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Distribution of physical therapists working on public and private establishments in different levels of complexity of health care in Brazil

Distribuição de fisioterapeutas entre estabelecimentos públicos e privados nos diferentes níveis de complexidade de atenção à saúde

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Abstract

Background: The Brazilian Health System is organized on a regional and hierarchical form with three levels of complexity of health care. The Primary Care represents the first element of a continuing health care process, complemented by specialized actions. However, the centrality of the specialized care is still a problem in Brazil, especially in the private sector. Studies on the distribution of professionals in the health system allowing the formulation of appropriate policies are needed. **Objectives:** To investigate the distribution of physical therapists in the levels of complexity of health care and between public and private establishments, according to data from the National Register of Health Service Providers (NRHSP). **Method:** A descriptive cross-sectional study was performed considering NRHSP-national bank data collected in March 2010 and demographic census 2010 data. Data were analyzed through descriptive statistics techniques. **Results:** We identified 53,181 registries of physical therapists, 60% linked to the private sector. Only 13% of all entries were linked to primary care. The predominance in specialized care occurred in the public sector (65%) and private sector (100%). The specialized establishments of private sector linked to the southeast region (16,043) were the main sites of physical therapists. Only the public sector in the south had a majority in the Primary Care. When considering the sizes of the cities, there is focus on specialist care in bigger cities. **Conclusions:** This study identified the concentration of physical therapists in the specialized care, mostly in metropolis and big cities and in the private sector, with restricted to participation in the primary care.

Keywords: physical therapy; public health; private sector; primary health care; ambulatory care; hospital care.

Resumo

Contextualização: O Sistema Único de Saúde (SUS) é organizado de forma regionalizada e hierarquizada, apresentando três níveis de complexidade de atenção à saúde. A atenção primária à saúde (APS) representa o primeiro elemento de um continuado processo de assistência à saúde, sendo complementada pelas ações especializadas. No entanto, a centralidade na atenção especializada ainda é uma realidade no país, principalmente no setor privado. Estudos sobre a distribuição das profissões no sistema de saúde permitem a formulação de políticas adequadas que fortaleçam a APS. **Objetivos:** Investigar a distribuição dos fisioterapeutas nos níveis de complexidade de atenção à saúde e entre os estabelecimentos públicos e privados de acordo com dados do Cadastro Nacional de Estabelecimentos de Saúde (CNES). **Método:** Foi realizado um estudo transversal descritivo. Os dados foram coletados no banco nacional do CNES, em março de 2010, sendo analisados por técnicas estatísticas descritivas. **Resultados:** Foram identificados 53.181 cadastros de fisioterapeutas, com 60% vinculados ao setor privado. Apenas 13% de todos os cadastros estiveram vinculados à APS. A predominância na atenção especializada ocorreu no setor público (65%) e privado (aproximadamente 100%), sendo o maior número de profissionais vinculados a estabelecimentos privados especializados da região Sudeste (16.043). Apenas o setor público da região Sul apresentou maioria na APS. Quando considerados os portes dos municípios, verifica-se concentração na atenção especializada em municípios de maior porte. **Conclusão**: Este estudo identificou concentração de fisioterapeutas na atenção especializada, majoritariamente em municípios de maior porte populacional e no setor privado, sendo ainda restrita a participação na APS.

Palavras-chave: fisioterapia; saúde pública; setor privado; atenção primaria à saúde; assistência ambulatorial; assistência hospitalar.

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Introduction

The Brazilian Unified Health System (known as SUS) has as objective to ensure health as the citizen's right and as the responsibility of the State. SUS is structured under the principles of universality, comprehensiveness and equity and is organized by regions and in three hierarchical levels of complexity: primary health care, medium complexity health care and high complexity health care[1,2].

The primary care represents the preferential entry door of this health system, using low-density technologies for resolution of health problems of higher frequency and relevance in its territory[3]. As the resolution of problems demand availability of specialized professionals and use of technological resources of higher density, the primary care is complemented by the other levels, through diagnosis and therapy support services, developed in a clinic or hospital setting, to provide integral healthcare to the population[2]. The primary care is the first element of a continuous process of healthcare, representing the main focus and guiding axis of the other actions[3,4].

