

Assessment of the reception capacity of spontaneous demand in primary care services Avaliação da capacidade de acolhimento da demanda espontânea nos serviços de atenção básica

Evaluación de la capacidad de acogida de la demanda espontánea en los servicios de atención primaria

Received: 09/11/2015

Approved: 29/02/2016

Published: 01/05/2016

Maria Cristina Traldi¹

Laís Rabesco²

Márcia Regina Campos Costa da Fonseca³

This study's aim was to evaluate the receptivity of primary health care services, based on the records classified as non-urgent on the Manchester scale. This is an exploratory study with random sample consisting of 384 blue and green records of children and adolescents attended by public emergency services. The address in the records allowed the identification of the primary care service of the patients' region of residency. 20.6% were classified as blue and 79.4% as green. The median was equal to eight calls per Unit of Primary Care. Twenty units (55.5%) had a score equal to or lower than the median, and were considered moderate in terms of receptivity and 16 (44.5%) were above the limit line and were considered to have low receptivity. The study found that the receptivity of children and adolescents was considered mostly moderate, with better performance of the units working in the Family Health Strategy.

Descriptors: Primary health care; Health services accessibility; Humanization of assistance.

O objetivo do estudo foi avaliar o acolhimento dos serviços de atenção básica a partir das fichas classificadas como não urgência na escala de Manchester. Estudo exploratório com amostra aleatória constituída por 384 fichas azuis e verdes de crianças e adolescentes atendidos em serviço público de emergência. O endereço inscrito nas fichas possibilitou identificar a Unidade Básica da região de residência dos pacientes. 20,6% tinham classificação verde e 79,4% azul. A mediana foi igual a oito atendimentos por Unidade de Atenção Básica. Vinte Unidades (55,5%) obtiveram escore igual ou inferior à mediana, sendo considerados moderados na capacidade de acolhimento e 16 (44,5%) ficaram acima da linha de corte e foram considerados como tendo baixa capacidade de acolhimento. O estudo concluiu que a capacidade de acolhimento de crianças e adolescentes foi moderada, com melhor desempenho das unidades que atuam na Estratégia Saúde da Família.

Descritores: Atenção primária à saúde; Acesso aos serviços de saúde; Humanização da assistência.

El objetivo de este estudio fue evaluar el acogimiento en los servicios de atención primaria de salud por medio de los registros clasificados como sin urgencia según la escala Manchester. Estudio exploratorio con muestra aleatoria que consistió de 384 registros de niños y adolescentes atendidos en servicio gubernamental de emergencia y con clasificación en colores azul y verde. Por la dirección introducida en los registros se identificó la región de la unidad básica de la residencia de los pacientes. 20,6% tenían clasificación azul y 79,4% verde. El promedio fue de ocho atendimientos por unidad de atención primaria. Veinte unidades de salud (55,5%) tuvieron una puntuación igual o inferior a la mediana y fueron considerados como teniendo moderada capacidad de acogida y 16 (44,5%) por encima de la línea de corte y se consideraron con baja capacidad de acogimiento. El estudio indicó que la mayoría de los servicios de salud tenían capacidad de acogimiento moderada, con un mejor rendimiento de las unidades de trabajo en la Estrategia Salud de la Familia.

Descriptor: Atención primária de salud; Accesibilidad a los servicios de salud; Humanización de la atención.

¹ Nurse. Specialist in Preventive Social Medicine. Master and Doctor in Education. Adjunct Professor at the Undergraduation Course in Nursing and the Academic Master's degree Program in Health Sciences in the Medicine Faculty at Jundiaí (FMJ), SP, Brazil. mcristraldi@gmail.com. Brazil.

² Nurse. Graduated at the Medicine Faculty at Jundiaí, SP, Brazil. lais-rbesco@hotmail.com. Brazil.

³ Nurse. Master in Pharmacology. Doctor in Health Sciences. Adjunct Professor at the Undergraduation and Master's Degree Courses in Health Sciences at the Medicine Faculty at Jundiaí (FMJ), and Professor at the Faculty São Leopoldo Mandic - Campinas. fonseca100@uol.com.br. Brazil.

INTRODUCTION

The Unified Health System (SUS) in Brazil, established in 1990 with the purpose of changing the situation of inequality in access to and quality of health care for Brazilians, still faces today the challenge of effective policies that ensure equity in access to services and the universality of integral assistance to health¹.

One of the central points in the proposals of the SUS in the first decade of its implementation was the need to promote a radical change in the current assistance model. Within that context, basic attention was rightly regarded as the path to the universalization of assistance. However, what prevailed was a focus on preventive actions, centered on controlling the most prevalent diseases and on low-complexity assistance directed to women and children^{2,3}.

