensiveness in the national health system (the *Sistema Único de Saúde* or SUS)[1]. However, it remains a challenge to guarantee the children population to access the services and continue the treatment on communication disorders: impairments on the ability to receive and/or process a symbolic system, such as disturbances in hearing, language and speaking[2]. These disorders affect the competence and communicative performance generating suffering, because they restrict the acquisition of knowledge, the development of ideas and social participation[3].

There are a few studies on the magnitude of this problem, but estimations indicate that in the world between 5% and 10% of the children under three years of age have some type of communication

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disorder[4]. In 2001, a population base survey developed in the South region of Brazil found that 24.6% of elementary school students have phonetic-phonological deviations and 57% at the age of five[5]. In 2003, also in the South region states, 5.3% and 6.7% between 4 and 9 years old, respectively, present hearing loss and mild speech reduction[6].

The communication disorders tend to increase due to the cases of delayed growth and development, hearing deficiency, motor, mental and physical resulting from premature survival[7]. Furthermore, the expansion of neonatal hearing screening and access to primary care through the Family Health Strategy (FHS) increases the probability of detecting problems and risks in speech therapy. To minimize the disabilities and to develop communicative skills, speech therapy assistance needs to be done early, regularly and continuous through the regional and integrated healthcare network organization[8,9].

Viewing the universality and the attention on comprehensiveness, the Ministry of Health blames SUS for the access to specialized care for people with disabilities and carriers of diseases that cause deficiencies in three interrelated levels. Competing at primary level, the basic actions of rehabilitation, presumptive diagnosis and appropriate reference; the secondary level, the diagnosis and early specialized outpatient treatment, and the tertiary, the outpatient and hospital care of high complexity[10]. The 2001 Operational Health Care Norms (OHCN/2001) and the 2005 SUS Mangement Pact, reaffirm the conformation of the articuled network services referred to the delimited territories from FHS[1].

The implantation of district health subsystems represents to Recife one of the main actions related to the comprehensiveness and equity in care. Since 2002, the districts are responsible for planning and managing the reference ward system and being against in supporting the FHS, relying on medical specialties, dental, physiotherapy and speech therapy[11]. Since 2006, the nucleus implantation of the rehabilitation reference, articuled from the Nucleus Family Health Support (NFHS), to expand and qualify the reference services. The municipal polyclinics were prioritized, a secondary level support, to increase the access in specialized consultations[12].

However, there are still problems related to health services accessibility. A concept that, according to Donabedian[13] translates the easiness of obtaining the required health care assistance, resulting from the characteristics of the services and the health resources, as well as the possibilities of people overcoming the existance of barriers. This author distinguishes two interconnected dimensions of accessibility: (a) the socio-organizational related to the provision of activities, hours of attendance, making appointments, wait time for attendance, criteria for selecting demands, adequacy of demand for available resources and formal coordenation mechanisms between the assistance levels; and (b) geographical, alluding to the spatial distribution of resources and the displacement (form, time and traveling costs) [13-16].

In Brazil, some studies that refer to the accessibility in speech therapy affirm long waiting hours after making an appointment for the first speech therapy consultation at the SUS[17-21]. Barriers for diagnosis and appropriate treatment of communication disorders were also identified in Ontario[22] (Canada) and in London[9] (England).

The assessment of accessibility to health services is of great importance enabling to present recommendations to assist the planning and management in different levels of network organization of the health services. In this context, seeking to contribute in identifying obstacles in speech therapy assistance provided for children less than 10 years old, this research used the Donabedian reference[13] with the objective of assessing the accessibility to speech therapist in a mean complexity service in Recife.

METHODS

This project was approved by the Research Ethics Committee at the Instituto de Medicina Integral Prof. Fernando Figueira (IMIP), number 1923 dated on 11/19/2010. The participants signed the informed consent.

The evaluative study used the quantitative method with triangulation sources of information held at the polyclinic in Recife, which represented the only municipal reference service for speech therapy care of mean complexity in SUS, in a health district with a population of approximately 280.000 inhabitants. This service which was created in the municipal in 1995, it constitutes of a reference for speech therapy assistance network for basic health services for more than two decades. One of the authors collected the data between February and October 2011.

