ADEQUACY OF DEMAND AND MORBIDITY PROFILE ASSISTED AT A NON-HOSPITAL URGENT AND EMERGENCY CARE UNIT

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ABSTRACT

The use and demand for non-hospital emergency services has been a major gateway to the National Health System (SUS). This study aimed to evaluate the adequacy of the demand of adults assisted in an emergency non-hospital service of a city in the interior of São Paulo state. Data were collected through medical records of urgency of adults who used the service during the year 2011. A descriptive and analytical analysis was performed on the reports of emergency care in 2011. The demand assisted was considered inadequate in 67.9% of the attendances; among women this percentage was 71%. Adequacy was associated with the *time of attendances*, with the highest demand considered inadequate in the morning and afternoon, period when the basic health units are functioning. As for the morbidity profile, it was identified that clinical cases considered urgent, also more sensitive situations the level of complexity of primary care, receive assistance. The knowledge of the use of health services can bring benefits to providing the most effective answers to the health needs of the population.

Keywords: Emergency medical services. Health services needs and demand. Health Services Evaluation.

INTRODUCTION

Urgent and emergency care situations and their deficiencies are seen by society as the most visible aspect of healthcare systems worldwide. In Brazil, fragmented organization is prevalent, making it inadequate for coping with the epidemiological picture, dominated by chronic conditions with high aggravation rates[1].

Faced with this problem, Brazil's Ministry of Health implemented the National Policy on Urgent Care, which aims to provide integral and thorough care for people's health needs[3] under different conditions (clinical, surgical, trauma, mental health, etc.), consisting of different points of care, constituting an Urgent Care Network (UCN) in order to account for several different actions for responding to urgent care situations[2].

To that end, integration becomes necessary between the different levels of care, as a strategy to assure the optimization of resources as well as the full and resolutive care for the health needs of users.

Emergency Care Units (UPA, in Portuguese) involve an organized network of care for urgent and emergency situations, with previously defined tasks and workflows. They are regarded as medium-complexity structures within basic healthcare units, family health units and the hospital network. They must remain open 24h a day, every day of the week, in order to guarantee patient intake, intervene in their clinical condition and assure resolution of care, through counter-referrals to the other points of care within the healthcare network – either basic care and specialized services, or hospital admission – providing continuity of treatment with a positive impact on the individual and collective health picture of the population[2].

The city of Ribeirão Preto, SP, is divided into five health districts, comprising several health units focused on basic care and one District Basic Health Unit (UBDS). Each health district is responsible for urgent and emergency care at the Emergency Service (PA). The use and demand for these services is widespread, with 744,018 consultations at the PA and 617,106 consultations in basic care[3].

The reasons behind the demand and use of urgent care services are varied, such as: low resolution rate of basic health units (availability of specialists, exams and medications), hindered access (months-long waitlists for appointments, long lines, limited opening hours), as well as use of services by the population of other, smaller cities (given the low investments in their own network or in associated networks)[4].

A study in Londrina, Paraná, southern Brazil, showed the inadequacy in serving the demand at

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medium-complexity urgent care services[5], as well as in urgent hospital care services, adult[6] and pediatric[7] alike. Among the latter, rates of service inadequacy stood over 70%. In this regard, of the guidelines of the National Policy on Urgent Care is to decentralize low- and medium-complexity assistance, in order to reduce the overload on larger hospitals[8].

Nevertheless, there have been very studies that evaluate the profile of demand in medium-complexity urgent care services. These services are structured around secondary reference units, at which it is possible to have consultations, specialized exams, as well as urgent and emergency care for self-referrals, as well as cases referred by primary level units. They are situated in an intermediary position, between basic care and the hospitals that represent important components of the healthcare network, and must be prepared for structural and functional organization, in response to the health needs of the population[9].

These services have often represented the "gateway" to the health system, receiving urgent care situations as well as individuals who are outside the primary and specialized care healthcare system[9].

The frequent use of PA services is widespread, under the perspective of users, as a way to gain quick and easy access to health services. This denotes the hardships in care and follow-up at basic units, in the form of delays in service, appointment scheduling and problems in organization accessibility, due to operating shifts – type of scheduling and appointment of consultations[10].