To address this problem of focusing actions, the family health Program (PSF), which was presented as an alternative in order to promote reforms that had been ineffective, was established in 1994. Anticipating the implementation of this process on a large scale, the program assumed a strategic character. Due to possibility of structures being imposed on municipal health systems, the family health Strategy (ESF) has initiated an important movement to reorganize the model of attention in SUS, seeking a more rational use of other levels of attention. This strategy showed considerable positive results in the evaluation of healthcare users, managers and professionals, specifically with regard to the range of healthcare options, as well as access to and use of services^{1,4}, and even reducing infant mortality rate⁵.

However, there still remains the challenge of the effectiveness of actions to keep up with the expansion of the network, reducing the gap between practices that are recommended and those that are actually implemented, with respect both to rhythm and proportion in the different conditions presented in different regions of the country⁶.

In public policies, the expression Basic Attention is used as a synonym for Primary Health Attention. It is defined as a set of actions designed to promote and protect the health of the population, to prevent, diagnose and treat diseases, and to rehabilitate and maintain the health of individuals and collectives in populations in delimited territories. In short, these are actions aimed at a population assigned to a health service that is, generally speaking, a basic health unit (UBS) or a family health unit (USF)⁷.

The prevailing perspective among local systems and healthcare is that primary health care is responsible for the integral care of users, which includes, among other things, first response to urgent care and emergencies, constituting the strongest link in the relationship with users who, according to their healthcare needs, seek some kind of response to the conditions of their lives in order to enhance and prolong their existence^{1,4,2-7}.

To be decisive and allow access to users, primary care services must demonstrate the capacity to listen to and offer solutions that meet the complex demands of the health problems and needs of the people. In other words, they must demonstrate the ability to serve and give positive responses to users, either by integrating them into a network of attention or soliciting the support of professionals who can subsidize the local team. In this model, primary care is expected to resolve most of the health needs of individuals and collectives who reside in the territory of the units^{3,8}.

The guarantee of universal access to those who really need this type of care has not yet been accomplished in the SUS, and the reasons for difficulties in its implementation vary, depending, necessarily, on patient capacity and the local demand for services. This is influenced by the level of technology available, level of user information, influences

the medical-industrial complex exerts on society, and, above all, the capacity of primary care services¹ for service and resolution.

Regardless of the reasons, the immediate consequence of the restriction on access to demands not included in primary care is the increased demand for emergency care services, which overloads a service level designed to receive, fundamentally, more complex cases within that demand condition, which is organized by the construction of care network policies, not by spontaneous demand^{8,9}.

Overloading inpatient urgent care services disrupts the system, overloads services for non-urgent demands and contributes to the increase of user wait time for care. It exposes, on the other hand, the failures in implementing a national healthcare policy in which the structuring element of the care network is primary attention and family care as the main action strategy for a comprehensive model to healthcare⁶.

In order to reduce wait time and make care more equitable, public services have adopted standardized measures for care in a protocol used to assess risk in emergency care services. This provides parameters for identifying priorities based on complaints referred to by the user and the signs and symptoms presented at the time of the evaluation. The protocol is divided into four levels of severity, using colors to identify and prioritize services. Thus, cases considered emergencies are assigned a red stripe on the treatment card, urgent cases a yellow one, non-urgent cases a green one, and, for low complexity consultations, the card is assigned a blue color¹⁰.

Emergency room services with high demand for services classified as non-emergency, marked green and blue colors, are an important indicator of low patient capacity and success of primary care^{11,12}.

Spontaneous demand for urgent care and emergency services involving complaints not characterized as such may be, among other

things, an indicator that the patient capacity and effectiveness of primary care services do not match the proposals of the assistance-based model, which established a connection with the responsibility for health care with respect to action, completeness of attention, and the centrality in the coordination of health care under the SUS^{10,11}.

The question that has guided this research was that of analyzing patient capacity for demands for primary care services from the child and adolescent sector of the population. With this focus, the study aims to evaluate the greeting of basic services based on the treatment records of children and adolescents classified as non-urgent on the Manchester scale (green and blue), in emergency service of a hospital of the SUS, in a municipality in the State of São Paulo, SP, Brazil.

METHOD

This is a cross-sectional and retrospective study conducted in the emergency department of a hospital located in a medium-sized municipality in the state of São Paulo, Brazil, with approximately 400,000 inhabitants. The hospital is highly referred for users of the health system in the maternal and childcare specialties and caters to spontaneous demand via an "open door" policy, that is, with no requirement for referral.

The sample was calculated based on the treatment number of children and adolescents 0 to 14 years old, residents of the city, treated in the hospital's emergency room in the year 2013, on weekdays and during business hours. The criterion for certain times of the day and certain days aimed to ensure that the visits occurred during the normal hours of primary health care units.

