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### REFERÊNCIA

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## Perceptions of city health managers about the provision and activity of physicians from the More Doctors Program

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In Brazil, the challenge of redistributing physicians has been the subject of several government interventions. The objective of this paper was to analyze the provision of physicians through the More Doctors Program, according to city health managers. This was a qualitative study carried out with 63 managers in 32 Brazilian cities. The interviews were submitted to content analysis using Atlas.ti software. It is noteworthy to highlight the contributions of the program physicians to improvements in health care, humanized and differentiated clinical practices, and changes to health care networks after implementation of the program. The managers reiterated the importance of the program in providing and securing physicians in primary health care in vulnerable and hard-to-access cities.

**Keywords:** Primary Health Care Physicians. Health Management. Public policies. Primary Health Care.

## Introduction

The right to health care in Brazil is constitutionally guaranteed and regulated. Some national and international authors have acknowledged that the Brazilian National Health System (SUS) is a successful Brazilian experience of implementation of a public policy inspired by social democracy and oriented towards valuing and including health care users in the universal public and social protection system in an integral and cross-sectorial format<sup>1</sup>.

It should also be acknowledged that the universal, equitable, and integral SUS was born, developed, and operates as a Brazilian State policy in a context of inequalities and social exclusion. The system involves the national government and local and state governments in order to ensure oversight, promotion, prevention and comprehensiveness in the provision of health care to the population. In this scenario, several challenges have been prioritized by the Ministry of Health, jointly with states and cities. Regarding the organization of primary health services, Brazil instituted the National Primary Healthcare Policy (PNAB)<sup>2</sup>, published in 2011, and described as:

[...] a set of individual and collective health actions, which include health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, damage reduction, and health maintenance aimed at developing comprehensive care that could have an impact on the health status and autonomy of people and on the health determinants and condition of populations. (p.19, emphasis added)

In this document, the Family Health Strategy (FHS) is presented by the Ministry of Health (MS), the National Council of State Health Secretaries (CONASS), and the National Council of Municipal Health Secretaries (CONASEMS) as a proposal for reorganizing primary health care (PHC)<sup>2</sup>:

The goal of the Family Health Strategy is the reorganization of primary health care in the country [...] as an expansion, qualification, and consolidation primary care strategy favoring a work process reorientation with major potential to further primary care principles and guidelines, increase responsibility, and have an impact on the health status of people and populations, besides providing an important cost-effectiveness ratio. (p. 54, bolded emphasis added).

Through the decentralization process proposed in the Constitution and subsequent rulings in the 1990s and 2000s, Brazilian cities became, jointly with the federal government and state government, manager of the SUS; in other words, Brazil now had 5,561 healthcare system managers. In this process, the cities have taken on major responsibility for implementation of PNAB. The Brazilian experience is unique from the international point of view.

Through management spaces created by the SUS, the regional bipartite commissions (CIBs) and the national Tripartite Interagency Commission (CIT), the Brazilian State agreed on the PNAB and established the FHS as its main format<sup>3</sup>. The FHS organizational framework consists of teams made up of general practitioners, nurses, community health agents, dental surgeons, and nursing and dental care technicians. From its creation in 1994 to 2012, thousands of family healthcare teams were implemented, and the primary care decentralization process led the cities to become employers of 69% of the healthcare professionals in the country.<sup>4</sup> In 2012, there were 32,000 FHS teams, of which 21,279 had dental care teams.

Evidence of the effectiveness of the FHS during its implementation includes reductions in hospitalizations due to conditions in children and adults that are treatable by primary care<sup>6</sup>; reductions in non-urgent consultations in emergency care units<sup>7</sup>, and reductions in child mortality<sup>8</sup>. However, other health problems treatable by primary care remained at high levels, such as maternal mortality, congenital syphilis, and cervical cancer, showing the need for improvements in this strategy.

Another challenge faced in organizing PHC in the Brazilian cities was high turnover and, in remote and vulnerable areas, shortages of healthcare professionals –

particularly physicians – in the teams. This compromised the execution of longitudinal and continuing care for users, a practice that is of vital importance for the prevention and treatment of chronic diseases<sup>9</sup>.

