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CROSS-BORDER ACCESS TO HEALTH SERVICES IN TWIN CITIES OF PARANÁ

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ABSTRACT

Objective: to understand the dynamics of cross-border access to health services. **Method:** exploratory, descriptive and field research in four twin cities of Paraná (Foz do Iguaçu, Guaíra, Santo Antônio do Sudoeste and Barracão). Data were obtained through semi-structured interviews applied to health managers and submitted to the thematic content analysis proposed by Bardin. **Results:** it was observed in the study four thematic categories critically discussed with the literature a) there is a greater reception in smaller municipalities, especially in primary care; b) financing as a major barrier to cross-border access; c) the discretionary decision of the health professional at the time of care due to the absence of institutionalized long-lasting guidelines. **Final considerations:** it has been found that access to cross-border health services is unstable and confusing, but the dissemination of integrative thinking and solidarity among population from the local level may contribute to broadening the idea of citizenship and cross-border hosting.

Keywords: Health policy. Border heath. Health Services Accessibility.

INTRODUCTION

Brazil has a land border range of 15,719 kilometers and in this region AND there are 588 municipalities that border 10 South American countries[1]. In the state of Paraná, there are 139 border municipalities[2]. Border municipalities have been treated as areas of hybrid and ambiguous identities, with boundaries that are surpassed by the integration processes produced by the population of these locations. This way, the resignification of the border as an integrating space was an economic requirement.

In this sense, in Brazil, the Ministry of National Integration's Border Development Program (PDFF) stands out[2,3]. The geographical environment that best characterizes the border zone is that composed by the twin cities[1-3]. The state of Paraná has four municipalities whose headquarters are characterized as twin cities: Foz do Iguaçu, Guaíra, Santo Antonio do Sudoeste and Barracão[2,3,4]. In these cities, cross-border interactions involve a set of material and immaterial, cultural and identity interactions. They are spaces where local and international articulate, establish their own dynamics, built and reinforced by cross-borders[2,4]. The classification was based on analysis models in which each scenario corresponds to an arrangement of particular dynamic situations, such as: margin, progression, front, synapse and capillary. The synapse model, a term imported from biology, refers to the twin cities that have the highest degree of interaction.

Brazilian governments have understood the twin cities as an integration laboratory space. In recent years, attempts have been made to formalize grassroots integration among border populations. Basic (informal) phatic integration at borders is known to precede vertex (formal) integration projects. However, both are relevant and complementary in regional integration processes[1].

Integration between cross-border populations can be enhanced through public policies. However, border integration projects and actions in many cases bump into the limits of nationalized state policies, civil, political and social rights. Among the different migratory dynamics in the border areas are public services such as health and education. The universal, integral and egalitarian Brazilian health system is pointed as a motivator for the movement of foreigners towards us[3,4].

In the face of diplomatic, legal and bureaucratic barriers, understanding the problem and mechanisms of foreign access to public services provides elements that may contribute to future conjunctures more favorable to the

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reality of these municipalities. The aim of this study was to understand the dynamics of access to cross-border health services from the perspective of managers and health professionals in the four twin cities of Paraná.

MATERIALS AND METHODS

Descriptive, exploratory and field research with qualitative approach.

Data were obtained through semi-structured interviews conducted with municipal managers and health professionals. As a criterion for inclusion and delimitation of participants, the current municipal health managers were included in the year the research performed, by prior appointment for the application of a semi-structured questionnaire, and this manager was responsible for referring other key informants with at least one year of experience. For sample criteria, information saturation and the period available for the research were observed. The interviewed group was multiprofessional, totaling thirteen participants who work or have recently worked in management positions in public health services in the four twin cities, four from Foz do Iguaçu, three from Guaíra, three from Santo Antônio do Sudoeste and three from Barracão.

The interviews were recorded and fully transcribed in a text editing program for later descriptive analysis, using the thematic content analysis proposed by Bardin[5], with three phases: pre-analysis, data exploration, and interpretation of the findings. Exploring the material sought to identify the meanings attributed by the subjects to the questions raised, seeking to understand the internal logic through a dialogue with the literature, resulting in four thematic categories[5]. (1) Characterization of frontier municipalities and SUS decentralization; (2) the foreigner's restricted right to health services; (3) health financing as a restrictive factor; and (4) integration into twin cities.