However, this model is still in progress, existing insufficient integration between services and predominance of actions in specialized levels, compromising the quality and effectiveness of the healthcare network, with increase of costs and inequalities in access[5].

Physical Therapy has been characterized as a profession with emphasis on specialized actions[6,7]. Originated during the world wars, when there were high rates of occupational injuries and high incidence of individuals with poliomyelitis sequels, the professional field was guided to rehabilitation activities. These aspects, reinforced by the formation focused on individual treatments and on clinic and hospital actions, historically, have classified Physical Therapy as belonging to the medium and high complexities, remaining for a long time with limited act in primary care[8,9].

In spite of the expansion of the number of physical therapists, it is possible that its concentration occurs in specialized sectors, hindering the access to the population. It becomes important the investigation of the distribution between the complexity levels as a constant practice, guiding interventions that improve the structure of system and strengthen the prioritization of actions in primary care.

The proposed study should consider, however, the hybrid characteristics of the health system, in which public actions linked to SUS coexist with private actions[1]. The plural structure of health systems worldwide is covered by less than 10% of the private sector[10]. However, in Brazil there is an important participation of private sector, which concentrates 50% of the jobs that require higher education in health area, according to data of the Survey of Medical Care (SMC), conducted in 2009[11]. Among the specialized actions, the participation of private sector is more significant, reaching 90.9% of the establishments that perform Therapeutic and Diagnosis Support Services (TDSS)[11].

Whereas only a portion of population has financial conditions that allow the use of private services, this concentration promotes inequity in the access to certain professionals and procedures. The access becomes even more restricted when considering that the geographical distribution of private services follows the economical logic.

It was established in the Federal Constitution of 1988, the right of private participation in the complementation of health actions[1]. Therefore it is important to ensure public actions aimed at the entire population. Investigation of the distribution of jobs must, therefore, include data from public and private sectors, allowing the formulation of appropriate policies for each sector, reducing the access barriers and promoting the strengthening of the SUS principles.

Previous studies on the distribution of jobs, however, involve more often medical professionals and nursing due to the characteristics of centrality of these professions[11]. Studies on Physical Therapy are scarce and there is a lack of a widespread study that investigates the situation of the Physical Therapy in Brazil. The present study had as objective to investigate the physical therapists' distribution in the complexity levels of healthcare and among the public and private establishments, according to data from the National Register of Health Service Providers (NRHSP).

Method

A descriptive cross-sectional study was conducted based on data from the NRHSP, which is the main information system of national scope on health establishments and instituted by the Ministry of Health[12].

The obligatory registration in the register is extended to all health establishments, publics and private, however some of the existent establishments still do not provide information to the system and there is no estimates on the proportion of establishments that do not provide information.

Among the public and private establishments insured to the SUS, the registration in NRHSP is established as prerequirement for payment of services. Therefore it is probably that the number of these establishments is close to the number actually existent[13].

Likewise, the National Agency of Supplementary Health (NASH) stipulates the register in NRHSP as obligatory requirement in the contracts between service providers and operators of private health insurers. Therefore it is possible that the total of establishments providing services in the supplementary health currently registered in NRHSP is also close to the total number of establishments[13-15].

Therefore it can be considered that the private establishments non insured to SUS and not linked to supplementary health are the types of institutions which present the greatest difference among the number of registrations in NRHSP and the number of existing services[13].

This study was approved by the Ethics in Human Research Committee of the Universidade Federal de São Carlos (UFSCar), São Carlos, SP, Brazil, protocol 386/2009.

Data collection

The data, concerning the updating of February 2010, were collected in the database of NRHSP, in Brasília, Brazil, in March 2010. The search included information from the 5.564 municipalities of Brazil, involving establishments with at least, one registered physical therapist.

Information obtained for each establishment was: establishment type; number of physical therapists; administrative type (public or private); region, state and municipality location. Professionals who work in more than one establishment have a record for each local of work, so, it may have more than one registration for the same professional. The analyses of this study considered the total number of registries.

Later, the types of establishments were classified according to the level of complexity:

- Primary Care: health center/ basic unit, family health support centers, fluvial mobile unit;
- Specialized Ambulatory Care: specialized clinic/ambulatory of specialties, polyclinic, isolated clinic, cooperative, psychosocial center and support, diagnosis and therapy unit, (TDSS);
- Hospital/Urgent and Emergency Care: general hospital, specialized hospital, day-hospital, normal birth centers, general emergency room, specialized emergency room, mobile unit of pre-hospital level and hematology center;
- Mixed unit: where are developed both services of Primary Care and of specialized care (hospitalization and urgencies);
- Other: central regulation of health services, health department, health surveillance unit, land mobile unit, indigenous health care center.

