



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

DETERMINANTS OF DIRECT DEMAND BY THE POPULATION WITH PREVENTABLE SITUATIONS IN ER

DETERMINANTES DA PROCURA DIRETA PELA POPULAÇÃO COM ACOMETIMENTOS PREVENÍVEIS NO PRONTO ATENDIMENTO

DETERMINANTES DE LA BÚSQUEDA DIRECTA POR LA POBLACIÓN CON SITUACIONES PREVENIBLES EN EL PRONTO SOCORRO

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ABSTRACT

Objective: to understand the determinants of direct demand by the population with preventable solutions in the emergency room. **Method:** qualitative study with emergency room users who were waiting for consultations. Semi-structured interviews were used and observation of the emergency room entryway. In the analysis, the technique of analysis of discourse was used, in Categorical Analysis mode, resulting in three categories: Profile of the population assisted in emergency room, emergency and urgent cases understanding and the role of the emergency room, the role of basic care. **Results:** the clients belong to various municipalities; understanding of urgent and emergency has only one meaning or the term is unknown. The emergency room is a facilitator of access to the system, in addition to be a misunderstanding of the role of Basic Health Unit. **Conclusion:** the population has no connection with the source unit and the displacement generates burden for the municipality, which receives higher demand of its possibilities, demanding local health reorganization. **Descriptors:** Hospital Emergency Service; Health Centers; Access to Health Services.

RESUMO

Objetivo: compreender os determinantes da procura direta pela população com acometimentos preveníveis no Pronto Atendimento. **Método:** estudo qualitativo com usuários do Pronto Atendimento que aguardavam consultas. Utilizaram-se entrevistas semiestruturadas e observação da porta de entrada do Pronto Atendimento. Na análise, foi empregada a Técnica de Análise de discurso, na modalidade Análise Categorical, resultando em três categorias: Perfil da população atendida no PA, Compreensão de urgência, emergência e o papel do Pronto Atendimento, O papel da atenção básica. **Resultados:** a clientela pertence a vários municípios; a compreensão de urgência e emergência possui único significado ou o termo é desconhecido. O Pronto Atendimento é uma unidade facilitadora de acesso ao sistema, além de haver um desconhecimento do papel da Unidade Básica de Saúde. **Conclusão:** a população não possui vínculo com a unidade de origem e o seu deslocamento gera ônus para o município, que recebe procura superior as suas possibilidades, demandando reorganização da saúde local. **Descritores:** Serviço Hospitalar de Emergência; Centros de Saúde; Acesso aos Serviços de Saúde.

RESUMEN

Objetivo: comprender los determinantes de la búsqueda directa por la población con situaciones prevenibles en el Pronto Socorro. **Método:** estudio cualitativo con usuarios del Pronto Socorro que aguardaban consultas. Se utilizaron entrevistas semi-estructuradas y observación de la puerta de entrada del Pronto Socorro. En el análisis, fue empleada la Técnica de Análisis de discurso, en la modalidad Análisis Categorical, resultando en tres categorías: Perfil de la población atendida en el PS, Comprensión de urgencia, emergencia y el papel del Pronto Socorro, El papel de la atención básica. **Resultados:** la clientela pertenece a varios municipios; la comprensión de urgencia y emergencia posee único significado o el término es desconocido. El Pronto Socorro es una unidad facilitadora de acceso al sistema, además de haber un desconocimiento del papel de la Unidad Básica de Salud. **Conclusión:** la población no posee vínculo con la unidad de origen y su desplazamiento genera carga para el municipio, que recibe búsqueda superior a sus posibilidades, demandando reorganización de la salud local. **Descritores:** Servicio Hospitalario de Emergencia; Centros de Salud; Acceso a los Servicios de Salud.

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INTRODUCTION

The Unified Health System better known by the acronym SUS, is Brazil's publicly funded health care system, results of the experiences and discussions over the past few decades, seeking changes in Brazilian population health picture, using new models for health care, with the constitutional principles as universality of access, the entirety of shares and equity.^{1,8} In this way, reforms have been developed over the 90s of the last century, reaching mainly the Basic Care (BC) that from 1994 has the Family Health as its main organizational model.²

With the effectuation of the Unified Health System and on the proposed change of the assistencial model of public health in Brazil, there has been the development of strategies of care focused on the bio-psychic and social dimensions of individuals with the aim of creating a collective commitment to changes in interpersonal relationships, in the process of work and action strategies.³

