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Epidemiological profile of care in a private emergency service in southern Brazil

Perfil epidemiológico dos atendimentos de um pronto atendimento privado do sul do Brasil

Perfil epidemiológico de la atención en un servicio de emergencia privada en el sur de Brasil

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Abstract: Objective: to analyze the profile of the services provided in a private emergency service in southern Brazil. **Method:** this is an epidemiological and cross-sectional study of 53,949 records made in 2017, submitted to the techniques of descriptive and inferential data analysis. **Results:** the study suggests generational and gender differences capable of interfering in the accessibility and use of the service, as well as in the seasonal behavior of cases between the days of the week. The demand met at the service is not characterized only by urgent and emergency situations, a fact justified by the guarantee of reception regardless of clinical complexity. **Conclusion:** less complex care, anxious demand from users for the emergency service and the need to increase actions that guide the flow of users in different spheres of care predominated.

Descriptors: Nursing; Health profile; Emergency medical services; Health Service Needs and Demands; Health Facilities, Proprietary

Resumo: Objetivo: analisar o perfil dos atendimentos realizados em um pronto atendimento privado do sul do Brasil. **Método:** trata-se de um estudo epidemiológico e transversal dos 53.949 registros realizados no ano de 2017, submetidos às técnicas de análise descritiva e inferencial de dados. **Resultados:** o estudo sugere diferenças geracionais e de gênero capazes de interferir na acessibilidade e na utilização do serviço, bem como no comportamento sazonal dos casos entre os dias da semana. A demanda atendida no serviço não se caracteriza, somente, por situações de urgência e de emergência, fato justificado pela garantia de acolhimento independente da complexidade clínica. **Conclusão:** predominou atendimentos de menor complexidade, procura ansiosa dos usuários pelo serviço de emergência e a necessidade de incremento em ações que orientem o fluxo dos usuários nas diferentes esferas de atenção.

Descritores: Enfermagem; Perfil de saúde; Serviços médicos de emergência; Necessidades e Demandas de Serviços de Saúde; Instituições privadas de saúde

Resumen: Objetivo: analizar el perfil de los servicios prestados en un servicio privado de emergencia en el sur de Brasil. **Método:** este es un estudio epidemiológico y transversal de 53,949 registros realizados en 2017, sometidos a las técnicas de análisis de datos descriptivos e inferenciales. **Resultados:** el estudio sugiere diferencias generacionales y de género capaces de interferir en la accesibilidad y el uso del servicio, así como en el comportamiento estacional de los casos entre los días de la semana. La demanda satisfecha en el servicio no se

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caracteriza solo por situaciones urgentes y de emergencia, un hecho justificado por la garantía de recepción independientemente de la complejidad clínica. **Conclusión:** predominó la atención menos compleja, la demanda ansiosa de los usuarios por el servicio de emergencia y la necesidad de aumentar las acciones que guían el flujo de usuarios en diferentes ámbitos de atención.
Descriptores: Enfermería; Perfil de Salud; Servicios Médicos de Urgencia; Necesidades y Demandas de Servicios de Salud; Instituciones Privadas de Salud

Introduction

The Emergency Services (ES) are considered intermediate structures between the Basic Health Units (BHU), Family Health Strategies (FHS) and the hospital network, with operation scheduled for 24 hours a day, every day of the week. In this sense, they require technological apparatus and trained human resources to ensure agility and quality of care. It is understood that ES are fundamental for the reduction of morbidity and mortality and disabling sequelae, playing a strategic role in the health care structure of the Unified Health System[1] (UHS – SUS/Brazil).

There are several urgent and emergent phenomena capable of reaching the individual and collectivities, based on cultural, social, psychological, environmental and physical influences. The occurrence of trauma, infectious processes, burns, ischemia, among other health problems, require a structure of open doors to welcome the patient and provide the necessary assistance[2].