The municipality in which the study was undertaken is located in the southeast of the State of São Paulo, approximately 60 kilometers from the capital. In 2015, it had an estimated population of 400,000 inhabitants (IBGE cities 2010:

www.cidades.ibge.gov.br/xtras/perfil.php?lang=&codmun=352590), of which approximately 4,500 are children under one year of old, 18,000 in the range of one to four years old and 59,000 between the age of five and 14, with a total child population of 81,500. The human development index of the municipality IDHM is 0.822, meaning that it belongs to the highest bracket in the country.

The sample was calculated, assuming the greatest possible variability, based on prevalence $p=50\%$, a level of significance of 5% and a sampling error of 5%, assuming 5,500 cases/month, giving $n = 384$.

For the division of the sample, a percentage of 0.6% was applied in each month of the year to obtain the number of treatment records to be chosen.

Randomization was guaranteed by choosing every third day (3; 6; 9; 12; ...), excluding Saturdays, Sundays, and holidays. The selection of records followed the same systematic records as the selection of days, choosing every third card, following the increasing order of numbering of same until obtaining the number required to complete the monthly proportional percentage of the sample.

The sociodemographic variables of interest were: residential address; age and sex. The variables for the characterization of the treatment were: the main complaint and the classification of risk and outcome. The variables for the characterization of primary care service were: type of unit (UBS/USF) and the time of treatment.

Due to the diversity of complaints, a categorization was adopted in order to group them according to symptom groups and/or the proximity to the major systems of the human body: digestive, respiratory, genitourinary, and integumentary. Because a non-specific fever, either alone or associated with other symptoms, was cited so frequently among the reasons for requesting emergency service, it was considered a complaint group of its own.

The identification of the residential address of the child or adolescent within the area of UBS\USF was made on the basis of the list of streets and neighborhoods made available by the local Secretary of Municipal Health.

For the purposes of this study, units that adopt the family health strategy and that rely on Community Health Agents Program (PACS) were considered part of the USF and UBS. In the period of the study, primary care services amounted to 36 units, 18 of which were USFs and 18 UBSs, located primarily on the outskirts of the city.

The data, collected in 2014, was entered in an Excel spreadsheet and subjected to descriptive analysis to calculate measures of central tendency and dispersion. To evaluate the patient capacity of the units, a score set was established from the median frequency of the sample treatments. Units with below average treatment card scores were included in the category of moderate patient capacity; those above the average were included in that of low patient capacity.

The criteria for classifying patient capacity as moderate or low were justified in the high demand for treatment of events with no urgent or emergency characteristics in the service studied. According to the children's emergency room reports (PSI), there were 63,569 medical consultations performed in the year of 2013 of which 1,190 (1.87%) were adolescents who were hospitalized. This percentage is much lower than the 6% to 7% recorded in the emergency room of Pelotas-RS, produced by the Municipal Council of Health for the municipality of Pelotas, RS, Brazil, in 2007 with data from 2006. (www.pelotas.rs.gov.br/cmspel/relatorio_psp.pdf).

The study was submitted to and approved by the Ethics Committee of the School of Medicine of Jundiai under number 045535/2014. Because it is a retrospective study based on secondary data, the

requirement for informed consent was not applied.

RESULTS

The sample of this study (n=384) was obtained from the treatment records (FA) of the patients who were effectively processed and actually received care, since some users come to the emergency room and complete treatment records but do not wait for medical attention. In 2013, the service studied had a percentage of abandonment ("did not wait for treatment") of 1.11% (n=715).

The sample was composed of treatment records for 384 children and adolescents (0 to 14 years of age). The sociodemographic profile indicates that the average age of the sample was 4.47 ± 4.13 years, with a variation of 12 days to 14 years of age, being most prevalent the treatment of children in the age group of 1 to 4 years old (45.8%)

The records sampled resulted in the following percentages for risk classification: green 20.57% (79/384), blue 73.95% (284/384), yellow 5.2% (20/384) and 0.26% red (1/384), with 94.52% of calls placed in the category of not urgent.