The research was approved by the research ethics committee under opinion n. 1,741,583. To ensure confidentiality, passages that could identify the participants were omitted, and their lines were characterized by the letter P, followed by a cardinal number

RESULTS AND DISCUSSION

1. Characterization of border municipalities and SUS decentralization

Border municipalities have particularities that are often not considered when proposing public health policies at the federal level. Table 1 presents general data on the structure and health care network of the municipalities housing the four twin cities of this study.

Table 1. General population, population covered by health plans, federal transfer of funds, primary care coverage and family health strategy in the municipalities of Foz do Iguaçu, Guaíra, Santo Antônio do Sudoeste and Barracão.

General data/ Municipalities	Foz do Iguaçu	Guaíra	Santo Antônio do Sudoeste	Barracão
Population (2016):	263,915	32,784	20,059	10,273
% of the population with health insurance (2016):	26.09	10.77	2.52	6.46
Fixed-PAB* (per capita)	Border 3 24.00	Border 2 26.00	Border 1 28.00	Border 1 28.00
Federal transfer of funds in R$	511,436.00	67,194.83	44,445.33	22,857.33
Primary Care Coverage	60.89%	78.00%	100%	100.00%
Family Health Strategy Coverage	46.00 %.	78.00 %	100%	100.00%

* PAB: Primary Care Wage

Source: Technical Note (Primary Care Department-DAB/ Health Care Secretariat-SAS)(2017).

From the point of view of the size of the municipalities, only Foz do Iguaçu is considered medium size, and the others are small, that is, they have less than 50 thousand inhabitants. Of the 197 Brazilian cities located within the border range, only 18 has a population of over 20,000[2].

Regarding coverage by the Family Health Strategy (ESF), small municipalities generally have greater coverage, while having a lower percentage of people with health plans, which means greater dependency on public health services, as the case of the municipalities of Barracão and Santo Antônio do Sudoeste (table 1). As a complementary data, the municipality of Foz do Iguaçu has full management of the municipal system, which implies the transfer of differentiated federal resources, since the municipality is responsible for all levels of the system, Primary Care (AB), Medium and High Complexity (MAC).

Decentralization after the creation of the SUS was based on municipalization and marked a process of intense transfer of competences, resources, responsibilities, planning and organization to the municipalities. The autarchic municipalization implicitly has given the message that in order to achieve a superior municipal management, it was necessary to establish as many health services as possible in the municipality, which led to unfair and destructive inter-municipal competition for scarce financial resources[6.7].

The research subjects recognize the common problems of border municipalities, but emphasize the need to be treated individually, given the differences between them:

> [...] the reality was different from other realities [...] a local difference was noticed, the border of Foz do Iguaçu was different from that of Barracão, is different from Novo Mundo (P4).

The difficulties of municipalization are maximized in the border municipalities, which, in addition to the common problems, are responsible for solving those arising from the cross-bordering of public services. The municipalization originated different realities, on the one hand the large municipalities with greater political, administrative and financial potential, and on the other, the smaller municipalities with low operating capacity, low indebtedness and little autonomy[7].

Recognition of this situation has led to another SUS guideline, the regionalization, was prioritized from the 2000s onwards, as an essential tool for comprehensive care and equity in access to health actions and services in the national territory[6]. The process of regionalization should be divided into two: the attempt to organize services as a way of making them more efficient and effective, and the creation of health regions. These regions are defined as territorial cuts inserted in a continuous geographical space, identified by municipal and state managers based on cultural, economic and social identities, communication networks and infrastructure[8]. The Health Pact, signed in 2006, reinforced the regionalization and territorializing of health as a basis for the system's n organization, raising the expectation of important changes in SUS management, among them one that generated great expectations was the implementation of care networks to health[7].