According to the Pan American Health Organization (PAHO), ischemic heart disease and stroke are the biggest cause of death in the world, accounting for a total of 15.2 million deaths in 2016. These diseases have remained the main causes of global mortality in the last 15 years.[3] In Brazil, for 2018, diseases of the circulatory system and neoplasms (tumors), first and second in number of deaths, respectively, account for approximately 44.5% of the deaths.[4]

Added to this information are the cases of urgency (clinical or surgical situation without imminent risk of death) and emergency (conditions that imply intense suffering or imminent risk of death) researched in public health services. Data from these scenarios indicate that diseases and disorders of neurological and cardiovascular origin can account for more than 70% of the services provided.[5-6]

In this sense, tracing the epidemiological profile of the urgencies and emergencies of a private service collaborates with health managers to make more effective decisions and interventions. Each region has its particularities and health needs, requesting decentralized analysis proposals, capable of enabling the transparency of the social challenges to be faced. Thus, this strategy has the main advantage of promoting subsidies for the formulation of sustainable and integrated public health policies, as well as assisting in the construction of coping strategies for the health problems of individuals and groups.[7]

It is also believed that the investigation of the characteristics of the demand for these services can contribute to the elaboration of criteria for decision making during care practices, directing efforts towards the qualification of human resources. It is emphasized that the reach of reliable information, both in an advisory and decision-making position, is a strategy to verify and improve the performance of services and the health system. Even with contemporary advances related to the development of public policies, few studies investigate the use of evidence and the potential influence on health equity.[7-8]

Thus, the objective of this study is to analyze the profile of the services provided in a private emergency service in southern Brazil.

Method

This is an epidemiological, cross-sectional study submitted and approved by the Ethics and Research Committee of the Feevale University (Brazil), under the protocol No. 2.973.903 of October 22, 2018. The data came from the private emergency service (PES) registry database in a state of *Rio Grande do Sul* (Brazil) and correspond, in full, to the 53,949 services provided in 2017.

The studied region consists of 10 municipalities, with an area of approximately 1,732.8 km^2, 219,969 populations, 73.03 years of life expectancy at birth and an illiteracy rate of 4.31% for

people aged 15 and over.[9] PES is a reference in urgency and emergency for all age groups in the region. It has laboratory services, radiological exams, ultrasound, tomography, magnetic resonance, endoscopy and colonoscopy. It is structurally composed, with regard to assistance spaces, by the reception, waiting room, emergency and risk classification room, nursing station, five offices, dressing room, suture room, plaster room, treatment room, pediatric observation and adult observation. The service uses the Welcoming and Risk Classification protocol of the National Humanization Policy (denominate HumanizaSus - Brazil) to screen users.[10]

The variables investigated were: sex, race, age group, month, day of the week, shift, risk classification, length of stay, main complaint, outcome and exams performed. Access to the records of electronic medical records was supported by a professional from the Information Technology (IT) sector, linked to the co-participant institution, with data available in an electronic spreadsheet.

Nominal variables were expressed in frequency analysis and continuous variables were expressed by means and standard deviations. To verify the possible associations between the risk classification at the time of service and the variables related to the profile of the users analyzed, the chi-square test (χ^2), was used, according to the assumptions of the normality test (*Kolmogorov- Smirnov*) and 95% confidence interval. For data analysis, the SPSS 21.0 program was used.

Results

The results refer to the 53,949 consultations carried out during the study period, contained and influenced by the space-time approach and the historical-cultural process of the place where the health service is inserted. Thus, Table 1 presents the sociodemographic characteristics of the users attended in relation to sex, race and age group.

Table 1 - Sex, race and age group of users seen in a Private Emergency Service, in southern Brazil, for the year 2017. (N = 53.949)

Variables	N	%
Sex		
Female	33,918	62.9
Male	20,006	37.0
Not informed	25	0.1
Race		
No information	53,883	99.8
White	46	0.1
Brown	20	-*
Age range		
Less than a year	3	-*
1 to 4 years	1914	3.5
5 to 9 years	1670	3.1
10 to 14 years	1328	2.5
15 to 19 years	2125	3.9
20 to 29 years	10,745	19.9
30 to 39 years	12,876	23.9
40 to 49 years	9159	17.0
50 to 59 years	6583	12.2
60 to 69 years	3589	6.7
70 to 79 years	2123	3.9
80 years and over	1834	3.4

Source: database of the institution co-participating in the research. * Percentages less than 0.05%.