The number of inhabitants of the municipalities, according to Demographic Census data of 2010 was also included, using the following classification of the population size of the municipalities[16]:

- Small size: population up to 20.000 inhabitants
- Medium size: between 20.001 and 100.000 inhabitants
- Large size: between 100.001 and 500.000 inhabitants
- Metropolises: over 500.000 inhabitants

The physical therapists ratio per 1.000 inhabitants was calculated according to the following equation:

$$\text{Physical therapists ratio per 1.000 inhabitants} = \frac{\text{total of physical therapists records} * 1.000}{\text{Number of inhabitants of municipalities with physical therapists}}$$

Data analysis

The data were analyzed using descriptive statistical techniques, considering: state, region, establishment type, complexity level, administrative type, population size of the municipalities and physical therapists' ratio per 1.000 inhabitants.

Results

Distribution of physical therapists according to the complexity levels

The study identified 53.181 registrations of physical therapists in the NRHSP, distributed into 22.238 establishments. The main types of establishments were Specialized Clinic/Ambulatory of Specialties (17.399 registries = 32%) and General Hospitals (12.329 registries=23%). The sum of these registries was higher than all others combined (Table 1).

Considering the classification according to the healthcare complexity, 13% of the registrations were linked to primary care, 29% to hospital/UE and 57% to specialized ambulatory care, and this number (30.155) was higher than the other registries (23.026) (Table 1). The sum of the physical therapists' registrations in the specialized ambulatory care and in the hospital/UE shows that about 90% of the jobs were concentrated in specialized services.

This concentration is observed in the physical therapists' ratio per 1.000 inhabitants (primary care=0.05, specialized

ambulatory=0.20 and hospital/UE=0.11), indicating higher offer in the specialized ambulatory care. The lowest ratio of professional/inhabitants happened in the north for the three levels (Table 2).

The analysis of regions separately indicates the predominance of registries in the specialized ambulatory care in all places. The south showed the higher contrast among the proportion of specialized ambulatory care (71%) and the other levels (primary care 12% and hospital/UE 17%). Primary care showed the lowest percentage of registries in all regions (from 11 to 15%) – Table 1.

The greatest number of registries in specialized establishments does not reflect, however, in a greater number of municipalities with physical therapists in these care levels and there was a trend to the concentration in municipal districts of larger size. Primary care, which represented only 13% of the registries, is distributed in a greater number of municipal districts (46% of the existent municipalities)

Distribution of physical therapists between public and private establishment

Approximately 60% of registries are linked to private establishments (Table 3) and the participation of the private sector was higher in the south, southeast and central-west. The north region was the only one to show participation in the public sector higher than in the private.

Among the Brazilian states, the number of registries in private places was triple of the total of registries of public sector in all states of south. Distrito Federal and São Paulo showed double of registries in private establishments. In the north and northeast, differently, registries in public establishments were equal or over to the private ones in most of the states, being Roraima, Amapá and Paraíba the states with the highest percentage of physical therapists in the public system.

Regarding the establishment type, there are divergences between the two subsystems, and, in the private sector, the number of professionals in specialized clinic/ambulatory of specialties (13,749) was higher while, in the public, this number was higher in health centers (6,507) and general hospitals (5,907) – Table 1.

Investigation by complexity (Table 1) points out the strong concentration of physical therapists of the private sector in the specialized ambulatory care, exceeding 70% in all regions. In south, this concentration reached 84%. The private participation in primary care was of only 0.2%, administered mostly by philanthropic entities.

In the public sector, north, northeast and central-west had the highest number of professionals in the hospital/UE; in southeast, the registries were similar between the three levels, and the prioritization of primary care was observed only in the South.

Finally, the analysis of Table 1 highlights the disparity among the physical therapists' total number in the southeast in relation to other regions, with greater emphasis on specialized ambulatory care of the private health system.