Concerning the outcome, 7.29% (28/384) remained under observation in the

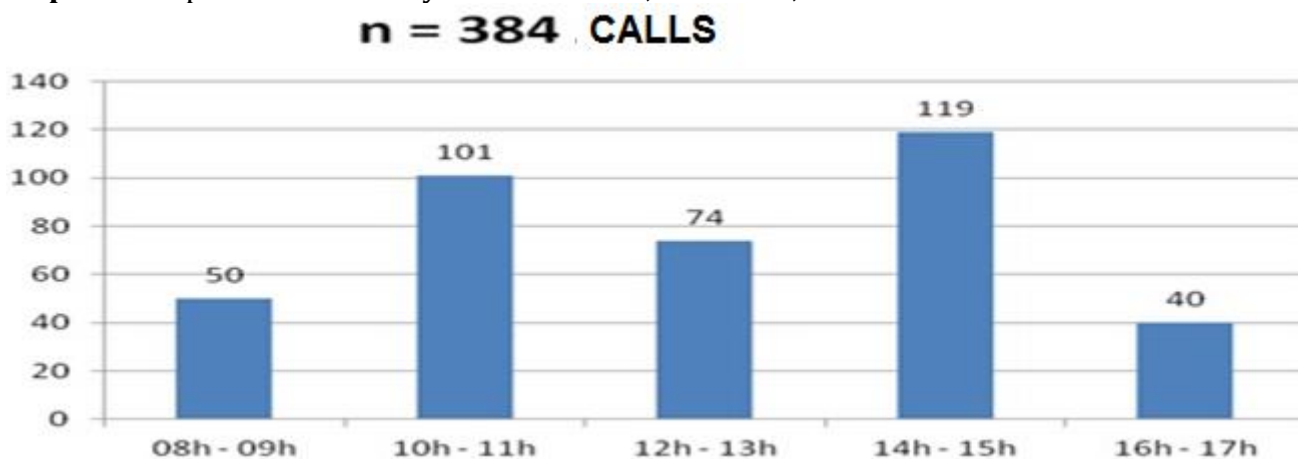
emergency room without resulting in hospitalization; the remaining (356/384) were dismissed after medical consultation.

The months with the highest demand for care in the children's emergency room were May (11.7%) and April (10.7%). The increased demand in these months is attributed to the influence of seasonality on demand associated with the change in climate, characteristic of autumn, in which temperatures tend to drop and the environment continues to be poorly ventilated, allowing for the transmission of viruses by aerosols and the consequent increase in respiratory complaints.

The range of hours that concentrated the largest number of treatments was early afternoon, between 2:00 pm and 3:00 pm, the evening period having higher frequency (60.2%) of calls (graph 1). It is worth noting that the consultation hours of the UBS/USF in the municipality is 8:00 a.m. at 5:00 pm, excepting those that operate on extended hours (third shift).

The average monthly treatment records completed in PSI per unit of primary care was 10.97 ± 9.87 records per service (2-53); one unit did not register treatment at PSI-HU.

Graph 1. Sample distribution by time of the call, São Paulo, 2013.



The complaints most often recorded in the treatment records were those of groups G1 and G2, including isolated or associated fever and symptoms characteristic of respiratory

illnesses such as a cough and runny nose. Together, the complaints of these two groups constituted 47.14% of treatments administered in the emergency service, including all age groups (Tables 1 and 2).

Table 1. Absolute and relative frequency of complaints recorded in treatment records, by group, Sao Paulo, 2013.

Group of Complaints	n	%
G1. Nonspecific fever, isolated or associated	84	21.88
G2. Dry cough, productive, runny nose, nasal secretion, wheezing, dyspnoea	97	25.26
G3. Accidents: falls, foreign bodies, trauma, insect bites, dog bites	57	14.84
G4. Abdominal pain, diarrhea, vomiting	61	15.89
G5. Problems on the skin or mucous; allergies: itching, rash and blotchy skin, boils, ingrown toenail	15	3.91
G6. Problems related to eyes, throat, ears, lip/oral lesion	36	9.38
G7. Communicable diseases: varicella	6	1.56
G8. Menstrual cramps, scrotal edema, dysuria, haematuria	8	2.08
G9. Other: Headache, dizziness, fainting, lack of appetite, sneezing, crying, loss of appetite	20	5.21
Total	384	100.00

Table 2. Distribution of absolute and relative frequency of complaints by age group, Sao Paulo, 2013.

Complaints	< 1 year		1-4 years		5-09 years		10-14 years	
	n	%	N	%	N	%	n	%
G1	19	28.79	46	26.14	16	57.50	3	4.84
G2	26	39.39	42	23.86	18	52.50	21	33.87
G3	4	6.06	30	17.05	11	37.50	2	3.23
G4	4	6.06	24	13.64	20	30.00	13	20.97
G5	4	6.06	6	3.41	2	7.50	3	4.84
G6	5	7.58	20	11.36	6	25.00	5	8.06
G7		0.00	4	2.27	2	5.00		0.00
G8	1	1.52		0.00	1	0.00	6	9.68
G9	3	4.55	4	2.27	4	5.00	9	14.51
Total	66	100.00	176	100.00	80	100.00	62	100.00

The median of consultations in the Manchester scale in the colors green and blue was eight. In assessing patient capacity, 20 (55.5%) Health Units had a score equal to or lower than the median, and thus were considered moderate in patient capacity and 16 (44.5%) were above the cut line and were considered in this study as low patient capacity.

Together, the 14 health units with low patient capacity accounted for 70.6% (271/384) of consultations with Manchester

rating blue and green in PSI; six are UBS, eight are UBS that also receive the support of community health agents program (PACS), as well as a unit identified as UBS/ESF, in which the neighborhoods that compose the area are part of the same region with a single name and could not be identified in the treatment records (Table 3).

