Original Article

https://doi.org/10.1590/2317-6431-2021-2590

Audiology Communication Research
ISSN 2317-6431

Hearing health care in the Regional Health Coordinating Bodies in Rio Grande do Sul: access regulation, challenges, and perspectives

Saúde auditiva nas Coordenadorias Regionais de Saúde do estado do Rio Grande do Sul: regulação de acesso, desafios e perspectivas

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ABSTRACT

Purpose: To understand the dynamics of access regulation, the challenges, and perspectives of the performance of the Regional Health Coordinating Bodies of Rio Grande do Sul (RHCB/RS) in hearing health care. **Methods:** This is an exploratory, cross-sectional, census study and the analysis is descriptive. It involved those responsible for the regulation of hearing health care procedures in RHCB/RS, interviewed about professional training, identification of available procedures and their respective offer, access regulation systematics, and other actions in hearing health care. **Results:** 15 professionals participated, all were women, from 16 of the 18 existing RHCB/RS, aged between 30 and 47; 13 speech-language pathologists and audiologists and two physiotherapists, who graduated between 1997 and 2012; and 13 had post -graduate degrees. Regarding regulation in RHCB/RS, 13 used the National Regulation System and three performed it manually; 12 used the protocol provided by the State Health Department/RS; ten RHCB/RS regulated procedures for Neonatal Hearing Screening and 16 for assessment and diagnosis, as well as auditory rehabilitation. There is a repressed demand for all procedures (greater for auditory rehabilitation) in 12 RHCB/RS. All RHCB/RS performed one or more actions to promote hearing health care such as surveillance, matrix support, and health education. **Conclusion:** The access regulation in hearing health care is performed in a qualified way in most RHCB/RS; the offer of procedures is insufficient, especially in auditory rehabilitation, which includes exclusive speech-language pathologists and audiologists' performance through soft and soft-hard technologies.

Keywords: Unified Health System; Regional health planning; Public health policy; Hearing; Persons with hearing impairments

RESUMO

Objetivo: compreender a dinâmica da regulação de acesso, os desafios e as perspectivas da atuação das Coordenadorias Regionais de Saúde do Rio Grande do Sul (CRS/RS) em saúde auditiva. **Métodos:** estudo exploratório, transversal, de natureza censitária e análise descritiva. Envolveu os responsáveis pela regulação dos procedimentos de saúde auditiva nas CRS/RS, entrevistados quanto à formação profissional, identificação dos procedimentos disponíveis e respectiva oferta, sistemática da regulação de acesso e outras ações em saúde auditiva. **Resultados:** participaram 15 profissionais, todas mulheres, de 16 das 18 CRS/RS existentes, entre 30 e 47 anos de idade: 13 fonoaudiólogas e duas fisioterapeutas, graduadas entre 1997 e 2012; 13 possuíam pós-graduação. Sobre a regulação nas CRS/RS, 13 utilizavam o Sistema Nacional de Regulação e três a realizavam manualmente; 12 utilizavam o protocolo disponibilizado pela Secretaria Estadual de Saúde/RS; dez CRS/RS regulavam procedimentos de Triagem Auditiva Neonatal e 16, de avaliação e diagnóstico, bem como de reabilitação. Verificou-se demanda reprimida para todos os procedimentos (maior para reabilitação auditiva) em 12 CRS/RS. Todas as CRS/RS realizavam uma ou mais ações promotoras da saúde auditiva, como vigilância, apoio matricial e atividades de educação em saúde. **Conclusão:** a regulação de acesso em saúde auditiva é realizada de forma qualificada na maioria das CRS/RS. A oferta de procedimentos é insuficiente, sobretudo em reabilitação auditiva, que implica exclusiva atuação fonoaudiológica por meio de tecnologias leves e leve-duras.

