

Oh my God, they are here again! Providing health assistance for high users in Primary Care

Meu Deus, lá vem ele de novo! O cuidado à saúde aos “hiperutilizadores” na Atenção Básica (resumo: p. 16)

¡Ay, Dios mío, él otra vez! El cuidado de la salud a los “hiperutilizadores” en la Atención Básica (resumen: p. 16)

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This article aims to analyze aspects involved in the health assistance provided for “high users” in primary care, based on the perception of professionals and users. A qualitative and exploratory case study was carried out in which “high users” and professionals were interviewed. The way in which primary care professionals define who is a “high user” is more complex than the total number of medical consultations and involves identifying the health needs that motivate users to seek assistance. Users whose needs are beyond the scope of the biomedical model often do not have their needs correctly identified or considered legitimate and are viewed as “high users” regardless of the number of appointments. The study served as an analyzer of primary care. A model still centered on the biomedical rationality is maintained, with little opening to “life as it is” and to “lay-action” and knowledge.

Keywords: Primary Health Care. Health services needs and demand. Health services overuse. Patient-centered care. Primary Healthcare models.



Introduction

The existence of high users in primary healthcare (PHC) is known and represents a great challenge to health teams. Although they constitute a small portion of the universe of people assisted in PHC, they can consume up to 40% of the medical consultations and services provided by healthcare units¹. In addition, 36% of such users are classified by professionals as difficult patients². This can hinder treatment or care provision, producing conflicts and representing work and emotional overloads both to the team and to the users.

In the literature, the definition of high user in PHC is not consensual. Many studies have used quantitative criteria, such as the absolute number of medical consultations over a certain period^{1,3-6}, frequency of medical consultations in percentile⁷⁻¹⁴, or variations in the number of medical consultations compared to the health center's mean^{14,15}. Other studies have used qualitative criteria, such as the team's perception that the high frequency with which the user attends the unit is excessive or unnecessary, as it does not match the user's clinical situation, regardless of the number of consultations¹⁵⁻¹⁹.

Many investigations have shown that there is not a predominance of gender among high users; however, they have found an increase in the number of medical consultations related to aging and presence of comorbidities^{1,8,20}. There is not a specific clinical pathology related to the high PHC attendance pattern, in spite of the high frequency of patients with chronic diseases^{21,22}, and mood and anxiety disorders^{9,20}. High users from economically disadvantaged classes predominate¹, which is attributed to a greater social vulnerability^{20,23}.

Independently of the criterion used to define who is a high user, it is necessary to bear in mind that guarantee of continuity and longitudinal care are desired characteristics of PHC, which necessarily means frequent visits to the service²⁴.

In Brazil, the value of PHC is recognized, as it provides territorialized services, near to people's residences, that offer an important number of actions, from medicine dispensation to medical consultations, not to mention access to other health services²⁵.

Mendes discusses the demand of primary care and argues that part of the assistance is concentrated on high users. According to the author, "understanding the phenomenon of high users is important from the point of view of the healthcare system, in the perspective of cost savings and also in the perspective of quality"²⁶ (p. 64).

This article aims to analyze aspects involved in the provision of care for high PHC users based on the perception of team professionals and patients. Comprehending whether their needs are understood and met by health teams, and in what way, can provide subsidies for the development of strategies, revealing care management arrangements tailored to individuals who 'use the services excessively'.



Methodology

A qualitative exploratory research was carried out in which multiple techniques were used for data production. The investigation was conducted at two Primary Care Units in a city located in the health region of Planalto Norte of Santa Catarina (Southern Brazil), with approximately 55 thousand inhabitants.

The first Unit was chosen because of the diversity found in the profile of its users and due to the stability of its professional team. Subsequently, we asked the coordinators of the city's PHC to suggest a second Primary Care Unit, recognized for the quality of the care it provides. The two studied Units are managed directly by the city and have two family health teams.

The main instrument used for data production was the semi-structured interview. Fourteen people were interviewed: 6 individuals considered "high users", 2 of these users' family members, and 6 professionals. According to Poupart²⁷, the utilization of this instrument in qualitative research allows to explore, in detail, the social actors' perspective and to understand internally the dilemmas and issues faced by them.

Initially, a meeting was held with the multiprofessional teams to introduce the research. On that occasion, the participants were asked to indicate users considered frequent attenders.