Considering that knowing the profile of use of health services can more effectively support the responses to the health needs of the population, as well as strengthen Brazil's Unified Health System (SUS), there is also the need to overcome the fragmentation of health actions and services, allowing for integral resolution of the health needs demanded or transferring it responsibly to another, more complex service. Therefore, the objective of this study was to evaluate the morbidity profile and the adequacy of demand for adults, assisted at a non-hospital urgent and emergency care service

in the western health district of Ribeirão Preto-SP, Brazil.

METHODOLOGY

This is a descriptive and retrospective study, with a quantitative approach, performed at a non-hospital urgent care service at the abovementioned mid-size city, located in São Paulo state, with an estimated population of 649,556[11]. The Ribeirão Preto health network consists of five health districts, delimited according to geographic, population, economic and social criteria.

The PA is located within the service in which the study was carried out. It represents a reference point of urgent and emergency care for the population of nine Basic Health Units (UBS) and eight Family Health Units (USF) from different west side neighborhoods. Its role is to assist in acute urgent case and clinical, trauma and psychiatric emergency situations, served by generalist clinical physicians.

The sample consisted of urgent care admission forms for adult individuals who sought the PA, in the period between January 1st and December 31st, 2011, totaling 93,283 cases. Sample size was calculated from the number of cases in 2011. A 5% margin of error was established, with a 95% confidence level and losses of 20%. The random sampling technique was used to select the sample, in which the number of the first form was drawn (no. 191), after the calculated interval of 194, using the *Statistical Package for the Social Sciences* (SPSS). Next, form 385 was collected, and so on.

Data collection was carried out by the researchers themselves, between December 2011 and June 2012, using a tool developed from the data found in urgent care admission forms, and using the following variables: user profile (gender and age group), time of day when the user was seen, considering cases recorded from 6 a.m. to 12 p.m. (morning), 12 p.m. to 6 p.m. (afternoon), 6 p.m. and 12 a.m. (evening), and 12 a.m. and 6 a.m. (late night); days of the week, neighborhood in relation to the area served; outcomes of cases following

medical consultation (discharge, observation at the unit, referrals to other services (UBS and specialty outpatient services), regulation for services of greater complexity and technological density), and morbidity profile, classified according to the International Disease Classification (ICD)[12] and based on its chapters. The outcome variable was the adequacy or inadequacy of demand.

The urgent care admission forms were created using the Hygia system, which represents the main data processing tool of city's Health Department. Although the cases were recorded, these data were not processed in the system; therefore, the forms were analyzed manually.

To classify demand according to adequacy or inadequacy, the assistance role of this service within the network was considered, in concordance with the Policy on Urgent Care. The following conditions were regarded as adequate:

- referral cases – adequacy in these cases considered the city's organization, acknowledging that referral cases result from the unavailability of human or technological resources at services with lower technological complexity;

- cases referred to hospital services – the outcome resulted in referral to hospital admission, considering the need for more complex technological resources at these services;

- use of diagnostic and/or therapeutic technologies not available at basic care – for instance, urgent lab exams, intravenous therapies requiring clinical observation, sutures or drains, electrocardiograms, heart rate or dissolved oxygen monitoring using heart monitor and wrist oximeter.

After data collection, the served demand was classified as adequate or inadequate according to the established criteria. Morbidity was classified based on the ICD, as it is an official publication of the World Health Organization (WHO) that aims to standardize the codification of diseases. For the ICD classification, cases were classified following the standardized criteria, according to the data recorded in the admission form, filled out by physicians, defining the medical diagnoses found in the admission forms, with the signs and symptom exhibited by the patient at the time of care. There was difficulty with data collection, especially regarding the full completion of the clinical history and medical diagnosis, as well as the actions adopted by the physician.

An Excel spreadsheet was created for data analysis, with dual input. After validation, the data were processed and analyzed using SPSS version 17.0. Data analysis employed descriptive statistics, and the association between the adequacy of demand and the variables of interest was tested through the Latin square test, adopting a significance level of $p < 0.05$.

This study is part of the project named: *The integrality of care in urgent and emergency cases at health units in the city of Ribeirão Preto, SP*, which was approved by the Committee for Ethics in Research of the Ribeirão Preto Nursing School, USP, case n° 1308/2011, in accordance with the recommendations set in Resolution 196/96 of Brazil's National Health Council. No Free and Informed Consent Form was used in this study, considering that it used secondary data.

