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INTEGRATIVE REVIEW ARTICLE

SPONTANEOUS DEMAND IN THE FAMILY HEALTH STRATEGY: AN INTEGRATIVE REVIEW

A DEMANDA ESPONTÂNEA NA ESTRATÉGIA DE SAÚDE DA FAMÍLIA: REVISÃO INTEGRATIVA LA DEMANDA ESPONTÂNEA EN LA ESTRATEGIA DE SALUD DE LA FAMILIA: UNA REVISIÓN INTEGRADORA

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ABSTRACT

Objective: analyzing the scientific literature that approach about spontaneous demand in the Family Health Strategy. **Method:** an integrative review, in the last 5 years, the LILACS and BDEF databases, in order to answer the following question << How is the integration of spontaneous demand to the planned activities of the Family Health Strategy? >> Combinations were used between descriptors, "spontaneous demand", "primary care", "Family Health Strategy" and the descriptor: "Primary Health Care". The data were analyzed from the Content Analysis Technique in thematic analysis mode. **Results:** seven articles were analyzed, all found in the LILACS database. **Conclusion:** it was perceived shortages of material of the last five years discussing the issue; it suggests the continuity of research turned to spontaneous demand in the scenario of the Family Health Strategy. **Descriptors:** Family Health Strategy, Nursing process, Primary Health Care, Health Services Needs and Demand.

RESUMO

Objetivo: analisar a produção científica que tratem sobre a demanda espontânea na Estratégia de Saúde da Família. **Método:** revisão integrativa, nos últimos 5 anos, nas bases de dados LILACS e BDEF, com vistas a responder a seguinte questão << Como se dá a integração da demanda espontânea às atividades programadas da Estratégia de Saúde da Família? >> Foram utilizadas combinações entre as palavras-chave: "demanda espontânea", "atenção básica", "estratégia Saúde da Família" e o descritor: "Atenção Primária à saúde". Os dados foram tratados a partir da Técnica de Análise de Conteúdo na modalidade Análise Temática. **Resultados:** foram analisados sete artigos, todos encontrados na base LILACS. **Conclusão:** Foi percebida a escassez de material dos últimos cinco anos que discute a temática, sugere-se a continuidade de estudos voltados à demanda espontânea no cenário da Estratégia de Saúde da Família. **Descritores:** Estratégia Saúde da Família, Processos de enfermagem, Atenção Primária à saúde, Necessidades e Demanda de Serviços de Saúde.

RESUMEN

Objetivo: analizar la literatura científica que trata sobre la demanda espontánea en la Estrategia de Salud de la Familia. **Método:** una revisión integradora, en los últimos 5 años, las bases de datos LILACS y BDEF, con el fin de responder a la siguiente pregunta << ¿Cómo es la integración de la demanda espontánea de las actividades previstas de la Estrategia de Salud de la Familia? >> Las combinaciones se utilizaron entre los descriptores, "demanda espontánea", "atención primaria", "Estrategia de Salud de la Familia" y el descriptor: "Atención Primaria a la Salud". Los datos fueron analizados por la Técnica de Análisis de Conteúdo en el modo de Análisis Temático. **Resultados:** se analizaron siete artículos, todos se encuentran en la base de datos LILACS. **Conclusión:** se percibe escasez de material de los últimos cinco años que habla acerca del tema, sugiere la continuidad de la investigación a la demanda espontánea en el escenario de la Estrategia Salud de la Familia. **Descritores:** Estrategia Salud de la Familia, Proceso de Enfermería, Atención Primaria de la Salud, Necesidades y la Demanda de Servicios de Salud.

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INTRODUCTION

The Family Health Strategy/FHS has been the target of many Ministry of Health investments for expansion and maintenance of its implementation process in the country since 1994. The strategy, today presented as a national policy, but initially thought as a programming, was created with the aim of strengthening primary care, the redirection of the current health care model (ie, the biomedical model or medical welfare), in contrast to this traditional model, focused on the disease, based on flexnerian model (which divides all in parts in order to understand it), characterized by mostly interventionist actions based on the complaint-conduct approach during consultations.

To be responding to many economic and social expectations, it is relevant to discussion of any component of the work process of professionals working in this scenario, where the territorial, the establishment of ties and comprehensive care to the individual reign as margins guidance to the actions developed in the care process.

Unlike current family medicine in many countries in Europe, Canada and Oceania, the FHS of Brazil assumes the multidisciplinary and team work as the basis for the construction of comprehensive care in primary health care.¹ This work highlighted the issue the spontaneous demand as a challenge in organizing the work process in the strategy.