The interviews with users aimed to collect their life reports on the use of health services and to outline a brief social portrait of these people. They were conducted at the users' homes, before the onset of the Covid-19 pandemic. To ensure anonymity, each interviewee was identified by the letter U followed by a number corresponding to the order in which they were interviewed. Frame 1 describes the main characteristics of the interviewed high users.

Frame 1. Profile of the Interviewed Users

Code	Unit	Age	Sex	Interview	Employment Situation	Social Benefit	Distance ¹	Family Situation	Main Diagnosis
U1	1	32	F	Individual	Informal - Recyclable Material	BPC (Continuous Cash Benefit Program) - child	750 m	Lives with partner, 6 children	Anxiety Disorder
U2	1	35	M	Individual	No formal employment relationship	Sick Pay	700 m	Single, lives with his father, who has stroke sequelae	Schizophrenia
U3	1	65	M	Individual	Retired	No	1300 m	Lives with partner, 2 children	Cardiac Insufficiency + Osteoarthritis
U4	2	69	M	Accompanied by his wife	Retired	Sick Pay (wife)	1500 m	Married; children of previous marriages	Depressive Disorder + Osteoarthritis
U5	2	33	F	Individual	Housewife	No	1500 m	Lives with partner, 5 children	URTI + Routine Consultation
U6	2	44	M	Accompanied by his wife	Retired	No	1400 m	Married, 2 children, husband's mother recently moved into their house	Epilepsy + GERD

¹Distance between the house and the Healthcare Unit estimated through the Google Maps website



To Houle²⁸, as individual as the reports that compose the life histories may be, they grant access to a practice that is also social and can be considered as experiences of life in society. When we listened to the high users reporting on their experience of using the PHC services, we could learn about their health needs and the reasons that lead them to attend the services frequently; furthermore, the reports revealed the way in which they perceive the care that the team provides for them.

After the stage of interviews with users and families was completed, 6 interviews were conducted with professionals from the studied healthcare units, selected through a convenience sample. They took place at the Units, during the professionals' working hours, and complied with all the sanitary recommendations, as they were conducted during the Covid-19 pandemic. Some characteristics of the interviewed professionals, identified by the letter P, are presented in Frame 2.

Frame 2. Profile of the Interviewed Professionals

Code	Unit	Function	Employment Relationship	Professional Action
P1	1	Unit Coordinator	Civil Servant	In addition to Primary Care, works in an Emergency Unit on the other shift
P2	1	Nurse	Civil Servant	Experience in Primary Care
P3	1	Physician	More Doctors Program	Immigrated to Brazil one year after graduation; started working in Primary Care 5 years ago, when the diploma was revalidated
P4	2	Physician	More Doctors Program	First formal job after graduation; was on duty in Emergency Units for a short period, but prefers to work in Primary Care
P5	2	Nurse	Civil Servant	Experience in Primary Care
P6	2	Administrative Assistant	Civil Servant	Administrative Assistant, has already worked at other health centers of the network (hospitals)

All the interviews were digitally recorded and transcribed. After the material was carefully read, an initial analysis was performed in which four “possible dialogs” were developed. The objective of the “possible dialogs” was to seek for common elements, agreements and disagreements in the professionals’ and users’ discourses in relation to the same theme (Frame 3).

Frame 3. Possible dialogs

What do professionals and users say about the high frequency with which some people seek assistance and about their real need?
According to professionals and users, what are the main reasons that lead the high user to attend the Primary Care Unit?
Do professionals and users talk about conflicts, disagreements or changes in the way care is provided that can be seen as punishments to the high user?
What strategies do professionals and users employ to provide or receive the necessary care?



The “possible dialogs” were presented to the Units’ teams during two Shared Seminars, one at each studied Unit, to guide the groups’ discussion. The interviewed professionals participated in both seminars, together with other members of the health teams. This technique of restitution and construction of new findings and of a shared reflection by all the individuals involved in the act of researching is based on the theoretical discussions proposed by Lourau²⁹ and Cecilio²⁵, and aims to make the analysis of the findings a shared production between subjects and researchers.

In the seminars, the participants were stimulated to reflect on and give their opinions about the “possible dialogs” that were presented; thus, the professionals could reflect on their professional practice in the provision of healthcare for high users. The Shared Seminars are identified as SC1 and SC2. They were digitally recorded and subsequently transcribed, resulting in a vast material that was used in the analysis of the findings from the interviews.

