





THEORIZING DEMAND BY FAMILY HEALTH STRATEGY PROFESSIONALS AND USERS: SPONTANEOUS, SCHEDULED, SUPPRESSED

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ABSTRACT

Objective: to understand spontaneous, scheduled and suppressed demands in the face of health needs and accessibility, from the perspective of Family Health Strategy professionals and users.

Method: a qualitative study using Grounded Theory and Symbolic Interactionism, with 34 participants, 16 of whom are health professionals and 18 are users. The sources of evidence were open, intensive and individual interviews and memos. Data collection occurred between October/2016 to May/2017. Data analysis took place in interdependent steps: open, axial, selective coding, for the process.

Results: thirty-two *in vivo* codes were indicated that represent the statement and meanings of the research participants regarding demand at Family Health Strategy, compiled in three theoretical codes that originated the central category “The Theory of Demand at Family Health Strategy: spontaneous, scheduled or suppressed?”. Spontaneous demand turns to complaints and illness, in daily appointments without previous scheduling, with restricted hours and as a means of accessing the health service. Scheduled demand is established in scheduling medical appointments for specific groups. Suppressed demand, more and more frequent in the daily routine of health services, is associated with the lack of access and resolution.

Conclusion: health demands are configured in a space of lack of access and accessibility, denoting the main problem experienced by FHS users and professionals.

DESCRIPTORS: Health service needs and demands. Health services accessibility. Family health strategy. Primary health care. Health’s judicialization.

HOW CITED: Chávez GM, Almeida NA, Nitschke RG, Viegas SMF. Theorizing demand by family health strategy professionals and users: spontaneous, scheduled, suppressed. *Texto Contexto Enferm* [Internet]. 2020 [cited YEAR MONTH DAY]; 29:e20180331. Available from: <https://doi.org/10.1590/1980-265X-TCE-2018-0331>.

TEORIZAÇÃO DA DEMANDA POR PROFISSIONAIS E USUÁRIOS DA ESTRATÉGIA SAÚDE DA FAMÍLIA: ESPONTÂNEA, PROGRAMADA, REPRIMIDA

RESUMO

Objetivo: compreender as demandas espontânea, programada e reprimida frente às necessidades de saúde e à acessibilidade, sob a ótica de profissionais e usuários da Estratégia Saúde da Família.

Método: estudo qualitativo, sob o método da Teoria Fundamentada nos Dados e do referencial teórico Interacionismo Simbólico, com 34 participantes, sendo 16 profissionais de saúde e 18 usuários. As fontes de evidências foram entrevistas abertas, intensivas e individuais e memorandos. A coleta de dados ocorreu entre outubro/2016 a maio/2017. A análise dos dados se deu em etapas interdependentes: codificação aberta, axial, seletiva, para o processo.

Resultados: indicaram 32 códigos *in vivo* que representam a alocação e os significados dos participantes da pesquisa frente à demanda na Estratégia Saúde da Família, compilados em três códigos teóricos que originaram a categoria central “A teoria da demanda na Estratégia Saúde da Família: espontânea, programada ou reprimida?”. A demanda espontânea se volta à queixa e ao adoecimento, em atendimentos diários sem agendamento prévio, com restrição de horários e como meio de acesso ao serviço de saúde. A demanda programada se estabelece no agendamento de consultas médicas para grupos específicos. A demanda reprimida, cada vez mais frequente no cotidiano dos serviços de saúde, está associada à falta de acesso e de resolutividade.

Conclusão: as demandas em saúde se configuram em um espaço de falta de acesso e acessibilidade, denotando o principal problema vivenciado pelos usuários e profissionais da ESF.

DESCRITORES: Necessidades e demandas de serviços de saúde. Acesso aos serviços de saúde. Estratégia saúde da família. Atenção primária à saúde. Judicialização da saúde.

TEORIZACIÓN DE LA DEMANDA POR PROFESIONALES Y USUARIOS DE LA ESTRATEGIA DE SALUD FAMILIAR: ESPONTÁNEO, PROGRAMADO, REPRIMIDO

RESUMEN

Objetivo: comprender las demandas espontáneas, programadas y reprimidas ante las necesidades de salud y accesibilidad, desde la perspectiva de los profesionales y usuarios de la Estrategia de Salud Familiar.

Método: estudio cualitativo, utilizando el método de la Teoría Fundamentada y el marco teórico Interaccionismo Simbólico, con 34 participantes, entre ellos 16 profesionales de la salud y 18 usuarios. Las fuentes de evidencia fueron entrevistas y memorandos abiertos, intensivos e individuales. La recolección de datos ocurrió entre octubre/2016 y mayo/2017. El análisis de datos se llevó a cabo en pasos interdependientes: codificación abierta, axial, selectiva, para el proceso.