The data collection instruments were constructed on the basis of the theoretical framework used on the accessibility of services[13]. To characterize the organization of the service related to the accessibility of speech therapy attendance, in the questionnaire applied to the speech therapist, contained information about the availability of activities and of professionals, appointments, articulation with service's professionals and the health service network, introducing open questions about the difficulties, advancements and suggestions for

improving accessibility, whose responses were recorded and transcribed in full.

Two of the four employees at the Medical File Service (MFS) answered a self-applied questionnaire: making appointments for speech therapy, complaints on demands and suggestions to qualify the appointments, including questions on frequency informing not being the day for appointments ("once a month", "a few times a month", "once a week", "a few times a week", "daily").

To learn more about the accessibility at the polyclinic, the children were identified in the Daily Healthcare Bulletin and in the professionals´ file book, preparing a list with those younger than 10 years old, residents in Recife, in attendance with the speech therapist during data collection. All 38 children met the inclusion criteria for participation in this research.

The information was gathered from: (a) the accompanying, in the waiting room: sociodemographic profile (child/accompanying), the child linked to FHS, type of demand, appointments, continuity of the treatment and displacement, with open questions about the easiness and the difficulties for the accessibility and suggestions to improve it, whose responses were recorded and fully transcribed. Evaluation questions were used about the perception of post-appointment time, satisfied with the appointment and displacement difficulty; (b) the children´s medical file: diagnosis and date of the first consultation. A pilot study was proceeded to adjust the instrument.

The answers to the open questionnaires forms were submitted to analysis the content of the classification type with frequency counts of the categories. The ideas which converged to a common significance were classified in the same category[23], supporting the concept of accessibility[13-16]. The Epi-info 3.5.3 program was used. The children were compared according to the enrollment in the FHS ("RFH" - registered and "NRFH"- not registered), due to the fact that in Recife there is a government guideline for primary care as the axis organizer of the health service network[12].

In the analysis, a chi-square and Fisher's exact test were utilised, when indicated, with a significance level of 5%. The term "tendancy" was used to describe results which were outlining differences with statistical significance between 0.05 and 0.10. To avoid covering up essential information to provide subsidies to the decision-making process, despite the possibility of fluctuations resulting from a small number of children in some categories of answers, it was opted to present almost all the answer categories.

In dealing with this polyclinic, if it outlines a profile that has singularities, but it is believed that the results found may subsidize other services to improve accessibility to speech therapy in "care networks". The lack of children´s participation that did not have access to the speech therapist´s assistance was the main limitation of this study.

RESULTS

Organization of speech therapy actions

The polyclinic has available speech therapist, specialist in oral motricity, who worked in the service for approximately 18 years, observing the population of the district in the fields of voice, motricity and language. The attendance was three times a week, during a shift. The professional would widen the offer, making a weekly session of speech therapy for individuals or in pairs. To offer new vacancies conditions were identified on the caretakers, seeking to reduce time of therapy by reinforcing support at home by performing at the unit, also removing the children from treatment. As for the speech therapist although it seems common for children to be absent, only removed those children who have been absent often. No reasons were considered acceptable (work for the accompanying, illness, necessity of psychological support, lack of transportation resource). At the service there were an otorhinolaryngologist, psychologist and social worker.

The first consultation with a speech therapist was scheduled at MFS, for the population of the district with a reference document, the speech therapist had available vacancies, but there were circumstances in which the professional would make the appointment. MFS offered everyone populational segments, ten vacancies in January and seven in September 2011. The date of the appointment was demonstrated on the billboard of the unit and the appointment was done by first come first serve, orienting the others to wait for another opportunity. According to the MFS employees "a few times a week" it was necessary to inform that there was no appointment making for the speech therapist, while listening to complaints about lack of vacancies.

The speech therapist highlighted the limitations in the provision of consultation and the complaints of those who ensured access to the multiple contacts to make an appointment for the first consultation. This professional rescheduled for the people to return. For internal reference, a specific or a prescription form was used with the date of consultation according to the calendar service. When the family´s financial conditions were precarious, someone would intervain to match a single contact

with the service required according to the necessity of the child (psychologist, pediatrician, etc.)

There were no outflows and agreed protocols between the polyclinics, the FHS units and NFHS. A direct appointment done by these units was suspended because according to the speech therapist, often the patients were not informed about making an appointment and would miss the first consultation. The counterreference was not systematic. The speech therapist had expectation of the articulation to the NFHS, to reduce the demand of children requiring only for guidance. Also there was no routine to forward them in the high complexity care. The professional informed, on his own, services that offered the necessary care. Often, the patients did not have access due to the excessive demand and the problems in the maintenance of the equipment.