Women were responsible for most of the visits made during the investigated period. Regarding race records, there was a 99.9% rate of failure to fill in this variable. The predominant age group of the visits refers to individuals aged 20 to 49 years, with 60.8% of the records. Table 2 shows the demand for assistance according to the month, day of the week, shift attendance, established risk classification and length of stay at the institution.

Table 2 - Characteristics of the services provided at a Private Emergency Service, in southern Brazil, for the year 2017. (N = 53.949)

Variables	N	%

Service month		
January	4,164	7.7
February	3,867	7.1
March	4,687	8.7
April	4,148	7.7
May	4,633	8.6
June	4,672	8.6
July	4,194	7.8
August	4,669	8.6
September	4,409	8.2
October	5,055	9.4
November	4,650	8.6
December	4,801	8.9
Day of the week		
Sunday	5,872	10.9
Monday	9,395	17.4
Tuesday	9,770	18.1
Wednesday	6,983	13.0
Thursday	7,629	14.1
Friday	7,414	13.7
Saturday	6,886	12.8
Service shift		
From 00:00 to 07:00	2694	5.0
From 07:00 to 13:00	22,170	41.1
From 13:00 to 19:00	18,357	34.0
From 19:00 to 00:00	10,728	19.9
Risk classification according to the *Humaniza SUS* (Brazilian protocol)		
Green *	36,845	68.3
Yellow †	14,291	26.5
Red ‡	2,052	3.8
Blue§	761	1.4
Lenght of stay		
Same day discharge	47,981	88.9
One day	5,507	10,3
Two days	392	0.7
No Information	69	0.1

Source: database of the institution co-participating in the research.

* includes less urgent clinical conditions, with assistance within 120 minutes

† includes urgent clinical pictures, with assistance within 60 minutes

‡ includes emergency medical conditions, requires immediate care

§ encompasses non-urgent clinical conditions, with assistance within 240 minutes

The month of October was the most sought after by the population, with 9.4% of visits. The days with the greatest demand were on Tuesdays (18.1%) and Mondays (17.4%). The shift

with the highest flow of users was in the morning (7:00 am to 13:00 pm), with 41.1% of calls. Most of the cases were classified as green (68.3%) and, with regard to the length of stay in the unit, 89% of the cases did not reach one day. Table 3 shows the main complaints of users (categorized according to the affected system) when accessing the service. Gastrointestinal and skeletal muscle complaints made up 55.2% of the cases.

Table 3 - Reason for assistance in a Private Emergency Service, in southern Brazil, for the year 2017. (N = 53.949)

Complaints	N	%
Gastrointestinal (diarrhea, vomiting, abdominal pain, others).	19,666	36.4
Skeletal muscle (low back pain, trauma from falls and traffic accidents, others).	10,132	18.8
Neurological (headache, sensory lowering, paraesthesia, seizures, others).	7,391	13.7
Respiratory (cough, fever, sore throat, others).	6,832	12.7
Excretory (dysuria, hematuria, polyuria, others).	3,559	6.6
Cardiovascular (hypertension, arrhythmia, chest pain, others).	2,669	4.9
Tegumentary (blunt cuts, skin lesions, others).	1,505	2.8
Psychiatric (anxiety, panic crisis, suicide attempt, others).	686	1.3
Gynecological / obstetric (vaginal bleeding, loss of fluid during pregnancy, vaginal discharge, others).	431	0.8
Others *	326	0.6
Ophthalmologic (ocular trauma, hyposphagma, pruritus, others).	274	0.5
Hearing (earache, otorrhagia, others).	256	0.5
Urological (testicular trauma, penile discharge, others).	122	0.2
Endocrine (hypoglycemia, hyperglycemia).	100	0.2

Source: database of the institution co-participating in the research.
Others *: unidentified description in the medical record.