It is worth highlighting the fact that the five units that operate in the ESF are included among the units with moderate patient capacity and all score below the median.

Table 3. Sample by age group and type of primary care unit, São Paulo, 2013.

Type Unit	Attendance		Age Group							
	n	%	< 1 a.	%	1-4	%	5-9	%	10-14	%
Total	384	100	66	17.2	176	45.8	80	20.8	62	16.1
UBS	4	2.7	2	3.0	1	0.6			1	1.6
UBS	6	4		0.0	2	1.1	2	2.5	2	3.2
UBS	4	2.7	1	1.5	3	1.7		0		0.0
UBS	4	2.7		0.0	1	0.6	1	1.25	2	3.2
UBS	9	6	1	1.5	4	2.3	2	2.5	2	3.2
UBS	3	2		0.0	2	1.1	1	1.25		0.0
UBS	7	4.7	2	3.0	3	1.7	2	2.5		0.0
UBS	4	2.7		0.0	3	1.7	1	1.25		0.0
UBS	5	3.4	2	3.0	1	0.6	1	1.25	1	1.6
UBS	20	13.4	4	6,1	9	5.1	5	6.25	2	3.2
UBS	13	8.7	1	1.5	7	4.0	3	3.75	2	3.2
UBS	12	8.1		0.0	8	4.5	3	3.75	1	1.6
UBS	13	8.7	3	4,5	5	2.8	3	3.75	2	3.2
UBS	8	5.4	1	1.5	3	1.7	3	3.75	1	1.6
UBS	13	8.7	4	6,1	4	2.3	3	3.75	2	3.2
UBS	8	5.4	1	1.5	4	2.3	3	3.75		0.0
UBS	16	10.7	3	4,5	6	3.4	4	5	3	4.8
UBS+PACS	13	7.3		0.0	7	4.0	5	6.25	1	1.6
UBS+PACS	2	1.12		0.0	1	0.6	1	1.25		0.0
UBS+PACS	3	1.69		0.0	2	1.1		0	1	1.6
UBS+PACS	8	4.49	2	3.0	5	2.8		0	1	1.6
UBS+PACS	3	1.69		0.0	2	1.1		0	1	1.6
UBS+PACS	15	8.43	2	3.0	8	4.5	2	2.5	3	4.8
UBS+PACS	21	11.8	1	1.5	12	6.8	5	6.25	3	4.8
UBS+PACS	53	29.78	11	16,7	22	12.5	9	11.25	11	17.7
UBS+PACS	11	6.18	2	3.0	6	3.4	2	2.5	1	1.6
UBS+PACS		0		0.0		0.0		0		0.0
UBS+PACS	23	12.92	5	7,6	7	4.0	7	8.75	4	6,5
UBS+PACS	8	4.49	1	1.5	6	3.4		0	1	1.6
UBS+PACS	18	10.11	4	6,1	9	5.1	2	2.5	3	4.8
UBS/PSF	30	52.63	5	7,6	13	7.4	6	7,5	6	9.7
USF	7	12.28	3	4,5	4	2.3		0		0.0
USF	7	12.28	3	4,5	2	1.1		0	2	3.2
USF	6	10.53	1	1.5	1	0.6	3	3.75	1	1.6
USF	2	3.51		0.0		0.0	1	1.25	1	1.6
USF	5	8.77	1	1.5	3	1.7		0	1	1.6

DISCUSSION

The results of this study provoke reflection on the impact of basic assistance, and in particular of the family health strategy, in promoting the reorganization of the attention-based model based on the reception of users. The assumption is that the link established between the team of local health professionals and the population makes primary care the gateway to the system and the main reference in meeting low-complexity health needs of users belonging to a particular region.

Since the first attempts to implement a model of assistance capable of changing the way the health system is organized, based on a hierarchy of comprehensive care, meeting demands for scheduled visits has been the hallmark of primary health care, with an emphasis on prenatal care, childcare, immunization, control of tuberculosis, leprosy and other endemic or epidemic communicable diseases¹⁵.

Individuals with chronic diseases like hypertension, diabetes, psychiatric disorders, as well as dental care, were progressively integrated into daily assistance. However, the expansion of the assistance spectrum continues to prioritize scheduled visits and attending to a production model of actions that is aligned more with a kind of management based on the control of processes to the detriment of the outcome, which runs contrary to new public management policies¹⁵.

The reception of users in their unscheduled health needs necessitates the establishment of a treatment flow initiated by listening to those who come to the service seeking a solution to a health problem^{16,17}. This attitude in the team favors management for results in that it seeks to attend to the user in an integral way, moving towards a proposal for humanization and contributes to providing access to the system via the gateway of primary care.