The simultaneity of the existence of spontaneous demand and scheduled activities in the Family Health Strategy is expected in the own National Primary Care Policy², but often not the correct handling of spontaneous demand sets major impediment to implementation of the strategy as it purports being, since its prioritization ultimately stimulate popular historical culture of searching for health services only in the presence of acute exacerbation of the problems (usually chronic) health and often ends up reproducing in basic units, a scenario of ready-service, as well as generating significant reduction in the levels of quality of programmed actions. In this sense, the excess demand is opposed to quality of nursing care in the strategy.³

It is noticed that there is no change in the original array of biomedical model in average service work process and high complexity, with no prioritization of actual needs of the subjects. That is, if the care model redirects from the basic to park its attention without this process to be expanded to the network,

we have an unfinished process that never shall give account to meet the search for service users about the network of health care.

Spontaneous demand is just one of the challenges that are part of routine work in the FHS; all the units have to organize the work process in order to put in place guidelines that national policy, without violating the integrity of the process care that it advocates.

The National Policy of Primary Care highlights the issue of demand as a necessity that must be integrated into the planned activities of the basic health units.² The practice in the FHS is permeated by contradictions and contrasts that requires continuous reflection on the work processes that it is configure lest we fall into the error of reproducing the model for which it was meant to oppose. Thus, this study aims to:

- Analyzing the scientific literature dealing on spontaneous demand in the Family Health Strategy.

METHOD

This is a descriptive, integrative review type,^{4,5} from the following steps:

- 1) The issue of research
- 2) The choice the inclusion and exclusion criteria, and the search terms for the Survey of bibliographic material
- 3) Election of databases and material selection (by first exploratory reading and later selectively reading), organizing it according to the criteria of inclusion and exclusion according to the content of interest for this research;
- 4) Systematic analysis of studies
- 5) Discussion of the found results
- 6) Synthesis of knowledge from the Integrative Review

The search was conducted in the third quarter of 2014, the databases bases Latin American and Caribbean Health Sciences (LILACS) and the Nursing Database (BDENF) using the following combinations with descriptors "spontaneous demand" [and] "the family health strategy", "spontaneous demand" [and] "primary care" and of the key word with descriptor "spontaneous demand" [and] "Primary health Care".

The inclusion criteria were: type of the articles published, which had been published in the last five years, available in full in Portuguese. Soon after, there was obtained a total of 11 items, each resulting from LILACS database. After reading in full, all publications were excluded whose content did not meet the prospects of this research, in addition to repeated publications, leaving only

seven articles were selected for analysis in this study.

Selected articles were analyzed with the aid of an instrument, which evaluated Information concerning the item identification, methodological characteristics of the study, author, site development research, publication year and journal publishing, training of authors, main results and level scientific evidence, defined as follows:

At level 1, the evidence comes from systematic review or meta-analysis of all relevant randomized controlled clinical trials or derived from clinical guidelines based on randomized clinical trials systematic reviews controlled; level 2 evidence derived from at least one randomized controlled clinical trial clearly delineated; level 3, evidence from well-designed clinical trials without

randomization; level 4, evidence from cohort studies and well-designed case-control; level 5 evidence originating systematic review of descriptive and qualitative studies; level 6, evidence derived from a single descriptive or qualitative study; level 7, evidence from opinion of authorities and / or expert committees report.^{7:43}

It is emphasized that this study covered research on basic health units in general, whether they are in the traditional model (without family health teams), or A type units (units that run only with the Family Health Strategy).

RESULTS

The information that adds up to set up the profile of the articles can be seen briefly in Figure 1, which sets the systematic evaluation step of the studies.

Title of the Article	Article Code	Place of the research development	Research method
The Health Service's actions Geared to the Individual Scope and Little Collective	A	Marília, São Paulo	Exploratory qualitative research
Demand analysis in family medicine in Brazil using the international classification of primary care	B	Betim, Minas Gerais	Cross-sectional descriptive study of quantitative and qualitative approach
Reception and social (DIS) medicalization: a challenge for family health teams	C	Non Informed	Essay
Spontaneous demand in the family health strategy: an analysis of the factors that influence and challenges on reorientation of the assistencial model of SUS	D	Juiz de Fora, Minas Gerais	Qualitative research
Restricted access and focused to the family health program in Alagoinhas, Bahia, Brazil: organized demand for specific population groups X spontaneous demand	E	Alagoinhas, Bahia	Qualitative research
Assistance practices of family health teams in four major urban centres	F	Aracaju, Belo Horizonte, Florianopolis e Vitoria.	Case study, non-informed approach
Everyday demands in primary care: the look of health professionals and users	G	Manhuaçu- Minas Gerais	Qualitative case study

Figure 1. Distribution of articles by year of publication, place and method of research.

