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THE (IN) VISIBILITY OF HEALTH NEEDS[1]

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ABSTRACT

Objective: to construct a theorization about the meaning of users' health needs, for professionals in the Family Health Strategy (FHS). **Method:** qualitative study based on the theoretical reference of Symbolic Interactionism (SI) and methodological in Theory Based on Data (PDT). Data collection was carried out from July to September 2015, with the interviewed of 20 health professionals who work in Primary Health Care (PHC) of a municipality in the interior of Minas Gerais. According to the PDT, the data were analyzed comparatively through the open, axial and selective coding process. **Results:** Analyzes and connections between the categories: *Needs visibility, Invisibilities of Needs and Integrated Care of Health Needs in PHC* highlighted the central category that constitutes the theoretical conception of this study, called "*The (in) visibility of needs of health: the dynamicity of our 'conviviality with the world*"'. **Final considerations:** health needs pass between visibility and invisibility, from the perspective of professionals, being permeated by the care that happens in the daily life of PHC. Emphasis is given to reception as a strategy to achieve integrality in the care of both visible and invisible health needs.

Keywords: Health Services Needs and Demand. Integrality in Health. Primary Health Care. Nursing. User Embracement.

INTRODUCTION

Primary Health Care (PHC) is characterized by being the user's preferential entrance door in the Unified Health System (SUS)[1]. In this context, the Family Health Strategy (FHS) is a model of care for the practical implementation of SUS guiding principles, allowing a therapeutic relationship, with space for dialogue between professionals and users[2].

Despite the potential of the FHS to overcome the biologicist model of care, it can be seen that even in this health work methodology there are still many care situations in which care practices predominate directed at meeting the clinical demands of the users, summarizing the needs from health to the biological sphere[1-3].

Health practices are driven by ways of understanding the world of individuals. In this line of reasoning it is understood that the meeting of care between professional and user-family-community is challenging, since it makes it possible to meet or disassociate two worlds of symbolic meanings[3].

It is understood that the user seeks the health service for different reasons and causes, having multiple needs in different historical, economic and social contexts[4].

Studies have shown that the meaning of health needs is at the heart of the elaboration of public health policies and guidelines for the achievement of integrality within SUS[3,5,6].

Thus, health needs have been the object of national and international studies, and the concept is discussed both with a view to guiding the operationalization of health care for individuals in services, and, in a broader analysis, in the search for integrality, with the user and his way of living in society as a center of care[3-7].

However, there are still gaps in the understanding of the meaning of health needs, because in daily services care has been directed to the clinical causes that involve the illness of the individual, being, in practice, the health needs summarized to the demands of users, in a biologicist logic of care[3,5,7].

The care practices and health services offered are focused on what professionals understand as users' health needs [3,6]. In this way, the meaning attributed by the health professional to the users' needs will influence the care offered and the services planned for the health care of the individuals[5-7].

Thus, it is questioned: what are the meanings attributed by the health professional who acts in

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the PHC to the health needs? How does the meaning attributed by him interfere with the professional practice in this context?

It is considered that researching about the conceptions of health needs is fundamental for understanding and advancing the planning and management of care, enabling practices that consider the uniqueness of the subjects and bring resolution within the scope of the PHC, in search of integrality in the care[7].

Thus, this study aimed to construct a theorization about the meaning of users' health needs, for professionals of the FHS.

METHODOLOGY

The methodological basis of this study, with a view to the construction of a theorizing, consisted of Data Based Theory (DBT), with Symbolic Interactionism (SI) being the theoretical reference used for designing, collecting and analyzing data[8- 9].

Participating in the research were health professionals from five FHS teams (physician, nurse, assistant and/or nursing technician and community health agent), in a municipality in the interior of Minas Gerais.

Professionals were interviewed in five health centers in the municipality, of diversified family health teams, considering the composition of the theoretical sample of this study[8]. For the composition of relational and variational sampling[8], it was asked: How does the host vary from one health unit to the other? How has the care of health needs occurred by each team?