In the municipality studied, 47.2% (17/36) of primary health units operate in the context of ESF, either as family health teams or

with PACS. The USF have positioned themselves between the units with moderate patient capacity and one of them did not have a treatment record included in the sample of this study.

The results suggest better patient capacity for the teams involved in ESF, compared those in UBS, and reaffirm public policy that the ESF adopted nationwide, as reorienting the service model to improve access for the population to primary care¹³. This study corroborates other studies that point to the service and the link as the main changes observed in health facilities who adopt the family health strategy, where the focus of the analysis is demand^{5,17-19}.

Complaints registered in the call records that led parents and/or guardians of and adolescents to PSI service suggest that attending to spontaneous demand in primary care is not entirely effective, which has been observed in other regions²⁰.

Programmatic monitoring of children under one year of age in health units, along with periodic scheduled check-ups, is an opportunity to meet the spontaneous demands of this population group and may explain the lower frequency of requests in the emergency room for this population group, who recorded one of the lowest percentages of attendance to complaints characterized as not urgent. Children between the ages of 1 to 4 years, in contrast, were those who sought emergency medical attention most frequently and are precisely those patients who no longer enjoy regularly scheduled follow-up visits, unlike infants.

To effectively assume reception as a guideline is a process that demands real transformations in the way we think about and provide primary health care. It requires a set of articulated actions, involving users, workers and managers, since the implantation of reception can hardly be achieved by the will of an isolated individual. In fact, multiple politico-institutional and technical aspects need to be mobilized for its successful implementation¹⁸.

Public policies related to health care and humanization assert that reception in primary care is an objective way to identify, recognize, and intervene in user demands, accepting the fact that this also defines health needs in varied ways and degrees.

In this conception of the humanization of assistance, reception must be understood as a powerful device for change in the process of work that enables the link between health care staff and the population, and that contributes to increasing informed attitudes on the ethics of institutional responsibility and of workers in the integral care of users in the area.

Attendance, in practice, is implemented based on the receipt of the user by a qualified professional who listens to the user's complaints and continues with a guarantee of effective treatment of the health need, which leads to a local, immediate or scheduled action in the unit itself, depending on the case, or in conjunction with other health services, for the continuation of assistance¹⁰.

Some complaints that led parents/guardians to seek emergency care may reflect ignorance about the purpose of an emergency room, about fundamental principles of the SUS, as well as the expected result of primary care services. This statement can be valid for all complaints classified as green and blue, but especially for those included in the category "other," in which lack of appetite was identified as a reason to seeking attendance at PSI. On the other hand, it may reflect a failure in attending to a health need identified by the user.

In this respect it is important to highlight that listening accurately to and receiving effectively spontaneous demands legitimates and acknowledges the problem that led to the individual seeking treatment, regardless of whether or not the user's perception of need and that of the health staff are congruent.

An effort to establish dialogue and understanding must be made, without which complications may arise which sometimes

require repeated follow-ups or other services, such as emergency services, in an attempt to receive treatment, even though the health system is not organized for that¹². Failure to properly receive users by neglecting to listen to them not only impoverishes the care process, by suppressing the longitudinality of this component of it, but also disrespects the needs of the individual user²¹.

It should be noted that attending to spontaneous demand is, also, an opportunity for the staff to evaluate the effectiveness of previous therapeutic measures and projects, or to encounter situations that require the invention of new care strategies and the restructuring of the work process, all of which constitutes an important device for reorienting the care model, given that the basic health care network has not been successfully converted into the main gateway to the health system¹².

The evaluation of result indicators gives local teams a chance to develop situational diagnosis and to critically analyze their results by evaluating established goals and by comparing their results with other, similar units, redirecting actions according to a proposal for a care-based model, if necessary.

In the assessment for the planning of health work, as well as the preparation of human resources to attend to the perspective of comprehensive care²², other aspects of the organization of the system are identified as weaknesses that may compromise user access and that lack coordination with other health care levels; the installed capacity of the unit as concerns the multidisciplinary team, as well as the lack of inter-sector, municipal policies that enable the implementation of actions that promote the health of the local population, since they reduce attempts by the local health staff to take on a proper attitude of volunteerism that, many times, acts against the lack of action from municipal managers²³⁻²⁵.

Taking action on these fronts to change the assistance perspective and to reorient the work process of staff in order to guarantee access and improve the effectiveness of

primary care is a challenge yet to be confronted by managers, health professionals, and society as a whole.

Studies show that changes in the country's care model are still incipient and result from specific advances and as such not attributable to the adoption of Family Health as a priority and a core strategy at the local level^{13,26}. They also underline that despite policies aimed at improving access and reception, the difficulty of incorporating the substitutive character of the care model persists²¹. Even in places where universal access has been achieved, this is generally associated with programmatic activities, to the detriment of meeting spontaneous demands^{18,27}.