Palavras-chave: Sistema Único de Saúde; Regionalização da saúde; Política pública de saúde; Audição; Pessoas com deficiência auditiva

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Conflito de interesses: Não.
Authors' contribution: ABOT were responsible for the idealization of the study, acquisition, analysis and interpretation of data and elaboration of the manuscript; MSG collaborated in the design of the study, analysis and interpretation of results and writing of the manuscript; EF participated, as a supervisor, in the design of the study, analysis and interpretation of data and elaboration of the manuscript.
Funding: None.
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Received: October 20, 2021; **Accepted:** January 18, 2022

INTRODUCTION

The coverage of the Unified Health System (UHS) covers the more than 213 million people of Brazil; almost 11.5 million are in the state of Rio Grande do Sul (RS)[1]. Such coverage has been made possible, mostly, by the implementation and realization of one of the operational guidelines of the UHS – regionalization –, responsible for decentralizing management (by the states and municipalities) and health services and, thus, minimizing the effects of territorial social inequalities[2].

The decentralization process in RS began in 1999, with the establishment of 19 Regional Health Coordinating Bodies (RHCB/RS) – administrative bodies of the State Health Department of RS (SHD/RS)[3], responsible for planning, monitoring and management of health actions and services in a territory[4]. Currently, RS is divided politically and administratively into 18 RHCB, which aim to technically support the local and regional health systems of 30 health regions, organized into seven macro-regions, which are the basis for health planning. The macro-regions are: Metropolitana (1st and 18th RHCB), Norte (2nd, 6th, 11th and 15th RHCB), Sul (3rd and 7th RHCB), Centro-Oeste (4th and 10th RHCB), Serra (5th RHCB), Vales (8th, 13th and 16th RHCB) and Missioneira (9th, 12th, 14th and 17th RHCB)[5].

Through the RHCB/RS, the public policies of the UHS in the region are made possible, which are presented as responses to the demands of the population and, therefore, are in constant transformation and improvement, increasingly involving different health professionals[6] and with different attributions, among them, the health access regulation. The access regulation seeks to answer the principles and guidelines of the UHS and, mainly, the timely access of users to health services[7].

Ordinance GM/MS No. 1,559/2008 instituted the Brazilian Regulatory Policy of UHS[8], which is currently governed by the Consolidation Ordinance No. 2/2017, Annex XXVI (Brazilian Regulatory Policy of UHS)[9]. It is argued that access regulation should be carried out by professionals with technical-scientific knowledge about public policies, respective actions, and procedures. Therefore, it is based on effective regulation that the offer condition can be improved. Thus, in this study, the following question was asked: "How has the regulation been in relation to hearing health, a field of intervention that includes, above all, the Speech-Language Pathology and Audiology performance?".

Hearing health care began with the implementation of Ordinance GM/MS No. 1,278/1999, referring to cochlear implants. It was revoked by Ordinance GM/MS No. 2,776/2014[10], which incorporated procedures for specialized care for people with hearing impairment. In 2004, auditory rehabilitation was standardized by Ordinances GM/MS No. 2,073/2004, SAS/MS No. 587, and SAS/MS No. 589/2004, which established the National Policy for Hearing Health Care (NPHHC) and the State Networks of Hearing Health Care. Subsequently, Ordinance GM/MS No. 793/2012 established the Care Network for People with Disabilities (CNPD)[11], preceded by the National Plan for the Rights of People with Disabilities – Living without Limits[12] – which already aimed to guarantee humanized care centered on the needs of each user. Currently, hearing health care, within the scope of UHS, is standardized by Consolidation Ordinance No. 2/2017, Annex XIII (National Health Policy for People with Disabilities)[9] and by Consolidation Ordinance No. 3/2017, Annex VI (CNPD)[13].

Given the above, the objective of this study was to understand the dynamics of access regulation, the challenges, and perspectives of the performance of RHCB/RS in hearing health care.

METHODS

This was an exploratory, cross-sectional, and census-type study. It followed the guidelines of the National Health Council (Resolution No. 466/2012), which regulates research involving human beings. It was approved by the Department of Specialized Care Management of the SHD/RS and by the Ethics Committee in Research with Human Beings of the Federal University of Santa Maria – ECR/UFSM, under the number 4,313,572. The adhesion of the participants took place through the signing of the Consent Term.

The population was composed by the professionals responsible for access regulation of hearing health procedures at the RHCB/RS, including only those who participated in all phases of the study. RHCB/RS professionals whose providers for hearing procedures were in municipalities with full local health system management were excluded and, therefore, access regulation was not carried out by RHCB/RS, but by the municipality itself.

