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ACCESS TO SPECIALIZED CONSULTATIONS: CASE OF THE CITY OF PELOTAS/RS

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Abstract: Access to specialized consultation provided by the Unified Health System (SUS) in the city of Pelotas/RS depends on visiting the Basic Health Unit (UBS), which works as a triage to define whether there is a need and the level of priority of this service. secondary. Based on this, this study aims to identify the referencing process and possible failures that could overload this system, carried out through exploratory research. The existence of a regulation center was evidenced, which is computerized by the AGHOS system, which has a regulatory doctor responsible for assessing whether the patient, in fact, needs to be referred to a specialist and whether this has priority on the waiting list among the other people. It was found that in some stages of this process mistakes may occur that negatively impact the patient's prognosis, such as longer waiting times, undue return to the queue, and also the system itself, which may become overloaded. Therefore, standardization of this process is necessary, such as the presence of pre-established criteria for pathologies that have higher priority, in order to increase the efficiency of this system and reduce any unnecessary expenses.
Keywords: Specialized medical consultation. Regulation. Basic health care. Priority.

INTRODUCTION

Primary health care is the gateway to the health system, serving as the basis of care networks and articulating care coordination [1]. Regulating access to specialized consultations is an essential tool in managing care networks. Regarding primary care, there is generalist care, which has a wide scope in the field of medicine as a whole, treating the health-disease process in a broader way. Secondary care is associated with this, which has another type of medical care, specialized consultation. In this last model, care is focused on specific areas of medicine, such as cardiology,

nephrology, among others. [1,2].

In relation to specialized consultations, there are different ways of accessing this service. There is one in which the patient is referred to the specialist after a consultation with the general practitioner, or the patient can schedule a meeting with the specialist directly in private offices. [3]. In Brazil there is a strong culture of scheduling specialized consultations according to the patient's own assessment, increasing the sometimes-unnecessary expenses for the patient. Unlike some European countries, where the system is organized in such a way that there is initially a consultation with a generalist and, if indicated, a referral to a specialist [4].

When we direct attention to the Unified Health System (SUS), we notice a completely functional patient care proposal, which has as its main objective, based mainly on the principles of the SUS, complete health support for Brazilians. Among the principles of this system, Comprehensiveness contemplates the foundation of specialized consultations, which has a proposal to guarantee the individual health care that transcends the curative practice, contemplating the individual at all levels of care and considering the subject inserted in a social, family and cultural context [2,3,5].

Therefore, comprehensiveness aims to interconnect a network of services that communicate to ensure better accessibility to the individual, in an efficient and effective way. Some of these services include monitoring at a Basic Health Unit (UBS), requesting laboratory and imaging tests, transferring a patient between Health Care Networks (RAS), and the main focus of the article, referrals to specialized consultations [3,5].

Concomitant to comprehensiveness, there is another principle that we can observe, equity in access to health services. This is guaranteed through the regulation of the health system, mainly assistance. With regulation, care flows and clinical protocols are defined to be followed, achieving integration between health services, in addition to observing the relationship of need, demand and supply. This way, more effective and efficient management is made available to patients[6,7].

It is clear that there is a growing demand for specialized medical procedures. Some factors are related to this reality, such as the expansion of basic care coverage, which added more users to the SUS. Furthermore, the increase in life expectancy and the prevalence of chronic diseases are other reasons that have inflated a system, unable to support the demand for so many patients in a timely manner.[8]. After stating this, it is professional and popular knowledge that some system proposals do not have the ideal functionality for practice, resulting in major social and economic problems, both for the individual seeking the services and for the Brazilian state1[,7,8].

One of the biggest challenges in the public health system is the increase in demand for consultations with specialist doctors, resulting in a delay in making diagnoses, which can negatively impact the prognosis and quality of life of users. In this sense, there are cases where it is necessary to repeat laboratory and imaging tests and request procedures that, if it weren't for the long time between scheduling and the consultation itself, would be unnecessary measures. This leads to an increase in healthcare costs, which demonstrates a decrease in the productivity and efficiency of the system.[3,7]. Furthermore, there are studies that prove that waiting time creates a barrier for the patient to receive care following the principles of the SUS, reiterating defective functionality. [1,6,7].

In view of the above, this study aims to analyze the process of accessing specialized consultations in the municipality of Pelotas, Rio Grande do Sul (RS), in the year 2022.

METHODS:

The research is classified as applied and exploratory. Applied, because according to Gil (2008) its results can be applied to solving the problem. Exploratory, as according to Gil (2002) it aims to provide greater familiarity with the problem, with a view to making it more explicit or building hypotheses, which includes bibliographical research and interviews9.

This is a case study carried out in the city of Pelotas (RS) that aims to deepen the details regarding the methods used to refer a patient from primary care to specialized consultations, as well as the way in which this is framed in the priority queue. To this end, exploratory research was used, which collected information from the Municipal Health Department of Pelotas, associated with the comparative survey and analysis of bibliographic data, selected from related studies and online legislation data. Collecting data on the city's flow through predetermined group questions together with research guidance. Its main objective is to collect data about the steps and methods used in referral to specialized consultations in the city of Pelotas, providing study material for future research on the topic.