The district established outflow of exams with two services on the secondary level in the municipal health network. The speech therapist requested the audiometry using a prescription and the video laryngoscopy was requested by an otolaryngologist from the polyclinic. In both cases, the family went to the service to make an appointment. For the professional the long waiting time to receive the results, especially the laryngoscopy that took up to six months, compromising the quality of the therapy. The definition of the reference for these two services was one of the few advances identified in relation to organizational accessibility.

In the opinion of the speech therapist, the absence of formal outflows for pediatric neurologists, physical therapist and occupational therapist hindered the whole care, affecting the results of the treatment. The main suggestions for improving accessibility were: increase the number of speech therapists (also indicated by officials of MFS; to purchase equipment for speech therapy evaluation (recorder, camcorder and camera) and organize the reference system to ensure the monitoring of the child by professionals required for speech therapy care.

Children´s accessibility

Regarding children, 97.4% of the accompanying were women (73.7% the mother and 21.1% the grandmother), 84.2% their accountables (12.5% the grandmother) and 52.6% were between 20 and 34 years of age. The amplitude of the distribution included people between 20 and 74 years with a median age of 32.5 years and interquartile interval between 27 and 41 years old. About 23.7% concluded high school, and one was studying at a college. The distribution of people ranged from two to 15 years of schooling, with a median of eight years and interquartile range of five to 11 years. Approximately 76.3% were out of the economical active population (86.2% developed domestic activities) and among nine (23.7 %) entered the job market and four missed work to bring their child.

Proportion of 73.7% of the children was boys with a concentration between 5-9 years (73.7 %) and the trendency (p=0.083) for a greater fraction of RFH to be less than five years old. When diagnosed, 60.5% were less than five years old (median 4.4 years, with interquartile range of 3.7 to 6 years). Approximately 89.5% presented phonemic change and/or phonetic and 18.4% omission, 21.0% overlapping communication disorders. Two of the RFH children had delayed language development and dysphagia as a secondary pathology. The polyclinic was the location for the diagnosis of 94.7% of them (Table 1).

Table 1 - Demographic profile, clinical and the access to the speech therapist for children younger than 10 years of age seen at the polyclinic in Recife, February to October 2011

Variables	Registered at the Family Health Care Team			
	Yes (N= 23)		Not (N= 15)	
	No.	%	No.	%
Sex				
Female	5	21.7	5	33.3
Male	18	78.3	10	66.7
Current Age (years)				
0-4	8	34.8	2	13.4
5-9	15	65.2	13	86.6
Age of diagnosis (years)				
0-4	14	60.9	8	53.3
5-9	9	39.1	7	46.7
Type of disorder				
Phonemic Exchange and/or phonetic	19	82.6	15	100.00
Stuttering	2	8.7	-	-
Omission	5	21.7	2	13.3
Delayed secondary language	2	8.7	-	-
Dysphagia	1	4.3	-	-
Service diagnostic				
Polyclinic	23	100.0	13	86.6
Public Hospital	-	-	2	13.4

The percentage of 89.5% of the children came to the polyclinic recommended by a specialist, but part is significantly higher (p= 0.013) than the RFH (56.5 %) which was reported by a physician from Family Health Unit (FHU), while 73.3% of the NRFH were by pediatrician at the service. The reference always was documented. For 76.3% of the first consultation was marked in the MFS, with 18.4% having scheduled with the speech therapist (regardless to the type of demand); 65.7% of the people arrived at the service at dawn (median for waiting time of four hours and 30 minutes, with a minimum of two hours and a maximum of six hours), corresponding 76.9% of NRFH children and 62.0% of RFH. The percentage of 83.3% made an appointment on the first attempt, being 92.3% NRFH children and 78.3% of RFH. One child had an appointment on the fourth and another on the seventh attempt. Half of them had to wait between seven and 14 days after making an appointment (76.3% waited maximum of 15 days). This time was considered to be “short” by 83.3% of the accompanying (Table 2).

A fraction of 22.2% found it difficult to make an appointment for the first consultation, observing the tendency (p= 0.069) to have a greater difficulty among the RFH children (30.4 %) in relation to the NRFH (7.7 %). Lack of vacancies, only for those who are RFH, and disorganization of the appointment system (waiting time for the service and disorganized line) were the difficulties mentioned. About 83.3% expressed satisfaction of making an appointment for the first consultation, which was higher for NRFH children (92.3 %) when compared to RFH (78.3 %) (Table 3).

