

**REASONS FOR SEEKING SECONDARY RATHER THAN PRIMARY CARE IN
NON-URGENT CASES****MOTIVOS DE PROCURA DE ATENDIMENTOS NÃO URGENTES NA ATENÇÃO
SECUNDÁRIA AO INVÉS DA ATENÇÃO PRIMÁRIA****MOTIVOS PARA ACUDIR A LA ATENCIÓN SECUNDARIA EN LUGAR DE A LA
ATENCIÓN PRIMARIA EN CASOS NO URGENTES**

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ABSTRACT

Objective: To identify the reasons that lead non-urgent patients to seek Secondary Care instead of Primary Care. **Methods:** Descriptive, qualitative and cross-sectional research addressing 36 post-screening patients classified as non-urgent according to the Manchester Code who sought care at the Hospital de Clínicas de Itajubá between January and December 2019. Participants answered a sociodemographic questionnaire and were submitted an interview addressing the reasons for seeking care in secondary care. The responses were submitted to content analysis. **Results:** The disbelief in the quality of services provided by primary care, the lack of knowledge about the organization of the health system and failures in the guidelines of primary care were the main reasons that led to the search for secondary care. **Conclusion:** The overload of emergency rooms is largely due to the lack of trust in primary care, ignorance of the health system and failures in primary care.

Descriptors: Triage; Primary Health Care; Secondary Care; Unified Health System; Emergency Medical Services.

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RESUMO

Objetivo: Identificar os motivos que levam pacientes não urgentes a procurarem a Atenção Secundária ao invés da Atenção Básica. **Métodos:** Pesquisa descritiva, qualitativa e transversal abordando 36 pacientes pós-triagem classificados como não urgentes de acordo com o Código de Manchester que procuraram atendimento no Hospital de Clínicas de Itajubá entre janeiro e dezembro de 2019. Os participantes responderam um questionário sociodemográfico e foram submetidos a uma entrevista abordando os motivos de procura de atendimento em atenção secundária. As respostas foram submetidas à análise de conteúdo. **Resultados:** A descrença na qualidade dos serviços prestados pela atenção primária, o desconhecimento sobre a organização do sistema de saúde e falhas nas orientações da atenção básica foram os principais motivos que levaram à procura da atenção secundária. **Conclusão:** A sobrecarga dos prontos-socorros decorre, em grande parte, da falta de confiança na atenção primária, desconhecimento do sistema de saúde e pelas falhas na atenção básica.

Descritores: Triagem; Atenção Primária à Saúde; Atenção Secundária à Saúde; Sistema Único de Saúde; Serviços Médicos de Emergência.

RESUMEN

Objetivo: Identificar los motivos que llevan a los pacientes no urgentes a acudir a la Atención Secundaria en lugar de a la Atención Primaria. **Métodos:** Investigación descriptiva, cualitativa y transversal con 36 pacientes clasificados en el triage como no urgentes según el Código Manchester que acudieron al Hospital de Clínicas de Itajubá entre enero y diciembre de 2019. Los participantes respondieron un cuestionario sociodemográfico y se les realizó una entrevista para determinar los motivos por los cuales acudieron a la atención secundaria. Las respuestas se sometieron a análisis de contenido. **Resultados:** La falta de confianza en la calidad de los servicios que brinda la atención primaria, la falta de conocimiento sobre la organización del sistema de salud y las fallas en la orientación de la atención primaria fueron los principales motivos que llevaron a los usuarios a acudir a la atención secundaria. **Conclusión:** La sobrecarga de las salas de emergencia se debe en gran parte a la falta de confianza que hay en la atención primaria, a la falta de conocimiento sobre el sistema de salud y a las fallas en la atención primaria.

Descriptores: Triage; Atención primaria de salud; Atención secundaria de salud; Sistema Único de Salud; Servicios Médicos de Emergencias.