The entire analysis of the empirical material took into account the researchers’ own experiences as health professionals, managers and teachers-researchers³⁰. Regarding epistemological precautions, we analyzed the implication of the investigators during the analysis process of the empirical material. Moreover, it is believed that approaching the object of investigation from three points of observation helps the choices and findings presented here.

The study complies with Resolution no. 466/12 of the National Health Council, which regulates research with human beings, and was approved by the Research Ethics Committee through opinion no. 3.689.071/2019. All the participants were volunteers and signed a consent document.

Results and discussion

Who defines high users? How do health professionals recognize (or fail to recognize) users’ health needs?

It became clear, since the beginning of the interviews, that distinct rationalities command the action of professionals and users concerning frequency of use and the real necessity with which they seek assistance. The professionals believe that users seek assistance excessively and unnecessarily, which is shown by the sentence “everyday that user we know very well comes to the Unit” (P4). On the other hand, the users state that they seek assistance fewer times compared to the average user and only when it is really necessary: “I see the doctor only when it’s necessary. But like, I wouldn’t make an appointment because of insignificant things [...] If I saw the doctor it’s because I really needed to” (U6).

The interviewed professionals believe that this perception might be explained by the naturalized form in which the high users routinely attend the healthcare unit. Or it is due to reasons that do not depend on the user: “They realize the demand is not exactly theirs [...] so they’re doing things that it’s natural to do, like follow-up, prescription renewal, things that they would have to do anyway [...]” (P4).



The teams were asked if, when defining someone as a high user, they refer to the frequency with which the person attends medical consultations or if they consider the frequency with which they go to the Unit, regardless of the reason. The professionals do not distinguish between these two possible reasons and state they seek assistance “Not only from doctors, but also from other professionals who work at the Unit” (P3).

The professionals do not consider users with severe or decompensated clinical pictures, who need frequent consultations, as high users. The same does not happen with people who seek assistance due to non-biomedical demands:

[...] we know he’s using the Unit’s services excessively now because his diabetes is decompensated. We require a follow-up visit, change the medication, increase the dose, tell them to come back in one week [...] When the patient gets better, the routine of coming back every six months returns and that’s it [...] But there are the high users who think they’re ill [...] you’ve searched for everything, they’ve already undergone all the tests and you find nothing. (P3)

By considering that high users seek assistance unnecessarily and that this group is composed of less severe patients, the professionals show that the health needs that do not conform to the parameters of severity instituted by the biomedical model, in which illness prevails to the detriment of the subjective and social dimension of leading one’s life, are not perceived as important or legitimate.

When we analyze Frame 1, would it not be fair to say that such people go to the services with needs that are not biomedical but are equally legitimate or severe? They may go to the Unit because they have formed a bond with a professional, because they live close to it (the farthest lives 1,500 meters far from the Unit), because they feel welcomed, because they are responsible for the care provided for their relatives, or because they are in a vulnerability situation and do not know who to turn to.

Although the Units operate according to the care model of the Family Health Strategy, providing person-centered care (at least in theory), the biomedical model prevails, defining what is important and severe and legitimating health needs. It seems that the professionals look at a set of individual needs related to the medical clinic, not at users’ family or social needs.

The taxonomy of health needs proposed by Cecilio³¹ helps to understand this issue. The life reports of the 6 users revealed needs deriving from the social conditions of existence, needs related to the use of health technologies, and needs connected with the creation of bonds, something that the teams recognize but do not necessarily value. However, the need of autonomy in the way users lead their lives is lacking. If the team recognized this last need, it would be able to interfere in the frequency of use of the services. The professionals’ value judgment in relation to these users indicates that they simply consider they use more than they need, that they do not conform to the desired behavior of users according to the rules and regulations²⁵.



What reasons lead users to seek assistance?

Most of the interviewed users presented organic chronic conditions (heart, gastric and neurological diseases) and psychiatric conditions (schizophrenia, anxiety and mood disorder), which corroborates previous studies which have found that the incidence of high users with chronic conditions was close to 90%^{1,14}. These results can reflect the profile of a sick person that is longitudinally followed up in primary care, rather than something related to frequent use.

All the interviewed users reported involvement in care provided for family members, accompanying them in consultations or examinations, making appointments, asking for prescription renewals, medical reports or referrals: "I don't go there because of me; I go mostly because of my children" (U5). This family situation is disregarded or minimized by the professionals when they list the reasons why users seek assistance: "He comes because of his issues [user], until all his problems are solved, and then he moves on to the rest of his list" (SC2).