The two groups did not differ regarding the reasons of satisfaction with 96.7% referred being easy to make an appointment (scheduled in the first attempt, arranged with the speech therapist and managed a date), 23.3% the interpersonal relationship was good and 20.0% for the appointment system (short time after making the appointment and organized line). For 16.7% dissatisfied with the appoinment making, the reasons were: making an appointment (had to arrive before dawn, risked his/her life, had to dislocate to make an appointment and disorganized line), lack of vacancies and poor interpersonal relationship (Table 3).

Table 2 - Organizational accessibility for children younger than 10 years old for the first consultation with a speech therapist at the polyclinic in Recife, February to October 2011

Variables	Registered at the Family Health Care Team			
	Yes		Not	
	No.	%	No.	%
Arrived at the speech therapist	(N= 23)		(N= 15)	
Referred for the health service	13	56.5	2	13.3
Spontaneous Demand	2	8.7	2	13.3
Internal Routing	8	34.8	11	73.4
Delivered Service:	(N= 21)		(N= 13)	
Family Health Unit	13	62.0	1	7.7
Polyclinic	8	38.0	11	84.6
Private Practice	-	-	1	7.7
Professional Said	(N= 21)		(N= 13)	
Doctor from the Family Health	13	62.0	1	7.7
Pediatrician	4	19.0	11	84.6
Psychologist	4	19.0	1	7.7
Reference was documented	(N= 21)		(N= 13)	
Yes	21	100.0	13	100.0
No	-		-	
Making the first consultation	(N= 23)		(N= 15)	
Medical File Service	18	78.3	11	73.4
Referral to the speech therapist	5	21.7	2	13.3
Attended on the day that it was demanded	-		2	13.3
The hour the person arrived to make the first consultation	(N=22) *		(N= 13)	
3-4	13	62.0	10	76.9
5-7	3	13.6	1	7.7
≥ 8	6	27.3	2	15.4
Number of trips to go to the service to make the first consultation	(N= 23)		(N= 13)	
One	18	78.3	12	92.3
Two	2	8.7	1	7.7
Three to seven	3	13.0	-	-
Reason not to make an appointment on the first visit	(N= 5)		(N= 1)	
Had no vacancies	5	100.0	1	100.0
It was not the day to make an appointment	3	60.0	-	-
Waiting Time after scheduling the first consultation (days)	(N= 23)		(N= 13)	
1-6	2	8.7	-	-
7-14	10	43.5	8	61.5
15-30	11	47.8	5	38.5
Perception between the time in making the appointment/ perform the first consultation	(N= 23)		(N= 13)	
Very long / Long	2	8.7	1	7.7
Neither large nor small	1	4.3	2	15.4
Small	20	87.0	10	76.9

* A child was excluded for lack of information

Table 3 – Accompanyings´ perception about making an appointment for the first consultation for speech therapy for children younger than 10 years old at the polyclinic in Recife, February to October 2011

Variables	Registered at the Family Health Care Team			
	Yes		No (*)	
	No.	%	No.	%
Difficulty in making an appointment	(N= 23)		(N= 13)	
Yes	7	30.4	1	7.7
No	16	69.6	12	92.3
Identified difficulties	(N= 7)		(N= 1)	
Had no vacancies	6	85.7	-	-
Disorganization of the appointment system	2	28.6	1	100.0
Perception of marking	(N= 23)		(N= 13)	
Very satisfied/satisfied	18	78.3	12	92.3
Little satisfied	2	8.7	1	7.7
Dissatisfied/very dissatisfied	3	13.0	-	-
Reasons for satisfaction	(N= 18)		(N= 12)	
Easy to make an appointment	17	94.4	12	100.0
Liked the form to treat	3	16.7	4	33.3
Characteristics of the appointment system	3	16.7	3	25.0
Reasons for dissatisfaction	(N= 5)		(N= 1)	
Disorganization of the appointment system	3	60.0	1	100.0
Did not like the form of treatment	2	40.0	-	-
There were few vacancies	2	40.0	-	-

*Two children of spontaneous demand were excluded.