Diversification between units and teams was fundamental for varying the meanings of the studied phenomenon, since each health unit had different processes of work and diverse care situations in the community, enabling clarification, specification and consistency for the developed theory[8-9].

The interviews were presented in acronyms defined by the professional category, as follows: Nurses (Nurse), Doctors (Doc), Nursing Technicians (NT) and Community Health Agents (CHA), being numbered according to the interview order. The data were collected until the theoretical saturation of the data, that is, there was no new information in the set of collected data that were relevant to the theoretical constructs, with consistency reach and foundation of the theory developed based on the data[8-9].

The data collection technique used was the interview, performed in a reserved room in the health unit, with an average duration of forty minutes. The data were collected by a researcher with experience in qualitative research. The interviews were recorded and later transcribed, being the analysis concomitant to data collection. To start the study, two questions were asked of health professionals: What do you mean by health needs? How does the service respond to the health needs of the user?

The observation of the moment of the interview and the theoretical and methodological reflections of the study supported the construction of the so-called memorandums [8]. The memos were written by means of running texts with reflections of the researcher about each interview, called theoretical notes[8]. At the end of each data analysis, the questions that would guide the next data collection, which consisted of operational notes, were recorded[8]. The memos also enabled the researcher to be directed during comparisons between the data collected, contributing to the identification of properties and to the construction of analytical diagrams[8].

The first analytical diagrams were just listings in code tables, however, according to the analysis, the diagrams evolved into visual schemas, being possible to interconnect concepts and thus to emerge the central theory[8].

Data were collected from July to September 2015 and analyzed in three steps: open coding of data, axial coding and selective coding[8].

In open coding, line-by-line reading of the transcribed interview was performed, being possible to identify phenomena and group them into categories[8]. In this way the interview was organized in a table, in which the paragraphs were underlined and the codes separated by colors.

In the axial codification, the categories were organized into tables that related the codes with the categories, allowing a better visualization of the common axis and the dimensional variation, allowing the connection between the categories and the subcategories[8].

For the improvement of theorization,

selective coding is necessary, which allows the integration of all categories and their essences, making possible the emergence of a central categorization[8]. In this way, the following categories were conceptually interconnected: The visibility of Needs, Needs Invisibilities and Integrated Care of Health Needs in PHC, making possible the construction of the theory presented in this study.

The fundamental precepts of Resolution No. 466/2012 of the National Health Council, which regulated the conduct of researches with human beings in Brazil, were followed. Thus, the Term of Free and Informed Consent was offered in two ways of equal content signed by the researcher and interviewed.

Data collection was initiated only after approval by the Research Ethics Committee of UFMG, under the registration number in the Brazil Platform - CAAE 41899115.0.0000.5149.

RESULTS AND DISCUSSION

Twenty health professionals were interviewed. The training time of the professionals varied between 2 and 30 years, and the age varied between 28 and 48 years-old, which made possible the analysis of perspectives constructed from experiences in different contexts, both health system and life[8].

The central category that constitutes the theoretical conception was denominated in this study as "The (in) visibility of health needs: the dynamicity of our 'conviviality with the world'", was constructed through analyzes and connections, under IS light, among the categories: The visibility of needs, The Needs Invisibilities and Integrated Care of Health Needs in PHC[8-9].

Thus, for a better understanding of theorization, the categories will be presented in bold and the "codes in vivo" written in italics[8].

The visibility of needs is directly related to an organic approach built both in the training of the professional and in the care provided in his/her role in the FHS. Thus, the visible needs are related to the individual's well-being, both in disease prevention and in treatment and rehabilitation, and are recognized as user needs that demand immediate attention from professionals in the context of PHC[3,4]. This visibility is associated with the clinical conditions of the body that initially guide the user to seek care in the health service, as evidenced in the following data:

> Health needs is when person is in physical well-being, let's say so commonly the absence of diseases, characterized by whether I am with physical well-being [...] (Nurse-12)

> I think that from the moment that the person has a complaint she has the need to seek the health service (NT - 05).