INTRODUCTION

In Brazil, public health is administered by the Unified Health System (SUS). It is a large and complex public health system that ranges from simple care, such as blood pressure assessment, to complex care, such as organ transplantation.¹ It comprises three levels of health care: primary (basic complexity) ,

secondary (medium complexity) and tertiary (high complexity) that, working together, through the SUS reference and counter-reference model, guarantee the integral health care of the citizen.²

The first level of health care, Primary Care, includes the Basic Health Units (UBS), the Community Health Agents (PACS) and the Family Health

Strategy (ESF). It integrates preventive, curative, and health promotion actions in order to help individuals and communities.^{3,4,5} This level of care should be the preferred gateway for SUS users and a channel of communication with all other points that make up the Health Care Networks (RAS).²

The Secondary Care Level includes the Emergency Room (ER), open 24 hours and responsible for the care of urgent or emergency cases that require rapid assistance due to the imminent risk of the patient's life.^{6,7} Although the services provided by each level of health care, the population often overloads one of these, especially the secondary level.^{2,3}

It is believed that, consciously or unconsciously, primary care is trivialized due to its lower complexity and technological density when compared to secondary and tertiary levels.^{1,8} A consequence of this behavior is, for example, the overload of emergency rooms, compromising the speed required in these places. Other factors also influence this overcrowding, such as the increase in population longevity, which results in urgent and emergency services being overcrowded with patients with chronic diseases, which often demonstrate the misunderstanding of the structuring of Health Care Networks (RAS), that is, by spontaneous choice. In addition, the

opening hours and the presence of specialized doctors 24 hours a day make the secondary level more attractive to the population.⁹⁻¹⁴

A survey carried out in 2015 at the Emergency Room of the Hospital de Clínicas de Itajubá (HCI) covering 44,676 consultations observed that approximately 71% (31,660) were of low urgency (Green) and approximately 8% (3,760) of non-urgency (Blue).¹⁴ The classification of patients according to colors is based on the Manchester Risk Classification System (SMCR), which aims to prioritize the care of patients with clinical conditions at greater risk (those classified as yellow, orange and red), which demonstrates that the demand for HCI care behaves erroneously according to the organization established by the RAS.^{11,6}

Overcrowding in hospital emergency services is exacerbated by the presence of non-urgent patients, which leads to a loss in the approach to cases that are more serious and are eligible for care in secondary care.^{3,5-7} Thus, it is reported by the literature that a considerable portion of the population makes incorrect use of secondary care, however, few studies have sought to identify the reasons that lead these people to seek the hospital service in an erroneous way, so the present study aimed to identify the reasons that lead patients non-urgent (classified as Blue or Green

under the Manchester Code) to seek Secondary Level rather than Primary Care.

METHODS

This is a cross-sectional and qualitative research with intentional sampling of 36 participants who sought the Emergency Room of Hospital de Clínicas de Itajubá (HCI) between January and December 2019.

Data collection was divided into three intervals: Morning (7:00 am to 12:59 pm), Afternoon (1:00 pm to 6:59 pm) and Night (7:00 pm to 11:59 pm) in order to address the different demands of seeking the PS according to the schedule, with 12 interviews being obtained in each interval.

Inclusion criteria were patients over 18 years of age who, after screening, were classified as green or blue by the Manchester Risk Rating System (SMCR)⁶ and who agreed to participate in the research. Those who were younger than 18 years of age or who were classified as yellow, orange or red according to the SMCR or who refused to participate in the study were excluded from the study.

After the participants accepted to participate in the study by signing the Free and Informed Consent Term, a structured questionnaire was applied to characterize the population, addressing gender (male or

female), origin (Itajubá or cities in the microregion), income per capita (up to one minimum wage or more than one minimum wage) and education (incomplete elementary education or complete elementary education or incomplete secondary education or complete secondary education or technical education or higher education).

The interview was applied right after the questionnaire, being recorded on a smartphone for later transcription and analysis. The following questions were applied: “Why did you seek care in the emergency room instead of the health unit?” and “Do you know the difference between the care provided at the health center and the care provided at the emergency room? If yes, explain.”