Resultados: indicó 32 códigos *in vivo* que representan el discurso y los significados de los participantes de la investigación sobre la demanda en la Estrategia de Salud Familiar, recopilados en tres códigos teóricos que dieron origen a la categoría central “La teoría de la demanda en la Estrategia Salud de la Familia: ¿espontánea, programada o reprimida?”. La demanda espontánea se convierte en quejas y enfermedades, en citas diarias sin programación previa, con horario restringido y como vía de acceso al servicio de salud. La demanda programada se establece en la programación de citas médicas para grupos específicos. La demanda reprimida, cada vez más frecuente en la vida cotidiana de los servicios de salud, se asocia a la falta de acceso y resolución.

Conclusión: las demandas de salud se configuran en un espacio de falta de acceso y accesibilidad, denotando el principal problema que viven los usuarios y profesionales de la ESF.

DESCRITORES: Necesidades y demandas de servicios de salud. Accesibilidad a los servicios de salud. Estrategia de salud familiar. Atención primaria de salud. Judicialización de la salud.

INTRODUCTION

The set of actions and health services must be provided to meet the right to health of the Brazilian population and the local circumstances to which they are assigned, according to the needs demanded by each one and by the community.¹ Health demand organization, whether scheduled or spontaneous, is a challenge for Primary Health Care (PHC) in Brazil.

Health demand within PHC is considered when individuals come to service requesting access and resolving their problem. Among health demands, spontaneous demand (SpD) is considered to be one in which individuals unexpectedly come to the health unit, due to acute events or situations considered as health needs by users, who are “domiciled (or not) to the territory”.^{2:172} Scheduled demand (SD) is characterized by the performance of actions and/or previous scheduling of health services.³ Suppressed demand is made up of users who were unassisted at some point, which favors an increase in the judicialization of health.⁴

Thus, health care demands include the translation of the individual needs experienced, and these interfere with the way users use health services. The main reason for seeking care is illness, whose trust is placed in the performance of exams or for reference to consultations with experts.⁵

It is relevant to identify the population’s main needs so that PHC can reorganize itself, in order to respond to each one’s, families’ and the community’s needs, through the Unified Health System (SUS - *Sistema Único de Saúde*) principles of universality, comprehensiveness and equity, with the purpose of guaranteeing the population’s access to actions and services in a timely and equitable manner.⁶ The combination of supply and demand for health services must be analyzed with priority, in an expanded and consistent manner, with the aim of minimizing inequalities in access to health services in SUS, providing improvements in the population’s health conditions.⁷

In order to improve access, continuity of care and coordination of services, the government of Quebec, Canada, initiated a health reform in 2003. However, a study carried out in that city, between 2003 and 2010, describes that equity of access is linked to the preliminary conditions for individuals to obtain and benefit from services. Thus, an equity-focused approach will be needed to address inequalities in access to PHC.⁸

In China, a study carried out in Tibet considered the importance of strengthening PHC in the local health system reform. It showed that the quality of primary care had a positive and significant association with self-rated health status. Patients (1,386) from seven hospitals and six health centers in two prefectures located in Tibet, Shigatse and Linzhi participated in the survey.⁹

Considering the context of demands, access and accessibility, the question arises: how do FHS professionals and users understand spontaneous demand, scheduled demand and suppressed demand in view of each person’s needs and accessibility? This discussion on health demands and accessibility is considered relevant considering the difficulties of access faced by users and professionals in the daily life of FHS.⁶

This study aimed to understand spontaneous, scheduled and suppressed demands in the face of health needs and accessibility, from the perspective of FHS professionals and users.

METHOD

Grounded Theory (GT)¹⁰ and Symbolic Interactionism (SI)¹¹ were the theoretical and methodological frameworks of this qualitative study for understanding health demand. GT is a systematic method for determining the development of a theory. GT is incorporated with hypotheses, considering that the points of view of social dynamics are interrelated to human status, and the interpretations of their actions and perspectives can generate theoretical concepts/codes that support theorizing.¹⁰

SI proposes a translation of meaning as one of the most important elements in understanding human behavior and how interactions and processes are manifested. SI seeks to understand how each individual deals with the events or the reality around them, and how it will influence their experience.¹¹

The notion of meaning is a social product, created through the activities of individuals as they interact with each other. SI is based on an analysis of three premises: the first is the orientation of human beings' actions towards things according to what they mean to them. The second premise states that the meaning of these things comes as a result of the social interaction that each individual has with his or her neighbor. The third describes that meanings are manipulated and modified by means of an interpretive process developed when faced with the things that are on their way.¹¹