> It is not because it's a disease, it is a dental treatment, vaccine, other things that the person have to come, but she didn't come because she is ill, she is okay, just keeping her health (CHA - 07).

It is verified that the needs are visible to the professionals, as they are demonstrated through the complaints presented by the users when entering the health service. The invisible needs are those that do not find space to be heard, because they are not part of the services offered in the unit and do not belong to any specific pathology, therefore they remain hidden and without care.

The Invisibilities of the users' needs is verified in the daily life of the health services by the professionals, being necessary the use of strategies so that the care happens. In this way, the health professional, who welcomes the individual, perceives that there are other needs besides the demand presented, however, these needs remain invisible until the bond is established[7,10].

> We just look at the patient and see that he has a problem, so it's an invisible problem; we know he's in trouble, so we're going to start caring that patient better. We can only observe this, through the course of the day, of the same bond, of friendship that we have, in the face of the patient that we can see it (Nurse-17).

It is observed that if the professional does not commit to seeking what is beyond organic complaints, the needs will remain invisible. Thus, the discovery of these invisible needs requires the professional to be user-centered, since there are different symbolic constructions, permeated by the experiences of health needs in society[3-4]. Thus, in an interactionist perspective, care needs to encompass individual subjectivity,

lifelong dynamism, the interaction of individuals, the variation of contexts and the family relationship[9].

> Oh I guess it sometimes varies, sometimes a problem {even} for two families can be seen differently, do you see? Sometimes two families have the same problem, but depending on the educational environment, social environment, there can be a change. And sometimes you have a family that I do not know whether they know more or not, I do not know if it's because they are lovelier, I do not know, but they can embrace it differently. We are very different (CHA- 10).

> It is the patient is a whole, it is not only his body, what happens external to him, what affects him, for example a family quarrel the person needs a psychological accompaniment, it is not only an organic cause no, never. The patient needs an accompaniment as a whole; it is our conviviality with the world (CHA - 18).

The symbolic construction of the individual, as well as the relationship with his/her own self in society, including the health service that he/she attends, according to IS premises, is perceived by professionals as influencing the way of seeking care for the individual[3,9]:

> What are behind, their afflictions, their feelings as well. This all interferes. How he sees his own problem. I will not only talk about illness, but there are also the problems (Doc - 15).

In FHS, the user needs to receive **integrated care** of the *visible needs with the invisible needs*.

The integrated care of the needs in PHC is constituted by both the aspects that involve the **discovery/supply of health needs** and by the obstacles to this discovery, denominated in this study as **obstacles to the visibility/supply of health needs**.

Discovering/meeting health needs presupposes that for health needs to be taken care, they need to move out of invisibility into care needs.

> In order to ensure that health needs are met and integrality is achieved, it is necessary to link the user with a welcoming multi-professional team, with articulated actions in society, applying active listening and inter-sectoriality in practice(2-4).

> I think in practice as a nurse it is more important to listen to the user, we have to know how to listen to the user, to have a very important listening, welcome this patient to see the problem and try to solve it. I think what helps me a lot here in the unit is that we listen to this patient, after all it is they who need to be here in the unit looking for the health service, they are the front line there, that says "oh this is wrong" because we are in here, so we cannot see better, cannot see, and they can see the problems better (Nurse -17)

> I have worked here for six years, only in this unit it is already five and a half years, we create bond, because sometimes FHS are always the same people that come, creates a bond, we already know all patients, we already know what that patient wants, what he does not want, sometimes he barely gets there and we already know what he's feeling. Because from the moment that we create the bond with the person, we will know, she will open up more with us and we will know what she really needs (NT-19)

In addition to the link, it opens the range of the importance of multi-professional work in the PHC, being possible the articulation and the use of creativity in the single care that arises, according to the IS, with each user that enters the doors of the health unit [2, 4.10].