Despite demographic and epidemiological challenges and high turnover of physicians in PHS, concentration of health professionals in large urban areas, especially physicians, has been seen. International experiences in providing and securing professionals in vulnerable areas cover a wide range of strategies, such as recruiting, education, compulsory civil service, regulation, incentives, and support<sup>10-11</sup>. Some of these strategies are based on recommendations promulgated by the World Health Organization<sup>12</sup>.

In Brazil, the challenge of redistributing physicians has been addressed by a number of government programs. Even though these programs have attracted some professionals to remote areas, they have been unable to reach the magnitude necessary for supplying the needs of the cities<sup>13-15</sup>.

The Ministry of Health and the Federal Council of Medicine (CFM) determined that the national average of physicians in the country is 1.8 per 1,000 inhabitants, but that this rate is lower than the national average in the North and Northeast regions of the country. Meanwhile, other nations, such as Argentina, Uruguay, and Portugal, have more than three physicians per 1,000 inhabitants, and Spain has more than four physicians per 1,000 inhabitants<sup>16,17</sup>.

Due to the shortage of physicians, on February 4, 2013, the Brazilian National Front of Mayors (FNP) launched the “Where’s the Doctor?” campaign and organized a petition to demand that the federal government take the necessary measures to hire foreign physicians to work in primary care in cities where there were shortages of physicians. This petition was signed by more than 2,500 mayors, and included 4,600 signatories and municipal bodies throughout the country<sup>18</sup>.

In response, the federal government created the More Doctors Program (MDP) in Brazil, through a provisional measure that was converted into Law no. 12,871, of October 22, 2013, establishing three strategic areas: 1) professional qualification, with more vacancies in medical courses and medical residencies, guided by new curricular

guidelines; 2) investments in the remodeling of primary health care units; 3) provision of more than 15,000 Brazilian and foreign physicians. The provision of physicians received more public exposure than the other proposed measures, provoking a lot of controversy.

Thus, the objective of this paper was to assess the component of the MDP that focused on provision of MDP physicians, according to the point of view and perceptions of city health managers.

## **Methodology**

The methodological emphasis of the current study was on the perceptions of the primary health care managers of various Brazilian cities, so the qualitative approach was the best option. Denzin and Lincoln<sup>19</sup> defined a qualitative approach as, above all, acting within a complex historical field. These authors also affirm that qualitative research is also, itself, a field of research; however, they state that qualitative research “[...] is a situated activity that places the observer in the world. It consists of a set of material and interpretative practices that gives visibility to the world” (p. 17).

The research was carried out in 32 cities, which met the following inclusion criteria: 20% or more of the population in a situation of extreme poverty; and registration in the first or second cycle of the MDP, with less than five physicians, and less than 0.5 physicians per 1,000 inhabitants prior to the program (June, 2013). The final selection of the city sample was randomized, with distribution proportional to the number of cities with the previously described characteristics for each Brazilian region, resulting in 14 cities in the North, 12 in the Northeast, three in the Southeast, two in the Midwest, and one in the South. Due to the characteristics described above, 98% of the physicians assigned by the MDP in the studied cities were brought in as part of a cooperation agreement with Cuba.

In each of the 32 selected cities, two managers were interviewed, preferably the municipal health secretary and the primary health care coordinator. Only in one city

was it not possible to interview two managers, because the second position was vacant at the time of the interview. Therefore, the study included the 63 managers of all the selected cities, since all of them agreed to participate in the study.

For specific purposes of obtaining empirical material, a semi-structured interview questionnaire was applied, which included some items regarding characterization of the respondents (socioeconomic aspects), questions that guided the interview, regarding subjects such as the structure of primary health care in the city, expectations related to the MDP provision component, and management contributions for the MDP, along with other possible questions that could lead to new questions based on the content that emerged from the statements of the respondents.