There was only research obtained in the years 2010, 2012 and 2013. Regarding the development of local research, there are representations of the South, Southeast and Northeast regions of Brazil, with emphasis for

the State of Minas Gerais. Moreover, it can be said that there was a higher prevalence of qualitative approach in the evaluated research.

Article Code	Year of publication	Journal	Level of scientific evidence	Training of authors
A	2012	Brazilian Journal of Medical Education	6	Non informed
B	2012	Science & Collective Health	6	Non informed
C	2010	Science & Collective Health	7	Author 1: physician Authors 2 and 3 : non informed
D	2012	Magazine APS	6	Author 1: Master of public health Author 2: non informed
E	2010	Bahia Public Health Magazine	6	Authors 1 and 2: nurses
F	2012	Science & Collective Health	6	Non informed
G	2013	Text and Context Nursing	6	Author 1: non informed Author 2: Doctorate in Nursing Philosophy

Figure 2. Distribution of articles by journals and scientific evidence and training level of the authors.

Articles in its entirety met in the Lilacs database, with a predominance of 42.8% of articles in the journal Science and Public Health.

Regarding the formation of the authors, although many have been categorized as not informed, it was observed that most of those who did not directly inform the training are linked to medical schools department, which enables us to infer Medical majority in the classification "uninformed".

Concerning the main findings in the articles analyzed, below the table summarizes these results:

Article Code	Summary of main results found
A	It was noted that regardless of the category interviewed (health professionals, users and students of medicine and nursing) and the area where the family health unit, understanding that the respondents have about the model of attention is purely medical-assistance private model, that makes transparent the predominance of healing actions, operated directly by the doctor and offered on spontaneous demand.
B	One of the most common reasons for seeking care almost 20% of consultations took place for administrative reasons. Female and increasing age determined as many reasons to consult. It is concluded that meet the query reasons for gender and age can help teams in the development of possibilities for addressing health problems presented in the host.
C	Suggest changes in routines, schedules and individual and collective professional activities, therapies and health promotion; so that the teams can host their users minimize the process of medicalization. The research concludes in favor of Host trials as a strategy to deal with spontaneous demand, always watching the medical potential.
D	In structuring the entryway of the surveyed services remains bureaucracies that serve as obstacles to the access of users to the services and enhance the service model focusing on medical consultation. For professionals, the excessive spontaneous demand is a result of the pressure of population by medical and the dismantling of the team work processes.
E	Access to services is narrowly and focused on programmatic actions for certain population groups, configuring a model based on procedures and characterized by a spontaneous demand, which shows in their health needs repressed. Universal access to health care has not been effective in its fullness, which leads users to search for service through the spontaneous demand by setting specific and fragmented actions.
F	The study points to a tendency to a balance between compliance with the scheduled and spontaneous demand, contributing to the people-centered practices. The study also highlights the insufficient involvement with community activities that restricts the possibilities of conventional care production practices and commits to change of care model.
G	The study points out that the demands are results of individual and social factors. The attendances occur from the spontaneous demand of the users and, according to professionals, the interest is presented in these sessions is mainly for medical consultation, referrals to specialists and free distribution of medicines.

Figure 3. Summary of main results found in articles analyzed.

It was found though five of the seven articles dealt with the spontaneous demand, while the other two focused on the issue of the work process and the model of care in family health units, at times, passing the issue of demand. This makes us reflect on the need for further advances in research related to this topic, as the undisputed relevance of the strategy for full consolidation of the Unified Health System, and taking into account the spontaneous demand has the potential to set

a factor that some in the quality of care, or it locks the work process of the teams as to reduce the quality of services provided.

The data found during reading of the material in its entirety, and after critical and interpretative reading, were treated according to the thematic analysis of Bardin, which aims to go beyond the uncertainties and enrich somehow, the data collected.⁸

DISCUSSION

After recognition of the significance units that were repeated over the texts, these have been organized into categories for discussion of the theme in question. The analysis of the material obtained pointed to two main directions: the integration of spontaneous demand to the planned activities of the FHS interferes with the quality of care offered by the teams and the question of spontaneous demand leads us to act to strengthen the biomedical model of health care.