Table 4 shows the outcome of visits, with 93.6% of users being discharged after being served. With regard to the requested exams, laboratory and x-ray examinations made up 88.4% of the total requests in the period.

Table 4 - Outcome of consultations and exams carried out in a Private Emergency Service, in southern Brazil, for the year 2017. (N = 53.949)

Variable	N	%
Outcome		
Discharge *	50,526	93.6
Hospitalization	1,770	3.3
Referred to specialist	1,175	2.2
Withdrawal †	207	0.4
Return for reevaluation after treatment	153	0.3
Evaded / discharged on request ‡	117	0.2
Death	1	-§
Exams (N = 12.312)		
Laboratory	6,976	56.7
X-ray	3,894	31.7
Ultrasound	876	7.1
Computed tomography	537	4.3
Doppler ultrasound	26	0.2
Angiotomography	3	-§

Source: database of the institution co-participating in the research.

* Discharge: after medical evaluation.

† Withdrawal: after risk classification, patient does not wait for medical consultation.

‡ Evaded / discharged on request: patient refuses to receive treatment.

§ Percentages less than 0.05%.

Table 5 lists the risk classification with the characteristics of the services and the sociodemographic profile of the users. There were statistically significant associations for the days of the week, length of stay, sex and age group.

Table 5 - Associations between the risk classification with the characteristics of the services and the profile of the users attended in a Private Emergency Service in Southern Brazil, for the year 2017.

VARIABLES	RISK RATING				p*
	GREEN (n = 36.845)	YELLOW (n = 14.291)	RED (n = 2.052)	BLUE (n = 761)	
Day of the week					0,01
Sunday	3,872 (10.4)	1,684 (11.8)	278 (13.5)	38 (5.0)	
Wednesday	4,786 (13)	1,793 (12.5)	307 (15)	97 (12.7)	
Thursday	5,215 (14.2)	2,055 (14.4)	259 (12.6)	100 (13.1)	
Saturday	4,711 (12.8)	1,803 (1.6)	287 (14.0)	85 (11.2)	
Monday	6,448 (17.5)	2,543 (17.8)	255 (12.4)	149 (19.6)	
Friday	4,999 (13.6)	2,011 (14.1)	322 (15.7)	82 (10.8)	
Tuesday	6,814 (18.5)	2,402 (16.8)	344 (16.8)	210 (27.6)	
Lenght of stay in days					0,01
Discharge on the same day	33,331 (90.4)	12,242 (85.6)	1,670 (81.4)	739 (97.1)	
One day	3245 (8.8)	1867 (13.1)	382 (18.6)	13 (1.7)	
Two days	241 (0.7)	142 (1.0)	-	9 (1.2)	
Not informed	28 (0.1)	40 (0.3)	-	-	
Sex					0.02
Male	2,3674 (64.3)	8,835 (61.8)	979 (47.7)	455 (59.8)	
Female	1,3171 (35.7)	5,456 (38.2)	1,073 (52.3)	306 (40.2)	
Age range					0.01
Less than a year	-	-	-	-	
1 to 4 years	1,265 (3.4)	509 (3.6)	132 (6.4)	11 (1.4)	
5 to 9 years	1,160 (3.1)	391 (2.7)	95 (4.6)	24 (3.2)	
10 to 14 years	952 (2.6)	314 (2.2)	41 (2.0)	21 (2.8)	
15 to 19 years	1,523 (4.1)	534 (3.7)	31 (1.5)	37 (4.9)	
20 to 29 years	8,209 (22.3)	2,202 (15.4)	324 (15.8)	156 (20.5)	
30 to 39 years	9,117 (24.7)	3,204 (22.4)	354 (17.3)	201 (26.4)	
40 to 49 years	6,001 (16.3)	2,652 (18.6)	368 (17.9)	138 (18.1)	
50 to 59 years	4,129 (11.2)	2,076 (14.5)	289 (14,1)	89 (11.7)	
60 to 69 years	2,232 (6.1)	1,065 (7.5)	102 (5.0)	44 (5.8)	
70 to 79 years	1,311 (3.6)	641 (4.5)	141 (6.9)	30 (3.9)	
80 years and over	946 (2.6)	703 (4.9)	175 (8.5)	10 (1.3)	
Outcome					0.6
Discharge	34,565 (93.8)	13,325 (93.3)	1,916 (93.4)	721 (94.7)	
Withdrawal	143 (0.4)	48 (0.3)	14 (0.7)	2 (0.3)	
Referred for admission	1,162 (3.2)	513 (3.6)	78 (3.8)	17 (2.2)	
Referred to specialist	790 (2.1)	333 (2.3)	35 (1.7)	17 (2.2)	
Evasion	85 (0.2)	27 (0.2)	3 (0.1)	2 (0.3)	
Retorn	100 (0.3)	45 (0.3)	6 (0.3)	2 (0.3)	
Death	-	-	-	-	