Regarding the interview, it is worth highlighting that it opened, as Poupart<sup>20</sup> pointed out, “[...] an access door to social realities [...]” (p. 215), namely, that it was possible to understand and grasp some issues related to the MDP based on the perceptions of the managers.

After the interviews were complete, they were transcribed and the resultant empirical material was analyzed with Atlas.ti software. The 63 transcribed interviews (from 32 cities) were organized according to a set of 23 semantic groups, generated by the main questions raised during the interview process. The categorizations were carried out by experienced researchers on semantically equivalent terms that were relevant to the study objectives. Eleven categories of analysis were included after predefinition by the group, taking into account the issues raised during several of the interviews.

Furthermore, the interviews were analyzed according to content analysis<sup>21</sup> theory, using Atlas.ti, Version 1.0.36 software<sup>22</sup>. Bardin<sup>21</sup> indicates that this analysis:

[...] is defined as a set of communication analysis techniques undertaken to obtain (quantitative and qualitative) indicators through systematic procedures and message content description objectives, allowing the inference of knowledge related to the conditions of the production (social context) of these messages. (p. 76)

The research complied with Resolution 466 of December 12, 2012 by the National Health Council, which regulates research studies. It is important to point out that an Informed Consent Form was created that conformed to this Resolution, guaranteeing compliance with bioethics principles. This protocol was reviewed and approved by the Research Ethics Committee of the School of Health of the University of Brasília, under no. 399.461/2013.

## **Results and discussion**

Interviews with 63 managers linked to City Health Secretaries were analyzed, in 32 selected cities for the research, which were distributed among the five Brazilian macro-regions. Among the interviewees, 43 (60%) were female and 21 (40%) male. There were 30 (46.9%) health secretaries, 24 (37.5%) primary health care coordinators, and ten (15.6%) who were assigned to other management positions in general coordination and administration. The mean age was 36.8 years (SD = 8.3), with a range from 24 and 58 years of age. 74% were under the age of 40. Regarding the characteristics of the city sampling, most of the interviewed managers were from the North (43.8%; n=28) and Northeast (40.6%; n=26) regions. Overall, the respondent managers had been in the position for an average of 1.87 years (SD = 1.63) in the position with length of stay ranging between 14 days and eight years. The city health secretaries had an average time in their position of 1.85 years (SD = 1.54), with range of 14 days to six years.

The analytical categories that emerged from the qualitative material are discussed below.

### **“We see a difference”: MDP professional provision contributions to the city**

It can be noted that the managers indicated that the MDP had made many contributions the city. They unanimously reported that a highlight was that provision of physicians to the city allowed increased access to medical care. Since the cities are



located in the interior of the states, the managers commented that by guaranteeing this provision, the MDP contributed to strengthening primary health care. Furthermore, they emphasized that the workload of program physicians was completed, which was a situation that many cities had not experienced before. The managers clearly expressed their satisfaction about having physicians working in primary care in the city from Monday to Friday.

[...] is strengthening the primary care, as I said; the issue about access, you know? We have a physician from Monday to Friday; in the old days, the physician used to come here to work with us and worked just three days at most, you know? The More Doctors physician really stays here from Monday to Friday with more commitment to the working time, access for the populations is higher, you know? He makes a lot of home visits. It is like this: it has improved primary care a lot, especially in the unit where he [the MDP physician] works, and we see the difference. (Health manager)

It reduced the shortage of physician here in the interior [...]. (Health manager).

This perception by the managers is justified since studies have shown that prior to the MDP, significant inequalities in access to medical care among populations throughout the Brazilian regions<sup>23</sup>. The Market Signs Research Station (EPSM) at the Federal University of Minas Gerais developed the Scale of Health Professional Shortage Areas (HPSA) in primary health care <sup>24</sup> and showed that the North and Northeast regions were the most affected by shortages of physicians<sup>25</sup>. Up to 2016, The MDP guaranteed the provision of 18,240 physicians distributed in 73% of Brazilian cities, reaching 63 million Brazilians without medical care<sup>26</sup>.