> Care… I see it how to care, care about the other. So, sometimes the patient that comes here does not know what he wants, right? … Why he came, then we have a different look, a cozy look, look like so oh let's think together, what he needs, what he is important, what can help and there we will direct the care to him (Nurse - 08)

It stands out, in this discovery of the health needs, the reception that functions like radar, therefore must be able to capture everything that is being signified by the subject through its language, be it verbal or corporal, allowing the establishment of bond and greater resolution in the care offered in PHC[10-11].

> Knowing, Knowing and beginning to trace, to go to one side and the other, to guide the patient a little. You see the patient as a whole, but we focus on his needs (Doc. 09).

> Ah, they're going to make a metaphor. Radar, the host is like radar of problems, of detection of problems. Not only from diseases, but from other problems, but so, the radar cannot be selective, it has to encompass everything, to take a complete approach. [...] it has to be a multi-professional approach, it's no use working alone in my practice, the nurse working alone, the CHAs

working alone, the nutritionist [...] (Doc -15).

In order to know *the Invisible Needs, the Radar Reception* needs to extrapolate the ready and standardized conducts, seeking the meaning of what is being said when the user translates needs through various forms of expression, from his symbolic constructions [3,4, 9,12]. In this way, in the search for *Invisible Needs*, it is possible to achieve success by establishing a bond with empathy, an attentive look and appreciation of every singularity that permeates the encounter of care [2-4].

Therefore, a strategy is proposed so that the health needs come out of the invisibility and are looked after, represented in the following diagram:

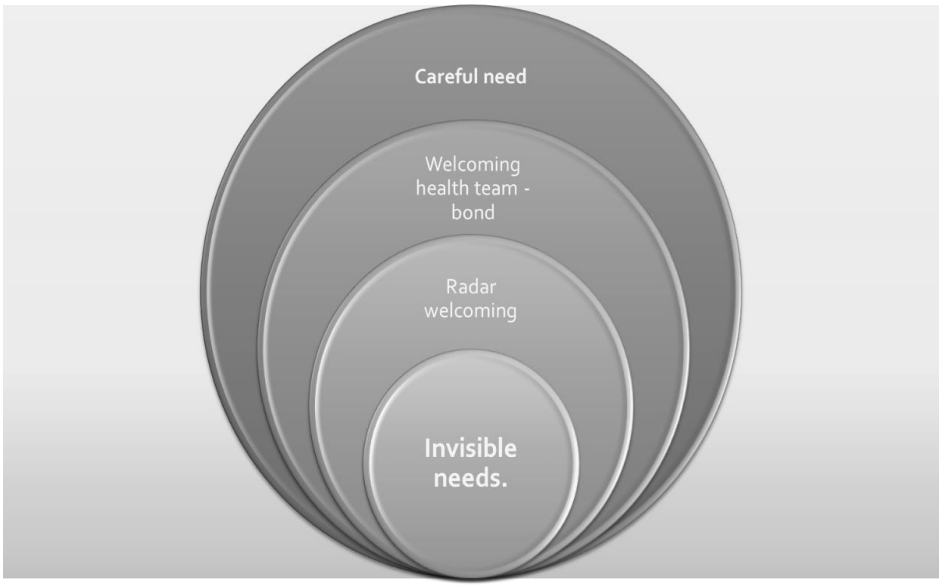

Figure 1. Strategy for "discovering" care needs.
Source: Research data, 2015.

It is observed that the *invisible need* can be achieved through a *radar reception*, operated by a *welcoming multi-professional team* that seeks the *bond*, transforming *invisible needs* into *care needs*.

Thus, the questions previously not addressed by the professionals, labeled as organic problems of clinical complexity, can be taken care of in a more comprehensive way, knowing the dynamics of the life of the families in the own territory through the home visit, without previous labeling and pre-established by rigid protocols [4,7].