Difficulties in overcoming the traditional care model and moving toward a more inclusive model was the aim of qualitative research involving 190 PS / AMA and UBS professionals, which concluded that the limited conception of the role of UBS, above all in professionals working in primary care, results, possibly, in practices that restrict public access²⁸. The study cited reveals an important aspect of access, which has to do with the lack of knowledge in professionals concerning the design of the attention model advocated in the SUS. Another study carried out in São Paulo analyzed the factors associated with access to basic health services and concluded that this is associated with previous experiences of treatment in the service and the image constructed by users about the service²⁹.

Whether because of parents' past negative experience or of ignorance regarding how the system works, users of SUS continue to seek emergency services in an attempt to resolve low complexity clinical health problems, primarily during the day, preferably during evening hours, a time during which primary care health units are in operation.

The peak hours of attendance at PSI found in this study suggest some situations, such as: the failed attempt to attend patients in

primary care, care in feeding a child before seeking medical attention, knowing the wait time in the emergency room, or even the possibility of receiving communication from the child's school or daycare center requesting that the parents pick up the child who shows signs or symptoms of illness.

CONCLUSION

The study concluded that the treatment capacity for children and adolescents in primary care services was mostly moderate (55.5%), with better performance in units working within the family health strategy.

Carrying out further research is recommended, in order to deepen understanding of the aspects associated with the low treatment capacity and the main contributing factors of non-reorientation in the attendance model, just as public health policies recommend.

REFERENCES

1. Almeida PF, Giovanella L. Avaliação em Atenção Básica à Saúde no Brasil: mapeamento e análise das pesquisas realizadas e/ou financiadas pelo Ministério da Saúde entre os anos de 2000 e 2006. *Cad Saúde Pública*. 2008; 24(8):1727-42.
2. Tesser CD, Norman AH. Repensando o acesso ao cuidado na Estratégia Saúde da Família. *Saúde Soc*. 2014; 23(3):869-83.
3. Nascimento APS, Santos LF, Carnut L. Atenção primária à saúde via estratégia de saúde da família no Sistema Único de Saúde: introdução aos problemas inerentes à operacionalização de suas ações. *J Manag Prim Health Care*. 2011; 2(1):18-24.
4. Lentsck MH, Kluthcovsky ACGC, Kluthcovsky FA. Avaliação do Programa Saúde da Família: uma revisão. *Ciênc Saúde Coletiva*. 2010; 15(Supl. 3):3455-66.
5. Vanderlei MIG, Almeida MCP. A concepção e prática dos gestores e gerentes da estratégia de saúde da família. *Ciênc Saúde Coletiva*. 2007; 12(2):443-53.
6. Giovanella L, Mendonça MHM. Atenção primária à saúde. In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI,