Data collection was carried out from October 2016 to May 2017, in a large municipality in Minas Gerais, Brazil, with an estimated population of 234,937 inhabitants and FHS coverage of 47.39%. Open, intensive and individual interviews were used as sources of evidence, with a semi-structured script, records in operational memos directed to the functional procedures of the research and the initial memos carried out after each data collection.¹⁰

The municipality has 32 FHS teams that were classified by lottery. The inclusion criterion included the minimum complete teams, 12 considering the composition with the following professionals: general practitioner, general nurse, auxiliary/nursing technician, Community Health Agent (CHA), dental surgeon, auxiliary/oral health technician; and as an exclusion criterion, Traditional PHC Units in transition to FHS.

Of the 32 teams, 12 (37.5%) met the adopted criteria. This study contemplated five FHS units as the study setting, obeying a drawing carried out to order data collection among the 12 FHS. Sampling was by theoretical saturation focused on "the development, densification and saturation of categories",^{10:197} which occurred and was confirmed in interviews with professionals from the fifth team, obeying GT data saturation.¹⁰ The population registered in the five FHS teams, the study setting, ranged from 2,646 to 7,000 people (memorandum).

The study had 34 participants, being 16 health professionals from FHS teams and 18 users. Health professionals with a minimum of six months of experience in the team have been included. Professionals away from work due to vacation or sick leave have been excluded. Users over 18 years old, registered and accompanied by the FHS team, attend the unit for SpD or SD assistance on the day of the interview have been included. Users unable to legally account for their acts temporarily or permanently have been excluded.

During data collection, it was necessary to add four questions to professionals' interview script and three to users' script (memorandum), to deepen the codes that emerged from the results and to contemplate the analysis process according to GT in order to achieve data saturation.¹⁰ All interviews lasted an average of eight minutes and were recorded and transcribed in full for later analysis. There was no refusal or withdrawal by any guest-participant in this study. All interviews were identified using alphanumeric codes. Letter "I" was used to represent all interviewees, plus letter "P" to identify health professionals, and letter "U" for users. Numbering was described according to the chronological order of collection (I_{p1} ; I_{u1} ; I_{p2} ; I_{u2} ...).

Data analysis¹⁰ took place in interdependent steps: open, axial, selective coding for the process. “Open coding is the analytical process by which concepts are identified and their properties and dimensions are discovered in the data; they are separated and compared in search of similarities and differences and divided into categories”.^{10:104–105}

Open coding was initiated by a thorough reading of the text, analyzing “each sentence, to identify which idea was revealed, naming a concept (s) and their properties and dimensions, configuring the conceptualization or abstraction in microanalysis”.^{10:119} The interviews’ text was highlighted using different colors for each idea and formulating the codes *in vivo* using the identified concepts. These concepts were sought/identified in each interview analyzed, according to their chronological order, for each FHS unit. Thus, coding in this phase was based on conceptualization, originating 32 codes *in vivo*, according to the meanings that they conveyed when examining the data, comparatively, and within the context, naming them according to the reported ideas, concepts, events and facts/acts in informants’ sentences. Events that shared some common characteristics were positioned in the same code *in vivo*. In other words, data were grouped and classified in each code *in vivo* according to the similarity and the different ones were separated. New meanings were being identified, giving rise to new concepts.

In axial coding, the conceptual definition of categories occurred through the organization of their properties and dimensions, relating the categories to their subcategories. The “categories represent a phenomenon, i.e., a problem, a notion, a question, a fact or event that was defined as important”^{10:124} by the research participants.

The paradigm of this phenomenon called “The theory of demand at Family Health Strategy: spontaneous, scheduled or suppressed?” conducted all the theory components, i.e., the central category made explicit the research participants’ experiences and understanding about health demand.¹⁰ The available structure and the conditions experienced by the research participants, in the daily life of FHS, create circumstances in which problems, issues, facts or events pertaining to health demand arise and are situated.

Structure and conditions were related to research participants’ strategies, actions/interactions in response to the problems and issues experienced and that bring SpD into the daily life at FHS. These actions/interactions arising from research participants’ daily experiences, the health demand process, were discussed according to SI.

