

Management of unexplained: poly-consultation and hyperfrequency on Primary Health Chilean Attention. A qualitative and exploratory study

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Abstract

Background: In Europe, Latin-America, and Asia, poly-consultation has become a complex problem for the management of different healthcare systems. However, in the current literature, little attention has been paid to exploring perspectives of territorial and critical analysis to manage unexplained symptoms. The purpose of this study is to analyze the socio-structural elements that underlie the users' phenomenon of poly-consultation or hyperfrequency in the Chilean primary healthcare system (PHCS).

Methods: This paper represents qualitative data collected as part of an exploratory study that used mixed methods across three metropolitan areas of Santiago, Valparaíso, and Concepción, Chile. The study involved a sample of 24 subjects from administrative and management positions in PHC who were recruited from Family Health Care Centers, considering urban municipalities from the low, medium, and high stratum. The study collected data using one set of semi-standardized interviews during a year. Data analysis used an qualitative content analysis.

Results: This article shows that poly-consultant patients provide a critical clinic category to management and mental health model (foreshadowing a social topology base that promotes a determinate unspecific and diffuse experience on users) that cannot be cover by current biomedical models. Data showed the strain of a somatoform clinic category, especially in the clinic and epistemological exercise, and, also, the relevance of particularities of Chile, a country with a mixed health system characteristics and their effects: the naturalization of collective problems managed as individual problems.

Conclusions: Results from the study have the potential to inform healthcare professionals and managers of strategies for developing effective and territorially based. We conclude that hyperfrequency and poly-consultation in Chile reveal relevant stratification in the territory who has particularities than could be studied from a quantitative perspective.

1.- Poly-consultation Or Hyperfrequency

Poly-consultation, i.e., repeated consultation by the same user to the healthcare services, reaches clinical category after six months of manifestation according to the ICD-10 and DSM IV diagnostic manuals (Florenzano et. Al, 2002; Riquelme and Schade, 2013). It is then called "somatization disorder" or "somatomorphic disorder," which is defined as a "group of disorders that include physical symptoms for which no medical explanation has been found, but which are serious enough to cause the patient to have an impairment in work or social functioning" (1).

In Europe, the most commonly used term for these patients is hyperfrequent, while in Chile, the most widely used name is poly-consultant. Despite this differentiation in conceptual terms, when the patient profile is made, it varies depending on the territorial and socio-cultural context. In general, it is associated with psychological disorders, such as depression, but also with others such as childhood trauma or anxiety disorders (2) (1).

Poly-consultation has become a complex problem for the management of different healthcare systems, especially about these models' economic aspects (3) (4) (1). In the United Kingdom, somatic symptoms and syndromes represent 20% of primary healthcare consultations. In the Netherlands, the complaint of somatization among outpatients represented 25% of new referrals, while in the United Kingdom, it was 35%. Concerning prevalence rates, unexplained symptoms in primary care vary from 11–60% (5). In Spain, it is estimated that 15% of the population can be poly-consultants and that this group consumes approximately 50% of the medical consultations in healthcare centers, being responsible for the 65% of health costs (6). This is in line with the progressive increase in this phenomenon during the 2010–2017 period, mainly in the re-consultations of hyperfrequent users in emergency care (7).

Territorially speaking, a higher prevalence is observed in those centers located in rural and smaller areas; however, when considering the hyperfrequent users' number per professional as a measure, intermediate size centers are those which present the highest hyperfrequency (8). Notwithstanding the above, most of the existing research analyzes the hyperfrequency phenomenon only from the user's characteristics. Although other works using multilevel methodology have been able to verify the factors related to the professional and the organization explain, the consultations use variability between 55% and 63% in PHCS (9).

In Latin America's case, Brazil and Chile stand out with common mental disorders, high prevalence rates characterized by the presence of somatomorphic claims (10). In this regard, several studies highlight the social, psychological, and cultural nature that would be at the base of these disorders and, therefore, the lack of clarity on limits for this phenomenon and its correct classification or definition. We emphasize this phenomenon of high prevalence in Costa Rica, where it is estimated that 20.8 percent of the annual healthcare budget is allocated to poly-consultation users of ambulatory care centers. Poly-consultation demographic represents 19.75 percent of the population served in the clinics. This group is mainly made up of married women or women living with a partner, aged 30 to 50, with a complete primary education (3). In Chile, this phenomenon prevalence is particularly high (approximately 16%), with Santiago standing out with 17.7%, according to a World Health Organization study (11).