> A home visit? From deep importance, because we are going there, seeing the reality not only of that patient, we go to visit Dona Maria, five more people live together with her, then some situation related to Dona Maria that can be {caused by} some inhabitant in there(Nurse-16).

However, the care of individuals involves all the complexity of operationalization of health services, such as numerous demands, goals proposed by the management and deadlines to be met, as well as the reduction of the number of professionals, with consequent overload of PHS[4].

> What I can seenow is an overload of health professionals with the number of programs created by the health ministry, there is an overload of bureaucratic work and it is a bit like that, it has so much bureaucratic work that sometimes health needs they are thrown there in the last place. And so on the one hand there is a professional overloaded, on the other there is a patient full of need, who is in need of care. We can do it, but sometimes, we cannot do it completely, there is not an integral follow-up (Nurse - 08).

The main obstacles to achieving full care of the sum of visible and invisible needs are described in the **Obstacles of Visibility/Supply of Health Needs**, of which they are properties, that is, *fundamental*

characteristics, the prison in the clinic, the overload of the system and the bureaucratic plaster of which host is a part of functionality.

> So it is the nursing professionals who are going to care this patient who will arrive here with a more serious case, he will be the first to be attended, and not someone who arrives here with a runny nose, so it is fundamental the first care by the nurses, because they are going to make this filter, it is the sieve of system functionality, otherwise I have a lot of patient, no priorities criteria, and this was resolved with the host(Doc-04).

In the dimension of the reception as sieve, there is a hierarchical relationship between the needs of the subjects who seek the health service, being accepted those that are biological and visible in the eyes of the professional that performs the screening [4,10-11]. On the other hand, the needs that distance themselves from the disease, such as those involving the family, the place of the individual in society in an interactionist perspective, are relegated to remain invisible, since they do not have a space of care in PHC.

> We make an exorbitant number of medical consultations. We offer a lot of medical consultation and the same patient who does not have such a very important comorbidity, for example, a severe heart failure or hypertension that is difficult to control, or diabetes that is difficult to control, has medical consultation four times in the same month, and they are patients who do not need it, you know, someone who has flu, for example, is oriented, it is an analgesic, do you see? Things like that have no resolution (Doc - 20).

The existence of so many daily obstacles makes it difficult to apply an interdisciplinary practice focused on the integrality of care. In addition, there is a prison in the clinic with predominance of the biologicist view [3-7].

> We are too attached in the clinic, with medical practicing, more than acting with prevention and health promotion out there (Nurse- 01).

> It looks like there is a need for a patient ... you have to assist 3 patients an hour. For example, a patient arrives here with a psychiatric complaint and I find it totally unfeasible to attend this patient in 20 min. And if I attend 3 patients per hour, I will have to attend him in 20 min, even if the complaint is psychiatric, a serious complaint, that sometimes I will take time to assist, even if it is a patient with many complaints, understood? (Doc-20).

The high demand and the timed time available for care contribute to centralized, non-occupational health care[4]. The line of thought, the host loses its capacity and its ability to reduce the schedules of medical care[4].

Care for the disease can be a daily counterpart in the provision of health services, which is universal access and the contribution to the principles of SUS to be effective in maintaining services[4,10-12].

> The reception is when you come here, and the nurse assists you, they look if the case is urgent if it is not urgent, you know why there really are people who do not need to go to the doctor(CHS - 03).

The *Reception dimension as a screening of the functionality* favors the organization of the demands, but because it is performed in a mechanized way, it also makes it difficult to take care of the health needs of the individuals by the health professionals, being summarized to the screening[4,10-12].

> Now I think the welcome for me is important, but sometimes it disturbs. For example now we have, I think the units all have problems with the reception, because the nurses are not able to do their service of PHC… consultation of pregnant women, hypertensive and diabetic, child, vaccine; because the reception is taking a lot of time from the health professional [...] since we come in, we attend from 7am until 5pm. It's bad when I have stop accompanying a diabetic, a hypertensive, a pregnant, a child. This interferes negatively (Nurse - 17).