In the definition of health regions, due to legal and bureaucratic obstacles, contiguous foreign cities are not included as participants in the sanitary region, which would represent the reality experienced socially. Thus, the political and social character of the regionalization process in these territories is lost[9], and the possibility of a greater integration of health promotion and prevention actions based on territories[6].

Despite adherence to the pact, access to health for Brazilians and foreigners was not expanded, and conditions were imposed for the transfer of financial resources, interfering authoritatively and centrally in the border municipalities[10].

2. Foreigner's restricted right to health services in twin cities of Paraná

Cross-border movements are established precisely by the heterogeneity between one side and the other of the border. The Mercosur Residence Agreement has facilitated these movements in recent years between bloc countries. The dynamics of cross-borderingprocesses are difficult to understand, as well as their quantification and qualification precisely because it is a social construction that is altered in time and in the use of shared territory[11].

> The border is a line that exists on the map, in cartography, in real life people cross. They transit because of commerce, transit because of tourism and transit because of health, even more

> because health is a vital good (P5).

> [...] people go where their problem is solved, no use thinking you will solve it by building a wall, it won't! People jump over the wall, go under the wall (P2).

The asymmetries between the bordered municipalities and the individual conjunctures are stimuli for temporary or permanent migration, often resulting from social, affective and/or solidarity ties between the cross-borders. These links are used at the time of address verification required for regular SUS care.

> [...] usually this patient has two identities, two nationalities, or he rents a house here to get care [...] sometimes the husband is sick, is Argentinian, but the woman works in the municipality, pays her tax and consumes here, so it ends up getting care because of her bond (P10).

Proof of residence in a border region can be classified as a selective border arrangement that establishes who is included or excluded from certain social rights, services and benefits. In other studies the issue of documents is also mentioned as a barrier[3,11].

When considering health policy as a social policy, one of the immediate consequences is to assume that the state will be the major regulator of access and services, and in Brazil health is an inherent right to citizen status[12]. The boundaries alter the objective and subjective condition between national and foreign citizens, generating a reassessment of concepts such as nationality, citizenship and sovereignty. Displacement and the pursuit of social rights across the border are often seen by states as illegitimate actions. The cross-border immigrant is a citizen of many orders, and modern citizenship, despite claiming universal rights, is profoundly national, since it is within the nation state that these rights are implemented and operated in everyday political practice. It expresses territorial inclusion and exclusion provisions marked by places of birth and housing, and the existence or absence of personal documents[11].

The access of foreigners to health services in the municipalities studied does not follow a pattern, that is, it is a discretionary action of each municipal manager to decide on what policy to adopt. Some restrict emergency care, as required by Brazilian law:

> Only in the case of emergency there, will be an established care, then there is no way not to [...] I know that in severe cases the institution must provide care (P1).

> The normative framework of the SUS is clear regarding the service to foreigners. Everyone in their national territory, irrespective of their status, has the right to be treated under urgent/emergency conditions (P2).

The constitution and ordinary Brazilian legislation implicitly guarantee the foreigner's right to care, since the right to health is an inseparable guarantee of the right to life. The denial of care to foreigners not only violates Brazilian constitutional principles, but also the treaties signed by Brazil, including the San Jose Pact of Costa Rica - the American Convention on Human Rights[13]. Some municipalities of the study, especially the smaller ones, in addition to cases of urgency and emergency, welcome the foreigner in the Primary Care (AB) services, which is the responsibility of the municipality. In general, care to foreigner is perceived as a burden on services, often insufficient for the needs of the resident population.

> The biggest impact for us is getting vacant beds when it is a medium and high complexity procedure. We have a waiting line that takes up to 02 months to get. If such a demand comes, that demand will compete and compete with the residents of our coverage area (P6).

Restricting access to the most complex levels of the system not only occurs to foreigners, but also to Brazilian citizens in the absence of professionals, especially in small municipalities, and through lines, where AB ends up working as a filter. The foreigner would also represent a workload for health teams:

> It is understandable that our worker would be bothered to attend [...] he/she is already overloaded with the Brazilian, and they are still bringing this overload to him/her (P2).

AB teams and emergency care teams often work on it limit, with demands above their capabilities, which is an additional difficulty to foreigners.