Selective coding is the “process of integrating and refining a theory”.^{10:143} In the integration, the categories were organized to determine the central category, which is the main theme of the research, refinement “consists of revising the scheme in search of internal consistency and flaws in logic, completing the categories, little developed, and validating the scheme theoretical”. The coding for the process is “represented by events and facts that may or may not occur in continuous forms or sequences”,^{10:155–64} is the interaction between structure and process and demonstrates the variability of a theory.¹⁰

The three originated categories were integrated to form a theoretical scheme, and the data were transformed into theory: the Theory of Demand at Family Health Strategy: spontaneous, scheduled or suppressed? This theory presents “the essence of research, meaning the central idea that relates the other concepts to it”.^{10:149}

Theoretical saturation occurred when developing the central category when realizing that no new properties, dimensions or relationships emerged during analysis. The theory of demand at Family Health Strategy: spontaneous, scheduled or suppressed? was validated by “comparing the theoretical scheme with the raw data”; the scheme was able to explain facts and ideas.^{10:157}

All voluntary participants signed the Informed Consent Form.

RESULTS

This study was carried out with 34 participants, being 16 health professionals and 18 users. Regarding participant characterization, 13 (81.3%) were women, the average age was 48 years and the average working time at FHS was 9.8 years. Five nurses, four doctors, three nursing technicians, three CHAs and one Oral Health Assistant (ASB) participated. Of the nine higher education professionals, seven had a specialization in Family Health. Concerning users, 13 (72.2%) women, five men, participated, and the average age was 42 years. As for level of education, nine had incomplete elementary school; three had completed elementary school; three had completed high school; two had higher education; one declared himself or herself illiterate. Of these, only five were from SD and eight had some type of health insurance.

Theorizing demand at FHS is presented in notions of demands by professionals and users: spontaneous, scheduled and suppressed; Interrelation of demand in the Family Health Strategy; Access, accessibility and demand at Family Health Strategy. The results indicated 32 codes *in vivo* that represent participants' statements and meanings regarding FHS demand.

The analysis paradigm was constituted by determinant conditions, the context, the strategies and the consequences inherent to the notions and the context of spontaneous, scheduled and suppressed demands in the daily routine of FHS, and form the theoretical relationships by which the categories are related to each other and to the central category: the Theory of Demand at Family Health Strategy: spontaneous, scheduled or suppressed? The three theoretical codes bring the representativeness and the occurrence of data in the theoretical sampling, as shown in Figure 1. This article is about the theoretical notions of demand for professionals and users: spontaneous, scheduled, and suppressed.