The radar reception and *the reception as a tool for functionality* are two dimensions of care that takes place in the daily life of PHC, influencing the quality of care and the recognition of both visible and invisible needs.

The relationships established between the theoretical constructs of the categories: **Visibility of Needs, Invisibility of Needs, and Integrated Care of Needs in PHC** led to the theorizing **The (in) visibility of health needs: the dynamicity of "our conviviality with the world"**, which can be represented by the following diagram.

Health needs transit between visibility and invisibility from the perspective of health professionals working in PHC. In this line of reasoning, for care based on our relationships and *conviviality with the world*, it must also be dynamic and unique, seeing this (in) visibility and being built daily in health services articulated to various sectors of society.

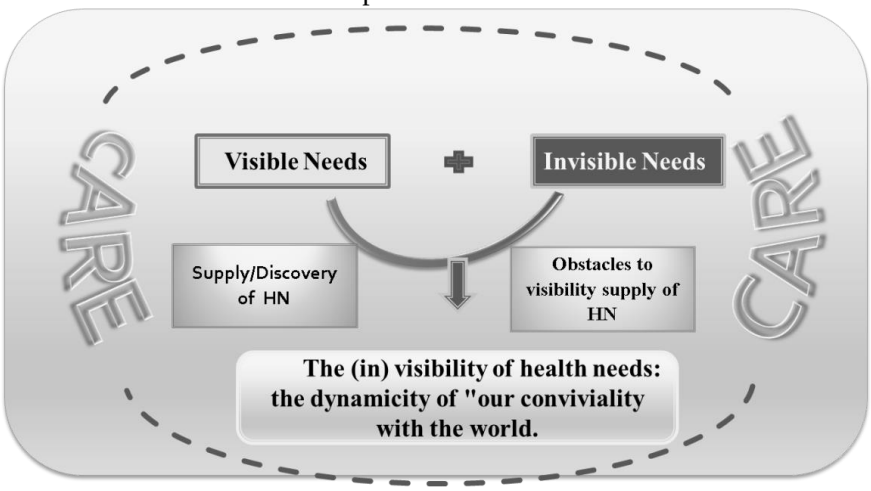

Figure 2. The (in) visibility of health needs: the dynamicity of "our conviviality with the world".
Source: Research data, 2015

In the search for the discovery/supply of health needs, it is relevant to establish an interdisciplinary role that establishes a link, with qualified listening both in the health unit and in home visits, establishing inter-sectoral articulation in the search for the integral and longitudinal care of the families in SUS[1,4,10-12].

Thus, overcoming obstacles to the visibility/supply of health needs in PHC remains a challenge for professionals working in SUS [3-7].

FINAL CONSIDERATIONS

The theoretical construction makes it possible to reflect on the (in) visibility of health needs, in an interactionist perspective, considering the daily reality of health services and pointing to *radar reception* as a paradigm in the way health care works in PHC in the theoretical construction of the meaning of health needs.

Care must be taken in addition to pre-established clinical roadmaps, so that the FHS is a *radar*, enabling opportunities for all health needs to emerge from the bowels of the subject's subjectivity and are potentially life-long.

In this sense, theorizing demonstrates the urgency of overcoming the biologicist mode of care in PHC, since the selection of the clinical view leaves essential elements for an integral health care.

The accomplishment of this study directs us to the expansion of the possibilities of the care with development of strategies for the discovery of the invisible necessities, advancing in the theoretical construction of the concept of health needs, in view of the possibility of constructing an integrated care that embraces the singularity of the people and families in the society in which they live.

The proposed objectives were reached, being possible to know the meaning attributed, by the professionals that work in the PHC, to the Health Needs, as well as the proposition of the presented theory.

As a limitation, it is pointed out the time for the study, and it is not possible to listen to users' voices regarding the meaning of health needs, making it possible to carry out future studies, aiming at this purpose.