♦ Spontaneous demand and the quality of care in the family health strategy (FHS)

It is known that it was aiming to reform the health care model, the FHS initially created as a program established itself as a strategic priority for reorganization of primary care in Brazil. In this sense, it is reflect the extent to which this program was created in view of complementing the health-care network in the system or raised in supplementary idea of the network in its shortcomings, when its creation occurred from the demand for health services raised after the advent of PACS (Community Health Agents Program), and that at this time, the NHS was in a nascent stage and was not yet able to deal with these health needs of population.⁹ It can see so, that the issue of the demand arises from the creation of the Family Health Program, and is part of its proposed actions.

The evidence suggests reading articles that account for the spontaneous demand somehow is directly linked to the achievement of Completeness of care in FHS. There is a widening pool care and Integral attention that the FHS provides with the ability to meet the planned and spontaneous demands, besides the essential feature of being also capable of producing program focused clinical activities people in various age range, and the most distinct health needs, behaving constructive meetings focused on curative actions as well as for the promotion of health both in individual stocks as collective.¹⁰ One must understand that articulate the spontaneous demand for preventive procedures can be considered one of the dimensions of wholeness.¹¹

Appropriating the idea of live work in action¹², which is the product of any health professional approach to the user, it is understood that in this meeting there is "a set of expectations and productions (...) in which there is production a welcome or not the intentions that these people put in this

meeting; complicity moments in which there is the production of accountability".^{12:308}

It becomes extremely important the enhancement of this professional-meeting and user-regardless of the source (programmed or not) of these moments. The articles show that the existence of the guarantee of fulfilling spontaneous demand is directly related to quality of care the health unit, since, taking into account what has already been discussed earlier, the spontaneous demand reflects increased access to services, leverages the issue of professional-user encounter and enables the achievement of humanization in care, understanding that the bureaucratization limits humanization.

Demand study was conducted through the use of the International Classification of Primary Care (ICPC-2) in three health units of the family of the municipality of Betim, MG.¹³ From then on it was found that almost 30% of queries were originated by clinical symptoms related to general or non-specific problems (such as fever, headache, rash). Moreover, the headache was taken as the third most frequent consultation reason, being second only to medication prescription and reasons related to test results. However, nearly 20% of demand queries, originated by administrative issues. Therefore it is up here, so the question: where are located actually nodes that overwhelm the waiting rooms of health facilities. Will we in fact these nodes originate simply from population disease process?

Other interesting findings brought by these authors regarding the demand profile held in that city, is that the female was sharply prevailing in seeking care, reaching 8.2 women for every man met in the range of 30-39 years old, and Monday and Friday are the days when users tend to demand more consultations.¹³

Regardless of the demand profile seen at a health facility any encounter between professionals and users has great potential to consolidate the work in family health, since these meetings is to be established the bond, trust and shared responsibility necessary to compliance with the proposals of the Strategy.

♦ Spontaneous demand and the biomedical model

Five of the seven articles raised associate in any way with the demand playback of the biomedical model, focused on user medicalization, centered in medical consultation guided by the complaint-conduct model and perpetuation of social construction

that a good service is one where the hard technology is explored (tests are requested and medications are prescribed). In this regard, we emphasize the following fact:

Social medicalization is a complex socio-cultural process that transforms the experiences in medical needs, sufferings and pains that were administered in other ways, in their own family and community environment, and involving autochthonous interpretations and care techniques (...) notes that by reorganizing the contact of primary care services with users and their demands, the Home of the strategy has the potential to activate the process of social medicalization in a micro-scale and local.^{14:3616}

How makes us think, it is worth asking what is the social medicalization process, expanding access to health services by expanding the primary care network to strengthen the FHS; also that although the idea of implementing the desired completeness for health services to be a reconciliation of curative and preventive activities in the same place,¹⁵ it can be seen that "the actions developed in accordance with the demands on services are focused predominantly on the curative model".^{15:61}

It is known that many assignments are required of professionals working in the family health teams, however, although the first instance a complaint-conduct approach seems the fastest way to solve the spontaneous demands of the service, it is constructive thinking is long term, this action to strengthen the medicalized model will only continue to generate more demand driven the search for hard technologies, totally dependent on the health professional, devoid of self-care ability. To what extent will it be sustainable?