Because of this phenomenon problematization as a social object, it is appropriate to include it in some more general problems. In this direction, our research seeks to understand the socio-structural implications related to meaning construction associated with healthcare within the primary care network in Chile. In this regard, we postulate as a general hypothesis, that poly-consultant patients constitute management and mental health models critical category, prefiguring a basic social topology that promotes a specific non-specific and diffuse symptomatological experience in users, which cannot be covered by current biomedical models. In this regard, we consider that there are sociostructural elements that are at the root of the discomfort expressed as hyperfrequency. Furthermore, it is proposed that hyperfrequency management logic aims at reducing PHCS overload, without being able to suggest any change for the discomfort specific causes, since, finally, the users' meanings and experience are symptoms that the current treatments cannot define.

2.- Methods

The findings presented reports on results of semi-structured interview data collected as part of a larger exploratory study that contemplates mixed methods to analyze the socio-structural elements that underlie the users' phenomenon of poli-consultation or hyperfrequency in the Chilean primary health system (PHCS). To this end, we proposed an epistemological approach in the path of Pierre Bourdieu's (12) "structuralist constructivism", seeking strategies triangulation throughout research (13). This article synthesizes the management and administrative path of the field that made it possible to produce information for the development of a quantitative instrument towards a chilean poly-consultant profile, which was carried out with collecting data objective from administrative and management positions in PHC.

In practical terms, this was done through a semi-structured interview. It consists of a conversation guided by topics proposed by the interviewer, while providing high levels of thematic flexibility, allowing an opportunity for new aspects of emerging or those not contemplated in the guideline. Among the different types of existing semi-structured interviews, we use a model that approaches the so-called "semi-standardized interview," which allows reconstructing the knowledge, opinions, and discourses set that the interviewees have about the topic(s) being studied (14) .

The study involved a sample of 24 interview from administrative and management positions in PHC who were recruited from Family Health Care Centers, considering urban municipalities from low, medium and high stratus of Chilean's metropolitan areas. Precisely, three FHC from Metropolitan Valparaíso (Quebrada Verde, Valparaíso, Aviador Acevedo, Quilpué and Concón, Concón); three from Metropolitan Santiago (Dr. Alessandri, Providencia, Manuel Bustos Huerta, Quilicura and Juan Pablo II, Padre Hurtado) and two from Metropolitan Concepción (Baldomero Lillo, Lota and Santa Sabina, Concepción).

2.1- Sampling

Within the metropolitan areas, the most homogeneous urban municipalities of high, medium and low status were selected (one for each stratum), based on current National Socioeconomic Characterization Survey (15) (CASEN in Spanish, 2015) data, as we can see on Table 1. Then, in each one, the Family Health Centers (CESFAM, in Spanish for *Centros de Salud Familiar*) with the largest registered population were selected. For this kind of research, it was considered relevant to carry out a non-probabilistic sample, since, as it is an exploratory study, no sample framework allows us to identify patients from CESFAMs that are Hyperfrequent, trying to develop a poly-consultation profile.

Table 1
Source: Own elaboration based on Casen 2015 data.

Metropolitan Valparaíso				
Deciles	I-IV	V-VII	VIII-X	
Valparaíso	48%	28%	24%	(Quebrada Verde's Cesfam)
Concón	30%	27%	44%	(Concón's Cesfam)
Quilpué	37%	33%	29%	(Aviador Acevedo's Cesfam)
Metropolitan Concepción				
Deciles	I-IV	V-VII	VIII-X	
Lota	45%	37%	18%	(Baldomero Lillo's Cesfam, Lota Alto)
Concepción	33%	29%	38%	(Santa Sabina's Cesfam)
Metropolitan Santiago				
Deciles	I-IV	V-VII	VIII-X	
Providencia	5%	13%	82%	(Dr. Hernán Alessandri's Cesfam)
Quilicura	42%	44%	15%	(Manuel Bustos Huerta's Cesfam)
Padre Hurtado	70%	26%	3%	(Juan Pablo II's Cesfam)

2.2- Analysis technique

The "Qualitative Content Analysis" was used as a mechanism of analysis, understood as:

a technique for interpreting texts, whether they are written, recorded, painted, filmed (...) or in any other form where there may be all kinds of data records, interviews transcriptions, speeches, observation protocols, documents, videos (...) the common denominator of all these materials is their ability to contain material that, read and interpreted accurately, opens the door to various aspects knowledge and social life phenomena (16) .