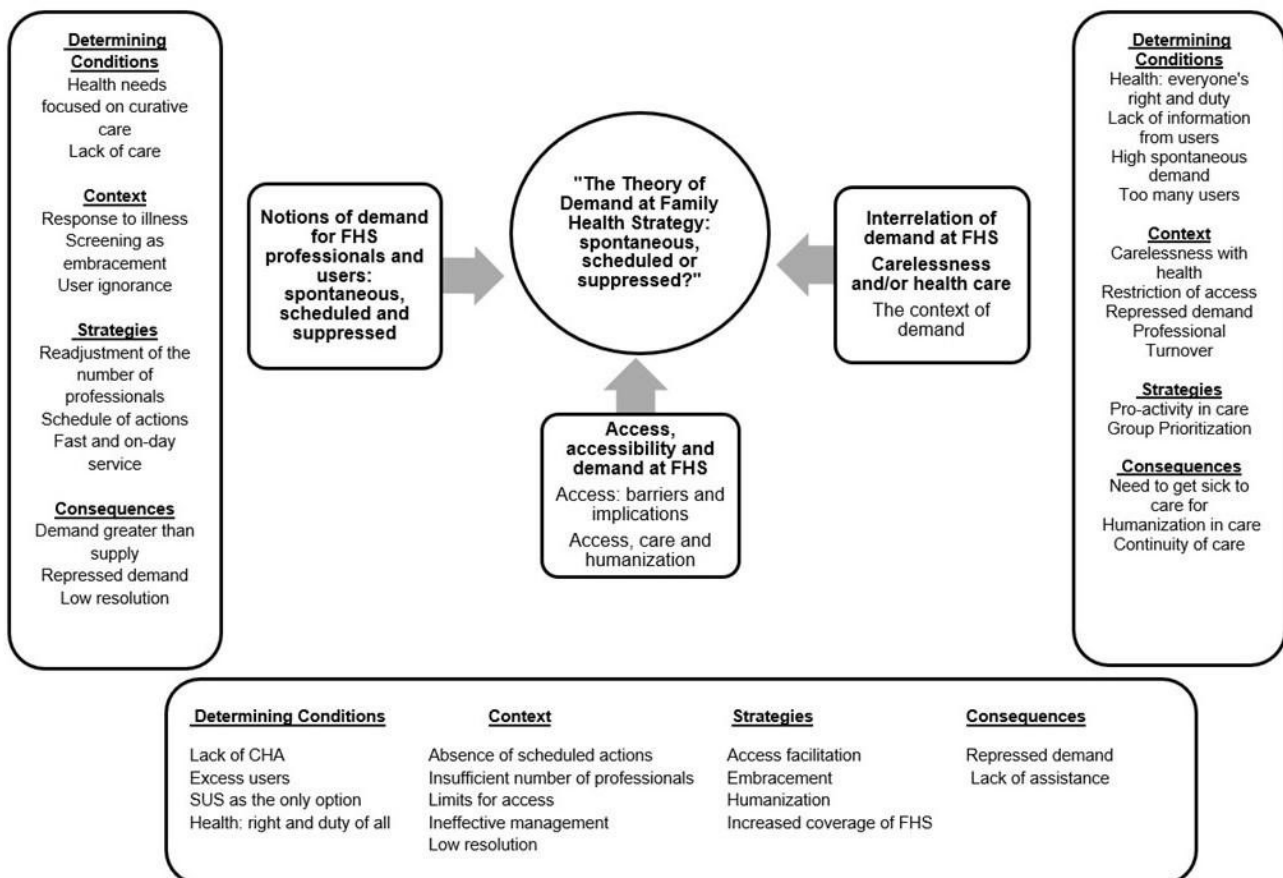


Figure 1 – Diagram of the representation of the Theory of Demand at FHS. Divinópolis, MG, Brazil, 2017.

GT and SI subsidize, from the perspective of research participants, the notions of health demands in the face of professionals and users' experiences at FHS. The notions of health demands allude to attention to complaints and illness, SpD associated with daily appointments, SD related to scheduling appointments, RD due to restrictions on access and resolution, the difficulty of contemplating equity that is closer to distributive justice than equality.

Through the GT analysis paradigm, participants' perceptions and conceptions of demand became explicit. The determinant conditions of FHS demands, in the understanding of health professionals and users, are expressed in meanings that determine them by the conditions of life, health or acute or chronic illness and that present themselves spontaneously by users or are scheduled health professionals or becomes suppressed.

Demand? I think it arises from the determinants and conditions of the health-disease process of individuals. In the environment they are, socioeconomic factors; from the issue of their housing, regarding the care we provide, all of this, what they need to promote their health or be helping them to continue healthy (I_{P1}).

Health demand ... I never thought about it, but I think it is in all demands, in all aspects of health, whether due to acute illness, chronic illness, treatment by specialty. Greater complexity, hospitalization, physiotherapy. I think health demand is users' health needs (I_{P12}).

There is spontaneous demand every day. What would spontaneous demand be? Was it an urgency, an emergency? (I_{P7}).

Spontaneous demand is when users come to the unit without being scheduled, but who are in need of assistance at that time (I_{P16}).

Scheduled? Consultations would be scheduled, the actions already pre-established by the team according to the conditions of the region that we serve, with the capacity of professionals here at the unit. So, we create a specific agenda to try to serve this population (I_{P1}).

I understand that scheduled demand would be the scheduling system, the availability of a doctor (I_{U2}).

Suppressed demand represents people who have not been served, who are waiting to be served. It must be a lot, I imagine. Sometimes, even due to lack of knowledge, I don't know (I_{U8}).

The context of spontaneous, scheduled and suppressed demands runs through the reason for seeking care at FHS due to the availability of resources and the right to health.

Because a person is sick, needs care, right? If a person comes here it is because they need it, so it has to be well served! We pay expensive tax and want to be well served, we need them, as they need us, users, to be working, to be performing their function (I_{U11}).

Demand varies, there are some people I don't know if it is due to lack of understanding or lack of patience, people are very impatient, they arrive and want to be served. There is a professional to serve, he is one, but there are several patients, this professional will serve all, but there is no way to serve all at the same time. I think that spontaneous demand occurs due to lack of understanding, right? (I_{U5}).

It is the person who comes without an appointment, spontaneously. People come early, come from seven-thirty to eight-thirty, come on demand (I_{P10}).

Scheduled demand is precisely the part of prenatal care, which we accompany the pregnant women within what is recommended [...] for the active search of absentees. Scheduled demand for childcare and for people with hypertension and diabetes (I_{P14}).

It has suppressed demand, which you are unable to meet completely. So, for example, demand suppressed here is hardworking users. We don't have a program for working users, we don't have a schedule for them, because when we arrive to work at the unit, they went to work, and when we leave the unit, they are arriving home. So, this is a suppressed demand (I_{P15}).

The strategies specify what the attributes would be or should be: spontaneous, programmed and suppressed, and what would be the possibilities for meeting these demands at FHS.