About 84.2% performed speech therapy, being the largest percentage of NRFH children (93.3 %) when collated to RFH (78.3 %). There was a tendency (p= 0.082) of RFH to have an increased treatment time (median of 15 months and interquartile ranging of 5 to 24 months), when compared to NRFH (median of 7.5 months, and interquartile range of three to 13 months). For 81.2% of the children identified easiness for the treatment, of these 76.9% cited geographical access, 26.9% making an appointment (it was not difficult to arrange a first consultation, short time after making an appointment and it was easy to make an appointment to return) and 19.2% organization of the attendance (time of consultation) (Table 4).

Table 4 – Accompanyings´ facilities, difficulties and suggestions in relation to accessibility for children younger than 10 years at polyclinic of Recife, February to October 2011

Variables	Register at the Family Health Care Team			
	Yes		Not	
	No.	%	No.	%
Is performing the treatment	(N= 23)		(N= 15)	
Yes	18	78.3	14	93.3
No	5	21.7	1	6.7
Treatment time (months)	(N= 18)		(N= 14)	
1-11	9	50.0	11	78.6
12-24	6	33.3	3	21.4
25-36	3	16.7	-	
Found to be easy to treat	(N= 18)		(N= 14)	
Yes	14	77.8	12	85.7
No	4	22.2	2	14.3
Facilities found	(N= 14)		(N= 12)	
It is close to home	11	78.6	9	75.0
Making system	2	14.3	5	41.7
Organization to attend	2	14.3	3	25.0
Encountered difficulty to treat	(N= 18)		(N= 14)	
Yes	5	21.7	-	-
No	13	78.3	14	100.0
Difficulties encountered	(N= 5)		(N= 0)	
Live far from servisse	2	40.0	-	-
Organization to attend	2	40.0	-	-
Making system	2	40.0	-	-
Treatment Interrupted	(N= 18)		(N= 14)	
No	17	94.4	13	92.8
Yes, the child's mother was ill	1	5.6	1	7.2
Suggestions to improve the access to the services	(N= 23)		(N= 15)	
Yes	10	43.5	9	60.0
No	13	56.5	6	40.0
Presented suggestions	(N= 10)		(N= 9)	
Increase number of weekly attendance	3	30.0	5	55.5
Improve in making system	2	20.0	4	44.4
Compliance of the schedule for professional	4	40.0	-	-
Changing the time to attend	3	30.0	1	11.1
Increase the number of vacancies	1	10.0	3	33.3

A proportion of 21.7% of RFH (15.6% of the total) found it difficult to have treatment: geographical access, dissatisfaction with the hours to have therapy and attendance by first come first serve, need to get to the service at dawn and bring a doctor statement to make an appointment. Two children interrupted their treatment because of maternal disease. Half of the accompanying made suggestions to improve the accessibility to go to the speech therapist, highlighting elements of availability of activities and the appointment making system (day pre-defined for scheduling) (Table 4).

Three children did not live in a health district where the polyclinic is located (the other two lived in municipalities in the Metropolitan Region, but showed the address of relatives). From the displacement up to the service, 78.9% used buses, there is a tendency of (p= 0.083) greater use of this means of transportion by RFH children (86.9 %) when compared to NRFH (66.7 %). Half spent between 16 and 30 minutes in displacement (median of 20 minutes and interquartile range between 15 and 30). The perception of having "little / no" difficulty in displacement for the service was greater for NRFH

children (86.6 %) compared to RFH (56.5 %). The reasons for the assessment about the displacement have indulged the proximity or the distance from the residency and the greater or lesser availability of transportion (Table 5).

Table 5 - Geographical accessibility to speech therapy assistance for children under 10 years of age seen at the polyclinic in Recife, February to October 2011