The research was carried out through the analysis of data obtained in an interview and the application of a questionnaire with the professionals, during the second half of 2020 and the first half of 2021. Data collection occurred virtually, via the Google Meet platform, between the researcher, who was guided by semi-structured questions (Annex 1), and the participant who answered them according to their work routine.

Data collection took place in two phases: phase 1 – when the participant's professional training and the time of work in the access regulation of hearing health procedures were questioned. At the end of this phase, a questionnaire that would guide the next one was sent. In phase 2, the questionnaire was applied, which sought to identify the available procedures and their offer in the RHCB/RS, as well as the description of the access regulation system and the actions developed in hearing health.

To respect the anonymity of the participants and of the RHCB/RS, it was decided to identify them by letters according to the order of the interviews. Data analysis was performed using descriptive statistics (mean, standard deviation, frequency, and percentage) and by categories, established by the authors, of the actions that promote hearing health reported by the participants.

RESULTS

Fifteen professionals were interviewed, all women, representing 16 (88.88%) of the RHCB/RS. It should be clarified that one of the participants was responsible for regulating hearing health procedures in two RHCB/RS in the same macro-region and, therefore, was interviewed at different times. As for the professionals from the two RHCB/RS who did not participate, one was due to exclusion criteria (the provider is in the municipality with full local health management) and the other, due to refusal of the invitation.

The results were organized to explain the characteristics of the participants, the access regulation system, the procedures

offered, the characteristics of the RHCB/RS, the offer of vacancies and the repressed demand, as well as the actions that promote hearing health. The professional characteristics of the participants is presented in Table 1.

As mentioned, all participants were female, hereinafter referred to as this gender, between 30 and 47 years old (average age = 35.44; standard deviation = ± 5.32) and graduated between 1997 and 2012. As for postgraduate studies, 12 (80%) had a specialization, 3 (20%) had a master's degree and 2 (13.33%) had a doctorate. Of the postgraduates, 5 (33.33%) had it in Public Health and after starting the job, 4 (26.66%) in Audiology, 2 (13.33%) in Speech-Language Pathology and Audiology, 2 (13.33%) in Education, 2 (13.33%) in Orofacial Motricity, one (6.66%) in Language, one (6.66%) in Physiotherapy, and one (6.66%) in Oncology.

Regarding the work of the interviewees, it is reaffirmed that a speech-language pathologist and audiologist works in the access regulation of two RHCB/RS that integrate a macro-region. It should be noted that none of the interviewees received training prior to the beginning of activities in the RHCB/RS. However, they mentioned the support received from the SHD/RS for the development of their activities, in particular the support of the State Coordination of the CNPD.

It is noteworthy that, in recent years, the SHD/RS has made what it calls "training and technical meetings" for UHS workers, which cannot yet be called Permanent Health Education (PHE) [13]. This fact shows, on the one hand, the concern of SHD/RS to support workers – including the RHCB/RS – and, on the other hand, it does not remove the possibility that the workers of the RHCB/RS demand PHE, especially regarding access regulation, which would significantly improve the work process and, consequently, the repercussion in the territories assisted by the RHCB/RS.

As for the procedures available for hearing health care, the results revealed the phases of the care line[13], divided into three groups: Group 1 – Neonatal Hearing Screening (otoacoustic emissions and auditory brainstem response for screening); Group 2 – hearing evaluation and diagnosis (hearing test, impedancemetry, auditory brainstem response for diagnosis, central auditory processing tests and vestibular tests) and Group 3 – auditory rehabilitation (hearing aids, frequency modulated system, cochlear implant and bone-anchored hearing aid).

All RHCB/RS made available, through their providers, the three groups of procedures. However, not all procedures had their respective accesses regulated by them. Detailed information on the forms of access regulation and the procedures regulated by the RHCB/RS are shown in Table 2.

Regarding the access regulation system, 13 (81.25%) RHCB/RS reported using the national access regulation system – Sistema Nacional de Regulação (SISREG) –, while 3 (18.75%), RHCB/RS B, C and M, indicated carrying out manually, using spreadsheets.