Another MDP contribution that was noted by most managers was improvements in primary health care indicators (such as prenatal and home visits) and health monitoring (such as increases in reporting of diarrhea and other illnesses requiring reporting).

We have a certain vision of the reality of our population, don't we? Based on health surveillance, in epidemiology we actually started to work on what public health is all about and the issue of the notification cases, research cases at the right time [...] the contribution was this: The indicators have been increased by the medical characteristic of being proper public health. (Health manager).

[...] I think some indicators improved a lot, such as prenatal and home visits [...]. (Health manager).

Although access to primary health care for the Brazilian population gradually expanded during the 1990s and 2000s, an evaluative cross-sectional study, carried out in 2005 in the South and Northeast regions, showed that a maximum of 50% of mothers made prenatal visits in the PHS units in the areas that covered their homes, with rates significantly higher in the FHS than in the traditional model in both regions. An average of six or more prenatal appointments was reached by approximately two-thirds of these mothers; therefore, there was still a significant percentage of pregnant women who did not have access to quality prenatal care<sup>27</sup>.

Another, more recent investigation was carried out in 2010, with 13,205 women who received prenatal and/or delivery care in the SUS, in 252 cities that were considered priorities for the reduction of child mortality, located in 17 Legal Amazon and Northeast states. The adequacy of the prenatal and delivery analyzed with regard to conformity with the process indicators proposed by the Brazilian Program for Humanization of Prenatal and Childbirth Care. Among the studied women, 75.4% had six or more prenatal appointments, but only 3.4% had access to prenatal care that was classified as adequate; childbirth care was considered proper for just 1% of the women. The study concluded that flaws in prenatal and childbirth care contributed to poor maternal-child health indicators in the Legal Amazon and the Northeast region<sup>28</sup>.

Another perception of the managers was improvement in the quality of the medical care provided to people from all age groups, from children to the elderly, especially to people with chronic diseases such as hypertension, diabetes, and asthma.

Great care for us, for our patients, especially chronic patients with diabetes, hypertension, and asthma; they have been monitored by the Cuban [physicians] like never before by other physicians. Not just the chronic patients, but also the children, during puerperium, and they provide care to everybody from children to the elderly. They are very active, very concerned, very committed, and do everything with quality. (Health manager).

Indeed, the literature on family and community health in Brazil indicates that the following are fundamental qualities for family physicians: a strong sense of responsibility for comprehensive and continuing care for people and families during health, disease, and rehabilitation; and an interest in a wide range of medical clinics, which implies providing assistance to people of all ages and with wide-ranging problems; and the skills for managing chronic illnesses<sup>29</sup>.

### **“Making the maximum of the minimum”: the clinical practice of the MDP physicians in primary health care**

Since the late 1970s, movements demanding changes in clinical practice have emerged. They are described in international and national publications, and criticize what has been called the “conventional medical model” or “the biomedical model” for oversimplifying the problems of being ill, and linking them mostly to processes that are purely biological and can be measured. There is no room in the structure of this model for the social, psychological, and behavioral dimensions of illness<sup>30</sup>.

The managers made comments about the practice of physicians prior to the MDP. They said that clinical practice was based on the biomedical model, was individual-centered, and was not concerned with the social and environmental determinants of health. Clinical practice suffered from a paternalistic and biomedical

bias in the physician–patient relationship. The managers also reported that the few medical professionals they were able hire in those cities were assigned to multiple duties and, consequently, suffered from work overload and lack of time to carry out care with quality.

The vast majority of the managers gave positive evaluations of the medical care provided. The positive aspects commonly mentioned included thorough medical care, with an effort to ensure the comprehension of users; adequate time spent on care for each user; performance of full physical exams; rational use of medications; respect for patients; responsible follow–up of the cases assisted; concern with treatment guarantees for users and troubleshooting; commitment to complying with the work schedule; an emphasis on preventive medicine; availability to carry out home visits and in more isolated areas that require long journeys; integration of clinical knowledge with the health status of the local population.

[...] the best possible, you know? Adequate and thorough care that evaluates everything, [...] she [the physician] examines everything, careful care [...] much more humanized care. She [the physician] makes the maximum of the minimum, you know? (Health manager).