Demand... It's complicated, isn't it? But the demand would be the quantity, you would have to have an ideal of doctors, an ideal of people for that day. But it also doesn't work because of schedules, everything (I_{P6}).

Suppressed demand would be those patients who are unaware of the unit. This happens due to lack of community agents. We always advertise here in the waiting room, talking a little bit about this flow, to avoid even this suppressed demand (I_{P2}).

Here it takes a while, they tell you to wait, but you wait and want to be served, right? So, I think the important thing is that even if it takes time, that you are served (I_{U16}).

We guide you if you're feeling sick in the morning, and we try to fit in anyway (I_{P4}).

The consequences are associated and integrated with the conditions, express the types of the scope of the "demand" phenomenon, meaning an action/interaction between health professionals and users, which was attended to or interrupted due to lack of necessary resources.

Health demand is people who are sick and demand X amount of actions. When we use the word demand, it is always accompanied, demand is always greater than supply (I_{P9}).

Suppressed demand are those people who would be in need of care, care, who are not having access. So, our FHS unit has a very big bottleneck, which is the lack of community agents, we have had this problem for about five years with micro-areas discovered (I_{P14}).

This is a difficult one. The economically active part, it is unassisted, because it has the problem of access, of schedule. So, they look for UEAS [Specialized Care Units] or ECUs, where it is not the right place to make an appointment, isn't it? Because the care provided by UEAS is for small emergencies and in ECUs, larger emergencies and emergencies (I_{P15}).

Always very crowded and few spaces. Sometimes, we have to wait many days for an appointment or exams. Several times I had to pay for tests, because the health system does not have the necessary tests available. When we need something that is really necessary, we can't get service (I_{U6}).

Ah, this is too much! We see so many cases of people in ECUs who have been there for a week and do not have the necessary resources for people. So, they stay there waiting to get a place in the hospital, I think it's very painful. I think the resources in that area are not good. In the case of a major problem, people even die, because they have no necessary resources, this is tragic for us. We are horrified to see people in places that do not have access to health (I_{U15}).

DISCUSSION

The theoretical code notions of demand for professionals and users: spontaneous, scheduled and suppressed presents us with the individual conceptions about the demands in health services, especially at FHS.

SI represents a theoretical perspective that enabled the understanding of how health professionals and users interpret health demands, how they interact and how such an interpretation process leads to individual behavior in face of demands. In relation to the three SI premises, it is clear that human beings act in relation to their health needs based on the meanings that these needs have for them. The sense of health demands is derived from or originates from the social interaction that individuals establish with others. These senses are manipulated and modified through an interpretive process, used by people when dealing with their needs and the situations in which they encounter.¹¹

Data analysis allowed us to identify that the notions of demand allude to illness and medical care, since the concept of health understood by professionals and users is still constituted by the absence of diseases. Thus, SpD is strongly associated with daily appointments in search of medical care, not those scheduled. In turn, SD is characterized by scheduling appointments for specific groups. Suppressed demand, on the other hand, results from restrictions on access and resolvability, as well as the difficulty of contemplating equity.

Concerning demands, search for care happens due to a need at the time of complaint or illness. Numerous advances have been made with the implementation of the FHS, especially with regard to universal access in Brazilian PHC.⁶ However, “the service that is sought is still to find answers to the illness, ensured by the trust placed in the performance of exams or consultation with professionals from other specialties.”^{3:151} Thus, health care is based on SpD and not on users’ real needs.

Health needs can be understood as properly human and socially determined needs, although they are sometimes apprehended in their individual dimension, and are related to living and working conditions, autonomy, freedom and well-being.^{13–14} Identifying them allows directing FHS actions, guaranteeing SUS principles of comprehensiveness and equity. However, FHS’ essential actions and principles for reorienting SUS care model are still poorly explored, such as territorialization and inclusion of clients, health education, social control, planning and assessment focused on the population’s real needs.¹⁵

The results show a demand for dignified, resolute and quality care, regardless of the type of demand presented by the individual. This brings us to the context of accessibility. According to a study that analyzed the perceptions of professionals and users about the quality of PHC system organization in Estonia, Finland, Germany, Hungary, Italy, Lithuania, and Spain, accessibility was described as the shortest possible time to reach health services, in particular to PHC. The study identified that patients request immediate care, the meaning of which is the speed and ease of access in a short waiting time. High expectation from users causes frustration among health professionals and, consequently, leads to the thought that waiting time is a limiting factor for their access to PHC actions.¹⁶