Source: database of the institution co-participating in the research.

* Chi-square test (χ^2) with a 95% confidence interval.

Discussion

The demand for care in health services by sex male is lower than that of sex female, and this behavior can be explained by the higher life expectancy of women. However, based on the results presented, it is believed that men, culturally, are seen as invulnerable, strong and virile subjects. Many believe that when looking for care, they will be seen as weak, fearful and insecure. Another aggravating factor in this scenario is the failure to exercise preventive measures, self-care, on a routine basis. These measures are widely practiced by women. These, among other factors, contribute to the aggravation of male health, constituting a serious public health problem.[11]

The association of risk classification with the sex variable indicates that men seek care when their clinical condition has already worsened. It is believed that this situation is due to the hegemonic model of masculinity, since heterosexuality, aggressiveness, being strong and unbeatable, make up the requirements to be an ideal man. The low male adherence to self-care measures justifies, in part, the seriousness of the cases and contributes to the high numbers of morbidity among men.[11-12]

In a study[12] related to the reasons for women to seek assistance in PES, the lack of resolution and acceptance of primary care and the difficulties of scheduling general and specialist appointments were mentioned as factors influencing this attitude. In this sense, it is understood that the search for urgent and emergency units is justified by the greater diagnostic capacity (imaging and laboratory tests) and resolvability of cases. Another contributing factor to this situation is the accumulation of daily functions, which can contribute to the increase in demand for female care outside of their working hours.[12]

Regarding the records of the race variable, there was a high rate of underreporting of this data. In this segment, there is a need for improvement in the execution of the attendance record and the impossibility of using this variable in the analytical proposal.

In this sense, data on the perception of health professionals (managers and healthcare workers) on the causes of underreporting in public services have multifaceted characteristics. Among these different causes, it is possible to highlight: problems in the patient's diagnosis; complexities of diseases or conditions; services routines and protocols; technical capacity of human resources; failure to value Epidemiological Surveillance, among others. It is worth mentioning the importance of contextualizing the different work spaces of health professionals, which substantially interfere in the care practices developed, including the quality of the registry.[13]

Services for adults was the most prevalent in the age group between 20 and 49 years old, and statistically significant among individuals between 30 and 39 years old. The urbanization process, intense migration, multiple tasks with no rest interval, inadequate nutrition, physical inactivity, among others, expose the population to risk factors that contribute to the emergence and chronicity of diseases. In addition to these causes, the increase in depressive disorders and morbidity and mortality due to chronic non-communicable diseases, foster harmful health behaviors and practices adopted in daily life.[8]

With regard to cases of violence, more than a million people lose their lives every year and many others suffer non-fatal injuries resulting from self-inflicted, interpersonal or collective events. Diseases arising from violent acts are among the main causes of death for people aged 15 to 44 years in the world. Its cost translates into billions spent annually on health care, lost work days, work disabilities and suffering for victims and family members.[14]

Added to these data are traffic accidents that interrupt the lives of approximately 1.35 million people in a world. In addition to this number, 20 to 50 million individuals suffer non-fatal injuries, many of them resulting in disability. The financial cost of traffic accidents is approximately 3% of a country's Gross Domestic Product (GDP). More than half of the deaths are vulnerable, such as pedestrians, cyclists and motorcyclists. It is noteworthy that 93% of

traffic deaths occur in low and middle income countries, with fatal injuries among children and young people aged 5 to 29 years.[15]