RESULTS

The profile and adequacy of demand for adults assisted at the PA level are shown in Table 1. Only a small share of the analyzed cases met adequacy requirements, according to the assistance role and technological density of the PA, given that, out of the 477 admission forms analyzed, 71.5% of cases assisting women and 63.8% of cases assisting men were considered inadequate, and individuals in the 40-49 age group has the highest rate (77.1%).

In 97.7% of cases, demand for the service consisted of users who sought PA assistance through their own initiative, while a minority (2.3%) was referred by services of the assistance network – 1.9% by the mobile urgent care assistance service (SAMU), and only 0.4% by the UBS and USF.

High rates (over 60%) of non-adequacy were found for all age groups.

The study identified that people sought PA services to solve their health problems, regardless of their severity. This result indicates the population's preference for it, as a gateway to the service and resolution of their health needs.

Table 1- Distribution of adult care situations, according to adequacy of demand, gender, age group, time of day and day of the week, and, served area. Western district UBDS, Ribeirão Preto, SP, 2012.

Adequacy of demand	Adequate		Inadequate		Total	p-valor
	n	%	n	%	n	
Gender						
Female	73	28.5	183	71.5	256	0.073
Male	80	36.2	141	63.8	221	
Age group (in years)						
< 20	10	30.3	23	69.7	33	
20-29	41	36.0	73	64.0	114	
30-39	22	26.8	60	73.2	82	0.101
40-49	16	22.9	54	77.1	70	
50-59	30	44.1	38	55.9	68	
> or = 60	34	30.9	76	69.1	110	
Time of day						
Late night	22	56.4	17	43.6	39	
Morning	55	30.2	127	69.8	182	0.007
Afternoon	49	31.2	108	68.8	157	
Evening	27	27.3	72	72.7	99	
Day of the week						
Weekdays	103	29.6	245	70.4	348	0.057
Weekend	50	38.8	79	61.2	129	
Served area						
Yes	116	30.6	263	69.4	379	0.151
No	31	38.8	49	61.3	80	

The late night period showed the highest adequacy of demand (56.4%), while evenings had the lowest (27.3%). There was a statistically significant difference between total cases attended and time of day (p<0.007).

Overall, demand was higher during weekdays (73.0%). However, a higher rate of adequate care situations during weekends (38.8%). The majority of users (79.5%) came from neighborhoods with the area served by the district health unit that comprises the city's western district. It was also identified that 16.8% of cases involved residents of other health districts, and in 3.8% of cases this information was not provided in the admission form.

With regard to the morbidity profile (Table 2), the study identified that the morbidities related to Chapters XV, XX, IV and IX showed a higher percentage of adequacy and consist of cases of hyperglycemia, precordial pain and suspected heart attack, and patient in trauma situations, while cases classified as inadequate refer to Chapters VIII, XI, X and XIII, related to situations with possible resolution in basic care, such as ear infections, gastrointestinal problems such as diarrhea, flu symptoms and musculoskeletal pain (lower back pain).

In the majority of cases (90.8%), the outcome was discharge following medical assistance – that is, not requiring continued care regarding the ailment that generated the assistance; 19 cases (4.0%) were referred to specialty outpatient services, 19 (4.0%) were sent to general hospitals, 1 (0.2%) resulted in death, and only 5 (1.0%) were referred back to the UBS of origin, demonstrating a failure in communication between these services and the UBDS under study, contributing to noncompliance with treatment and discontinuity of care.

Table 2 – Distribution of admission records of users selected in the sample, according to (Chapters of) the International Disease Classification (ICD 10)[12] and adequacy of demand. Western district UBDS, Ribeirão Preto, São Paulo, 2012.