> We have a lack of care structure for our population. We had a staff deficit, you think there is only a lack of physicians? Lack of

> physician, lack of nurse, lack of agent, lack of receptionist, lack of administrative, lack everything [...] it would need to resize its network in function of its population plus the external population (P2).

These aspects need to be taken into account when defining specific policies for border cities. The lack of clear rules on the care of foreigners, at the limit, leaves it to the professionals at the tip of the system to decide on access. Subjective criteria based on ethical and moral values end up being decisive in decision making:

> It is very difficult to say do not provide care, if it is an adult and not in a severe health condition, but if he is in a serious situation, or if he is a child (P11).

But the greatest difficulty of access appears to be chronic cases of prolonged treatment that require follow-up at other levels of the system.

> The problem occurs when you need a greater complexity that is beyond the sphere of the municipality, the patient will use other spheres of complexity, this is a problem (P10). We also have difficulty in specialized care if the patient has no documentation [...] the primary care we even provide the secondary we cannot (P9).

The demands derived from the SUS Card brought a complication for health managers, emphasizing the duality of understanding. At the core of the elaboration of this device, the proposition was that the card should identify migratory flows and not be used as an instrument to restrict access. The lack of positioning of other spheres of government enables municipal managers to use the SUS card as a barrier to access, not only to foreigners, but to Brazilians from other municipalities and or territories[13,14,15].

Both the restriction of access and the lack of continuity of care hurt the principles of SUS, especially the integrality that constitutes a central element for the consolidation of a health model that incorporates, more effectively, universality and equality. The reorganization of AB implies that demands are answered in secondary care[16]. The decision about care and even referrals to other levels of the system is mediated by professional sensitivity and non-institutionalized personal relationships.

> You give attendance for a Paraguayan child, make a diagnosis of leukemia [...] will I send him/her back to die? No! We call the family and send the child to Pequeno Príncipe(P2).

The lack of institutional support for care for the foreign causes discomfort and suffering for health professionals dealing straightly with people.

> Here it was anguish [...] to sometimes attending a severe case and not being able to continue caring for a case of a serious disease that has to occur in other instances and could not because he/she is from another country, the team was desperate (P4).

Common points were found in other realities[10,14,17], including the discontinuity of care abroad, the migration due to the free of charge of the Brazilian public service and the franchised access to urgency and emergency services. The lack of specific policies and guidelines for the care of foreigners in border cities has been reflected in the diversity of interpretations regarding the right to health, transferring to the professionals who work in the system the selectivity of who will or will not be attended[14].

3. Health financing as a restrictive factor for foreigners' access to health services in twin cities of Paraná

The financial burden assumed by the municipalities, the lack of specialized professionals, the insufficient offer of consultations in various specialties, as well as the dependence of the private sector, are characteristics pointed as obstacles to the guarantee of access to health care in SUS in small municipalities[18].

Given the historical underfunding of the SUS, any extra demand is contested by municipal managers who, with the decentralization process, eventually assumed responsibility for the provision of health services. In addition to a gradual reduction of the federal contribution in the percentage of health system resources, state governments, although they should apply 12% of their health budget, do not transfer these resources to municipalities, and when they do, do not use criteria clearly. Municipalities are the ones that most contribute

financially to the health sector in proportional terms to their collection[19].

> I think that the state and federal spheres have to give assistance in costing, which ends up burdening only the municipality (P9).

Several studies[3,9,14,17] show that, in general, the main dissatisfaction of municipal management in relation to the service abroad results from the transfer of resources being linked to the resident population, thus establishing an imbalance between demand and supply and health services, since the population in transit does not appear in the data of federal public resources transfers. Branco[13] points out that Law n. 8.080/90 already provided for the establishment of other criteria for setting values transferred to states and municipalities subject to a notorious migration process.

Two initiatives mentioned by the interviewees, one at the national level and the other at the state level, made transfers of funds to border municipalities. The Integrated Border Health System (*Sis-Fronteira*), launched in 2005, was a federal program that included 121 border municipalities and proposed the integration of health actions and services in the border region[17].