According to the author, these texts reading should be systematic, objective, and with the option to be replicated. This analysis technique has the characteristic of mixing observation, data production, interpretation, and content analysis. Interviews were transcribed verbatim and observational data from field notes were incorporated and analyzed. This, considering four aprioristic categories: relevant stratification criteria in the territory, multiple symptom management models, social symptoms and temporalities, considering that the purpose of this study is to analyze the socio-structural elements that underlie the users' phenomenon of poly-consultation or hyperfrequency.

Table 2
Source: Own elaboration data matrix analysis

Descriptor	Major themes	Indicators / Subthemes
What do you know	<ul style="list-style-type: none"> • Relevant stratification criteria in the territory • Social symptoms 	<ul style="list-style-type: none"> • Neglect • Precariousness • Childcare • Inefficiency of derivation • Migration • Ethnicity • Religion and related behaviours • Mental health • Unexplained symptoms • Psychological discomfort • Social discomfort
How do you manage	<ul style="list-style-type: none"> • Multiple symptom management models • Temporalities 	<ul style="list-style-type: none"> • Organizational culture • How many medical consultations make someone poly-consultant? • Poly-consultant profile • Participatory design • Medical derivation • Human resources • Key performance indicators for maintenance of health-care insurances • Digital clinic management • Electronic health record • Intercultural health care

3.- Results And Discussion

In general terms, the specialized literature relates non-medically explained symptoms to mental health, more specifically to disorders such as depression and anxiety. At least one-third of patients with somatoform disorders suffer from comorbid anxiety or depressive disorders. In this regard, depression, anxiety, and somatization, with a prevalence rate of 10% each, are identified as the most common mental health disorders in PHCS. All of these are associated with fundamental functional impairment, an

increased number of disability days, and high healthcare costs. Thus, psychometric scales assessing depression, anxiety, and somatization are highly related. This fact would reaffirm the overlap in diagnostic criteria and, consequently, the difficulty of classifying this phenomenon. In India, for example, somatomorphic disorders are conceptualized from CD-10 and DSM IV definitions, known as Functional Somatic Symptoms (FuSS) (5).

Internationally, the most common symptoms found in poly-consultant adults of primary care are fatigue, pain, dizziness, general malaise, gastrointestinal symptoms, abdominal discomfort, diarrhea, and constipation (5). Studies carried out in Southeast Asian countries, analyze at a global level, the concepts and mechanisms related to medically unexplained symptoms (from now on MUS) and argue that the psychological nature of somatoform disorders is due to the lack of organic origin diseases to explain them. The latter, seen from the predominant, cross-sectional biomedical viewpoint, displaces somatoform disorders to the realm of agent autonomy, where the only people responsible are the patients who suffer from them.

In this direction, research provides exciting characteristics to the hyperfrequent user profile. For example, the older the patient, the higher the healthcare services use. Also, it is noted that women between 37 and 75 have a worse subjective perception of their health, so they tend to have health services higher consumption. In short, the HF patient is characterized as a middle-aged person with a low-level education who belongs to a nuclear family, lives in the nearest central neighborhood, suffers from a chronic disease, and has a psychic dysfunction. This patient makes an average of 15 consultations a year and frequently uses the previous appointment, but also the scheduled visit by doctor and nurse (17).

In this sense, these studies indicate that the creation of a definition and clinical delimitation for those patients with hyperfrequency would directly contribute to the reduction of the overuse of Primary Care (PC) (18). Also, they suggest that the patient's type should be considered according to whether they have chronic organic or mental pathologies or both, and that the interventions should be adapted to patient type. Other strategies are those mentioned by Fuertes M, et al. (6), who infer that one of the points for reducing hyperfrequency lies in the incorporation of non-presence or telephone consultation modalities (telemedicine).