In Australia, a study that aimed to analyze the access of users in rural and remote areas to primary care, pointed out difficulties in the recruitment and continuity of experts, workforce, health infrastructure maintenance and extension as challenges inherent to the provision of health services. It was identified that there was a sense of importance in guaranteeing service access, quality and safety as well as accessibility, regardless of the difficulties of providing a wide range of PHC services.¹⁷

The notion of SD was declared when scheduling appointments according to the availability of professionals and exams. In a study carried out in the metropolitan region of Belo Horizonte, Minas Gerais, Brazil, it was identified that scheduling appointments is determined as a means of accessing the population to the care and turnover of professionals, especially doctors, and was described as one of the factors that collaborated for the difficulty of scheduling.¹⁸

According to professionals’ statements, SD is mainly focused on attention to maternal and child health and people in conditions of chronic non-communicable diseases such as systemic arterial hypertension (SAH) and Diabetes Mellitus (DM). In another study conducted in the city of Maceió, Alagoas, Brazil, reports were presented of users who received hostile care by some health professionals, as they did not consider their weaknesses and difficulties in accessing the service, such as illness, hunger, lack of among others, and prioritized groups of specific populations, such as older persons, people with SAH and DM, children and pregnant women.¹⁹ Thus, the need to readjust the health care provided is identified, based on the social context in which the families are inserted, as well as valuation of users’ subjectivity by health professionals.²⁰

Suppressed demand is becoming more and more frequent within SUS, which favors the increase in the judicialization of health. According to a study carried out between 1999 and 2009, in the state of Minas Gerais, Brazil, it was identified that 64.9% of the target procedures (93.6%) of judicialization were covered by SUS, configuring 28.7% of those classified as hospitalizations, surgeries, exams and treatment outside home. The total percentage of coverage by procedures was not subject to measurement; however, it was considered that the main objective of judicialization was to guarantee access to care and not necessarily to perform the procedure, since access that was hampered by lack of vacancies and other factors related to management.²¹

Health needs are not natural or homogeneous, therefore, they are implicated in the context of health products available on the market. The satisfaction of needs is linked to social structures, based on consubstantiality and circularity between market interests and state choices.^{14:302}

A study carried out in the province of Quebec, Canada, points out that all participants acknowledged limited health system resources as barriers to access to care. As a more significant problem, lack of family doctors was considered the main determinant of emergency room demand. Consultations at primary care clinics were not offered and their untreated conditions worsened.²²

Such finding allows to establish a relationship between participants' statements. Many seek Emergency Care Units (ECU) due to worsening, a chronic condition that was not followed up in PHC, or due to restricted access at the health unit of their reference. Emergency services "have been seen by the population as a place of treatment, regardless of the type of complaint, as it is a quick and resolving service".^{23:2} Faced with this, users seek ECUs not only in urgent or emergency situations, but also as an alternative to fill the gaps left by the precarious PHC organization.²³

Lack of access to other levels of care stands out as a detriment to the resolution of health care. This evidenced situation compares to that of other realities in which specialized care, such as nutrition, is problematic. Users have to consult the public health system and wait for a waiting time that, according to them, is greater than one year.²⁴

The attitudes of professionals participating in this study in providing universal, comprehensive and equitable access to users lead us to reflect on the ideals of SUS doctrinal principles. With regard to the principle of universality of access, a gap is noticeable. Access is often associated with SpD and has restricted opening hours in the morning and prioritization of some population groups for scheduling medical appointments. These attributes analyzed undermine the right to comprehensive and equitable care.

A study conducted in the city of Recife, Pernambuco, identified that access to PHC is like a narrow door and without reception, due to the scheduling of medical appointments being disputed among users. The schedule was due to a queue that formed during the night. In addition, there was no reception for users, and those who failed to obtain a password for medical consultation were excluded or had their access to FHS postponed for at least one week. Thus, users with greater vulnerability were at a disadvantage in the dispute for passwords, in face of cases that presented, potentially, lower health risks and, of course, were more apt to dispute.²⁵

The dispute for access by users, due to passwords or queues, shows that the health service is structured and organized to meet its own needs and priorities, since it establishes the flow of people's demand as the most appropriate for the carrying out the work of professionals. Thus, there is no concern with users' needs, as an arrival time is determined and not the time for service. This will reflect on users' credibility and trust and, consequently, it will affect the construction of a bond between teams and users as well as commitment to embracement.²⁶

Another aspect evidenced by this study was the insufficient amount of CHA, influencing the organization of actions at FHS, because the lack of knowledge about the characteristics of a population generates incipient and ineffective actions due to its practice not being directed by the determinants and conditions of the enrolled population. "Human resources in PHC are an essential element for Health Care Networks (RAS - *Rede de Atenção à Saúde*), as professionals must be trained to act as protagonists in governance systems for the benefit of the community".^{27:26}