As support in the regulation process, 12 (75%) participants reported that they were guided by the Protocol for Access Regulation to Specialized Care of the State Health Department of Rio Grande do Sul (Schuller, Gonçalves and Fabrício, in press), made available in 2020 by SHD/RS, while 4 (25%), RHCB/RS B, F, M and P, did not use the suggested protocol and reported that they followed their own criteria established based on their theoretical-practical knowledge. The non-use of the protocol implies difficulty in standardizing and classifying the risk in the state, however, the RHCB/RS that do not use it claimed the recent availability as a justification for its implementation to take place. It was noted that the two RHCB/RS where the access regulation was performed by physical therapists (professionals without hearing health knowledge), used the protocol.

Of the procedures, 10 (62.5%) RHCB/RS regulated access for Group 1, while the other 6 (37.5%) were regulated by the Municipal Health Departments; 16 (100%) RHCB/RS performed the access regulation of Group 2 and Group 3.

The data regarding the offer of procedures, the repressed demand, the comparison between the percentage of offer and the percentage of repressed demand for each of the three procedures groups, and the population of each RHCB/RS, are

Table 1. Professional characteristics of the participants (n=15)

Variables		N	%
Graduation	Speech-Language Pathology and Audiology	13	86.66
	Physiotherapy	2	13.33
Decade of conclusion	1990s	2	13.33
	2000s	5	33.33
	2010s	8	53.33
Postgraduation	Yes	13	86.66
	No	2	13.33

Subtitle: N = number of participants; % = corresponding percentage

Table 2. Access regulation characteristics regarding the Regional Health Coordinating Bodies of Rio Grande do Sul by procedure groups (n=16)

Variables	RHCB/RS (N)	%
Regulated G1 procedures	10	62.50
Regulated G2 procedures	16	100.00
Regulated G3 procedures	16	100.00
SISREG	13	81.25
SHD/RS Protocol	12	75.00

Subtitle: RHCB/RS = Regional Health Coordinating Bodies of Rio Grande do Sul; N = number of coordinating bodies; % = corresponding percentage; G1 = group 1 (neonatal hearing screening – otoacoustic emissions and auditory brainstem response for screening); G2 = group 2 (hearing evaluation and diagnosis – hearing test, impedancemetry, auditory brainstem response for diagnosis, central auditory processing tests and vestibular tests); G3 = group 3 (auditory rehabilitation – hearing aid, frequency modulated system, cochlear implant and bone-anchored hearing aid); SISREG = Sistema Nacional de Regulação; SHD/RS = State Health Department of Rio Grande do Sul

Table 3. Data of population, procedure offer, repressed demand, and percentage between offer and repressed demand by procedure groups in the Regional Health Coordinating Bodies of Rio Grande do Sul

RHCB/RS	Population	Offer G1	WL G1	%	Offer G2	WL G2	%	Offer G3	WL G3	%
A	233,741	184	0	100.00	250	0	100.00	50	240	20.83
B	327,158	353	0	100.00	502	0	100.00	73	923	7.91
C	451,313	4	0	100.00	0	70	0.00	14	1.641	0.85
D	563,134	16	67	23.88	13	261	4.98	20	1.628	1.23
E	2,765,808	999	0	100.00	209	3.400	6.15	497	-	-
F	347,535	0	18	0.00	0	13	0.00	50	570	8.77
G	166,744	7	0	100.00	33	32	100.00	22	144	15.28
H	188,916	20	19	100.00	2	41	4.88	27	291	9.28
I	626,126	18	30	60.00	70	0	100.00	128	481	26.61
J	235,963	8	14	35.71	6	10	60.00	10	390	2.56
K	877,265	60	0	100.00	32	0	100.00	60	0	100.00
L	184,032	-	-	-	40	324	12.35	-	-	-
M	214,166	-	-	-	32	8	100.00	25	447	5.59
N	223,034	-	-	-	47	-	-	28	137	20.44
O	287,613	17	0	100.00	193	1	100.00	51	123	41.46
P	151,846	-	-	-	2	0	100.00	20	0	100.00