Discussion

Distribution of physical therapists according to the complexity levels

Specialized clinic /ambulatory of specialties and general hospital were the main sites of physical therapists' performance in all regions, demonstrating concentration in specialized services. Considering complexity, the specialized ambulatory care was responsible for 57%, followed by hospital/UE (29%). Physical therapists in primary care represented only 13%.

Previous studies have also verified a higher number of physical therapists in the specialized care. Rodrigues[17] highlighted that the restricted treatment to these services causes restrained demand, with long waiting lists for care. The difficulty of articulation to specialized centers, so much due to physical as economic limitations, stands as an aggravating factor to the acess[17].

This concentration is similar to the structure of the health system. In 2011, among the 236,073 establishments registered in NRHSP, only 18% were related to the primary care[18]. The historical emphasis on curative and rehabilitating actions, offered through individual assistances in clinics and hospitals, may be one of the involved factors. In general, the bases of the first systems conformations were constituted under the dichotomous vision health versus disease, in which only sick individuals would need healthcare, concentrating the specialized performance[9].

Likewise, the formation of healthcare professionals under the Flexnerian education model, and the technological development was along decades focused primarily on interventions for individuals affected by injuries/diseases[7,19]. Additionally, there is the own Physical Therapy history that, when establishing its origin to the recovery of individuals with physical sequels, reinforced the integration of these professionals in clinics and hospitals, working in the late stages of the injuries/diseases[8,9].

Barreto and Rodrigues[20] affirmed that the formation, research and, consequently, the physical therapy practice were primarily addressed to clinics and hospitals and there is a

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Table 1. Number of registries of physical therapists in public and private establishments by type of establishment and level of complexity in the regions of Brazil.

Type of establishment	North			Northeast			Central-West			Southeast			South			Brazil		
	PUB	PRIV	TOT	PUB	PRIV	TOT	PUB	PRIV	TOT	PUB	PRIV	TOT	PUB	PRIV	TOT	PUB	PRIV	TOT
Primary Care	262 (21%)	08 (01%)	270 (13%)	1,649 (30%)	08 (<1%)	1,657 (15%)	404 (26%)	13 (<1%)	417 (11%)	3,354 (32%)	46 (<1%)	3,400 (13%)	1,140 (51%)	33 (<1%)	1,173 (12%)	6,809 (32%)	108 (<1%)	6,917 (13%)
Healthy Center	250	08	258	1,414	08	1,422	390	13	403	3,319	46	3,365	1,134	33	1,167	6,507	108	6,615
Family Health Support Centers	12	-	12	235	-	235	14	-	14	35	-	35	06	-	06	302	-	302
Specialized Ambulatory	351 (28%)	663 (78%)	1,014 (48%)	1,317 (24%)	4,127 (74%)	5,444 (49%)	561 (36%)	1,602 (75%)	2,163 (59%)	3,339 (32%)	11,479 (71%)	14,818 (56%)	642 (29%)	6,074 (84%)	6,716 (71%)	6,210 (30%)	23,945 (75%)	30,155 (57%)
Specialized clinic	153	485	638	817	2,656	3,473	460	825	1,285	1,853	6,659	8,512	367	3,124	3,491	3,650	13,749	17,399
Office	02	84	86	17	578	595	04	476	480	56	2,710	2,766	31	1,186	1,217	110	5,034	5,144
Diag. Therap. Support Services[1]	45	60	105	111	338	449	27	143	170	343	1,317	1,660	89	1,367	1,456	615	3,225	3,840
Polyclinic	104	33	137	287	555	842	60	148	208	1,016	792	1,808	125	391	516	1,592	1,919	3,511
Psychosocialcare Center	47	01	48	85	-	85	10	10	20	71	01	72	30	06	36	243	18	261
Hospital/ Urgent And Emergency Care	576 (45%)	182 (21%)	758 (36%)	2,341 (42%)	1,434 (26%)	3,775 (34%)	580 (37%)	530 (25%)	1,110 (30%)	3,716 (35%)	4,573 (29%)	8,289 (31%)	460 (20%)	1,161 (16%)	1,621 (17%)	7,673 (36%)	7,880 (25%)	15,553 (29%)
General Hospital	411	147	558	1,755	1,036	2,791	514	325	839	2,863	3,864	6,727	364	1,050	1,414	5,907	6,422	12,329
Specialized Hospital	112	33	145	479	291	770	10	178	188	566	608	1,174	57	96	153	1,224	1,206	2,430
General Emergencyroom	13	-	13	80	04	84	49	09	58	245	27	272	30	-	30	417	40	457
Specialized emergency room	32	-	32	12	65	77	02	-	02	35	11	46	-	07	07	81	83	164
Day-Hospital	06	02	08	10	30	40	03	04	07	04	53	57	09	08	17	32	97	129
Emergency Medical System	-	-	-	-	08	08	-	14	14	-	09	09	-	-	-	-	31	31
Hematology Centers	02	-	02	05	-	05	02	-	02	03	-	03	-	-	-	12	-	12
Normal Birth Centers	-	-	-	-	-	-	-	-	-	-	01	01	-	-	-	-	01	01
Mixed Units	70 (06%)	-	70 (03%)	240 (04%)	26 (<1%)	266 (02%)	17 (01%)	-	17 (<1%)	102 (1%)	09 (<1%)	111 (<1%)	07 (<1%)	02 -	09 (<1%)	436 (02%)	37 (<1%)	473 (1%)
Other[2]	10	-	10	20	04	24	06	-	06	34	04	38	05	-	05	75	08	83
Epidemiological surveillance Unit	01	-	01	14	-	14	-	-	-	14	-	14	03	-	03	32	-	32
Municipal Health Secretariat	05	-	05	03	-	03	02	-	02	11	-	11	02	-	02	23	-	23
Terrestrial Mobile Unit	-	-	-	-	04	04	01	-	01	06	04	10	-	-	-	07	08	15
Central Regulation	-	-	-	02	-	02	03	-	03	03	-	03	-	-	-	08	-	08
Indian Health Center	04	-	04	01	-	01	-	-	-	-	-	-	-	-	-	05	-	05
Total	1,269	853	2,122	5,567	5,599	11,166	1,568	2,145	3,713	10,545	16,111	26,656	2,254	7,270	9,524	21,203	31,978	53,181