RESULTS:

The Pelotas regulation center works exclusively through the AGHOS system, which can only forward requests from the SUS, which are from UBS, outpatient clinics and hospitals. These requests reach the regulatory service of the municipal secretariat of Pelotas, where they are carefully examined by the regulatory doctor. This assesses the degree of need for the requested consultation based on the information contained in the main complaint, as well as whether the priority is appropriate for the patient in question. The main complaint, which must be filled out by the requesting doctor at the time of the request, is the guide for the regulating doctor to understand whether the patient's case is suitable for the consultation to which he or she is resigned.

Furthermore, if the consultation is a priority, an item that the requesting doctor must establish in a responsible manner, the regulatory doctor must assess whether this really has priority in relation to other requests for specialized medical consultation. Furthermore, if the consultation is not a priority, but the regulatory physician understands that it needs priority, he or she has the authority to designate the consultation as priority.

It was understood during the research that there are no pre-established criteria to evaluate which pathologies are priorities within the same clinic, which was pointed out that elderly people, children, cancer patients and/or their cases, described by the main complaint, are considered serious.

The requesting physician may contact the regulatory physician to discuss the case, such as to advise him or her that the patient's condition worsened after the request, in an attempt to prioritize it. Therefore, the doctor assesses the evolution of the condition, thus being able to highlight the patient's worsening condition.

It is the doctor's role to provide data corresponding to the patient, mainly contact-related data, as this is how the patient is informed about their appointment. The secretariat contacts the patient three (3) days before the appointment date, and if the patient does not respond in three attempts at different times, their appointment slot is assigned to the next person in line. After missing the appointment date, the doctor can request a new appointment, however there is a new absence control sector which controls how many times the patient does

not attend the appointment, thus avoiding missed appointments and delays in specialist appointments.

During the research, information was made available from employees of the health department, through the regulatory sector, that there are other systems that may be more complete than AGHOS, which demonstrate, to the doctor, the patient's position in the waiting list, they request additional information to bring the patient into more suitable conditions for their consultation and which have greater system stability.

DISCUSSION

The study demonstrated all the steps necessary to request a specialized consultation. However, it was noticed that in these different phases there is the possibility of interruption of the process due to lack of systematization.

When we individually evaluate the AGHOS system, which serves as a gateway to the service, we notice that it has mechanical failures, knowing that it suffers from system instabilities, as well as a deficit in relation to the training of the requesting professional, evidenced by the absence of data in requests. This lack of data creates the possibility for the regulator to have control over the decision on the temporal importance of the requested consultation, that is, even if the requesting doctor believes that the patient's case must be evaluated urgently, if he has not described this in the request for consultation, the regulator disregards it due to data limitations. Conversely, the regulator can also characterize a patient as a priority even if the requesting physician has not included this option, as shown in FIGURE 1. However, this designation of the patient as a priority is based on a conclusion by the regulator, which did not have contact with the patient and only decides this based on the illness described in the request.

Furthermore, the priority decision becomes disordered when there is no prior table designating each pathology as a priority or not. This decision is solely based on the regulator's experience and the importance it gives to pathology. This can become disordered especially when changing regulators or in the existence of more than one for the same system, as the first may consider a certain pathology a priority and give preference to a patient and the second may not consider the same pathology a priority and not introducing the other patient to the priority, thus leaving unequal treatment between the same pathologies[1].

It was demonstrated that the requesting doctor can contact the regulating doctor to explain new data about the patient's condition, such as its worsening. However, it was also noted that this type of conduct is not known to professionals. The study proved to be favorable to the implementation of developments in the AGHOS system with the aim of generating follow-up on the patient's condition, enabling changes to prioritize those in need.

Furthermore, it was noted the need for the health department to contact the place where the consultation was requested in cases of lack of contact with the patient, as in some cases the patient misses the appointment due to lack of contact from the health department. healthcare with the patient's contact number. In cases of health centers, the social health agent may be informed by the health department to actively search for these patients, not making them enter the queue again.

Furthermore, when compared with the literature, it was evidenced that in the Metropolitan Region of Espírito Santo from January 2014 to December 2016 there was a progressive increase in the waiting time for specialized consultations, leading to an increase in the rate of absenteeism. When correlated, it was noted that this increase in