Subtitle: RHCB/RS = Regional Health Coordinating Bodies of Rio Grande do Sul; WL = waiting list; G1 = group 1 (neonatal hearing screening – otoacoustic emissions and auditory brainstem response for screening); G2 = group 2 (hearing evaluation and diagnosis – hearing test, impedancemetry, auditory brainstem response for diagnosis, central auditory processing tests and vestibular tests); G3 = group 3 (auditory rehabilitation – hearing aid, frequency modulated system, cochlear implant and bone-anchored hearing aid); % = percentage between offer and repressed demand by procedure group

presented in Table 3. It should be clarified that the amount of the monthly offer of procedures available in the RHCB/RS was based on the historical series for the year 2019, determined by the provider of each RHCB/RS.

It was noted that, in general, Group 3 was the one with the highest pent-up demand. Different realities were also observed between the RHCB/RS: RHCB/RS E and RHCB/RS L had only one waiting list for access to Groups 2 and 3, while the others had two independent waiting lists. In the case of the latter, the quantity was considered only in Group 2.

It is inferred that the offer of Group 1 procedures in the RHCB/RS E can trigger the repressed demand in Groups 2 and 3 of hearing procedures in this RHCB/RS.

Also, RHCB/RS B, C and M, which did not use SISREG, showed low rates of offer coverage for Group 3 (7.91%, 0.85%, and 5.59%, respectively). However, RHCB/RS B presented full coverage for Groups 1 and 2. The same coverage was evidenced in RHCB/RS C for Group 1, however, it did not have a regulated offer for Group 2. RHCB/RS M, which does not regulate the procedures of Group 1, presented a sufficient offer for those of Group 2.

The comparative percentage between offer and repressed demand of users of each RHCB/RS who access the procedures was observed and it was found that, in auditory rehabilitation, 12 (75%) RHCB/RS had insufficient vacancies for the existing demand.

Regarding the use of the Protocol for Access Regulation to Specialized Care of the State Health Department of Rio Grande do Sul, 3 of the RHCB/RS that do not use it (B, F and M) had low offer coverage – 7.91%, 8.77%, 5.59%, respectively – for Group 3, and RHCB/RS P did not have a waiting list. For Groups 1 and 2, RHCB/RS B had sufficient offers, while RHCB/RS F did not. RHCB/RS M and P did not regulate Group 1 and provided full coverage for Group 2 procedures.

About the actions to promote hearing health, 10 (62.5%) RHCB/RS carried out health education activities, 13 (81.25%), matrix support, and all of them (100%), health surveillance (Figure 1).

It was found that, of the educational actions in hearing health, speeches predominated. From the matrix support actions, training meetings dominated, and from the surveillance actions, the monitoring reports, typical of this type of action.

DISCUSSION

A recent study reinforces the importance of hearing health care[14]. It is also considered the relevance of studies on access, challenges, and perspectives of hearing health care, carried out in RHCB, such as the one presented here. It is worth noting that this study is a pioneer in terms of regulating hearing health procedures developed by the RHCB/RS and, thus, can contribute to improving management at local, state, and national levels on this topic.

In this study, there was a population totally composed by women, in agreement with data related to the feminization of health work[15]. A recent IPEA (Institute of Applied Economic Research, Ministry of Economy, Brazil, 2020) document revealed that 70% of health workers are women; in Speech-Language Pathology and Audiology, this percentage exceeds 90%[16]. Professional inequality between genders and the fact that women perform work socially linked to care and assistance are commonly mentioned, as, for example, in the study by Wermelinger et al.[17].

The professional qualification of the participants in this study is highlighted, since most of those responsible for access regulation in the RHCB/RS had a degree in Speech-Language Pathology and Audiology, that is, they had technical-scientific knowledge related to hearing health, improved by the specialty in Audiology and Public Health. This fact is an important prerequisite for an access regulation carried out in an orderly, timely and rational manner, as indicated by studies in this area[18,19].