The importance of the care that is carried out outside the walls of the health unit is also highlighted, since the knowledge of the place of residence of the families and the proximity to the routines of life contribute to the strengthening of the bond and extends the possibilities of the team's performance.

Based on these findings, it is proposed that the host be operated by multi-professional

teams trained for qualified listening, which in these opportunities promote the strengthening of the link between the user and the health team, making possible the knowledge and care of health needs.

Thus, it is suggested that the obstacles identified in the ways of managing PHC be minimized through an approximation between the realities experienced in the different communities and the managers, enabling paths for all health needs to be cared for in a singular, interdisciplinary, longitudinal and inter-sector way, in search of integrality.

A (IN) VISIBILIDADE DAS NECESSIDADES DE SAÚDE

RESUMO

Objetivo: construir uma teorização acerca do significado das necessidades de saúde dos usuários, para profissionais da Estratégia Saúde da Família(ESF). Método:estudo qualitativo fundamentado no referencial teórico do Interacionismo Simbólico (IS) e metodológico na Teoria Fundamentada nos Dados (TFD). A coleta de dados foi realizada no período de julho a setembro de 2015,sendo entrevistados 20 profissionais de saúde que atuam na Atenção Primária a Saúde (APS) de um município do interior de Minas Gerais. Conforme a TFD, os dados foram analisados comparativamente por meio do processo de codificação aberta, axial e seletiva.Resultados:As análises e conexões entre as categorias: *A visibilidade das necessidades, A Invisibilidades das Necessidades e O Cuidado Integrado das Necessidades de Saúde na APS* evidenciaram a categoria central que constitui a concepção teórica deste estudo, denominada "A (in) visibilidade das necessidades de saúde: a dinamicidade do *'convívio nosso com o mundo'*". Considerações finais: as necessidades de saúde transitam entre a visibilidade e a invisibilidade, na perspectiva dos profissionais, sendo permeadas pelo cuidado que acontece no cotidiano da APS. Destaca-se o acolhimento como uma estratégia para alcançar a integralidade no cuidado tanto de necessidades de saúde visíveis como das invisíveis.

Palavras-chave: Necessidades e Demandas de Serviços de Saúde. Integralidade em Saúde. Atenção Primária à Saúde. Enfermagem; Acolhimento.

LA (IN)VISIBILIDAD DE LAS NECESIDADES DE SALUD

RESUMEN

Objetivo: construir una teorización acerca del significado de las necesidades de salud de los usuarios para profesionales de la Estrategia Salud de la Familia (ESF). **Método**: estudio cualitativo basado en el referencial teórico del Interaccionismo Simbólico (IS) y metodológico en la Teoría Fundamentada en Datos (TFD). La recolección de datos fue realizada en el período de julio a septiembre de 2015; fueron entrevistados 20 profesionales de salud que actúan en la Atención Primaria de Salud (APS) de un municipio del interior de Minas Gerais-Brasil. Conforme la TFD, los datos fueron analizados comparativamente por medio del proceso de codificación abierta, axial y selectiva. **Resultados**: los análisis y las conexiones entre las categorías: *La visibilidad de las necesidades*; *La Invisibilidad de las Necesidades* y *El Cuidado Integrado de las Necesidades de Salud en la APS* evidenciaron la categoría central que constituye la concepción teórica de este estudio, denominada "La (in)visibilidad de las necesidades de salud: la dinamicidad del *'convivio nuestro con el mundo'*". **Consideraciones finales**: las necesidades de salud transitan entre la visibilidad y la invisibilidad, en la perspectiva de los profesionales, marcadas por el cuidado que ocurre en el cotidiano de la APS. Se destaca el acogimiento como una estrategia para alcanzar la integralidad en el cuidado tanto de necesidades de salud visibles como de las invisibles.

Palabras clave: Necesidades y Demandas de Servicios de Salud. Integralidad en Salud. Atención Primaria de Salud. Enfermería. Acogimiento.

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