Variables	Registered at the Family Health Care Team			
	Yes		Not	
	No.	%	No.	%
Resides in the same district as the polyclinic	(N= 23)		(N= 15)	
Yes	22	95.6	13	86.7
No	1	4.4	2	13.3
Transport used	(N= 23)		(N= 15)	
Bus	19	82.6	9	60.0
Walk	2	8.7	4	26.6
Bus + walking	1	4.3	1	6.7
Own vehicle	-	-	1	6.7
Bicycle	1	4.3	-	
Time spent in traveling (minutes)	(N= 23)		(N= 15)	
≤ 15	7	30.4	5	33.3
16-30	11	47.8	8	53.3
31-60	5	21.7	2	13.4
Difficulty in traveling	(N= 23)		(N= 15)	
Very much/ Much	7	30.4	1	6.7
Regular	3	13.0	1	6.7
Little	5	21.7	7	46.6
None	8	34.8	6	40.0
Reasons for little / no difficulty	(N= 13)		(N= 13)	
It is close to home	10	76.9	11	84.6
Availability of transport	7	53.8	7	53.8
Speed in traveling	4	30.8	4	30.8
You can go on foot	-	-	1	7.7
Reasons for higher difficulty	(N= 10)		(N= 2)	
It is distant from home	4	40.0	2	100.0
Delay waiting for the bus	6	60.0	-	-
Lack of money for the busfare	2	20.0	-	-

DISCUSSION

The children in this study presented sociodemographic and clinical profile similar to those studies developed in specialized services at SUS in the South, Southeast and Northeast regions: predominance of boys aged 5 to 9 years, with disturbances in the speech and language disorders[17-20]. The increased demand in this age group would result in intensification of the social interactions, especially at the entry of school where children are requested more in his/ her performance of the oral language and learning[17-18]. The reasons pointed out to explain a male preponderance as the biological factors (maturing of the brain is slower and genetics) and socially (higher charges on the performance), needing scientific confirmation.

Activities offering

The availability is the key element of organizacional accessibility[13,15,16]. The shortage of speech therapists who took the non-exhaustion of the potential capacity of the physical installation and the sporadic nature of making an

appointment, making it difficult to enroll for therapy at the polyclinic, configured in the opinion of the professional and officials, as a major reason to the systematic demand rejection. This restriction, of course, represented an obstacle at the first consultation, especially when one considers a significant frequency of communication disorders[4-6]. Another limitation relates to the non-availability of specialists in the areas of language, hearing and voice.

The existence of a single speech therapist also reflects in the work process, because, in order to relieve the pressure of a crushed demand, the professional performs only a weekly attendance. The majority of the accompanying who presented had suggestions for improving the accessibility to speech therapy requesting an increase in the number of weekly sessions, expressing dissatisfaction with the treatment of the child. The organizational accessibility cannot be treated without considering the degree between the needs of the patients and the services and resources used[13-15].

Scheduling the first consultation

During 10 months MFS offered very few vacancies for the first consultation with the speech therapist, contemplating all age groups. The employees of this sector and the professional highlighted the conflict between offering and demand. The non-use of the waiting list with an appointment at MFS began only when the service had vacancy available to be filled in a short time, darkening the magnitude of excess of demand. Also minimized the waiting time for the first consultation: 76.3% of the children waited for 15 days, a short interval of time, comparing to six to seven months in Brazilian studies[7,18-20] and other countries[9,22].

The first consultation to speech therapy for most of the children was scheduled in the first attempt, but among those who managed to make an appointment in the first attempt, 23.3% arranged a date with the speech therapist and 5.3% were attended on the day demanded. The enrollment of these children did not respond to the plan by the appointment system (scheduling at MFS and referral). The immediate guarantee of making an appointment or consultation decreases the number of vacancies offered by MFS, although it may appear as a resource of accessory use of potential capacity offering, conferring a preferential character to enter the service. During the study, all types of demand were favored. However, it is possible that the internal demand could use this privilege more often. The systematic of listening at the first contact with the service to define the entry is essential to ensure access to those who need it the most [24].

The easiness in the making an appointment for the first consultation was the main reason of satisfaction of their accompanying. On the other hand, few who were dissatisfied complained about the necessity to arrive at dawn to get a vacancy, this aspect was cited in another research explaining about the access being difficult[14]. It is suitable to recall that 63.9% arrived at dawn, waited in line on the sidewalk of the service, often, waiting for more than four hours to make an appointment. The positive assessment may translate low expectations regarding to the public services. The phenomenon of high satisfaction stem from the bias of gratitude, which is common in developing countries and in the assessment of the public services, which leads to reluctance in expressing negative opinions. Above all, when the user has a great affinity with the professional by which is being attended[25].