The interview was later transcribed for data analysis through content analysis by Bardin.¹¹ The following steps were applied for data analysis: preparation of information; unitarization or transformation of content into units; categorization or classification of units into categories; description and interpretation.¹¹

The preparation of information was carried out in order to identify the different samples of information to be analyzed, followed by the process of coding the materials, establishing a code to identify each element of the sample of testimonies. After this step, the unitarization began,

aiming to define the “unit of analysis”. Each unit had a set of information that has a complete meaning, being subsequently submitted to categorization, aiming to group data considering the common part existing between them. The following categories were defined for the question about reasons for seeking secondary care instead of primary care: disbelief in primary care; organization and functioning of health care networks; irregularity in the functioning of the SUS; lack of knowledge about SUS organization and the doctor-patient relationship.

The categorization of the question about the interviewee's knowledge about the difference in care provided by the health center and the emergency room was performed according to: knows the differences correctly; does not know and does not know, but believed to know.

The description of the data was carried out in each of the categories by means of direct quotations from the speeches of the research participants. Finally, the Interpretation of the data sought to correlate factors that could motivate the participants' decisions, seeking interaction between the results obtained and the interpretation by the researchers.

Quantitative data were tabulated in order to characterize the population, not being analyzed because they are not part of the main objective of the study.

It is worth mentioning that the present study was submitted to the Research Ethics Committee of the Faculty of Medicine of Itajubá with a favorable opinion, with the protocol number: 2,393,377.

RESULTS AND DISCUSSION

Table 1 shows the sociodemographic profile of the research participants.

Table 1: Sociodemographic profile of respondents awaiting care at the emergency room of Hospital de Clínicas de Itajubá (HCI), 2019. (N=36)

Variables	No	%
Genre		
Feminine	30	83.33
Male	6	16.67
provenance		
Itajubá (MG)	24	66.67
Cities in the micro-region of Itajubá (MG)	21	33.33
Per capita income		
up to 1 SM	13	36.84
above 1 SM	23	63.16
education		
Incomplete FE	0	0.00
Complete EF	4	10.52
IN Incomplete	0	0.00
IN Complete	23	63.15
Technical education	4	10.25
University education	5	15.79

SM: Minimum Wage; EF: Elementary School; EM: High School

Table 2 presents the reasons that were cited more frequently by respondents who sought care in secondary care instead of primary care. The category “Disbelief in primary care” was applied to responses whose content stated distrust or disbelief with the service provided in primary care. The answers classified as “Organization and functioning of health care networks” refer to referrals of patients previously treated in primary care. The category “Irregularity in the functioning of the SUS” considered the responses in which failures in the functioning of primary care were

pointed out, such as the absence of professionals, for example. The speeches classified as “Ignorance about the organization of the SUS” were those in which the participants claimed to seek secondary care due to lack of knowledge of how primary care works. Finally, the category “Doctor-patient relationship” addressed the speeches in which flaws were identified in the guidelines of primary care physicians to patients, causing them to seek care in emergency rooms in an erroneous way.

Table 2. Reasons for seeking secondary care instead of primary care informed by respondents who were waiting for care in the emergency room of Hospital de Clínicas de Itajubá (HCI), 2019. (N=36)

reasons	No	%
Disbelief in Primary Care	14	38.89
Organization and functioning of Health Care Networks	12	33.33
Irregularity in the functioning of the SUS	6	16.67
Lack of knowledge about the organization of the SUS	2	5.55
Doctor-Patient Relationship	2	5.55

The literature reports that services with low resolutivity cause the search for secondary care to the detriment of basic health units, causing primary care to lose its function of “gateway”.¹⁶ Therefore, customer satisfaction is directly related to the complexity of service technology, human resources and training of professionals.^{15,16} Thus, it is understood that the fact that “Disbelief in Primary Care” is reported as the most recurrent reason for seeking emergency care is a reflection of the low resolutivity of this level of care, which

can be explained as a result of faulty diagnoses or treatments.¹⁵ Another factor that can explain this situation is due to the physical structure of basic health units using unstructured properties for public care, such as houses, for example.¹⁷

The explanations reported in the literature apply to the patients approached in the present study. In addition, the local situation where neighboring cities have a lower quality of care than the city of Itajubá performs, which leads to greater demand by

the regional population for the Emergency Room.

“Look, I already went to the health center with my grandson, but now he got a little worse and I brought him here because it seems that the care here I like the care more. We trust more (E12).”