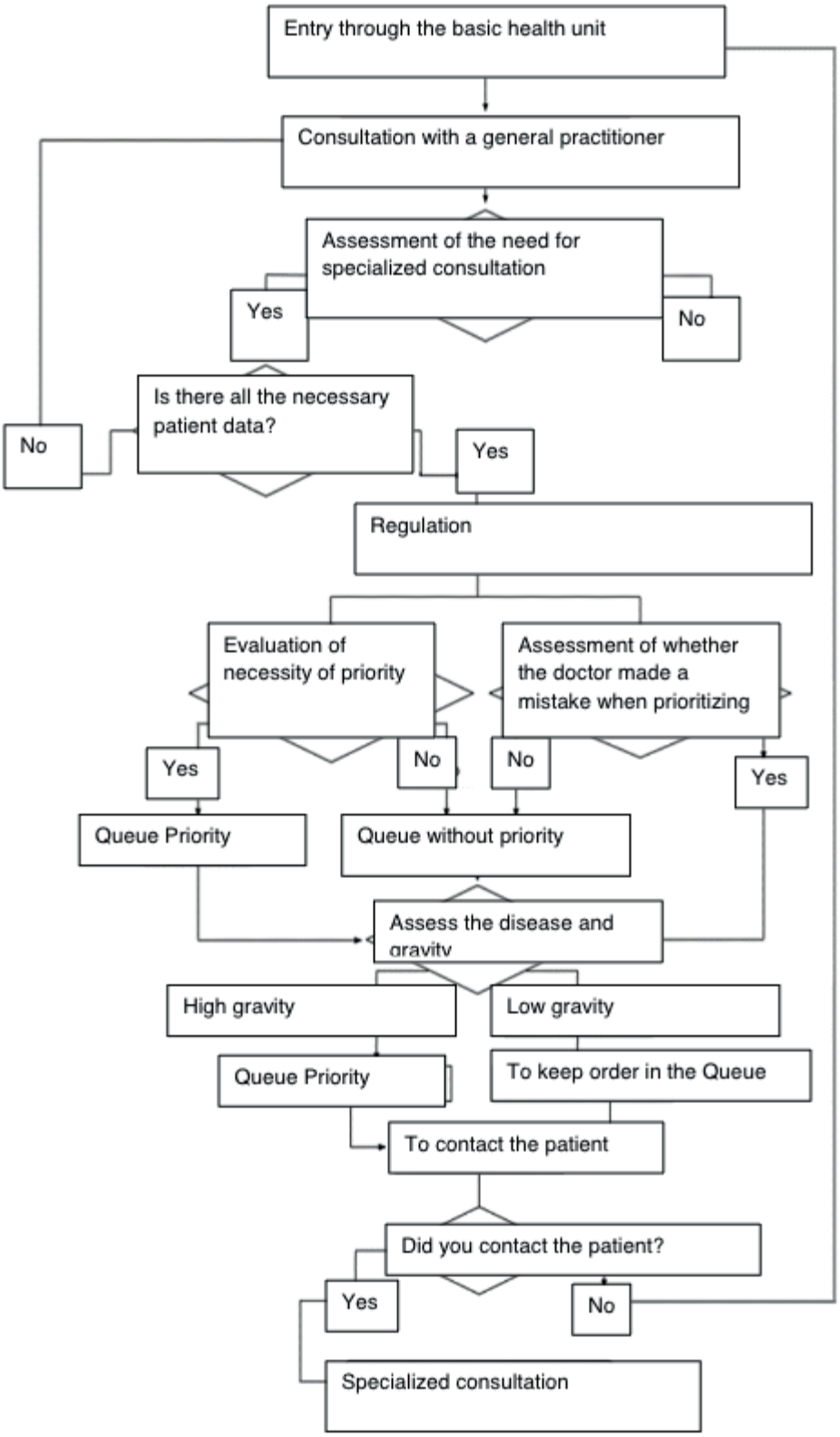

FIGURE 1 - Referencing flowchart. Prepared by the author.

waiting time was associated with the size of the municipalities in relation to the health system[1].

In the literature that evaluates the appointment system in the city of Aperibé-Rio de Janeiro, we have 83% of the 300 interviewees reporting the system as terrible or bad, with the most reported reason being the waiting time for specialized care. It was also described that this does not prioritize them according to urgency, but rather according to risk classification. The study reveals that this process, as evidenced in the present study, requires organization and improvement of guidelines related to referral and selection at the municipal regulation center[8].

The results demonstrated, mainly, the need for research on the due order related to priority in these consultations, taking into consideration, the evolution of the disease, the degree of impairment, the patient's age, degree of vulnerability, access to health services and benefit from immediate treatment, with the aim of generating order which does not only come from the empirical knowledge of the regulatory professional.

CONCLUSION

This research made it possible to identify components and map the practices of the referral process for specialized consultations in the city of Pelotas through the AGHOS system by the Unified Health System (SUS). This identifies the stages of this process, highlighting possible losses in the transition from a generalist doctor to a specialized doctor, as well as the ordering according to the priority of each clinical condition, which does not have pre-established criteria to guide the conduct in accordance with the needs of each patient. During the research, failures on the part of the system, including AGHOS and the care team, were noted, which cause the patient to either increase the waiting time for the specialized consultation or not obtain it due to the lack of data in the request.

These results were definitive in perceiving the urgency of new research related to changes in the AGHOS system, implementation of other data and evolution sheets to maintain updated regulation of the patient's condition. Furthermore, it is clear that it is essential to have pre-established criteria to distinguish patients who must or must not be prioritized for consultations, maintaining the impartiality of the process. These criteria must be studied through research that demonstrates the impact of the disease, evolution of the condition, benefit from early versus late treatment, survival, association with other diseases and basic patient data (age, BMI, previous illnesses). These will efficiently help to conduct and better organize the referral system for specialized consultations.

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