Differently from the data in this study, surveys conducted based on public urgent and emergency services registered percentages below 7% of visits related to gastrointestinal disorders. And, with regard to musculoskeletal disorders, the rates are less than 2%. In this sense, taking into account that public urgency and emergency services register high rates of interventions for cerebrovascular disorders, it is understood that further studies need to be carried out, since the findings of this study differ from the patterns of occurrence found in the literature.[1,5-6] It should be noted that the analyzed section concerns a private service and, therefore, the findings can be influenced by the customs and traditions of the region in Brazil where the service is inserted.

The data indicate a uniform distribution of cases across the months of the year. With regard to the days of the week, it was found that the beginning of the week (Tuesdays and Mondays) presented the highest rates of demand for the service, while the morning shift hosted the highest demands.

This feature of accessibility to the service, taking into account the days of the week and the time, may be related to the low complexity of the cases, allowing users to wait for the beginning of the week to receive assistance. Another potentially influential factor in these cases concerns high workloads, without adequate conditions and equipment. This practice makes many work environments stressful, full of tasks and demands, leading to physical and mental exhaustion of the employee, contributing to the illness and its clinical manifestations during working hours. It is also believed that, on these days, people are in full activity, that is, more vulnerable to violence, traffic accidents and robberies.[16-18]

The flow of care in urgent and emergency units is intense, also due to the assistance provided to users with less complex diseases or conditions, who could suffer intervention in the

Primary Health Care (PHC) services. [19] Lack of awareness of users, in relation to the complexity of the service, is evidenced by the high rate of care classified as not very urgent (green) and the length of stay in the unit, with a rate close to 89% of users being discharged on the same day. There are several justifications that take the user to the PES. Among them, the most evident, refers to the high technological density, since exams can be performed at the time of service. Thus, it becomes possible to close the diagnosis and start instant treatment.[20]

The demand for support in private institutions is due to several reasons, among them the lack of infrastructure associated with the lack of inputs and human resources in the basic health units. These factors can encourage the population to purchase agreements and use private services in hopes of resolving their needs. The literature mentions that people with higher purchasing power and higher education use private health services more frequently. The accumulation of knowledge, related to education, suggests a greater ability to interpret health problems and their short and long-term consequences.[19-20]

In addition to the proper management of the health team for the problem faced by the patient, there is a need for equalization of environmental conditions (housing and basic sanitation), adherence to sanitary measures such as vaccination, breastfeeding and promotional and preventive health measures.[21] Unlike this perspective, the identification of conditions such as traumatic brain injury, neurological and cardiovascular changes, exogenous intoxications, cardiopulmonary arrest, among others, signals the importance of counting as a unit with open doors. The immediate attendance of urgent and emergency cases, with adequate infrastructure and a qualified team for the management of the patient, is essential to support and organize the health system.[22]

The high number of laboratory and radiological exams used in the service studied adds evidence regarding the low complexity of the cases treated, in view of the availability of other diagnostic tools. It is understood that these tests facilitate rapid and accurate diagnosis,

especially in cases of trauma and cardiorespiratory impairment. It is also understood that, in medical practice, it is imperative to request exams of this nature due to the ease of request, execution and the desire for certainty of the diagnosis. However, this practice contributes to unnecessary expenses. The United Kingdom, Europe and Italy are examples of modification of this therapeutic pattern, since, to face this problem, they reorganized the service by investing in dialogue with the patient, complete anamnesis, adequate physical examination and updates from professionals. Revitalized practices that generated greater precision in clinical evaluation and, consequently, cost reduction.[23-24]

During the investigated period, most users attended were discharged after treatment. In this sense, it is understood that PHC has a defining role in building and orienting demand for other health spheres. Its intervention capacity can directly influence the prevention and non-chronicity of diseases and / or aggravations that constitute the demands met at the secondary and tertiary levels of the health system.[19]