- organizadores. Políticas e sistemas de saúde. Rio de Janeiro: Fiocruz; 2008.
7. Ministério da Saúde (Br). Política Nacional de Atenção Básica. Brasília (DF): Secretaria de Atenção Básica; Departamento de Atenção à Saúde; 2008.
 8. Ministério da Saúde (Br). Acolhimento à demanda espontânea na atenção básica. Brasília (DF): Ministério da Saúde; 2011. (Cadernos de Atenção Básica, n.28, v.1).
 9. Ministério da Saúde (Br). Implementação da rede de atenção às urgências/emergências. Brasília (DF): Ministério da Saúde; 2011.
 10. Ministério da Saúde (Br). Acolhimento e classificação de risco nos serviços de urgência. Brasília (DF): Ministério da Saúde; 2009.
 11. Souza CC, Chianca LM, Diniz AS, Chianca CM. Principais queixas de pacientes de urgência segundo o protocolo de classificação de risco de Manchester. Rev Enferm UFPE. 2012; 6(3):540-8.
 12. Souza ECF, Vilar RLA, Rocha NPD, Uchoa AC, Rocha PM. Acesso e acolhimento na atenção básica: uma análise da percepção dos usuários e profissionais de saúde. Cad Saúde Pública. 2008; 24(1):100-10.
 13. Rocha AS, Vilar RLA, Melo RHV, França RCS. O acolhimento na atenção básica em saúde: relações de reciprocidade entre trabalhadores e usuários. Saúde Debate. 2015; 39(104):114-23.
 14. Ministério da Saúde (Br). Acolhimento à demanda espontânea: queixas mais comuns na atenção básica. Brasília (DF): Ministério da Saúde; 2013. (Cadernos de Atenção Básica, n. 28; v.2).
 15. Traldi MC. As Políticas públicas de saúde e os principais desafios para a administração de enfermagem em saúde coletiva. In: Santos AS, Traldi MC, organizadores. Administração de enfermagem em saúde coletiva. Barueri: Manole; 2015.
 16. Farias DC, Celino SDM, Peixoto JBS, Mayara Lima Barbosa ML, Costa GMC. Acolhimento e resolubilidade das urgências na estratégia saúde da família. Rev Bras Educ Med. 2015; 39(1):79-87.
 17. Silva JA. Reorganizar e humanizar o processo de trabalho através do acolhimento: relato de experiência. Rev Baiana Saúde Pública. 2015; 39(1):174-81.
 18. Silva LA, Casotti CA, Chaves SCL. A produção científica brasileira sobre a Estratégia Saúde da Família e a mudança no modelo de atenção. Ciênc Saúde Coletiva. 2013; 18(1):221-32.
 19. Camargo Junior KR, Campos EAS, Bustamante-Teixeira MT, Mascarenhas MTM, Mauad NM, FrancoTB, et al. Avaliação da atenção básica pela ótica político-institucional e da organização da atenção com ênfase na integralidade. Cad Saúde Pública. 2008; 24(Supl.1):58-68.
 20. Finkler AL, Viera CS, Tacla MT, Toso BR. O acesso e a dificuldade na resolutividade do cuidado da criança na atenção primária à saúde. Acta Paul Enferm. 2014; 27(6):548-53.
 21. Coutinho LRP, Barbieri AR, Santos MLM. Acolhimento na atenção primária à saúde: revisão integrativa. Saúde Debate. 2015; 39(105):514-24.
 22. Gomes GP, Moulaz ALS, Pereira DL, Sá GB, Chaveiro ND, Santos TR. A análise do acolhimento na perspectiva das equipes de saúde da família e dos usuários no Centro de Saúde da Família 04 do Riacho Fundo II. Rev APS. 2014; 17(3):325-33.
 23. Lopes AS, Vilar RLA, Melo RHV, França RCS. O acolhimento na atenção básica em saúde: relações de reciprocidade entre trabalhadores e usuários. Saúde Debate. 2015; 39(104):114-23.
 24. Mitre SM, Andrade EIG, Cotta RMM. Avanços e desafios do acolhimento na operacionalização e qualificação do Sistema Único de Saúde na atenção primária: um resgate da produção bibliográfica do Brasil. Ciênc Saúde Coletiva. 2012; 17(8):2071-85.
 25. Viegas APB, Carmo RF, Luz ZMP. Fatores que influenciam o acesso aos serviços de saúde na visão de profissionais e usuários de uma unidade básica de referência. Saúde Soc. 2015; 24(1):100-12.

26. Simons DA. Avaliação do perfil da demanda na unidade de emergência em Alagoas a partir da municipalização da saúde e do Programa Saúde da Família. [Doutorado]. Recife: Centro de Pesquisas Aggeu Magalhães, Fundação Oswaldo Cruz; 2008.

27. Tesser CD, Norman AH. Repensando o acesso ao cuidado na Estratégia de Saúde da Família. *Saúde Soc.* 2014; 23(3):869-83.

28. Puccini PT, Cornetta VK, Sahyom TZ, Fuentes ICP, Botta LMG, Puccini RF. Concepção de profissionais de saúde sobre o papel das unidades básicas nas redes de atenção do SUS/Brasil. *Ciênc Saúde Coletiva.* 2012; 17(11):2941-52.

29. Bonello AALM, Corrêa CRS. Acesso aos serviços de saúde e fatores associados: estudo de base populacional. *Ciênc Saúde Coletiva.* 2014; 19(11):4397-406.

CONTRIBUTIONS

Maria Cristina Traldi, was responsible for the design of the research, analysis and discussion of the results and preparation of the article.

Laish Rabesco participated in the design of the research project, in the collection and analysis of data. **Márcia Regina Campos Costa da Fonseca** served on data analysis and revision of the article.

How to cite this article (Vancouver):

Traldi MC, Rabesco L, Fonseca MRCC. Assessment of the reception capacity of spontaneous demand in primary care services. *REFACS* [Online]. 2016 [cited in: *(insert day, month and year of access)*]; 4(2). Available in: *(access link)*. DOI: 10.18554/refacs.v4i2.1641.

How to cite this article (ABNT):

TRALDI, M. C.; RABESCO, L.; FONSECA, M. R. C. C. Assessment of the reception capacity of spontaneous demand in primary care services. *REFACS*, Uberaba, MG, v. 4, n. 2, p. 107-118, 2016. Available in: *(access link)*. DOI: 10.18554/refacs.v4i2.1641. Access in: *(insert day, month and year of access)*.

How to cite this article (APA):

Traldi M. C., Rabesco, L. & Fonseca, M. R. C. C. (2016). Assessment of the reception capacity of spontaneous demand in primary care services. *REFACS*, 4(2), 107-118. Recovered in: *(day)*, *(month)*, *(year)* from *(access link)*. *(access link)*. DOI: DOI: 10.18554/refacs.v4i2.1641.