Concerning to the overlap between mental health and poly-consultation, studies in Colombia have estimated that 10% of healthcare costs can be attributed to the consultation overuse (35% and 45% of work absenteeism are due to mental health problems). The somatization disorders prevalence of almost 40% in hyperfrequenters shows that, although they are often presented simultaneously, they are not synonymous, which makes it necessary to distinguish between both terms and to search for another kind of cause beyond the disorder itself. 41% of hyperfrequency cases can be attributed to chronic diseases, 31% to mental disorders, and 15% to acute and chronic stress. Together, these three factors would explain two-thirds of the total phenomenon. In the very same sense, when analyzing most frequent mental disorders present in PC, it could be inferred that these are under-diagnosed in the clinic, by contrasting patients diagnosed with depression, anxiety or mixed anxiety-depressive disorder records, 5.6% had been

diagnosed with depression, 6.3% with anxiety in the clinical history and 8.5% with mixed anxiety-depressive disorders (19).

However, after conducting a screening survey, it was revealed that 41.9% of the patients had depression symptoms or established depressive syndrome. Anxiety also occurred as a symptom or syndrome in 13.3% of the cases. On this basis, 55.2% of patients tested positive for mental symptoms or syndromes that had not been reported in clinical history (19). Clara Han (20), relates this as a depression to time to time, thinking in socio-structural perspective.

The low diagnostic capacity is especially important in the mental health field since several studies suggest that patients with anxiety and depression are twice as likely to be poly-consultants. The explanation given by the studies is that anxiety-depressive disorders can generate physical symptoms, and they may affect the health condition's self-perception. Therefore, spontaneous consultations number would increase as a result of this poor self-perception. It is, therefore, essential for the physician to consider research into the mental disorders underlying the reason for consultation (21).

Excuse me, but we have patients who are known to be poly-consultants, but they are in general, they are patients with senile dementia or people with their mental disorders as... we know them. A lady comes so much that her daughter, who comes to the doctor's attention, is torn out..

In Chile, research on poly-consultation is scant, and most relate hyperfrequency to somatization disorders. In this matter, the specialized literature estimates that somatic symptoms problem without clinical explanation represents PHC's consultations 15–25%, and up to 70% of this consultation type remains unexplained after being evaluated.

What I discovered, however, was a tense entanglement of municipal politics and health services, made even more acute by the fact that it was a municipal election year. Insecurity, fear, resentment, and frustration circulated among the local mental health workers and municipal health officers, affects in which I too became caught (20).

A study by the World Health Organization (WHO) indicates that in Santiago de Chile, there is a 17.7% prevalence of this disorder in primary care consultations (Riquelme and Schade, 2013). There is no poly-consultant patient homogeneous profile. However, several studies agree that poly-consultant users correspond mostly to women who own a home (without "formal" paid work), with an average age of 42 years, incomplete primary or average education, married, and with some chronic disease (22).

There is a "gypsy girl" who has a drug problem. A lady... several ladies, who have dementia, come here. We already know them, so at times we take blood pressure measurements to reassure them they're OK. Then we call their children for them to come and pick the ladies up.

From the mental health area, national research has addressed the phenomenon as a depression manifestation, using as reference the fact that this disorder affects 30% of primary health level beneficiaries (7.5% of the general population) (23). In the very same direction, other studies indicate that

poly-consultant patients should be treated not only themselves but also their families, since most of them present some family dysfunction, through a family therapy approach from the mental health perspective (24). Or, in Clara Hanwords, assuming that "life is by a thread" (25).

It's simple, with more than seven consultations in six months, we're on alert. Morbidity control is done with poly-consultant observation for evaluation, and we see if it is referred. If it's a chronic health problem, it's taken up by a nurse, and if you have a problem related to mental health or addictions, we refer you to the psychologist or our social worker

From the mental health units from the primary care level centers, various intervention proposals have shown high effectiveness, among which are: cognitive-behavioral therapies, psychodynamic therapies, and group therapies. However, a significant number of these patients refuse to be classified as having mental health problems, attributing the responsibility to the doctor, since he or she does not provide an adequate response to their physical affliction. It means that the doctor-patient relationship is damaged, and patients insist on the need for more evaluations and tests (1) .

And people acknowledge that it has to do with many things: the fact that nowadays both parents have to work produces a deep cut in the family dynamics, a break between getting to know each other and the relationship that can be established among parents and children.

The Brief Family Therapy (BFT) approach, whose main characteristics are to be simple, quick, to generate a greater user satisfaction and to reduce costs, aims to have patients being able to treat their own problems in their own homes through objectives set by themselves. BFT seeks to reduce the symptoms and recover the patient's autonomous functioning. With this therapy, the patient stopped using medication and did not request any more complementary examinations, thus saving on healthcare costs (26).

My idea, alongside the psychologist who set this up, is to complement this with team interventions such as home visits, family studies, and counseling.