The triangulation sources of information has allowed us to contextualize the analysis related to children who have managed to receive care, outlining the discrepancies between the quickiness to ensure the first consultation in this service and the restrictions on offering the activities, in making appointments for consultations, the organization of internal demand and the articulation to the FHS, as it was emphasized by the professional and the employees. It is plausible to assume that this behavior does not represent the standard of an organizational accessibility to the speech therapist. Variability can be encouraged by the absence of the actions provided in the guidelines to standardize a welcoming reception, the flow of making appointments/ remaking appointments and MFS in the municipal polyclinics[12], with this service acting in an isolated manner, making decisions about organizational accessibility were submitted to local contingencies.

The investigations diverge in relation to the origin of referral to the speech therapist, some find in schools and others at the health service[17]. At current, 85.3% of the 89.5% referred to were referral by a physician, agreed with those that identify this professional as the main source of referrals to speech therapy. In addition, it was noted an almost equivalent participation of FHS physician, rarely mentioned in the literature on media complexity[19], and the pediatrician. This difference could result in the role defined for each service in the integrated network of care. All the referrals were in writing, demonstrating professionals' adherence to a procedure that qualifies the SUS. The counter-reference which could serve as a mechanism of continuous training for local staff was not a routine.

The continuity care in speech therapy at the polyclinic

The restriction in the offering of activities is also a barrier inside the service[14,15], and may lead to a discontinuation of the treatment, compromising the technical quality and extend the time of the follow-up. In this research, some elements pointed out to this possibility: nine accompanying were inserted in the job market and these four missed work because they had to bring their child to be attended on the day they were interviewed. The speech therapist informed about the usual character of those not appearing for the attendance for reasons that were thought acceptable, as being one of them the lack due to the needs related to the job.

Some positive characteristics that humanize the service and facilitate the access to continue the care were stated. The user would leave the unit with a guarantee of returning and there was a commitment to ensure the appointments to consult other professionals, simultaneously with speech therapy. Carefully considering the conditions of life and the complexity of the child´s clinical status, allowing the decision about the discontinuation of the therapy would be taken in a wider context.

In this work, as well as in others[20], the younger people presented longer durations of the treatment. This profile was more frequent among RFH children, although this outlines the different suggestions that they found more organizational obstacles in its path to search for and the use of the polyclinic. This is suggestive that the FHS has increased the likelihood of early detection of problems and risks with speech therapists.

Articulation with the health services network

The lack of formalized flow of users between FHU and the polyclinic translated a setback: the suspension of making appointments by the institution for the non appearance at the consultation of appointments made. In the presence of the hindered demand to the lack of adherence to the assignation has repercussion far more serious in the accessibility of the population. The solution to the problem refers to the necessaity of the articulation with the local level.

In speech therapy care there should be responsable FHS teams: making the first attendance of the referral cases, informing the date of the appointment for the patient and make an active search of the absentees when requested by the reference service. The organization of demand is essential to the coordination of actions and may facilitate or hinder the entry into the service and continuity of assistence[15]. The monitoring of the appointment system is an important tool to facilitate the opportunity for diagnosis and treatment.

In addition, there were no formal mechanisms of integration between the NFHS and the polyclinic, which would increase the technical adequacy of demand. The lack of filter in the primary care potentializes the number of unnecessary consultations which overloads the secondary care and increases risks for the patients. NFHS does not constitue a port of entry for users in the health system, but should integrate to a network from the demands identified in a joint work with FHS teams[26].

In Recife, since 2002, the reorganization of the health system from the primary care with references to various healthcare levels, having FHU and the traditional basic units as port of entry is a government guideline. The speech therapy contains in the proposal for structuring by districts, the ward reference system and counterreference to support the FHS[11].

As regarding to the coordination of actions, even with the guarantee to assist the people needing rehabilitation is a managing compromise[12], the only advancement perceived by the speech therapist concerning the definition of two services of secondary level care as a reference for diagnostic support. Although it would be up to the families to make the appointments for the exams and it would be a long wait for the results.

In relation with the high complexity, the professional would turn to flows of non-formal reference and assigning it to the user to ensure the service. A large concentration of services at the sphere state and consequently low governability in the municipality led to municipal management to undertake the municipalization of specialized state services[27]. Also in Salvador (Bahia) identified the need to articulate high complexity services of different providers to support the speech therapy network[28]. The development of the articulation mechanisms is essential for resolubility and comprehensiveness care[29].

The health districts competes a task of the utmost importance in regionalization and integration of healthcare networks. In this sense, negotiation spaces must be created to structure the polyclinics (extending the availability of professionals from different areas of expertise in speech therapy), as a support of a medium complexity, to sustain the FHS and establish flows of patients articuled to a central place to make appointments for consultations and specialized examinations with the guarantee of being attended[30].