Although the Brazilian assistencial model have been showing efforts to reorganize recovery and strengthening of BC, basic health units are not yet as the primary input of the system.⁴ As a result, this strategy has stimulated the pursuit of population in big tertiary hospitals as faster access door and places that facilitated the resolution of their health problems. The emergency services work with large influx of spontaneous demand, culminating with the overcrowding and consequently, with the perceived low quality of care. Access to resources of Unified Health System is difficult, queues waiting for consultations, examinations and surgeries are long and there are not enough vacancies for hospitalization, as well as competent personnel.⁴

In this new health care proposal, the user requires access to services and the efficaciousness, associated with the professional work in a team, to encourage self-care and rethink about the lifestyle of individuals and their families. So, people become jointly responsible for active search of the solution to their problems properly taking advantage of existing levels of care.⁴

Acting on the Basic Care Center, the Family Health Strategy seeks to enhance the construction of the model proposed by Unified Health System, presenting a substitutionary proposal to the previous format of organization of health services, with technical, political and administrative innovative dimensions. This model aims to further enhance the reorientation of the work

process and actions that constitute the care model proposed by the Unified Health System within the Basic Care Center, seeking to enlarge them and assure them more effectiveness.⁵

An issue always coming up is the meaning given to emergency by professionals and users. The professionals assume that the user searches the emergency services for all kinds of care by not knowing what would happen and what are the assignment of these emergency services, so emergency room care (ER Care) are at the same level as the Health Center (HC). On the other hand, a user who searches for the ER Care have urgency to solve his health problems and often complains about the slowness of the assistance and the unwillingness of the professionals.⁴

Within this context, the ER Care play an important role in secondary care to the population and must comply with the principles of regionalization and hierarchizing in the areas where they are located.⁴ But the pursuit for more quick and resolute service causes these institutions constituting the required gateway to the Brazilian population, reversing the initial proposal of the Unified Health System.⁶

Overcrowding in hospital emergency services is a worldwide phenomenon and ultimately, underperforming health system as a whole and in particular hospital, inducing to low quality care.⁷

ER Care currently have in their context an increasing number of assistance and a spontaneous demand which not showing complaints classified as urgent or emergency, characterizing and fragmenting the proposal of an entire health system, in addition to unlink the user of their family health team of reference in the basic care.⁷ This process has interfered considerably in the process of work and in the quality of care provided to the population.⁸

On the other hand, the unlinked demand of basic units, without emergency characteristics, has been causing change in the profile of care in ER Care and raising new discussions of the real mission of these units and of their responsibilities, because it has generated several consequences for the health system:⁹

- ◆ Increased burden to the municipal public service due to frequent allocation needs of new human resources, materials and equipment;
- ◆ Increased conflict in the relationships between users and technical services regarding the real mission of the unit;



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◆ Differences between the concept that workers, users and managers have about emergency;

◆ Damage to users, to travel to distant sites of their housing and consequently less link, for service in units that are not specific to their needs;

◆ Difficulties in planning of the health system, since it cannot effectively create a reference and counter-reference network between levels of care.

The high rates of hospitalizations for primary care conditions in a population or its sub-group(s), may indicate serious problems of access to the health system or its performance representing a warning sign, which can trigger mechanisms for analysis and the search for explanations for its occurrence. Several studies show that high rates of hospitalizations for primary care conditions are associated with deficiencies in the coverage of services and/or the low resolution of primary care for certain health problems.¹⁰

The emergency services are increasing the expenses to the system, and the gap between user needs and the form of supply of services generate conflict between users and the professionals. Thus, the high demand for ER Care, significantly higher than the ability to offer and for reasons that could be met in the basic units has been cause for discussions about the organization of the system, such as the integration between the levels of care and responsibilities of each level.^{4,10,11}

The ER Care is a health facility where the focus of care is the stabilization of users who have urgent or emergency situations, being also indicated for the treatment of acute specific diseases, when the basic unit is closed. Thus, it is a place where customer service time can be lengthy due to the large number of users and the level of complexity.¹²

The health unit chosen for this study was the Emergency Room of the municipality of Diamantina for being the main place of urgencies and emergencies care clinics throughout the region of Vale do Jequitinhonha. The city is located in the region of Vale do Jequitinhonha, Minas Gerais State, whose population is 46,374 inhabitants.¹² The macroregion of Diamantina covers a population of 265,000 inhabitants, with 35 districts.