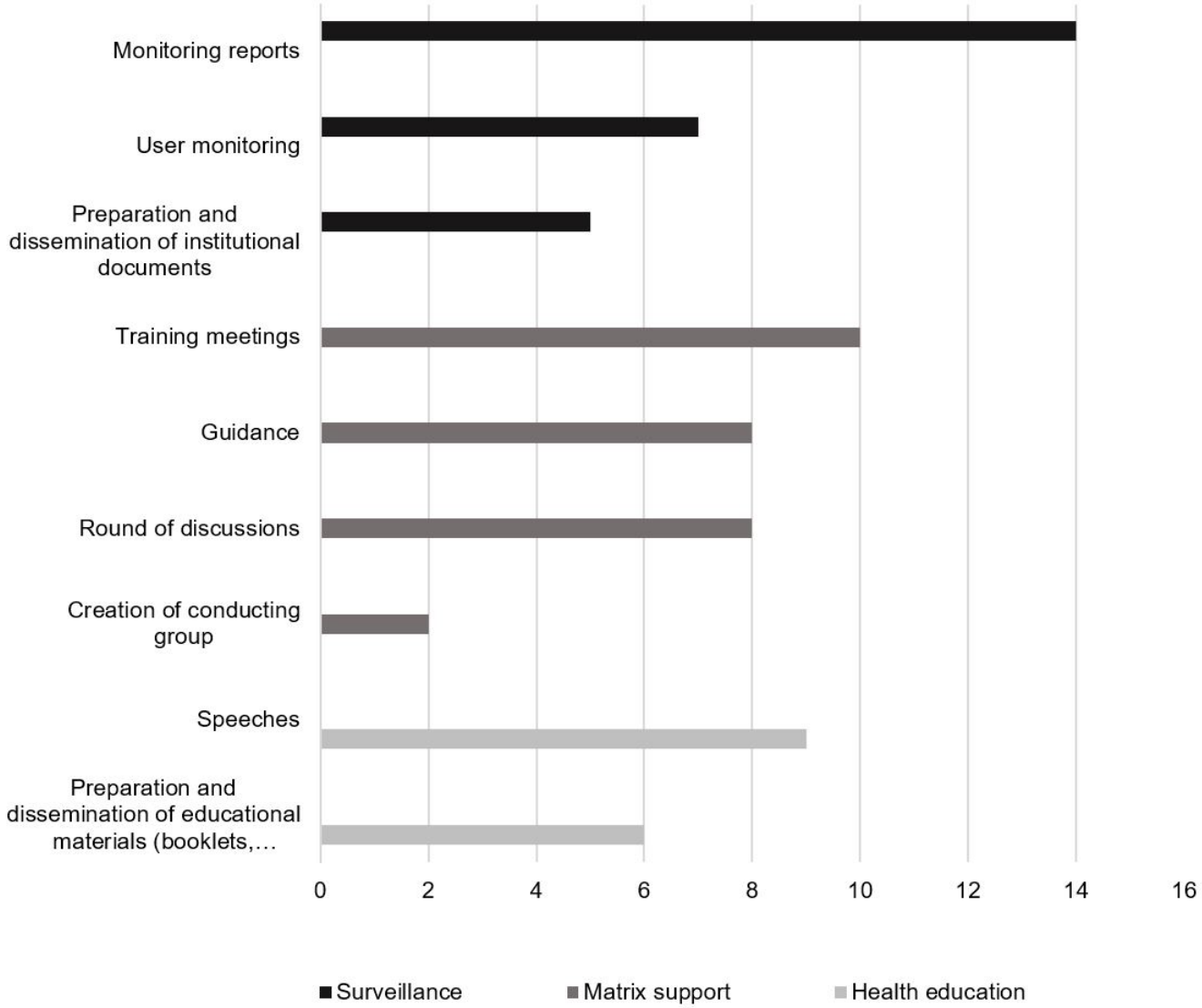

Figure 1. Hearing health care actions in the Regional Health Coordinating Bodies of Rio Grande do Sul

It is noteworthy that the ordinances that regulated hearing health in the UHS – NPHHC and State Networks for Hearing Health Care – are currently incorporated into the CNPD[11] and, with the expansion of public policies, Speech-Language Pathology and Audiology professionals have been able to disseminate its performance at all levels of health care in the UHS, especially in management positions that were previously little (or not) occupied[20].