Regarding the category “Organization and Functioning of the RAS”, those participants who declared that they had been referred from primary care to the hospital and those who claimed to seek it out because the care was immediate and performed 24 hours were included. This situation corresponded to 33.33% of respondents, as can be seen in the excerpt below:

Because today I was worried that I had one more symptom and, as the name says, emergency room, we will be attended on time. We have to make an appointment for the health center, we make an appointment in a month to be seen at least in the other month and I don't have time to make an appointment for college, internship and son. E6

The guidelines that make up this category are: The SUS referral system, in which patients were referred or counter-referred from a lower to a higher level of care and vice-versa, respectively²; Flexibility in emergency care (PA), which does not include the need to schedule appointments with specialist doctors in

advance, as in health posts; The lack of the presence of a medical professional full-time and every day of the week in primary care; and, finally, the 24h service.³⁻⁷

The literature says that the offer of quick medical appointments and in a larger supply, associated with the performance of tests and administration of medication during 24 hours are attractive to the sick.^{13,18} The flexibility of care in the PA service translates into an unbureaucratic service, without the need to schedule an appointment.¹⁷ The practically immediate solution of diseases that could not be foreseen becomes a great attraction to the population, especially when the reality of primary care goes in the opposite direction with appointments scheduled in advance and without meeting the free demands in some units.^{17,18}

The need for consultations on demand is reflected by the greater number of consultations performed in health units that have such a service compared to the traditional model with consultations with prior appointment, a fact that is observed in the municipality where the research was carried out. Unfortunately, not all primary care units have this service, which leads to the migration of non-urgent patients to the Emergency Department.

Regarding the category “Irregularity in the functioning of the SUS”, participants who claimed to seek the Emergency Room

for reasons associated with the lack of a Basic Health Unit (UBS) in the region where the researched person lives or the absence of a medical professional in the units were included, which represented 16.67% of cases, as can be seen in the report below:

"There is no health center where I live, so if we don't want to die there, we have to come to this place and wait until the goodwill of those inside. (E17)"

The literature shows that patients' search for a UBS is based on the expectation of care by a medical professional.¹⁸ Other members of the health team, even if trained, are not accepted, as they believe that they do not have sufficient knowledge to solve patients' demands.¹⁹ Such categorization was observed, above all, in the responses of patients coming from neighboring cities to Itajubá. It is known that there is a greater concentration of medical workforce in central locations and with better physical structure, which makes these professionals concentrate their activities in the municipality of Itajubá to the detriment of neighboring cities.

Regarding the category "Ignorance about the organization of the SUS", the reports of respondents who denied knowing the difference in the care provided in the UBSs and the care provided in the Emergency Care were included,

corresponding to 5.55% of the interviewees, with the report being exposed to follow:

"Because at the health center I don't know how their method of care works, so I always come to the hospital. (E9)"

It is reported in the national literature that a significant portion of its users is unaware of the functioning of the SUS.^{6,8,18} Thus, the guiding role of primary care in the prevention and control of diseases in the early stages is hampered by the low population demand, resulting in damage to the health of patients who seek secondary care as a result of the worsening of preventable pathologies. In addition, failures occur in the longitudinal follow-up of chronic diseases, causing preventable complications if the care is performed correctly.³⁻⁵

Regarding the category "Physician-patient relationship", responses that showed an incorrect hospital search due to failures in medical advice or patients' misunderstanding regarding the professionals' recommendations were included. This fact represented 5.55% of respondents, exemplified by the exposition of the report below:

"I came to take my blood pressure because the doctor who saw me said that I had very thick blood and that it could stop my organs, so I came here because he told me to take my blood pressure every week. (E18)"

This report shows a failure in communication between the doctor and the patient. Blood pressure control in patients with a suspected diagnosis of Chronic Arterial Hypertension or in medication adjustments should preferably be performed in primary care, preventing secondary care from performing such screening. This

situation is reported in the literature, which warns that a good doctor-patient relationship is essential to guarantee quality in care and trust in the services provided by primary care.¹⁸ This good relationship can be guaranteed through the physician's appropriate language with the patient in order to make the guidelines easy to interpret by SUS users.²⁰

Table 3. Answers to the question about the difference between the care provided in primary care and secondary care reported by participants awaiting care at Hospital de Clínicas de Itajubá, 2019 (N=36).