Chapter	Description	Total	Adequate		Inadequate	
			n	%	n	%
I	Certain infectious and parasitic diseases	57	40	70,2	17	29,8
II	Neoplasms [tumors]	1	1	100	0	0
III	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1	-	-	1	100
IV	Endocrine, nutritional and metabolic diseases	9	7	77.8	2	22.2
V	Mental and behavioral disorders	9	3	33.3	6	66.7
VI	Diseases of the nervous system	7	1	14.3	6	85.7
VII	Diseases of the eye and adnexa	12	2	16.7	10	83.3
VIII	Diseases of the ear and mastoid process	4	-	-	4	100
IX	Diseases of the circulatory system	19	14	73.7	5	26.3
X	Diseases of the respiratory system	73	6	8.2	67	91.8
XI	Diseases of the digestive system	26	1	3.8	25	96.2
XII	Diseases of the skin and subcutaneous tissue	10	3	30	7	70
XIII	Diseases of the musculoskeletal system and connective tissue	39	-	-	39	100
XIV	Diseases of the genitourinary system	11	-	-	11	100
XV	Pregnancy, childbirth and the puerperium	1	1	100	-	-
XVIII	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	9	4	44.4	5	55.6
XIX	Injury, poisoning and certain other consequences of external causes	35	25	71.4	10	28.6
XX	External causes of morbidity and mortality	24	23	95.8	1	4.2
	Not informed	130	22	16.9	108	83.1
	Total	477	153	100	324	100

DISCUSSION

Non-adequacy of demand at PA services was also reported in a study evaluating the profile of users of medium-complexity urgent care services[5], as well as adult[13] and pediatric[14] urgent care hospital services.

This result indicates that the PA under study functions as a medium-complexity urgent care service, but also serving situations that could be received, resolved and followed up by basic care, which may suggest noncompliance by a large share of the population with the actions services of UBS units.

Despite the emphasis given to the process of rearranging the assistance model and defining basic care as the gateway into the system, SUS user have historically shown preference for urgent care centers and hospitals, which implies the need to include SUS in the discussion over the process of rearranging the assistance model[15].

The conception and organization of the healthcare system into a pyramid, adopted since the 1990s, with upward and downward flows of users accessing different levels of technological complexity, has not yet achieved satisfactory results for the needs of the population. The inadequate relationship between supply and demand of services is noteworthy, as the production of care, assistance coverage, as well as complementarity and integration of actions in health units are insufficient[16].

As a proposal to reorganize this model, some authors defend more greater inclusion of the proposal for multiple gateways into the healthcare system, in which the user has access at an adequate time and space, using the necessary technology for his needs, either at the UBS, PA or in a hospital, considering that the inflexible definition of gateway into the system through basic care, using territorial references, does not promote inclusion, and actually hinders access[15].

The analysis of cases of users seeking assistance at the PA revealed that most cases could have been resolved at the basic healthcare network (UBS/USF), considering that differ offers of care would be available at that care level, increasing the clinical resolution rate beyond the medicalization based on immediate interventions based on immediate interventions focused on the complain/conduct, towards a user-centric logic with greater care capacity[16]. However, barriers to access such as limited opening hours and low appointment availability, inadequate consultations, poorly defined urgency criteria, slow service, disorganized referral and counter-referral systems, represent aspects that favor the continued use of PA services by the population to resolve their health needs[10,15].

Moreover, it is important to highlight that another reason for seeking PA services instead of UBS is the superior infrastructure, with more complex and sophisticated equipment[17].

The search for this type of service by the population requires considerations on the healthcare model, evidencing the need for changes in how health services are managed and organized, under the care network model, in order to achieve integral health care, which requires support for users in urgency and emergency conditions at all gateways of SUS, according to their technological density.

In this context, it becomes essential to improve access and resolution in the basic health network, welcoming users from the served area in acute, unexpected and unscheduled situations, aiming for integral care of the health needs of the population.

In order to enact the principle of health integrality, it is necessary to overcome the understanding of the basic network as a synonym for minimal, simplified staffing, with low resolution rates[17], and a bureaucratic, mandatory location for other services[18].

A very diverse morbidity profile was identified in the population assisted at the urgent care service. However, an important demand is observed of low-severity cases and non-urgent complaints in that service. The evaluated adequacy of demand was related especially with cases of accidents and trauma, and clinical situations related to cases of diseases of the cardiovascular and endocrine system, such as precordial pain, suspected heart attack and hyperglycemia. This reveals the complexity of assistance at this service that meets demands with various profiles, and which required diversified conducts and technologies, with important impacts on the quality of the service provided.

User access to the service is easy, and most users spontaneously seek out the PA because everyone is assisted – which not imply a guarantee of resolution and integrality of healthcare, considering the low use of counter-referrals to other specialized services and basic health units.