The family dimension of care, which, according to Cecilio³², becomes more important depending on the stage of life and in situations of greater vulnerability, is not perceived when the individual is responsible for providing care for their family members. However, the professionals recognize the importance of this dimension when they need to develop different strategies to provide care for high users.

The users reported that one of their main reasons to seek assistance is the need to replace or renew prescriptions: "The prescription is always once a month, I have to go there. This is normal, I have to go there every month" (U4). However, this demand is not perceived in the professionals' discourses. Modifications implemented in recent months in the city's PHC due to the professionals' request resulted in the need of a higher number of medical consultations to obtain and renew prescriptions: "the community agents were getting and taking prescriptions for patients [...] today, prescriptions are given only in the presence of the patient" (P4).

When these findings were presented to the professionals, they recognized the existence of administrative hurdles "yes, the person has to go to the Unit more times because of bureaucratic factors" (SC1), but they also blamed the users for the greater need of assistance to obtain prescriptions. Among the users' main 'faults', the professionals mentioned loss and misplacement of prescriptions, self-medication, and the loan of medicines to family members: "[...] they say they've lost [the prescription], they don't know where they've put it, you end up having to renew it [...]" (SC1). Or "Sometimes, they even lend medicines [...] They medicate other members of the family [...] and they end up running out of medication." (SC1).

When the physicians reaffirm that the user must go to the Unit and that their utilization pattern is within expectations in light of their clinical picture, they end up, without noticing it, causing or justifying the high users' frequent attendance^{14,33}. The users recognize that the physicians support the frequent use of the service when they mention that the user must go to the Unit if necessary: "if anything happens, come immediately to the Unit" (U3).



In the organizational dimension, it is possible to see that there is a limitation imposed on the number of demands that can be approached during each medical consultation. In case there is more than one demand, the user is instructed to go back to the Unit, undergo another screening and have another medical consultation: “[...] if he says: ‘As I’m already here, I’d like to ask you to fill in a test requisition form’”, but his demand was a prescription renewal, he’ll have to undergo the screening process and make a new appointment to request tests [...]” (P1).

The professionals’ incentive and the imposition to return for the assessment of additional health complaints, prescription renewals and referrals lead to the production of a high user that is ‘fabricated’ by the health system itself, when it adopts a care model that favors ‘demand-conduct’ to the detriment of comprehensive care.

The professionals’ discourses greatly emphasize that the responsibility for the higher demand lies with the user, deriving mainly from non-adherence to the ‘norms’ dictated by the teams: referrals, treatments and changes in life habits: “Usually, the demand is based on something that they have not done, our hands are tied” (P5). By analogy with the ‘moral worker’ described by Cecilio³⁴, who follows all the rules and the programming established by managers, many professionals expect to deal with a ‘moral user’ who complies with rules and prescriptions in an exemplary and complete way.

The bond constructed by the user with the team is not seen as something healthy, but as the cause of an excessive demand: “I don’t know if they don’t receive attention in their homes [...] they create a bond with us” (P6). The difficulties in dealing with people who go to the Unit because of the bond became clearer in the Shared Seminars: “You perceive it, but how can you send the person away? So, many times, the person ends up in a medical consultation” (SC1) Or “[...] she has been facing problems and needed to talk to someone. And the physician’s office ends up being the place she finds” (SC1).

A way of providing care characterized by the biomedical model transforms the bond-motivated attendance into medical consultations or procedures, with the increasing risk of excessive medicalization or unnecessary test requisitions, “making an unending succession of consultations, tests and procedures become the center of life”³⁵.

Based on the multiple dimensions of care proposed by Cecilio³², it was possible to see that changes implemented to improve user care produce additional norms and rules; they aim to rationalize healthcare, but do not include nor consider singularities in the systemic and organizational dimensions of care. Not all people need a type of healthcare that deviates from the established rules and protocols, but when this is necessary, there is resistance on the part of the professionals.



The rules, prescriptions and norms meet the fabricating user: is it possible to establish a dialog?

The fabricating users²⁵ emerge from the protagonism of the people who produce paths in their own way, seek solutions for their needs, and only partly correspond to the system's official regulation. These users 'break the rules', thus producing 'their own health system'. In their protagonism, in seeking for assistance, the user starts challenging the team and the professionals. The composition, the space of the harmonious encounter that takes place according to the instituted rules, generates a split and the team begins to see it as a problem.