[...] so i see that it improved a lot, the quality of her [the physician] care is good, like that, everything is in the medical record; she works hard on communication so we don't have problems with that [...] she gives more advice than what she is prescribing. She has a lot of advice. Besides, these Cuban physicians give us support in other areas. For example: we have a village here that we have to travel to by boat, beaches that we have to travel 3 to 4 hours by boat [...] they are always willing to go there with us [...]. (Health manager).

Considering the studies that analyzed the asymmetry of the physician–patient relationship in the FHS during the 2000s<sup>31</sup>, it is no surprise that most managers showed so much satisfaction with practice of the MDP physicians, since they noticed that the professionals of this program demonstrated time commitment, bonding with

patients and concern about continuity of patient care, punctuality and commitment to quality that they often had not experience in the past with other medical professionals.

Another aspect analyzed was the clinical practice of the MDP physicians. Most managers maintained that there was a positive difference: more time dedicated to each appointment; more thoroughness in performing anamnesis and physical examinations; fewer requests for additional exams; rational prescription of medications; more proximity and humanization in treating patient and toward their families; inclusion in the community; more frequent home visits; punctuality during consultation hours; concern with continuity of patient care; use of epidemiological data from the city; and prescription of medicinal plants. These differences in clinical practice can be attributed to the nature of medical training in Cuba, in which the “Education on Values” is emphasized and is part of the curriculum of that country<sup>32</sup>.

But this issue of humanized consultation, consultation from head to toe, thorough exam, and people feel more human. So, for me it is very positive, very positive, because if they treat them differently, the population complains, doesn't it? (Health manager).

Just like this, he [the physician] explains to you, he wants to know, he wants to know what is going on, he is concerned, he has this differential as well, he is concerned, just like that, he sees the patient and he wants to know about the follow-up and he has this characteristic [...]. (Health manager).

It is possible to think consider a different medical model in terms of health and subject concepts, similar to the Cuban physicians, that is drawn from experience with training based on education on work, in which the PHC context helps shape practice, and the education on values, having humanism as the key principle.

In Cuba, physicians are trained in healthcare centers and their first contact with theory and practice takes place while handling the health status of the people, and not exclusively with illnesses. Consequently, through a curricular reform in Cuban medicine courses that took place in the 1980s, one of the key features is what is called

Education on Values, which are cross-sectional contents of training, based on the Cuban medical ethical principles that, in their essence, express the following:<sup>32</sup>

To observe the ethical-moral principles of profound human, ideological, and patriotic content, to dedicate our efforts and knowledge to improving the health of people, to work where society requires, to always be willing to provide needed medical care, to dedicate efforts towards prevention, recovery, rehabilitation, and promotion of human health, to avoid the production of damage to healthy people or the ill in research. (Translated p. 142)

Furthermore, in a study carried out in a FHS in Ceará, in which four hundred medical appointments were observed, Caprara and Rodrigues<sup>31</sup> noted that the average time of appointments was nine minutes, varying from two to 24 minutes. In this same study, it was found that longer appointment times were associated with better quality of care. This study was carried out in Ceará, a state that has been recognized as having on average a good FHS organization, which demonstrates the insufficiencies of medical care even in such a city.

Most of health managers expressed satisfaction with the clinical practices of the MDP physicians, since they noted that the professionals of this program showed time commitment, bonds with patients and concern about continuity of patient care, which had not often been seen in the past.

### **“It is too early to say good-bye” vs. “It was a total change”: Are changes occurring throughout health care network as a result of implementation of the MDP?**

The provision of physicians through the MDP during these last two years of its existence has made many contributions to the country, especially for the 4,058 cities that received physicians from the program. This increase in the number of physicians has contributed to changes in the health care network, although the present study showed that significant number of managers reported that the time of implementation

in the city was not enough to allow evaluation of whether changes have taken place in the network. Others simply claimed that they had not seen any changes.

[...] it is too early to say that [whether the health care network has changed].