The healthcare system provides optimal conditions for poly-consultation to be produced and perpetuated since the biomedical approach to providing care and the Cartesian legacy are still deeply rooted in the given attention. Public health administration does not adequately answer to users' demands by using indicators. Healthcare officials tend to displace the psychosocial component to a secondary concern, producing a rupture between what the services offer and poly-consultant population demands, not enabling this problem to diminish (27).

3.1- The strains of a clinical category

The "somatoform disorder" classification is, precisely, the clinical approach to capture a discomfort refractory to the most common organic diagnoses (2). Therefore, the "hyperfrequency," "somatizers" or "poly-consultants" status of those users who repeatedly come for a short period (usually six months) is recognized by its name in diagnostic manuals (2) (22) (1). However, this attempt to capture the medical

device is quite questionable, as it allows neither an adequate conceptualization nor a practice around this kind of disorders.

While what is commonly criticized is the inadequate biomedical approach to this sort of phenomenon - criticism also associated with more general demands, such as a therapeutic relationship becoming more humanized (3) (23) - we are particularly interested in the "psychosocial" circumstances unspecific association which are used "to fill that space where some subjectivity is admitted" (28), becoming a "closed significance that is self-explanatory." In this direction, "professionals limit themselves to referring these patients on several occasions, as having 'psychosocial problems,' seems more to be a new effort to objectify these subjects' understanding" (28).

Instead, now, as I told you before, it is people's mental health that is relegated. And people recognize that this mental health issue is giving them a poor quality of life. It makes you get old in an awful way, along with everything else..

Moreover, from clinical experience, physical signs importance and laboratory findings are emphasized to give importance and credibility to patients with non-specific symptoms and subsequent diagnosis. Here we should ask ourselves why this phenomenon is so disregarded by professionals when it leads to a high social and economic burden. It could be explained broadly for the following reasons: 1) The conditions classification, in which people develop these non-specific symptoms, is diffuse; 2) psychiatrists do not have sufficient experience to be able to deal with these patients; 3) patients with these symptoms do not seek psychiatric help; and 4) general physicians, as well as specialists, do not refer for psychiatric help (29). Precisely, it opens an epistemic problem related to the semiology and clinic exercise (30).

Semiology (...) was constructed by disease symptom intelligent identification and acute observation of patients' body signs (...) in the diagnosis of the disease - "clinical or morbid entities" - one must distinguish "primary or peculiar symptoms from secondary or accidental ones." It is precisely the semiological knowledge that allows us to identify the disease's different manifestations (signs and symptoms), how to look for them (semiotherapy) and how to interpret them (clinical semiology).

To address this problem, there are models used in primary care that allow us to detect, recognize, and manage non-specific symptoms. Still, the literature highlights the importance of developing customized models that meet the needs of each center due to the phenomenon of complex and multifactorial nature. An exploratory model is therefore proposed for non-psychiatric users in six specific circumstances, each one with its own considerations when dealing with these users (29).

Based on this, and around a semiological problem, we find an epistemological problem. Specifically, between biomedicine targeting the disease and the condition experienced by the patient:

Sometimes the plaque that makes the body visible shows the doctor that the patient 'has nothing' wrong, contrary to what the latter claims, who complains of various aches and pains. The opposition between

the doctor's illness and the patient's condition is therefore clear. The objective illness proof was not provided (...), so the pain is imputed to the patient's sickly fantasy. He is an imaginary patient (31).

As Canguilhem points out, "instability and irregularity are (...) the vital phenomena essential characteristics, so that forcing them into the metric relations rigid framework means denaturing them" (32). The biomedical view, while observing from interpretative frameworks that make the pathologies exclusively biomechanical, physical, or biochemical problems, fails to reveal the seriousness that the body's interaction with its environment would have in the disease's etiology production.

Given this, life is not indifferent to the material and symbolic conditions that make it possible, hence it must be understood as a normative activity (32). In other words, life must be understood as installing normative standards that allow it to adapt to a constantly changing environment. It is why health manifests itself when the pathological, and the associated pain, impedes the individual's daily life development. The body, then, reveals its health or illness concerning the resistance and adaptation capacity towards the conditions of an environment that forces it to displace its own limits. This would explain the proposals for the biomedical model to be modified at different levels, from the "bio-psychosocial" approach development to the so-called "integrative medicine" (33) (24) (34) (35) (36) (37).