The management of public health policies, such as the access regulation of the CNPD, has been a reality. However, the development of such activity implies difficulties such as, for example: lack of budgetary, financial, and technical-administrative autonomy; impasses for the increase of human resources; delay in bidding processes. Often, these difficulties lead to the centralization of management, a fact that impairs the planning of managers[21], especially those who are in the regional sphere, such as the participants of this study, who understand and know the health needs of population in their region.

Access regulation balance the offer and demand of the actions through risk assessment and classification and, therefore, it is advisable to use instruments that facilitate this process. The SISREG, used by most RHCB/RS, is considered the main tool for regulating access, because through it the regulator receives, evaluates, classifies the risk, sends and approves requests[22,23]. Considering the importance of collecting epidemiological data from the use of computerized systems, it is essential to assess the quality of regulation in the three RHCB/RS that do not use SISREG, to verify, in addition to other aspects, whether there is a relation with low coverage in the procedures of Group 3.

In the reality researched, it was identified that the instrument guiding and organizing this process was the Protocol for Access Regulation to Specialized Care of the State Health Department of Rio Grande do Sul, recently made available, which establishes priority criteria and classifies the risk of the user's demand, with the perspective of coming up the doctrinal principle of equity in the UHS and providing improvements in the quality of access regulation. It is known that protocols are fundamental

for the ordering of referral flows, as they enable integral care for users and provide guidance on the competence of the levels of complexity of care so that resolution in health is achieved[24].

The access regulation to the procedures provided in the CNPD in a timely manner for integral care was one of the obstacles identified in the RHCB/RS. There was an imbalance between the relation between the offer of vacancies and the needs of users, that is, there is a repressed demand, especially regarding to auditory rehabilitation, despite indicators showing that, in the last 30 years, there was an increase in the provision of procedures in UHS[25].

The number of professionals working in the access regulation of hearing health in the CNPD, the offer of evaluation, diagnosis and rehabilitation procedures are not enough in most RHCB/RS. This imbalance between offer and demand, even though it is evidenced by the RHCB/RS and discussed in the territories, by the social controls, depends on attention to the epidemiological data of each region. Thus, using the Protocol for Access Regulation to Specialized Care of the State Health Department of Rio Grande do Sul, indicators can be established based on repressed demand (established waiting list), on monthly demand (number of users who join the waiting list) and the number of vacancies offered from the contracting of the state with the providers. This study revealed the need to analyze the regional profile of each regulated procedure, based on the indicated indicators, aiming at a balanced relation between offer and demand. It is known that auditory rehabilitation requires soft and soft-hard technologies[26], which implies the need for Speech-Language Pathology and Audiology professionals at different levels of care, developing soft technologies (those that prioritize relationships, bonds and work process management) and soft-hard (those that require specific and well-structured knowledge)[26]. Health technologies provide care, including to the professional himself and his strategies[27].

It was also evident that actions to promote hearing health are common in RHCB/RS. Surveillance and educational activities in health are powerful actions that expand and qualify the regulation of hearing health procedures. A more specialized look, made possible by the actions mentioned above, enables the identification of differences and specificities of territories, responding to the National Health Surveillance Policy[28]. It is responsibility of UHS to carry out health surveillance actions[29] and directly assist users through integrated actions, rehabilitating and preventing health problems[2]. In parallel with these actions, matrix support, which presents itself as a specialized back-up for the reference teams[30], certainly contributes to the greater professional qualification, especially those in the Primary Health Care (PHC). These actions, together, have an impact on improving access and assistance.

In this study, it was found that the RHCB/RS were committed to implementing the management of hearing health care, as provided in the CNPD, involved in providing greater proximity between the municipalities of the health regions, valuing the decentralization of the care line and seeking to favor humanized care for people with disabilities[11].