(Health manager)

No, the same thing. (Health manager)

According to Mendes<sup>33</sup>, health care networks are “polyarchic organizations of sets of health services [...], which allow for offering integral and continuing care to certain populations, coordinated by the primary health care provided in due course [...], with the proper quality and in a humanized fashion [...]” (p. 54). Yet they are capable of having a positive impact on the levels of health of the population.

In addition, most managers recognized that the MDP physicians perform their work in conformity with the PNAB, prioritizing preventive actions and following the FHS principles. In this sense, they carry out extramural activities, such as house visits and activities with the team in the community. They also participate in providing care to patients that is linked to the programs and are willing to report diseases.

[...] they [the MDP physicians] guide, work hard with prevention, are focused on family health [...] today the city health care network has improved a lot, and the programs work. (Health manager).

Definitely. It [was] a total change. Including us, we set up a schedule [...] for carrying out [...] traveling health care [...] to assist our riverside brothers, who need much more than those who are thirsty. (Health care manager).

It is important to emphasize that to be a family physician, one must provide the production of care, and be capable of valuing individuals and their environment, lending a qualified ear to listen to the needs of these individuals.

It should also be mentioned that the managers reported that, concomitant with the inclusion of the physicians in the FHS, there were investments in improving the infrastructure and acquisition of new equipment, including information technology. Another change mentioned was the hiring of other professional categories, such as physical therapists and speech therapists, and medical specialists, such as pediatricians and neurologists.

Structural and physical changes were made that bring more comfort to users, to get closer to the riverside communities. (Health care manager)

Our units are all being computerized for the entire population affiliated to that registered unit. [...] we are becoming 100% computerized. (Health care manager).

Many bedridden patients were identified by them [the MDP physicians] identified during their visits, so, there was a flow of patients that we had to get a physical therapist for. [...] a health care agreement with a clinic from another city for exams, medical specialists, which we don't have here (speech therapists, neurologists, pediatricians). (Health care manager)

There were divergent perceptions about the changes in the health care network with the implementation of the MDP; however, most respondents mentioned positive developments. Among the negative aspects expressed by the managers related to the organization of the health care networks were: local circumstances (the stage of the effective implementation of the SUS in the city); the distance from rural and remote localities; the difficulty of transferring patients; and setbacks in referral and counter-referral mechanisms.

Another important aspect of the perceptions of the managers was the strengthening of key elements of the FHD, such as health action planning; active searches for people with chronic diseases to guarantee continuity of the care; and



activation of special care with vulnerable groups, such as pregnant women and newborn children through the “Stork Network” program.

[...] we had to better organize the system so it could actually operate better [...]. Some time ago, the system was very disorganized [...] we are better organized in the primary care network, with schedules with goals to be reached. (Health care manager)

[...] our major change was to make PHC to operate the way it really should. [...] the FHS was what we really put to work, with an active search for patients who were “abandoned” by programs, they were able to reach out for them, bring them back to the unit so they could receive care again or continue with the appointments that used to be carried out monthly. (Health care manager)

It is important that health care to be seen as a dimension of human life that takes place in the intersubjective sphere. It is essential to note that there are various kinds of care and, yet, there is a pool of knowledge about this care<sup>34</sup>. Therefore, as shown by the excerpts from interviews with the managers, the practice of the MDP physicians has been shown to support safe and careful care that values the “human side” of users, through respect, hospitality, and attention to their suffering.

### **Final considerations**

The high turnover of physicians in primary care in Brazilian cities, associated with shortages in some localities, have compromised access to care and continuing care, which has a highly negative impact on the quality of the services offered to the population.

In order to face this challenge, the nation must be focused on efforts to prioritize public policies that allow the provision and securing of health professionals, especially physicians, to work jointly with Family Health Care teams, in order to

guarantee the consolidation of the SUS through the integrality of care and access to services that constitute the health care network in Brazilian cities.