Little communication was detected between the UBS and PA, considering that only 0.4% of cases were referred by UBS staff, typical of fragmented health care systems[1].

Moreover, errors were identified in terms of equity and integrality of care, give the non-existence of triage at the service, which would allow prioritization of assistance for patients with serious diseases or organ/systemic instability, optimizing resources, improving the quality of care, guiding users towards the most adequate response to their current demand.

Assistance at the service focuses on the complaint, from the moment the user enters the service until the medical consultation. The health team serves two types of demand: users in life-threatening emergency situations, and non-urgent care.

Thus, as was also found in a study among the pediatric population, PA and urgency/emergency services, although overcrowded and impersonal, still represent important gateways into the healthcare system, representing the possibility of immediate consultations, procedures, complementary exams, acquisition of medication and admission, if necessary[19].

In order to enact the integrality of healthcare, it becomes necessary to restructure the existing assistance model, hierarchical and pyramid-shaped, thus allowing for gull resolution of the demand or transferring it, responsibly, to a more complex service. In that respect, non-hospital PA units are regarded as medium complexity, between UBS/USF and the hospital network, representing a network of urgent care assistance[18].

The lack of resolution in basic care, the existence of a repressed demand, restrictions to access, slow speed of referral services and undefined flows of referral and counter-referral, as well as the non-implementation of lines of care, are factors that limit the functioning of the health service under a network perspective[19].

Understanding basic care as one of the gateways to the urgent care network implies a need for administrators to implement intake as a device of (re)organization of the work process[18]. Moreover, another important aspect refers to accessibility, reliability and resolution rate of basic care, as some authors indicate that the credibility of the services make the intake process more favorable, thus contributing to self-referral[15].

For self-referral assistance, administrators must provide structural conditions and the health team must be qualified, as it must be prepared to assist in cases of self-referral, especially case of users with chronic health problems, less severe, acute and urgent episodes, and also provide first aid in cases of emergency, initiating basic support actions and contacting the removal service for assistance another, more complex service, so that continuity of care is achieved[20,21].

It was observed that assistance at this urgent and emergency care service is based on complaint/conduct, focused on the biomedical model. Furthermore, fragility is observed in the counter-referral system for basic care, and for acute cases that require short-term reevaluation, thus expanding service beyond the complaint. This type of functioning is configured in the fragmented "isolated" system of other health services, which are incapable of providing continuous care to the population[22], causing users to seek continuity of care by themselves after the assistance[16]. In that regard, the search for mechanisms to strengthen the referral and counter-referral can be regarded as essential to implement the principle of integrality[23].

FINAL CONSIDERATIONS

To make the urgent care network fully operational, it is essential to know the demand and morbidity profile of the population assisted at non-hospital urgent care services, making it possible to analyze the demands and health needs of the population, as well as the supply and quality of services and direct health planning towards more effective and egalitarian actions, aiming for the integral health care.

In general, most cases analyzed at the emergency service of the UBDS under study are of low and medium complexity, which was evidenced in the figure of 67.9% inadequacy of assisted cases. These open-door services are widely sought by the population, even during hours when the basic network (UBS/USFs) are operating, during the morning and afternoon.

This degree of inadequacy, regarding not only individual demand, but also related to the complexity of the clinical situations found herein, directly reflect the overcrowding in emergency services, identifying the inefficiency and failures in the healthcare network, which features inadequate integrality, compromising individual care.

Moreover, it is necessary to improve the quality of offered services, both at UBS with intake of unscheduled or spontaneous, as well as the PAs by using the referral and counter-referral system, in order to organize the flow of care, communicating and referring users to the appropriate location for each specific injury.

Self-referral care, and especially care for urgent and emergency situations, involves actions to be undertaken at all points of care, including basic care services. These actions include organizational aspects of the team and its workflow, as well as resolutive aspects of care and conducts.

One limitation of this study is the use of secondary data, with the challenge of the field of medical diagnosis, clinical condition and conducts adopted, which hinders further knowledge of the severity profile and clinical condition of the individual, as well as the resolution rate and accountability of the service to the user.

Emphasis is due to the need for further studies to analyze the offer of services related to urgent demands and their intake in the basic care network of the abovementioned city, in addition to know the reasons for the demand, the use and search for health services, aiming to resolve user health needs.