Reinforcing our discussion, another study revealed yet, the occurrence of extremely fast queries, reaching lasting around five minutes / user, establishing distant relationships between professionals and users.¹⁶ In this scenario, workers were limited generally the problem of the moment, not taking into account the other problems that were not being put explicitly in the process of attention. Reproduction of this fact mechanized meetings between health professionals and users, reducing their potential for change in care practices and contradicts everything that is put in the National Policy of Primary Care, when its precepts, advocates the consideration of the subject in its uniqueness and sociocultural integration, aiming to produce comprehensive care.²

It is important noting that although there is some emphasis in the medical profession, medicalization is not limited to it, but it takes account of this process in all areas of health which ultimately categorize sufferings and symptoms in the form of diagnostics, as well as explanations naturalized and reductionist therapies against such great complexity of the problems.¹⁴

On the other hand, we can see that often, consultation under complains role model and the issue of medicalization is required by the users, being seen of them, often even as a sign of quality, as shown in a survey where users of the units studied stated that it is necessary to have availability of doctors and medicines so there is solution for emergency.¹⁵ The biomedical model is so ingrained in the social imaginary, that respondents even suggest the possibility of 24-hour service for avoid overcrowding of hospitals, and the inclusion of medical specialists in health facilities, in which case they justify the need alleging the great demand.

Although in many practical scenarios, the demand is seen as a burden on health professionals work routine¹⁷, it was found that is a "weight" which we cannot think of more agile ways to get rid of it, but smart ways to enhance their strength to perform transformation in care model, and how to take care of themselves from the user. In this sense, it is worth remembering that "not all needs are converted into demands, but all the demands refer to some kind of need that requires intervention"¹⁸, and this fact cannot be ignored.

♦ Synthesis of knowledge from the Integrative Review

The ability of teams to organize their work process through planned activities, from knowledge of the health needs of its population, is a crucial factor to succeed in dealing with the demands the best way possible.^{9,13,15,17}

The completion of the Home as recommended by the National Humanization Policy emerges not only as a solution but as a way to prevent the spontaneous demands to become an obstacle in team work process; to why they do not have to be seen that way. Since the creation of the FHP was a devaluation of spontaneous demand, guiding teams to centralize their actions in health programs.¹⁴ This model, in fact, sometimes becomes so flexinerian, ie fragments both the service and the individual and himself the biomedical model or medical welfare. Only fragments in the logic of classifying agenda of

priorities and activities for diseases of social importance and collective.

We noted also that "to rearrange the contact of primary care services with users and their demands, the Home of the strategy has the potential to activate the process of social medicalization in a micro-scale and local." ^{14:3616}

There is a "permanent cycle of teaching and learning" ^{19:2890} on the day of health professionals, which is incorporated consciously, certainly would fertilize a process of empowerment and emancipation in care in Family Health Strategy. This, over time, reduces the voltage generated by the excess of spontaneous demands. In this sense, despite the primary care units, health professionals often claim that the user does not recognize the services offered by the unit beyond medical appointments, often to be no activity aimed to clarify the public about the purpose of the FHS. This would be a good solution to give more strides toward the circulation of users of unified health system because it is providing information through the expansion of popular participation and feasibility of the implementation of social control, which build citizens who contribute to the development and implementation of the FHS in its fullness.⁹

FINAL NOTES

There are shortages of material of the last 5 years and taking into account such great importance to implementation of the SUS, it is suggested to continue more focused studies the issue of spontaneous demand in the FHS scenario, although the spontaneous demand can be seen from many angles different, you need to understand it in its bond-generating potential and magnifier access to health services.

The articles showed three aspects of how to handle the demand, in order to optimize the work process of the teams: popular participation, organization of the work process by staff and conducting the host.

Working at FHS is always the search for a balance in direct actions, as well as one can establish a priority among health promotion and curative actions for monitoring and treatment of injuries already in place; also cannot ignore the spontaneous demands prioritizing only scheduled activities.

Each family health team should know the best way to manage their demands, which does not mean that the unscheduled care cannot be made within pre-established flows in the health unit. Each unit, and more specifically each team, from diagnosis of their

population health needs, will be able, more than any state body to manage their work process in the most effective way possible, making spontaneous demand, just user input door, ideally not the main, thus failing to become an obstacle in the work of teams, one more "weight" in the routine of professionals, that the spontaneous demand, in its deepest sense, is to search by a user meeting with the professional, and the entire meeting has the potential to establish comprehensive care depending on the mode of how it happens.

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