The interviewed users do not perceive modifications in their care that can be seen as punishments for their frequent attendance of the Unit, and the professionals deny any changes in the assistance provided for high users. In spite of this, there may be 'punishments' to patients considered difficult, such as denying new prescriptions when they lose them, or offering an appointment to a user that, according to the team, will adhere better to the treatment³⁶. A greater tendency towards referrals and test requisitions was also found, in an attempt to avoid early follow-up visits or new medical consultations².

Although the users do not report quarrels or conflicts, some professionals mention that people who seek assistance more frequently tend to argue more with the nursing and reception teams, which are responsible for the initial screening: "There are some people whose profile we know well, and who, depending on what happens, will be hostile. There aren't many, but they do exist." (P5) Other professionals believe that, as the high users know the team better, they create a stronger bond, resulting in a better relationship between users and professionals; after all, "[...] they know what we do, how the routine and the flow function, and they respect the flow more than other patients do" (SC2).

According to the professionals, these users are difficult patients: "That patient we take a deep breath before we assist them once again [...]" (P4). One of the reasons for the discomfort caused by these users is that the health workers start questioning their own professional capacity. The professionals question if the proposed conducts are correct or sufficient, as "the high user really generates stress, not because you get tired of seeing that patient, [... but] because you think that what you're doing is not working. It seems that we're failing either in the diagnosis or in the treatment" (P3).

Another reason that makes these people difficult users is the fact that, most of the time, they have chronic diseases, whose control requires, in addition to medicines, guidance about life conditions and habits: "I think it gets redundant, you say the same things in the consultation, it seems you're bringing sand to the beach" (SC1).

Despite the difficulties in providing care for these people, the professionals state they feel a great pleasure when their clinical picture improves:



The high users sometimes make me wonder if I'm really in the right place because they suck the energy out of us, but when one of them, after we repeat the same things a dozen times, is able to get on the right path [...] when we get a win, however small, we say it was worth it, it worked. (P4)

In the Shared Seminars, the issue of high users returns to the systemic dimension of care management. That is, the workers believe that more rules are necessary and the system must be better controlled, as it may become overburdened by those who use it a lot: “[...] they are patients who encumber the system, because they may occupy a place that could be used by another person [...] But then we end up overburdening it and insisting with those same patients all the time” (SC2).

Care provision for “high users”: are there possible encounters?

The strategies employed to provide care for high users aim to meet the needs perceived by the professionals, majorly connected with the operational knowledge of biomedicine: medications, tests, referrals, and prescriptive rules that do not necessarily consider people's modes of existence. There is no attempt to involve the patient in their own care, nor to develop an individualized therapeutic project that effectively provides the needed care.

The professionals report the concern that clinical diagnoses may not be made due to the undermining of the high users' demands, and state that they redouble the attention during assistance:

[...] I think that, because of the frequent attendance, we tend to think “oh no, not again”, “one more time with the same thing”, so we always have to turn on that little light that says, is it possible it's something new? Maybe something has really happened? (P4)

According to the professionals, if strategies to restrain user access were implemented, such as charging by direct disbursement, the high users' frequency of attendance would decrease. “If he had to pay, he'd think ten times before coming” (SC2).

Cecílio²⁵ argues that the ‘lay action’ emerges from the protagonism of men and women who search for the care they deem necessary for themselves, developing their own regulatory practices through the knowledge they have acquired about formal regulation mechanisms, or, even more so, through their knowledge of how to get around the rules to fulfil their objectives. During the Shared Seminars, many professionals reported that they perceive the ‘lay action’ in motion. Users get to know which professionals are more collaborative in relation to their requests, and they even know the functioning of the professionals' work schedule.



By means of the multiple forms of regulation and flows created by the patient in 'their' health circuit, the user gradually builds their map of care²⁵, in their own way, using their relationships, often composing a public-private mix, choosing the referrals and treatments they consider necessary. Users seek the private sector, among other reasons, due to the inefficiency of the public system, the general belief that private physicians provide a better assistance³⁷, and because of the delay in scheduling procedures, tests, and making appointments with specialists³⁸: "if you want to accelerate the process, you must get the paper and go to the private system" (U6). In our study, the users composed their care with the private sector spontaneously. The professionals did not induce them to use the services of the private sector instead of using the public one³⁷.

On the other hand, we perceived that the care network does not have articulation between sectors to provide tailored care; many times, patients do not know what path to follow: "Even the Emergency Unit's professionals say: "but why didn't you go to the Healthcare Unit?" And I say: "they told me I had to come here", "no, this problem has to be solved there", they tell me" (U1).