> Through *Sis-Fronteira*, there was recognition of the situation faced by border municipalities, despite the standardization, focus on investments and their brevity. With the program, which expanded the structure of health services, reference units were built to serve foreigners, which, due to the non-continuity of the program, ended up uncharacterized:
>
> They mapped, they brought money to build reference units, they did some flow studies, they built the unit [...] afterwards it is uncharacterized because the unit itself no longer recognizes itself as a unit that was born with this perspective (P2).

Often, projects start with infrastructure resources, although the main issue is maintaining them:

> The SIS-Fronteira had an infrastructure portion, but the biggest bottleneck of any project is not infrastructure resources, it's human resources and their maintenance (P4).

One of the merits of the program has been to explain and publicize a problem experienced daily by workers and health managers in border municipalities. It was not a joint action of the countries, it is a Brazilian program, unilaterally planned to be jointly operationalized, which is one of the possible reasons for its failure. A study by Ferreira *et al*.[17] revealed that most professionals reported not knowing the *Sis-Fronteira* program, unlike the present research in which almost all respondents mentioned the program as an initiative that helped to analyze the situation of health care to the of foreigners.

The Traveler's Health program, an initiative of the Paraná State Department of Health, aimed to implement actions that contribute to the prevention, promotion, assistance and surveillance of traveler's health. It includes transferring financial resources with costing expense element, intended for municipalities with large flow of people.

Table 2. Amounts transferred on to municipalities through the Traveler's Health Program. 2016

Data	Foz do Iguaçu	Guaíra	Santo Antônio do Sudoeste	Barracão
Estimated Population (2012)	255,718	31,013	19,048	9,796
Per capita fixed factor R$ 27.37	7,000,000.00	848,946.89	521,418.12	268,154.76
Accumulated-PAB* /year in R$	6,137,232.00	806.337.96	533,343.96	274,287.96

* PAB: Primary Care Wage
Source: Health Secretariat-SESA, 2016.

This program represented an important contribution in the municipalities' budget. As can be seen in Table 2, the amounts received represent approximately one year of the accumulated monthly PAB. The fact that resources can be used for funding was a positive aspect highlighted by respondents, despite the lack of continuity.

> The traveler's health came for a year or two, but it was an advance from the initiative of this

> unmet demand. [...] before everything was burdened in the municipality, there was left over to the municipality, after the traveler's health, there was an improvement, it is a resource that can pay consultations, exams, there is a resource that we get stuck (P10).

The municipal managers, when financially supported, implement actions that favor and improve the service to foreigners. Bento[1] clarifies that public policies related to cross-border processes are a recognition of this modality of (informal) integration, a way for the state to value this socio-cultural, political and economic production of border cities. According to the author, with or without institutional support, border cities will continue to perform the daily practice of integration as a phatic instrument of existence, or even of survival.

4. Integration in twin cities of Paraná: the challenge of instituting lasting public policies

Integration initiatives, often punctual, are not the result of a long-term policy and move forward or backward according to specific situations, sensitivity of the technical teams and vision of each municipal management. The personal aspect of the initiatives and their non-institutionalization make them disappear with changes in positions, management, transfer or absence of the professional, without continuity.

> The programs are not institutionalized, they are personalized. Let's think about it: the person who works, the person who does it, when the person leaves his or her position, has no other person to do the follow up (P4).

The provisional character is a source of disenchantment for workers who participate in initiatives considered as interesting and are abandoned due to their non-institutionalization as a state policy, often not even government. Health in the border region needs greater stability, as it involves different countries, agreements that demand time, energy, dialogue and overcoming bureaucratic barriers in each country.

> The solution will hardly come from the political will of a municipality, so this is the greatest difficulty in integrating the three spheres of the three levels of government to effectively discuss the solutions of the problem as a policy (P3).

As observed above, integration into a border region exceeds the municipal level and requires federal intervention for its solution. Noting that the federal intervention must be articulated with the neighboring country in order to be effective. However, our Constitution concentrates much of its competence on Union frontier issues, thus leaving little scope for articulating local development policies[11,13].