Also, this asymmetry incorporation (between the target disease and the experienced condition) to the clinic's normal functioning, either through the somatoform concept disorder development or in its association to non-specific psychosocial factors, approaches to "social determinants" currently proposed by the World Health Organization more complex (11), due to the a-criticity and non-specificity that the "social environment" acquires, and the individualizing biomedical feature that regulates its incorporation (38). This issue is crucial since it is directly linked to the social position of scientific medicine and its link to the requirements of the State and the market (39) (40). It is not surprising then that both, specialized literature and the health institutions, recognize a biomedical approach relative incapacity to face the new challenges in healthcare successfully. This is directly related to how biomedicine is presented as a technique for managing discomfort, namely: processing social problems on an individual basis.

3.2 - The Chilean healthcare system's transformations

As well as the epistemological problem that affects the care, diagnosis and treatment of conditions classified as somatization disorders, the literature reports, with a full agreement level, that such benefits generate economic disadvantages, make public care systems more expensive and more burdensome, reaching an international prevalence in primary care around 15–22% (3) (22). This global observation is particularly sensitive to Chile due to the conditions of its public health system. To highlight the importance of this point (the rise in cost and the overcharging due to hyperfrequency in Chile's public health system), it is necessary to describe the current health system characteristics and the context in which they were produced.

In 1979, twenty-seven health services and the National Healthcare Fund (FONASA, for its name in Spanish *Fondo Nacional de Salud*) were created to decentralize healthcare services into a National

Healthcare Services System (SNSS). Later, in 1980, the Primary Health Care Clinics were transferred to local municipalities, which, according to the WHO, would have affected healthcare equity, as economic differences in the municipalities structures caused inequalities in users' care. However, the most radical healthcare system reform took place when the Social Security Institutions (ISAPRE, for its initials in Spanish *Instituciones de Salud Previsional*) were created in 1981, leading to a sustained drop in public system financing, from 3.3% in 1974 to less than 2% in 1990 (41) (42). Only in 2008, the GDP percentage reserved for public healthcare reached the figures it used to have in 1974. Nevertheless, healthcare expenditure has increased significantly, even above OECD countries (7.3% of GDP), but is still far below the average for OECD countries (9.3%), and since 2013 there has been a slowdown.

The mixed provision system has produced significant inequalities between benefits and sustained pressure on the public system, as it has had to deal with increasingly scarce resources and with universal coverage that forces it to receive a significantly higher number of affiliates. By 2011, more than 80% of Chile's inhabitants are FONASA's members or beneficiaries, while only 13% are ISAPRE's. The diagnosis is even worse if we consider that the private system spends per capita exactly twice as much as FONASA (42).

These numbers must also be contrasted with healthcare financing ways. In most OECD countries, public spending on this item exceeds 70% as an average, with Chile and the United States as exceptions. Chile barely reaches 49% of public expenditure, a heavy burden on households that are responsible for financing almost a third of the cost, compared to the average for OECD countries, which barely reaches 20%. This last point implies a noticeable healthcare problems individualization kind of management and the correlative market liberalization. Moreover, the number of health professionals is also noticeably lower than the other countries of the international organization, placing Chile in the last place next to Turkey in the physicians quantity, with 1.7 per 1000 inhabitants, well below the 3.3 OECD average in 2012 (not even reaching the standard of 2000 which was 2.7). Similarly, in the nursing professionals case in Chile, it reaches 4.2 per 1000 inhabitants in 2012, compared to an average of 8.8 for the organization's member countries. These structural pressures and limitations are transferred to Chilean public healthcare professionals, imposing on them a competitive market model that installs life just as any other commodity (38) (43).

It is within this framework -which imposes extreme resources rationalization and optimization (1) - that the recognized burdens that hyperfrequent patients represent for the health system take on particular relevance.

If we are responsible for people in their lives progress, by helping them at the right moments, we can prevent them from becoming poly-consultants and sick.

It is estimated that 30% of users consume 80% of healthcare resources, and it is estimated that unexplained somatic symptoms problem fluctuates around 15–25% total consultations in Primary Health Care (PHC), which would imply a broad impact of this sort of conditions in the full benefits of primary

healthcare services, constituting between 60% and 80% of users' total demand who attend to those centers (22).