It is noticed that there is a growing increase of assistance of users seeking the ER Care with complaints that are considered as non-urgent. Therefore, it becomes important to question about the great spontaneous demand for urgent/emergency services to

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patients with preventable situations leading to a mismatch between the role of the ER Care and the basic health network.

From this, we question: how do users perceive the role of the ER Care and the basic health network, in the municipality of Diamantina? How is the efficaciousness of the ER Care and the basic health network?

This study was justified by the possibility of offering subsidies to the understanding of health needs of the population and to the organization of health services, in general, and of the ER Care in particular, from an attentive listener of their users.

OBJECTIVES

- To understand the determinants of direct demand by the population with preventable situations in the ER Care.
- Profiling of the population looking for ER Care.
- To understand the role of the ER Care.
- To understand the resolutive role of BC.

METHOD

Study with quantitative approach¹³ seeking to perceive in depth meanings and social relations in the process of work of health professionals.¹⁴

The instruments of investigation included interviews and observation in November 2011 to March 2012. Data production was made through direct observation of the entrance door of the ER Care for monitoring nursing consultations during the risk classification, guided by an instrument of collection and semi-structured interviews with users recorded in MP3 from the guiding questions of the study.

The interviews were conducted randomly with ER users who were in the reception of the ER Care, awaiting the consultation with the nurse of the risk classification and others who were in the seats of the hall inside the unit waiting for service. The user was assisted when the contact was possible, i.e. contact with consciousness and preserved cognition and if he was not seriously ill. Patients with medical emergency picture, those under 18 years old without a responsible and those brought by ambulances were excluded from this study.

Evidently, it is clear that not all informants were accompanied individually and only a few participated in the interviews, since because it is a qualitative research there is not, a priori, delimitation of the sample being interrupted the data collection when there



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was saturation information i.e. no new data were added.

Before the interview, a pre-test was carried out with two users in ER Care in order to highlight flaws in the guiding questions, and may cause embarrassment and/or exhaustion to informants. In this way the pre-test ensured the validity and accuracy of the questions.¹⁴

The analysis of the data was used according to the Technique of Analysis of discourse, in Categorical Analysis mode according to the following steps:¹³

1. Ordering of observed data and transcripts of the interviews;

2. Classification of data, consisting of exhaustive reading, interrogative and repeated text. From there, it starts the creation of empirical categories and the identification of topics, grouped by kinship, building the central categories. The final analysis of these categories with excerpts from speeches of the respondents is a movement between the empirical and theoretical. Thus, three categories were formed: Profile of the population assisted in ER Care, Understanding urgency and emergency and the role of the ER Care, The role of basic care.

All study subjects have signed an informed consent, having been informed about individual autonomy, privacy, confidentiality of information and the results that would be used exclusively for scientific purposes. To ensure the anonymity of the subjects of the study names of figures from Greco-Roman mythology were used, as well as to identify them in this research in the data analysis phase. The direction of the institution signed a consent form and agreeing to the Institution's commitment to conducting the research. In addition, the project was evaluated by the Nursing Supervision.

The research project was approved by the Ethics Committee in Research of the State University of Montes Claros through opinion 3097 of 2011 given the Resolution 196/96 of the Ministry of Health.

RESULTS AND DISCUSSION

◆ Profile of the population assisted in ER Care

The approach of the reality of assistance in ER Care began with observations carried out by researchers on the gateway. The records had as purpose to detailed observation of how the clients reached to being assisted. Accordingly, it was possible to observe that the clients arrive, mostly on foot or by car, from the adjacent neighborhoods or of one of

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the municipalities belonging to the macroregion of Diamantina.

The user, when arriving at the door of the ER Care, usually seeks the reception to do the record and then go to the seats to wait assistance in risk classification, by the nurse. These clients, most of the time, are checking the movement of health professionals who pass through the place. It is important to note that most users awaiting service at the reception does not show signs of pain or be in an emergency situation. Only in some cases it is noted the face of pain, weakness, or being sick.

In interviews with users who were waiting for service, it was possible to identify the profile of the customers and then to compare with some data available from the information system of the Municipal Health Secretary of Diamantina.

The characteristic of the customers are adults, in the range of 30 years old, of both genders, who seek the unit mostly in the mornings and afternoon. The increased demand of the ER Care is to the medical clinic. Although there are no pediatricians on duty in the unit, the care to children is also done, but by general practitioners. The demands are: sore throat, pain in the body, hyperthermia, abdominal pain. The following speeches show the reported:

[...] my children and I are with sore throat. (Athena).