ADEQUAÇÃO DA DEMANDA E PERFIL DE MORBIDADE ATENDIDA EM UMA UNIDADE NÃO HOSPITALAR DE URGÊNCIA E EMERGÊNCIA

RESUMO

A utilização e procura pelos serviços não hospitalares de urgência tem sido uma das principais portas de entrada para o Sistema Único de Saúde. Neste estudo, objetivou-se avaliar a adequação da demanda de adultos atendidos em um serviço não hospitalar de urgência e emergência de um município do interior paulista. Os dados foram coletados por meio das fichas de atendimento de urgência de indivíduos atendidos durante o ano 2011. Foi realizada análise descritiva e analítica dos boletins de atendimento do pronto atendimento, no ano de 2011. A demanda atendida foi considerada inadequada em 67,9% dos atendimentos, sendo que, entre as mulheres, esse percentual foi de 71,%. A adequação teve associação com o horário de atendimento, sendo a maior procura considerada inadequada, nos períodos da manhã e tarde, horários em que as unidades básicas de saúde estão em funcionamento. Quanto ao perfil de morbidade, identificou-se que são atendidos casos clínicos considerados urgentes, mas também, situações sensíveis no nível de complexidade da atenção básica. O conhecimento do perfil de utilização dos serviços de saúde pode trazer subsídios para as respostas às necessidades de saúde da população mais efetivas.

Palavras-chave: Serviços médicos de emergência. Necessidades e demandas de serviços de saúde. Avaliação de serviços de saúde.

ADECUACIÓN DEL LA DEMANDA Y PERFIL DEL LA MORBILIDAD ATENDIDOS EN UN HOSPITAL DE LA UNIDAD NO DE EMERGENCIA Y DE EMERGENCIA

RESUMEN

El uso y la demanda de los servicios no hospitalarios de urgencias han sido una importante vía de acceso al Sistema Único de Salud. Este estudio tuvo el objetivo de evaluar la adecuación de la demanda de los adultos atendidos en un servicio no hospitalario de urgencias de una ciudad del interior del estado de São Paulo. Los datos fueron recolectados a través de los registros médicos de urgencia de los atendidos durante el año de 2011. Fue realizado un análisis descriptivo y analítico de los registros de atendimiento de la pronta atención, en el año de 2011. La demanda atendida fue considerada inadecuada en el 67,9% de los atendimientos, y entre las mujeres este porcentaje fue del 71%. La adecuación se asoció con el horario de atendimiento, siendo la mayor demanda considerada inadecuada en el período de la mañana y de la tarde cuando las unidades básicas de salud están funcionando. En cuanto al perfil de morbilidad, se identificó que son atendidos los casos clínicos considerados urgencias, pero también, las situaciones sensibles al nivel de complejidad de la atención primaria. El conocimiento del perfil de la utilización de los servicios de salud puede traer contribuciones para las respuestas a las necesidades de salud de la población más eficaces.

Palabras clave: Servicios médicos de urgência. Necesidades y demandas de servicios de salud. Evaluación de Servicios de Salud.

REFERENCES

1. Mendes EV. As redes de atenção à saúde. Ciênc saúde colet. 2010; 15(5): 2297-2305.

2. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Especializada. Manual instrutivo da Rede de Atenção às Urgências e Emergências no Sistema Único de Saúde (SUS) / Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção Especializada. Brasília (DF): Editora do Ministério da Saúde; 2013.

3. Ribeirão Preto. Prefeitura Municipal de Ribeirão Preto. Secretaria Municipal de Saúde. Relatório de Gestão de 2009. Ribeirão Preto (SP); 2009.

4. Deslandes SF. O cuidado humanizado como valor e ethos da prática em saúde. In.: Pinheiro R, Mattos RA. Razões públicas para a integralidade em saúde: o cuidado como valor. 2a ed. Rio de Janeiro (RJ); 2009. p.15-28.

5. Oliveira R. Adequação da demanda atendida em serviço de urgência de média complexidade em Londrina, Paraná,

Brasil (dissertação). Londrina(PR): Universidade Estadual de Londrina; 2008.

6. Furtado, BMASM, Araújo Jr. JL, Cavalcanti P. O perfil da emergência do Hospital da restauração: uma análise dos possíveis impactos após a municipalização dos serviços de saúde. Rev Bras Epidemiol. 2004; 7(3):279-289.