The continuity of care – starting from the PHC and covering the different services of the Health Care Network (HCN) and in its different levels of complexity – is linked to the health regulation processes, since this, aiming at the integrality of care, implies building a balanced relation between demand and offer and using principles such as equity, transparency, and timely use of access time. There are determining factors regarding the role of regulation in the articulation and interaction of the different points and levels of the HCN, such as, for example, the quality of referrals and requests, the elaboration and use of regulation protocols and clinical guidelines, the establishment of unbureaucratic access flows, the rational use of health resources, in order to prevent unnecessary displacements and bring greater efficiency and equity to the management of waiting lists, the agreement of new procedures based on health indicators aligned with the population's needs, monitoring and systematic evaluation of services.

It can be considered that the fact that this study did not count on the voluntary participation of all professionals involved with the regulation in the RHCB/RS limited its census-type, since, unfortunately, a speech-language pathologist and audiologist refused to participate. Another limiting factor for the adequate dimensioning of the CNPD in the state was the non-inclusion of one RHCB/RS whose providers for hearing procedures were in municipalities with full local management of the health system, which implies the autonomy of municipalities to manage their network. Furthermore, the scarcity of scientific papers discussing the role of Speech-Language Pathology and Audiology in access regulation restricted the possibilities for discussion. Thus, it is convenient to expand research that focus on the participation of Speech-Language Pathology and Audiology in health management, considering that scientific production influences the elaboration and implementation of public policies. It is necessary to know different realities and contexts to provide arguments for advances in the practices and fields of work of speech-language pathologists and audiologists, such as the one carried out in this study.

CONCLUSION

The access regulation of hearing health in the RHCB/RS revealed strengths and weaknesses. Among the strengths, the following stand out: the high qualification of the professionals, most of them through their own efforts; the understanding of regionalization and the HCN, and, also, the involvement of professionals in carrying out health-promoting actions in addition to surveillance.

The regulation proved to be qualified in most RHCB/RS, possibly due to the professional qualification and guidance of the SHD/RS, which recently made available the Protocol for Access Regulation to Specialized Care of the State Health Department of Rio Grande do Sul. Such facts tend to raise the quality of services. Thus, it can be reiterated that the access regulation must be carried out by specialists – professionals who have the knowledge to recognize the real need of the demands of users and, consequently, apply the principle of equity of UHS. From the specialized point of view, policies can be improved and expanded.

The weaknesses observed were: the insufficient offer of evaluation, diagnosis and, above all, auditory rehabilitation procedures, which imply the exclusive performance of speech-language pathologists and audiologists through soft and soft-hard technologies; the non-use of SISREG and the protocol suggested by SHD/RS which, when added to the lack of offer, contribute to the repressed demand in auditory rehabilitation.

From the situational analysis of the regulation in each RHCB/RS carried out in this study, the use of epidemiological data and

the Protocol for Access Regulation to Specialized Care of the State Health Department of Rio Grande do Sul is reaffirmed to support the agreement of indicators, considering pent-up demand, monthly demand and the number of vacancies offered, to achieve a balanced relation between offer and demand.

ACKNOWLEDGEMENTS

In addition to thanking her for her availability to contribute as a reviewer in the undergraduate thesis, this paper is dedicated to the speech-language pathologist and audiologist Márcia Falcão Fabrício, for her constant struggle for inclusion and expansion of the professional category in the management of the Unified Health System.

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Annex 1. Semi-structured questionnaire for the interviews

PHASE 1 (applied by video call):
1. Name:
2. Age:
3. Graduation (year of conclusion):
4. Postgraduation (area and year of conclusion):
5. Job position:
6. Time held in this position:
7. Department of the RHCB where you held this position:
8. Have you received any training to work in the management of hearing health care?

PHASE 2 (sent on the first meeting and applied on the second, also by video call):
1. What are the available audiological procedures and their respective providers (medium and high complexity) in the Hearing Health Network at your RHCB?
2. Of the procedures described by you, which are regulated by your RHCB?
3. You do the access regulation:
3.1. Using an online system? Which one?
3.2. Manually? How?
4. Which criteria do you use to do the access regulation of each procedure?
5. Do you use a protocol? Which?
6. Indicate the number of users in the waiting list for each procedure to date.
7. What is the monthly offer (vacancies) for each procedure?
8. Have you carried out surveillance actions in hearing health? Which? Why?
9. Did you carry out matrix support in hearing health? Describe.
10. Have you performed educational actions in hearing health?