However, when there is an attempt to provide networked assistance, the professionals notice that the referred high users do not participate in the multidisciplinary groups of the Units and, sometimes, they do not attend the medical consultations and referrals proposed by the team: "But I see that these patients who demand more do not participate in the groups" (P1).

Some clues indicate that care production based on the understanding of users' different needs can promote the fundamental and much needed encounter between users and professionals. From the professionals' discourses emerge some openings for the construction of a common plan, a 'zone of mediation' where decisions can be shared, aiming at the provision of care. A space of interaction, interlocution, negotiation, not subordinated to the rationalities and rules of management and/or to the command of biomedical knowledge, which is necessary, but has proved to be insufficient, mainly in the case of care for chronic conditions in situations of high social vulnerability.

Final remarks

Patients are expected to use the Primary Care Unit as a reference and as the front door of the system, utilizing all the available services on a regular basis. However, it became clear, since the first contacts with the professionals, that there is a group of users that draws the attention of the team or causes discomfort because they attend the unit in an excessive or unnecessary way, in the opinion of the professionals who work at the two Units studied here.

The way in which the PHC professionals define who is a "high user" is more complex than the total number of medical consultations over a given period of time and is related to the identification of the health needs that motivate the user to seek assistance. Therefore, users whose needs are beyond the scope of the biomedical model may not have their needs correctly identified or even considered as legitimate by the professionals and are viewed as "high users", independently of the number of medical consultations.



The study of patients considered as “high users” by the teams helped us analyze PHC, showing that we still have a long way to go. We maintain a model that is still based on ‘outpatient care’, centered on the biomedical rationality, with hardly any opening to ‘life as it is’, and with few possibilities of interlocution with ‘lay action’ and knowledge.

It is necessary to understand that our actions must enable that “each person, with their multiple and unique needs, is always the focus, the object, and the justification for the existence of each health service and of the health system”³¹. In this way, we can improve the healthcare provided for these people and put an end to the vicious circle of the user who increasingly attends the unit, but does not receive the necessary care.

Authors’ contribution

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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Este artigo visa analisar aspectos no cuidado aos “hiperutilizadores” na Atenção Básica por meio da percepção dos profissionais e dos usuários. Foi realizada uma pesquisa qualitativa de caráter exploratório, do tipo estudo de caso, em que “hiperutilizadores” e profissionais foram entrevistados. A maneira como os profissionais definem quem é um usuário “hiperutilizador” é mais complexa do que o número total de consultas realizadas, passando pela identificação das necessidades em saúde que motivam a busca por cuidados. Os usuários com necessidades que extrapolam o alcance do modelo biomédico muitas vezes não têm as suas necessidades corretamente identificadas ou consideradas legítimas, e são considerados “hiperutilizadores” independentemente do número de consultas. O estudo serviu como um analisador da Atenção Básica à Saúde (ABS). Mantém-se um modelo ainda centrado na racionalidade biomédica, com pouca abertura para a “vida como ela é” e para o conhecimento e o “agir-leigo”.

Palavras-chave: Atenção básica à saúde. Necessidades e demanda de serviços de saúde. Uso excessivo de serviço de saúde. Cuidado centrado no paciente. Modelos de atenção primária.

El objetivo de este artículo es analizar aspectos en el cuidado a los “hiperutilizadores” en la atención básica, a partir de la percepción de los profesionales y de los usuarios. Se realizó una investigación cualitativa, de carácter exploratorio, del tipo estudio de caso, en la que fueron entrevistados “hiperutilizadores” y profesionales. La manera en que los profesionales definen quién es un usuario “hiperutilizador” es más compleja que el número total de consultas realizadas y pasa por la identificación de las necesidades de salud que motivan la búsqueda de cuidados. Los usuarios con necesidades que extrapolan el alcance del modelo biomédico, muchas veces no tienen sus necesidades correctamente identificadas o consideradas legítimas y son considerados “hiperutilizadores”, independientemente del número de consultas. El estudio sirvió como un analizador de la ABS. Se mantiene un modelo que todavía está centrado en la racionalidad biomédica, con poca apertura para la “vida tal como es” y para el conocimiento y el “actuar-leigo”.

Palabras clave: Atención Básica de la Salud. Necesidades y demanda de servicios de salud. Uso excesivo de servicio de salud. Cuidado centrado en el paciente. Modelos de Atención Primaria.