Equity as a SUS principle is compared to the concept of justice. Service focused on team availability and not on users' real needs leads to a compromise in equity. A Canadian-Australian research program, carried out over a five-year period, identified that, in order to improve access, it is necessary to achieve equity in health, even if this is challenging. Interventions that seek equity of access can expand when considering social and health determinants, individuals' and populations' specific needs, as well as the availability of available resources in face of multilevel and multisectoral approaches.²⁸

FHS is essential if the principle of equity is to be fully achieved. For provision of services to reach all individuals, classifying them by inequalities, i.e., those who most need care, they must receive priority. An efficient execution of the work of health teams is also considered essential.²⁹

FHS expansion in Brazil has favored equity and universality of assistance, since all teams are implemented, primarily, in communities that previously had restricted access to health services. However, "it cannot be admitted only by the statistics of the expansion of the number of teams that the comprehensiveness of actions is no longer a problem in the daily care".^{30:239}

The notions of demand presented here lead us to reflect on participants' experiences. They indicate that understanding the other, considering the meanings that this other attributes to their experiences and their relationships, can guide new paths for knowledge about demand and for professional practice. In this respect, theorizing demand at FHS allowed discovery of users' and professionals' meanings and feelings in the face of inaccessibility in health and new perspectives of access in the face of health demands.

SI allows interpretation and definition of the interaction process between people and how it can be modified, depending on the adaptation that occurs in the actions of the actors involved. In this way, what each of the actors does depends, in part, on what the others do, in an interaction that generates what we do collectively and what underlies SI premises.¹¹

From these perceptions, it became possible to understand the dimension and impact of health demands, how they are understood by users and how they are organized by professionals in the daily routine of health services. The Theory of Demand at Family Health Strategy allows to explain the health care dynamics, constructed, daily, through experience and its relationships.

Nevertheless, it is known that a study based on GT is not intended to be conclusive, but is open to new reformulations based on studies³¹ that will emphasize this theme. The indication of research with this method is presented.

As limitations of the research, it is considered absence of participation of managers of municipality's sanitary sectors due to turnover and do not contemplate the inclusion criteria of this study. Among the contributions, it is proposed to replicate theorizing of demand at FHS in other realities.

CONCLUSION

This study revealed that interventions aimed at the health needs demanded, spontaneously, are related to care for illness; thus, important actions considered as essential elements for changing the biomedical model are not satisfactorily addressed by the Family Health teams.

The notions of SpD were associated with daily appointments, without prior appointment, with restricted hours and as a means of accessing the health service. SpD was declared mainly when scheduling medical appointments, which are characterized by the prioritization of some population groups, which negatively influences access by non-prioritized populations and perpetuates physician-centered actions.

An increasingly suppressed demand was evidenced in the daily routine of health services. It was identified that this demand is associated with lack of access and resolution and that it is the main cause of an increased judicialization of health, as it is seen as an instrument of access to certain services and procedures that were suppressed.

The performance of Family Health teams does not address the population's real needs and was associated with a lack of planning, an insufficient number of professionals, especially CHAs, lack of equity in care, assistance that is not closely related to interventions on the determinants and conditions of the health-disease process, especially in attending to illness.

The present study has subsidies for health professionals, users and managers to outline strategies to face spontaneous and suppressed demand, in order to effectively organize SD and expand access to comprehensive and equitable actions within FHS in a participatory way.

Health demands are configured in a space of lack of access and accessibility, denoting the main problem experienced by FHS users and professionals: "the lack". Access is limited by the restriction of service hours, the number of appointments stipulated daily and the minimum quotas for exams. Accessibility is conceived as "hope" in an exorbitant time to guarantee access to the necessary service, or is meant as a repression of the right to health.

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NOTES

ORIGIN OF THE ARTICLE

The article is part of the residency completion work - *Demanda espontânea e programática na Estratégia Saúde da Família: a Teoria Fundamentada nos Dados*, which was presented to the *Lato Sensu* Graduate Program in Nursing Residency in Primary Care/Family Health at *Universidade Federal de São João del-Rei*, Center-West Campus, in 2018.

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APPROVAL OF ETHICS COMMITTEE IN RESEARCH

This article was approved by the Research Ethics Committee of *Universidade Federal de São João del-Rei*, Center-West Campus, under Opinion 1,686,000 Certificate of Presentation for Ethical Appreciation (CAAE): 58465316.1.0000.5545.

CONFLICT OF INTEREST

There is no conflict of interest.

HISTORICAL

Received: October 7, 2018.

Approved: March 1, 2019.

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