Based on international studies, it is estimated that users characterized as hyperfrequent users cause twice the cost of any other type of patient, due to the number of examinations requested and medicines administered. Considering the figures already mentioned, the specialized literature agrees on the need to improve the resolution of this sort of disorders, as well as the need to discuss the allopathic, orthodox, scientific or biomedical medicine limitations (2) (4) (22) (28) (1). In this direction, it is necessary to have a profile that allows us to know who these hyperfrequent patients are beyond the limited case studies that have been carried out in our country. A poly-consultant general profile would enable us to rethink, among other things, the management mechanisms of these patients in the public healthcare system.

3.3 A way of understanding social relations: collective problems managed as individual problems

A third problem overlapping with the previous ones has deserved -and still deserves- an in-depth study that shows its importance in the more or less global matrix of assessment deployment make up what has been called "connectionist world" (44). In this regard, the socio-economic transformations that Chile has undergone in the last 40 years have produced a particular way of understanding social relations (45). This series of reforms -which broadly contained fiscal discipline, macroeconomic stabilization, price, and market liberalization, state enterprises and social services privatization, and finally, the reduction of State intervention in capital markets and economy in general (46) (47) (45) -, would be at the base of a new institutionality associated with generalized privatization that allows the action of free agents as a base element for the management of their lives (38) (48) (49). The first result of Chile's transformations is that, in less than two decades, went from being "a closed economy with a high level of state intervention to being one of the most, if not the most, open and market-based economies in the world" (45), whose main support point is individual modulation.

Since the 1990s, governments have not (yet) substantially amended any of these reforms, keeping in line with world trends. On the contrary, it could be said that the country intensified possibility conditions for individuals exposed to general habitat modification, could assume this as natural, and renewed society, freedom, politics conceptions imposed by the weight of the immutable, having modified the public administration own logic, and committing individuals to manage their lives based on their personal projects, quite far from community logics (46) (48).

In this direction, we are currently witnessing a highly individual way of experiencing inter-subjective relations (50), which has made possible the transition to a new way of understanding the overlap between State, market and society, and the role that each of these has in the management of social problems. Generalized privatization of social affairs emerges in which "freedom of agents" operates as the basis for the management of their environment and their lives, thus transferring the structural inequality burden and the competitiveness demands to "citizens" who must, from now on, individually manage their precariousness and their lack of certainties (51) (52) (25) .

This crosses over the possible answers to the two previous points, namely the "burden" imposed by non-specific somatic consultation and the limits of biomedicine in this regard. It also conditions the understanding that individuals themselves have of their discomforts and how they deal with them. It is precisely at the intersection of these problems that our research is focused, unraveling from a sociological perspective who the hyperfrequent patients are (sociodemographic characterization), how their care is managed (the governmental rationalities behind the logics of care plans and programs expressed in specific protocols), and what obstacles and possibilities people face in a deeply individualized healthcare system such as the Chilean one (the daily and symbolic construction of healthcare service conditions).

So the ones from [territory] are different, so in general, people here are like quiet. There are city neighborhoods that we have known all our lives, as I said, the ones that slip through our fingers, are from that area where we should work more. Over there, we have to act differently, have a particular family doctor, a team that goes frequently enough. We make different strategies to deal with them.

4.- Conclusion

As a brief overview, during this article, we have outlined elements that allow us to understand how the Chilean healthcare system manages hyper-frequency from the words of those who execute and handle the medical protocols. In this regard, this research allowed us to find four major analytical categories to understand hyper-frequency in Chile that will structure the study's quantitative phase.

Also, a quantitative research instrument will be made to investigate relevant stratification criteria in the territory, since, as demonstrated in this article, cases may vary with each social space particularities. Furthermore, the search for multiple symptom management models will allow us to understand to what degree these territorial particularities become administration methods with their own temporalities that may or may not be replicated. In this sense, it is worth thinking whether the social symptoms suggested by the literature on hyper-frequency such as mental health or chronic diseases or abandonment are replicated in the Chilean case.

Declarations

Ethics approval and consent to participate

This investigation has ethics approval and consent to participate from "Comité ético-científico" from University of Valparaíso (CEC-UV). The protocol number is CEC179-18.

Consent for publication

Not applicable.

Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

NFS and DRL analyzed and interpreted the data exploring perspectives of territorial and critical analysis to manage unexplained symptoms. HSR performed the state of art of examination of poly-consultation of hyperquency. CGP and MDT made data recollection. All authors read and approved the final manuscript.

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