The municipal administration has made a commitment to decentralize healthcare setting to the health districts, structuring and qualifying the reference system and counterreference

(examinations and consultations) [30]. These regulatory mechanisms hardly promote equitable and comprehensive access while acting up on an only portion of the services under the municipal management without the attention on the regional network formation for a continuity care[31].

Geographical accessibility

The regionalisation of assistance is a necessary condition to improve the accessibility to the care in SUS, especially the geographical accessibility, as it seeks to greater proximity between population and available resources[1,8,32]. A walk between 20 and 30 minutes, at the most, would be the ideal parameter to shift the residence to the healthcare service[14]. In this study, the mean displacement time was 20 minutes, but 78.9% used the bus. It should be noted that this is a specialist service and the availability of transport was highly valued by the accompanying, especially the NRFH children, justifying the easiness of displacement during the treatment. Despite the indirect spending of money with assistance for a long period of time, the restrictions imposed by the financial conditions cited by the professional, as an adherence obstacle to the appointment making were little mentioned by the accompanying.

In relation to specialized care, it is not always possible to ensure that the resolution of the health problem with available resources in a given territory, so the diagnostic support services were located in another health district. The shortage of offering speech therapy consultation may have motivated the use of the polyclinic by five children residing outside the district. This invasion of demand can be assessed as little, translating a step forward in the process of regionalisation: for decades, the attendance in this reference unit independently of place of residency. Note that in order to operate a proposal for the health system organization, there is a need for a better understanding of the perceptions and expectations of the users to have access to the health services[33].

CONCLUSION

Despite the limitations in consultation offering, in the appointment system and the coordination of actions which represent obstacles to the access and the continuity of care in speech therapy at the polyclinic, compromising its role as a mean complexity support, in this study, most of the children did not find difficulty to be attended by a speech therapist. However, the disparity between the organizational conditions and the absence of major obstacles in port of entry suggests the possibility of this behavior does not represent the standard of organizational accessibility to assist in speech therapy in the assessed service. The scarcity of articuled networks to health services has compromised the resolubility and comprehensiveness of speech therapy care. A good performance of geographical accessibility deserves to be highlighted.

RESUMO

Objetivo: avaliar a acessibilidade ao fonoaudiólogo em serviço de média complexidade do Recife. **Métodos:** estudo avaliativo com triangulação de fontes de informação, realizado de fevereiro a outubro/2011. Participaram 38 menores de dez anos de idade, o fonoaudiólogo e dois funcionários do Serviço de Arquivo Médico (SAME). Utilizaram-se três questionários (acompanhantes das crianças, profissional e funcionários) elaborados com base no referencial de Donabedian. As crianças foram comparadas segundo cadastramento em Unidade de Saúde da Família, usando qui-quadrado e teste exato de Fisher. **Resultados:** o profissional atendia três vezes por semana, durante um turno. O SAME entre janeiro e outubro/2011 ofereceu 17 vagas à população do distrito, ocorrendo sistemático rechaço de demanda, conforme profissional e funcionários. Das crianças, 73,7% eram meninos, 73,7% com 5-9 anos, sendo 94,7% diagnosticadas na policlínica. Para primeira consulta, 89,5% vieram encaminhadas por médico; 76,3% com agendamento no SAME, 63,9% chegaram de madrugada para aprazar (mediana do tempo de espera foi de 4h30min); 83,3% marcaram na primeira tentativa, 22,2% encontraram dificuldade e 76,3% esperaram até 15 dias pelo atendimento. Observou-se tendência de maior dificuldade na marcação das cadastradas (p=0,069), provocando mais insatisfação. O fonoaudiólogo aprazava retorno. Para 68,4% acessibilidade geográfica foi satisfatória, existindo maior insatisfação quando cadastradas. **Conclusões:** apesar das limitações na oferta de consulta, agendamento e coordenação das ações, a maioria das crianças não encontrou dificuldade para ser atendida por fonoaudiólogo. A disparidade entre condições organizacionais e ausência de maiores obstáculos à entrada sugere que este comportamento não representa o padrão da acessibilidade organizacional no serviço avaliado.

DESCRITORES: Acesso aos Serviços de Saúde; Sistemas de Saúde; Comunicação; Fonoaudiologia

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