[...] pain in the body for about seven days [...]. (Gaya).

Health services of these cities have not been able to structure or do not have enough number of inhabitants to require a unit of ER Care, and therefore has the ER Care as its only reference requiring users to move looking for assistance in Diamantina. A large part of the population have low socio-economic and cultural conditions.

◆ Understanding of urgent and emergency and the role of the ER Care

If we check the use of the words urgent and emergency in Portuguese, we can remember that in both the Dictionary Houaiss¹⁶ and the Dictionary Ferreira, it is possible to note that these concepts are similar, not pointing a clear distinction between one and another in the following testimonials:¹⁶ Urgent. From Latin Urgent. 1. Urgent need; that needs to be done quickly. 2. Essential, indispensable. 3. Impending, impendente. Emergency. From Latin emergentia. 1. Action to emerge. 2. Birth (the Sun). 3. Critical situation; dangerous and fortuitous event, incident. 4. In case of



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urgency and emergency: medical emergencies; cardiac emergencies.

In this sense, it is difficult to define the urgency and emergency, because other factors contribute to the understanding of the terms, as well as concepts adopted by the user population.¹⁷ This same difficulty can be perceived in the interview with the user frequenter of ER Care. We note that, for them, the urgency and emergency concepts had the same meaning, and some even unaware of the meaning of the terms, as outlined in these speeches:

[...] Here is to assist all things. (Perseus).

[...] to assist when we are sick, all types of disease. (Athena).

[...] the not serious patients take longer to be assist [...]. (Antigone).

It is said that the population seeks ER Care units for everything and not just for emergencies. It is a derogatory vision in the concept of urgency or emergency not determinant of demand for the service. Often, when discussing with the user, it was necessary to use the word more severe, replacing the term of urgent and emergency because people could not answer and the question was followed by a long moment of silence. For the population, several needs are related (affliction, anguish, abandonment and misery), which require assistance and/or help with immediate solution to a passing difficulty.¹⁸

For customers, there are threatening conditions of life and signs and symptoms suggestive of gravity.⁹ In relation to life threatening conditions, there are exemplified: firearm, knife, cuts, wounds, broken leg, high blood pressure, stroke, heart attack, hit, hurt. In relation to the life-threatening signs and symptoms, we can check in speeches the fever, pain, lying, unable to walk and talk. For this people, it is where they assist the threatening signs of life, there are also assistance for the life threatening conditions. These signals may not be necessarily urgent or emergency, however are relevant and need to be assist by the doctor. This seems to be not well understood even by the professionals who make the same complaint, in the same patient, expressed in different ways as the following statements:

I thought it was going to be assisted [...] every time I come here they give me medicine for sore throat and today this has happened, they didn't give me any medicine [...]. (Athena).

I've been given medicated here (by the same complaint). (Pandora)

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He Said I had to come here, because it was more serious [...] now it not big deal [...]. (Tethys).

In hierarchical network of services, it is expected that the ER Care is used for urgent and emergency cases, but in reality these units are searched for consultations that should occur in the BHU. This picture leads us to infer that the Emergency Room Unit is as a facilitator of access to the health system. For some users, other ER Care's role is to facilitate access to medical consultations in basic units as in following speeches:

[...] with this paper here and go to the Board of Health to see if I can be assisted by a doctor today. (Athena)

The demand by the ER Care can be due to the greater technological infrastructure, combined with speed and agility, which allow the user greater efficaciousness of their health problems.⁴ For patients despite the long wait, at the end will be assist by a doctor and carry out complementary examinations. Confirming what was expected, most of the users interviewed reported that he does not seek the BHU but the ER Care, reflecting on the inefficiency of the health network:

[...] (here) I know I'll be assisted [...]. (Tethys). I came straight here [...]. (Pandora)

◆ The role of basic care

When the the basic care units was used by the same users, they said they use them close to home for some procedures of medical consultations, vaccinations, tests, consultations for children, groups of hypertension and assistance to elderly relatives, however, many of the interviewees reported that they came straight to the ER Care, not going to the BHU before. It was observed the ignorance by the users of BHU's name next to their residence, because many of them knew the units and used them for assistance, but did not know for sure the name and its real role:

[...]There is no solution there, it's just for injection, child and nothing else [...]If you are sick you have to come here. (Gaya)

Users presented several reasons for not seeking the BHU close to their homes. Among them was the poor assistance, lack of reliability and quality in the service, the delay in assistance, the lack of professional physician and high turnover, as it is possible to check in the following speeches:

There is not a doctor to any day [...] it seems that he has left again [...]. (Antigone)

I didn't like the service because it doesn't pay attention to people [...]. (Pandora)



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Only medicine for worm, then it does not improve the pain [...]. (Perseus)

You take a number today, to be assisted by the end of next month [...]. (Antigone).