PUB=Public Establishments; PRIV=Private Establishments; TOT=Total. [1]Diagnostic and Therapeutic Support Services; [2]Percentage≤1%. Data from National Register of Health Service Providers-NRHSP, February 2010.

Table 2. Ratio of physical therapists to 1,000 inhabitants according to level of complexity in the regions of Brazil.

Regions	Ratio of physical therapists /1,000 inhabitants*		
	Primary Care	Specialized Ambulatory	Hospital/ Urgent and Emergency Care
North	0.03	0.11	0.07
Northeast	0.05	0.15	0.12
Central-West	0.04	0.19	0.11
Southeast	0.06	0.20	0.12
South	0.07	0.27	0.08
Brazil	0.05	0.20	0.11

*Data from National Register of Health Service Providers-NRHSP, February 2010, and Census 2010.

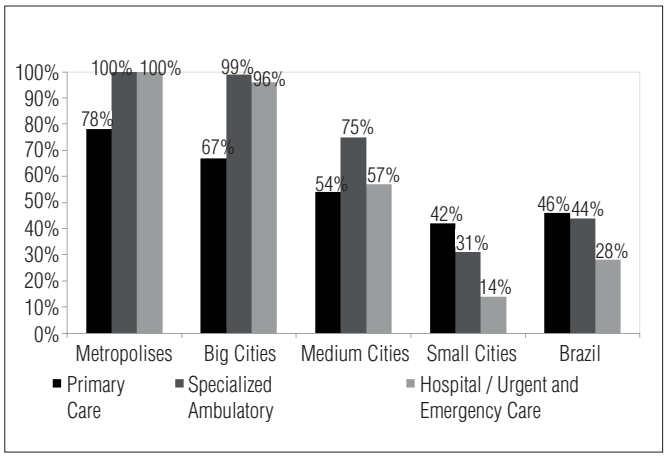

Figure 1. Percentage of cities with physical therapists´ registries per population size according to level of complexity. Data from National Register of Health Service Providers-NRHSP, February 2010.

trend in the higher education to value the individual, therapy, expertise and the use of sophisticated methods and techniques. Such factors influence the professional practice directed to the locals of higher complexity levels of healthcare. This situation tends to change in medium and long term, since the National Curriculum Guidelines for Undergraduate Physical Therapy[21] reorient the formation for a generalist view, with training to work in all healthcare levels, in both individual and collective settings.