Thus, it is believed that PHC can influence users and communities in understanding the use of the health system. It is also understood that it is necessary to take into account the service characteristic, public or private, the levels of complexity and the doors of access to SUS (Brazil). It is noteworthy that preventive and promotional health practices can influence the reordering of the flow to services, reduction in the rates of illness and / or health problems.[7,16]

It is understood that secondary care aims to provide resolute and qualified assistance to acute or acute cases of a clinical nature, providing the first assistance to surgical and / or traumatic cases, stabilizing them. In addition, perform an initial diagnostic investigation and, when necessary, direct referral to more complex hospital services.[7,18]

However, we add to the discussions that have already been held that the most complex calls, performed by the service in question, occurred between Tuesday and Monday and were aimed at adult users, economically active, and, consequently, more exposed to risk factors.

Researchers and scholars stress the importance of more accurate and attentive assessments of vulnerable populations defined locally. With regard to the complexity of cases, international studies indicate a decrease in the number of visits throughout the week, with an increase on Monday, and less demand on weekends. This trend demonstrates that many users seek the service without having an emergency.[25-26]

The risk classification for cases classified in blue shows a statistical relationship with the length of stay of users in the service. In this sense, it is believed that the low complexity of the cases justifies this data, since 99.1% of the visits refer to the sum of the discharge on the same day and the users who remained in the service for up to one day.

According to an American study, which investigated the reasons for users looking for emergency services, the main causes are the difficulty in obtaining or the lack of knowledge about how to obtain an outpatient consultation, the belief that their health problem could not wait and the understanding that the emergency services provide better quality assistance.[27] In this perspective, a research based on the risk classification priorities of a public service presents similarities with the profile described here. According to the authors, the use of emergency services by the population does not reflect emergencies. It is understood that they are linked to the understanding of the use of these services, as a qualified door of access to the health system, disregarding PHC, a niche designed to absorb the low complexity demand.[28]

Conclusion

The results indicate generational and gender differences in the use of the service and show the seasonal usage behavior between the days of the week. Mondays, Tuesdays and the morning shift showed the highest demand for the service. The high demand of users with gastrointestinal disorders is a characteristic that needs to be explored in other studies, in view of their distance from the reports found in the literature.

The low complexity of the care provided and the anxious demand of users to solve their needs, even if these are not characterized as urgent / emerging, characterize, in terms of the severity of the cases, the profile of the demand served. This scenario can be explained in the reception guarantee, because it is an “open door service”, and for its therapeutic and diagnostic capacity, which drives the wide demand regardless of clinical complexity.

Emergency services (ES) are fundamental structures in the health sphere and in their organization, since they can influence the reduction of health problems, affecting morbidity and mortality rates and disabling sequelae. By identifying the epidemiological profile of the population served, it is possible to plan actions, direct flow, train professionals, and collaborate with the formulation of public health policies.

It is worth mentioning that, far from exhausting the different aspects that make up the theme of urgent and emergency care, this study portrays the profile of demand in a private ES unit, with a flow composed of a specific spatial clipping and contained analysis for the year of 2017. The methodological excerpts used here provide an opportunity to understand the dynamics of performance of this type of service, but make generalizations unfeasible and require analytical care when making comparisons with public urgency and emergency services.

The results point, in an expanded perspective, to the need to increase PHC, aiming at the elaboration of strategies capable of impacting health problems in this sphere of care in a resolute way. Thus, it is understood that the sum of governmental efforts, civil society and health workers can improve social understanding, developing practices and conducts capable of influencing the use of emergency services. In this sense, public health policies can add greater efforts, with regard to the education of users, in order to improve the understanding of the flow of care within the health system. It is believed that systematic actions, in this sense, can socially value PHC, in addition to promoting better living conditions and citizenship for the population.

Finally, when studying the profile of users served by private health services, this research corroborates the outline of the population's health-disease process, contributing to the development of health policies. The construction of these policies must be based on local evidence, according to the needs of each community, thus increasing the success of management and the quality of care at different levels of health care.

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