[...]sometimes going to a doctor, but there are times when he's not going to not [...] there is very difficult [...]. (Gaya)

The term facilities¹⁹ is mentioned as one of the properties of quality, being that its definition relates to the conditions of comfort and esthetics of the facilities and equipment of health services.

Among the reasons given by users the efficaciousness in basic network is directly related to the instrumental resources available, to the knowledge of the professionals, and the warm and action to link established with the user.²⁰

The turnover of staff can be associated with job satisfaction, since it is related to lower rates of employee turnover. Employees less satisfied may exhibit higher rates of turnover, because there is a lack of professional fulfilment, little recognition of their role, experiencing constant conflicts with the boss or colleagues or not having reached the desired level in their careers.²¹

This type of information seeks to identify the reasons for the instability of professionals in FHS, considering that the quality of health care tends to be hampered by the lack of professional binding to particular community.²²

On the other hand, it should be noted also that the regional health system needs expansion. The municipal network has with 09 FHS teams (Family Health Strategy), and eight teams in the urban area and a team in the countryside, covering 71.07% of the population; and three teams of CHAS (Community Health Agent Strategy), located in the countryside, covering 14.25% of the population, a total of 85.32% population coverage.²⁵

For us there is not assistance, only this one here [...]. (Tethys)

I wish there where I live had one, because then we don't need to come here [...]. (Antigone)

The access of the population to health services network must occur at primary health care level, which must be qualified to assist and solve the main problems presented. The more complex cases should be referenced to the other levels of technological assistance. Soon, the network of services organized in hierarchical and regionalized way, it allows the recognition of the health problems of the population of the area bounded by favouring actions of epidemiological surveillance,

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health, vector control, health education, in addition to the actions of outpatient and hospital care at all levels of complexity.³

The access of the population to health services can be questioned, since the access by the wrong door and with their needs is seen as the possible, contrary to the rationalist logic in which the technicians of the health sector continue to defend a network of services in the form of pyramid. Soon, the most modern concepts of network should offer assistance to qualify all entry doors in order to identify the most vulnerable groups of the population and organize them to each person access to the type of service best suited to each case.⁹

For the FHS is fundamental the stability for the construction of a working model that includes all elements of completeness, because the turnover undermines the effectiveness of FHS. In addition, this type of information can identify the reasons for the instability of professionals in FHS, considering that the quality of health care tends to be hampered by the lack of professional binding to a particular community.²²

As a strategy of change of this reality, it is necessary the implementation of public policies, in a more effective and efficient way to ensure greater fluidity in assistance and autonomy to the user, in addition to higher resolution and liability of health managers.²³

FINAL REMARKS

The displacement of the users has generated greater financial burden for the municipality of Diamantina, despite agreeing with these municipalities care to their populations for specialized consultations and high complexity exams, has received a demand for much higher assistance than those established, surpassing the offers available.

Health professionals assist an endless demand for servicing in ER Care, recognized by many managers as the exhaust valve of the population looking for medical assistance and services 24 hours as a way to overcome the shortcomings in the basic care.

It was clear the search for quick service and the difficulty of planning assistance that is sought only in the event of diseases already installed. The user reports that the emergency unit, in addition to enabling the medical consultation on the same day, can still provide higher resolution, because he can solve their problems through laboratory tests, x-ray and others. Thus, the spontaneous demand, caused by the patient's complaint and consulted by the doctor, becomes the



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main demand of the organization of the local health system. It is establishing a network of conversations between services, promoting integration between them so that, instead of being competitors in the provision of health services, the services may be complementary and facilitate the completeness of the care.

According to the Ordinance GM/MH No. 2048/2002, the implementation of regional networks and prioritized assistance, besides allowing a better organization of services, assistance, define flows and the resolute references is an essential element in order to promote the universality of access, equity in the allocation of resources and completeness in care. It is essential that the Primary Health Care and Family Health Strategy take responsibility for reception of users with acute or chronic pictures of in their coverage area, whose complexity is compatible with this level of assistance.

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Submission: 2013/04/29

Accepted: 2014/08/17

Publishing: 2014/10/01

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