The organization of systems focused on medium and high complexities tends to show higher expenses, with lower efficiency and effectiveness than to organizations centered in primary care actions[22]. In this context, primary care has been seen as priority in the health system.

The focus of the system in primary care, however, does not mean that all professions should be distributed in the same way. The ideal proportion of each profession among the healthcare levels so that the system reach emphasis on Primary Care, representing in fact the coordinator level and with warranty of specialized support, should be object of constant evaluations.

Table 3. Number and percentage of physical therapists´ registries in public and private establishments according to regions and federative units (FU).

Regions / FU	Public Establishments		Private Establishments		Total
	n	%	n	%	n
North	1,269	59.8	853	40.2	2,122
Acre	83	51.2	79	48.8	162
Amapá	131	72.8	49	27.2	180
Amazonas	226	63.3	131	36.7	357
Pará	382	53.1	337	46.9	719
Rondônia	164	61.4	103	38.6	267
Roraima	100	86.2	16	13.8	116
Tocantins	183	57.0	138	43.0	321
Northeast	5,567	49.9	5,599	50.1	11,166
Alagoas	311	48.5	331	51.5	642
Bahia	1,355	40.2	2,016	59.8	3,371
Ceará	1,062	49.4	1,087	50.6	2,149
Maranhão	448	59.1	310	40.9	758
Paraíba	754	70.2	320	29.8	1,074
Pernambuco	788	52.8	704	47.2	1,492
Piauí	301	51.2	287	48.8	588
Rio Grande do Norte	404	58.1	291	41.9	695
Sergipe	144	36.3	253	63.7	397
Central-West	1,568	42.2	2,145	57.8	3,713
Distrito Federal	271	31.7	584	68.3	855
Goiás	503	43.6	651	56.4	1,154
Mato Grosso	507	58.6	368	41.4	875
Mato Grosso do Sul	287	34.6	542	65.4	829
Southeast	10,545	39.6	16,111	60.4	26,656
Espírito Santo	497	41.2	709	58.8	1,206
Minas Gerais	2,829	39.6	4,319	60.4	7,148
Rio de Janeiro	2,575	48.9	2,690	51.1	5,265
São Paulo	4,644	35.6	8,393	64.4	13,037
South	2,254	23.7	7,270	76.3	9,524
Paraná	969	22.9	3,263	77.1	4,232
Rio Grande do Sul	748	24.2	2,347	75.8	3,095
Santa Catarina	537	24.4	1,660	75.6	2,197
Brazil (100%)	21,203	39.9	31,978	60.1	53,181

Data from National Register of Health Service Providers-NRHSP, February 2010.

Distribution of physical therapists between public and private establishment

In Brazil, the private sector was responsible for 60% of the physical therapists' registries, but, in the south and southeast regions, which are characterized as the most economical developed regions, this concentration was even higher (76.3% South and 60.4% Southeast). In the central-west region, there were approximately 58% of registrations in the private sector and, in the northeast, the distribution was equal among the two sectors. Only in the north, there was professionals' majority in the public sector (60%).

The concentration in the private sector is verified in other professions. According to results of the Survey of Medical

Care (SMC)[11], since 1999, the private sector offers most of the medical jobs. This offer is majority in the southeast, south and central-west. In the north and northeast, there was majority in public establishments, probably due to the restricted participation of the private sector in less economical developed regions and the increasing expansion of the public sector in areas of high social vulnerability.

Several authors have been pointing out the influence of health policies on the concentration of jobs in the private sector[10,23]. Initially, the lack of a public system that has individual assistance to healthcare determined the private care as practically the only option for access to individual healthcare in the country[24].

From 1920, and more intensely in the 60s and 70s, the state assistance becomes guaranteed to the formal workers as social security benefit. With a scarce establishment network, the public system has outsourced the service through the purchase of private services, influencing the expansion of private assistance over the expansion of the public network[23].

In the eighties, with the social security crisis, the relationship between the business employers and the health plans occurred by direct agreements, expanding even more the private sector[23]. This expansion depended on government incentives that had been important for its institutionalization and legitimacy in face of users and companies. Governmental policies have acted as indirect incentive for the companies to maintain health plans, allowing the transfer of healthcare costs to product prices and availability of tax deductions[23].