FINAL CONSIDERATIONS

The border regions and the problems experienced there still lack visibility and specific policies to address them. The absence of such initiatives causes cross-border populations to face discrimination, creates dual citizenship, making cross-border access to the health care network unstable and dependent on the subjective decisions of health professionals who deals straightly with people.

The smaller municipalities, with 100% of ESF, have a larger reception in the AB. The regionalization and organization of care networks in search of comprehensiveness and equity is a challenge in SUS, since sometimes the core of political-social discussion inherent to these policies is overlooked, and in practice are limited only to bureaucratic and administrative issues. Another complication stems from the decrease in public health spending. In Brazil, the reduction of resources interferes with the supply of health goods and services, and implies more and greater difficulties for the realization of the right to health.

Sis-Fronteira and Traveler's Health were important initiatives in recognizing the problematic, but punctual and discontinuous, as well as non-institutionalized local initiatives. It is noteworthy that both programs were unilateral and vertically hierarchized, with no room for shared discussion among those involved, both in implementation and financing. The dissemination of integrative thinking and solidarity among population from the local level can help to broaden the notion of citizenship and embracing the cross-border.

Limitations of this study are the voluntary participation of respondents, which may generate a self-selection bias in the results and/or inadequate understanding of the meaning of the

questions. It would be important to broaden discussions of peculiarities of other twin cities.

ACESSO DO TRANSFRONTEIRIÇO AOS SERVIÇOS DE SAÚDE EM CIDADES GÊMEAS DO PARANÁ

ABSTRACT

Objetivo: compreender a dinâmica de acesso do transfronteiriço aos serviços de saúde. **Método:** pesquisa exploratória, descritiva e de campo em quatro cidades gêmeas do Paraná (Foz do Iguaçu, Guaíra, Santo Antônio do Sudoeste e Barracão). Os dados foram obtidos por meio de entrevista semiestruturada aplicada aos gestores de saúde e submetidos à análise temática de conteúdo proposta por Bardin. **Resultados:** quatro categorias temáticas discutidas criticamente com a literatura**,** observou-se no estudo que a) há um maior acolhimento nos municípios menores, sobretudo na atenção básica; b) o financiamento como principal entrave para o acesso do transfronteiriço; c) a decisão discricionária do profissional de saúde no momento do atendimento face à ausência de diretrizes institucionalizadas que perdurem. **Considerações finais:** verificou-se que o acesso ao serviço de saúde do transfronteiriço é instável e confuso, mas a disseminação do pensamento integrador e de solidariedade entre os povos, a partir do nível local, poderá contribuir para ampliar a noção de cidadania e de acolhimento ao transfronteiriço.

Keywords: Política de Saúde. Saúde na fronteira. Acesso aos serviços de saúde.

ACCESO DEL TRANSFRONTERIZO A LOS SERVICIOS DE SALUD EN CIUDADES GEMELAS DE PARANÁ

RESUMEN

Objetivo: comprender la dinámica de acceso del transfronterizo a los servicios de salud. **Método:** investigación exploratoria, descriptiva y de campo en cuatro ciudades gemelas de Paraná-Brasil (Foz do Iguaçu, Guaíra, Santo Antônio do Sudoeste y Barracão). Los datos fueron obtenidos por medio de entrevista semiestructurada aplicada a los gestores de salud y sometidos al análisis temático de contenido propuesto por Bardin. **Resultados:** cuatro categorías temáticas discutidas críticamente con la literatura, se observó en el estudio que a) hay una mayor acogida en los municipios menores, sobre todo en la atención básica; b) la financiación como principal obstáculo para el acceso del transfronterizo; c) la decisión discrecional del profesional de salud en el momento de la atención ante la ausencia de directrices institucionalizadas que perduren. **Consideraciones finales:** se verificó que el acceso al servicio de salud del transfronterizo es inestable y confuso, pero la diseminación del pensamiento integrador y de solidaridad entre los pueblos, a partir del nivel local, podrá contribuir para ampliar el concepto de ciudadanía y acogida al transfronterizo.

Palabras clave: Política de Salud. Salud en la frontera. Acceso a los servicios de salud.

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