7. Simons DA, Monlléo IL, Simons AS, Júnior Araújo JL. Adequação da demanda de crianças e adolescentes atendidos na Unidade de Emergência de Maceió, Alagoas, Brasil. Rev. Bras. Saúde Matern. Infant. 2010; 10 (1):59-67.

8. Randow RMV, Brito MJM, Silva KL, Andrade AM, Caçador BS, Siman AG. Articulação com atenção primária à saúde na perspectiva de gerentes de unidade de pronto-atendimento. Rev Rene 2011; 12 esp: 904-912.

9. Brasil. Ministério da Saúde. Política Nacional de Atenção às Urgências. 3a ed. ampl. Brasília (DF): Editora do Ministério da Saúde; 2006.

10. Souza MF, Figueiredo LA, Pinto IC. Análise da utilização do serviço de pronto-socorro na percepção do usuário. Cienc. Cuid. Saude 2010 jan-mar; 9(1):13-20.

11. Instituto Brasileiro de Geografia e Estatística (IBGE). Censo demográfico 2010. [on-line]. Rio de Janeiro: IBGE; 2012. [citado 2013 fev 15]. Disponível em:http://www.censo2010.ibge.gov.br/amostra.

12. Organização Mundial da Saúde. CID-10 Classificação Estatística Internacional de Doenças e Problemas Relacionados à Saúde. Edusp – Editora da Universidade de São Paulo. 10a rev. São Paulo: Universidade de São Paulo; 2008. v. l2. p. 1200.

13. Furtado, BMASM, Araújo Jr. JL, Cavalcanti P. O perfil da emergência do Hospital da restauração: uma análise dos possíveis impactos após a municipalização dos serviços de saúde. Rev Bras Epidemiol. 2004; 7(3):279-289.

14. Simons DA, Monlléo IL, Simons AS, Júnior Araújo JL. Adequação da demanda de crianças e adolescentes atendidos na Unidade de Emergência de Maceió, Alagoas, Brasil. Rev. bras saúde matern infant. 2010; 10(1): 59-67.

15. Oliveira LH, Mattos RA, Souza AIS. Cidadãos peregrinos: os "usuários" do SUS e os significados de sua demanda a prontos-socorros e hospitais no contexto de um processo de reorientação do modelo assistencial. Ciênc saúde colet. 2009; 14(5):1930-1938.

16. Marques GQ, Lima MADS. Demandas de usuários a um serviço de pronto atendimento e seu acolhimento ao sistema de saúde. Rev Latino-Am Enfermagem. 2007; 15(1): 1-8.

17. Puccini PT, Cornetta VK .Ocorrências em pronto-socorro: eventos sentinela para o monitoramento da atenção básica de saúde. Cad saúde pública. 2008, 24(9):2032-2042.

18. Ministério da Saúde (DF). Acolhimento à demanda espontânea. Brasília (DF), 2011. (Série A. Normas e Manuais Técnicos. Caderno de Atenção Básica, n. 28, v. 1).

19. Erdman AL, Andrade SR, Mello ALSF, Drago LC. A atenção secundária em saúde: melhores práticas na rede de serviços. Rev Latino-Am Enfermagem 2013; 21esp:131-139.

20. Rose Meire Silva Rati, Lúcia Maria Horta de Figueiredo Goulart, Cristina Gonçalves Alvim, Joaquim Antônio César Mota. "Criança não pode esperar": a busca de serviço de urgência e emergência por mães e suas crianças em condições não urgentes. Ciência saúde colet. 2013, 18(12):3663-3672.

21. Ministério da Saúde (BR). Portaria n. 1.600, de 07 de julho de 2011. Reformula a Política Nacional de Atenção às Urgências e institui a Rede de Atenção às Urgências no Sistema Único de Saúde. Diário Oficial da União, Brasília (DF); jul. 2011.

22. Ministério da Saúde (BR). Acolhimento e Classificação de Risco nos Serviços de Urgência. Secretaria de Atenção a Saúde. Política Nacional de Humanização da Atenção e Gestão do SUS. Brasília (DF); 2009.

23. Fratini JRG, Saupe R, Massaroli A. Referência e contra referência: contribuição para a integralidade em saúde. Cienc cuid saúde. 2008; 7(1): 65-72

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