Answers	No	%
Know the differences correctly	4	11.11
unaware	12	33.33
Does not know, but believed to know*	20	55.55

* Participants who claimed to know the difference were included in this question, but their answers were incorrect according to the definitions established by the Ministry of Health.

Table 3 was obtained by questioning the participants regarding their knowledge about the difference between the care provided in the Emergency Room and the care provided in Primary Care. The answers classified as “Know the differences correctly” were those in which the interviewees correctly stated the differences in care. In the “Unknown” category, responses were included in which individuals claimed to be unaware of the differences in care and that they did not justify their responses. Finally, in the category “Does not know, but believed to know” were included the answers in which

the individuals incorrectly explained the differences in care.

It was observed that 55.5% of the interviewees did not know how to recognize the difference, justifying their statements in a wrong way with the provisions of ORDINANCE No. 4,279, DECEMBER 30, 2010, as we can see in the following report:

"The health center is more for serving the neighborhood, the hospital has to serve the entire city. I think that's the difference, because once I went to my sister's house and there was a very good doctor who attended the clinic there and they didn't let me consult because I wasn't from that neighborhood. So I think those are the differences. (E16)"

It was observed that almost 90% of the study participants did not know the difference between the care provided in PAs and in UBSs, a fact that highlights the need to educate the population about the real function of the spheres of care. This need was reinforced by the 55% who claimed to know the difference, but reported erroneous explanations compared to the definitions of the Ministry of Health. The literature agrees with the finding, showing that a large part of the population believes they have enough knowledge to distinguish their place of care, but they search in the wrong way.^{5,14} One third of the interviewees said they did not know the difference in care, which highlights a data worrying about the population that seeks the emergency room, identifying that a significant portion of respondents do not even have knowledge regarding the functions of care provided in Basic Health Units. This fact is reported in the literature and shows that this reality is not exclusive to the place where the research was carried out.^{8,20}

Finally, 11.11% of respondents said they knew the difference between the care provided at the health center and the care provided at the emergency room, correctly justifying it, as shown below:

"You know. Look at the service at the health unit, I think, for example, this Bezetacil should be given at the health unit, why not?"

Because there wasn't a doctor there prepared to be able to attend in case of an emergency. Perhaps the post does not have a structure to respond to an emergency. I don't know, it's my deduction. Because this care of mine shouldn't be in the emergency room, it should be at the health center, because it's an injection, a Bezetacil that I'm going to take. If there is a structure in the health center that has an emergency there, there is no reason to send it to the emergency room, overload the emergency room. The care at the health post has to be the most basic care. For example, a flu, why do I come to the Emergency Room because I have the flu, diarrhea, even renal colic why do I come to the emergency room? These are things that can be resolved at the health center. Hypertension, why come to the emergency room if you can solve it at the health center? The health post must have the structure to attend to these basic things. The emergency room would really have to deal with emergencies, right, and not deal with primary or secondary things, okay." (E7)

As can be seen, 11.11% of respondents, that is, the minority, correctly justified their statements about knowledge about the functioning of the SUS. The literature recognizes that only a small part of the Brazilian population is committed to social participation policies. In addition, he describes that the population's knowledge about aspects related to the SUS is insufficient, a fact observed in the present study.²⁰

CONCLUSION

It can be concluded that a large part of the population has difficulties in distinguishing the functioning of primary care and secondary care, being evident when observing that the reasons for seeking emergency care were likely to be attended in primary care, in addition to the lack of knowledge about the responsibilities and functions of each service sphere.

Based on this study, it is recommended to formulate educational campaigns aimed at raising the population's awareness of the functioning of the health system, in addition to serving as a bibliographic basis for the development of other studies, given the diversity of sociocultural situations in Brazil.

Finally, it should be noted that the present study has two main limitations, the first one corresponding to the data collection being carried out in only one hospital unit, and the second in relation to the limited number of research participants.

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