In the end of the 80s, the private assistance also intensified among the segments of the population with higher incomes, justified by the low quality of public services. Deductions related to health expenditures on the income from individuals also contributed to the inclusion of private plans and use of the liberal medicine[23].

The concentration of Physical Therapy in the private sector is, therefore, partially influenced by the history of health policies and, before the restricted offer of jobs in the public sector, the participation in private clinics and private practices are, in several times, the only existing option of employment.

Between the complexity levels, there is superiority of physical therapists in specialized establishments in both sectors, showing a trend of the profession. This tendency is, however, intensified in the private sector. While, in the public sector, the three care levels were distributed in similar proportions (32% primary care, 30% Specialized Ambulatory and 36% Hospital/UE), tallying 66% of the registries for specialized services, in the private sector, there was a high concentration in the specialized ambulatory care (75%), followed by hospital/UE (25%), with practically 100% of professionals in specialized services.

The total of professionals in the specialized ambulatory care of the private sector (23.945) was grater than the sum of all registries of public sector (21.203), so, there is strong influence of private sector on the physical therapists' distribution in the country.

The physical therapists' concentration in the specialized care of private sector is reported by Caldas[6], Barreto and Rodrigues[20], Almeida and Guimarães[25] and Census[26] carried out by The Registration Board from the state of São Paulo State, in 2008. According to Barreto and Rodrigues[20], the opportunities of physical therapy job market have been happening, specially, in private clinics, through its sub-specializations, directing the professional field to the secondary level.

Rodrigues[17], discussing the consequences of a system organized according to the market logic, detaches that the competition in the private sector is determined by differentiation of the product, influencing the incorporation of equipments and professionals' expertise, with the reproduction of curative and segmented practice.

The market logic of the private services, through the law of supply and demand, also influences the geographical location of the establishments. According to the investigated data, approximately 73% of the registries of the private sector are shown linked to establishments located in the South and Southeast regions. According to Farias[27], the distribution of private establishments is determined by the degree of economical development and by the percentage of population covered by health plans. Therefore the choices of locations for investments are based on economical criteria and not considering the needs of health and social justice.

Therefore SUS has not yet been capable to overcome the segmented assistance, not consolidating, in particular, as a proposal effectively with the universality and equity principles. The expansion of the municipalization of actions, the amplification of the health family strategy and the new government policies to induce the professionals' formation focused on the public system and the needs of population, probably, will generate impacts on the observed situation. In south, where were observed superior registries in the public sector in the primary care, the physical therapist's proportion in the first level of care reaches 50%, showing a changing reality. The promotion of studies that accompany the expansion of physical therapy, looking for greater equity and integrality, becomes fundamental.

Finally, an observation fits regarding the difference among the total of registries in NRHSP (53,181) and the number of professionals registered in the Federal Council of Physical Therapy and Occupational Therapy (COFFITO)[28] which, in November 2011, totaled 154,563 physical therapists. The disparity is due, partly, to the growth of the number of physical therapists from the date of data collection and the data of COFFITO. It should also be considered the fact that NRHSP contain only information concerning professionals linked to health establishments that, in

agreement with census carried out previously by Crefito-3[26] and Crefito-12[29], represent less than the half of the registered professionals. Thus, physical therapists who are unemployment, who are not working in the area or do not have links with health establishments, although they are counted among the professionals registered in the Council, they are not registered in NRHSP.

It remains to stand out the partial practice of formalization of the registries in NRHSP. Although there is legal determination on the compulsory nature of registration of all health establishments, there are some locals without the respective registration. It is believed that this gap coverage occurs mainly in private establishments.

Therefore, the present study worked with data from a portion of the existent professionals and it is possible that the observed proportions are partially different from the real ones. Nevertheless, NRHSP is currently the database with more information on healthcare services in the country and it is characterized as an important source of studies and researches and in health management.

Conclusion

This study identified establishments of specialized healthcare as the main locals of work of physical therapists and the participation in primary care was restricted. The concentration in specialized services occurred mostly in municipalities with larger population and in the private sector, which tends to restrict the access to this professional.

Studies that investigate physical therapy actions in primary care, directing the adaptation of the action offering of this professional to the whole population in a comprehensive way become fundamental in the identified context.

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