The provision and securing of physicians in primary health care through the MDP, according to the accounts of the managers, have resulted in significant advances in improvements in health care, access to the network, and humanization of care. However, the sustainability of guaranteeing this right is linked to structuring the measures of the MDP, such as job openings, creation of new medical courses, policies regarding positions, careers, and salaries for health care professionals, and improvements in the infrastructure of healthcare units in compliance with the guidelines and strategies set forth by the PNAB.

The aim here is to reassert the importance of the provision component in the MDP in Brazil, and at the same time draw attention to expectations related to continuity, quality, humanization in care, access to other levels of care, and the effectiveness of actions developed by Family Health Care teams.

### **Collaborators**

CAM Arruda developed the article proposal, and participated in the collection, categorization, and analysis of the qualitative material, proofreading, completion of the final draft of the article, and approval of the final version of the paper. VM Pessoa and IVHC Barreto participated in the conception of the article and processing and analysis of the qualitative material. Y Comes and JS Trindade participated in the development of the introduction, methodology, and translations of the summaries. DD da Silva participated in the categorization of the qualitative material, profile of the managers, and standardization and format the article. LMP Santos and FF Carneiro coordinated the field work and participated in creation and revision of the final version of the article.

### **References**

1. Cotlear D, Gómez-Dantés O, Knaul F, Atun R, Barreto IC, Cetrángolo O, et al. Overcoming social segregation in health care in Latin America. *The Lancet*. 2014;14 (9974):1248–59.
2. Ministério da Saúde (BR). Departamento de Atenção Básica (DAB). Política Nacional de Atenção Básica. Brasília: Editora do Ministério da Saúde; 2011.

3. Andrade LOM, Barreto ICHC, Coelho LCA. A Estratégia Saúde da Família e o SUS. In: Rouquayrol MZ, Gurgel M. In: *Epidemiologia e Saúde*. 7a ed. Rio de Janeiro: Medbook; 2013. cap. 31, p. 601–21.
4. Instituto Brasileiro de Geografia e Estatística (IBGE). Coordenação de População e Indicadores Sociais. *Estatísticas da saúde: assistência médico-sanitária*. Brasília; 2016 [citado 2016 Jan 20]; Disponível em: <http://www.ibge.gov.br/english/estatistica/populacao/condicaodevida/ams/2009/ams2009.pdf>.
5. Victora CG, Aquino EM, Leal MC, Monteiro CA, Barros FC, Szwarcwald CL. Saúde de mães e crianças no Brasil: progressos e desafios. *The Lancet*. 2011; 6736(11):32–46.
6. Barreto ML, Teixeira MG, Bastos FI, Ximenes RA, Barata RB, Rodrigues LC. Sucessos e fracassos no controle de doenças infecciosas no Brasil: o contexto social e ambiental, políticas, intervenções e necessidades de pesquisa. *The Lancet*. 2011;6736(11):47–60.
7. Stein A, Harzheim E, Costa M, Busnello E, Rodrigues L. The relevance of continuity of care: a solution for the chaos in the emergency services. *Fam Prac*. 2002; 19(2):7–10.
8. Macinko J, Guanais FC, Souza MFM. Evaluation of the impact of the Family Health Program on infant mortality in Brazil, 1990–2002. *J Epidemiol Commun Health*. 2006; 60(1):13–9.
9. Schmidt MI, Duncan BB, Silva GA, Menezes AM, Monteiro CA, Barreto SM, et al. Chronic non-communicable diseases in Brazil: burden and current challenges. *The Lancet*. 2011; 377(9781):1949–61.
10. Dolea C, Stormont L, Braichet J–M. Evaluated strategies to increase attraction and retention of health workers in remote and rural areas. *Bull World Health Organ*. 2010; 88(5):379–85.
11. Wilson N, Couper I, De Vries E, Reid S, Fish T, Marais B. A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas. *Rural Remote Health*. 2009; 9(2):1060.
12. Rourke J. WHO. Recommendations to improve retention of rural and remote health workers—important for all countries. *Rural Remote Health*. 2010;10(4):1654.
13. Maciel Filho R. *Estratégias para a distribuição e fixação de médicos em sistemas nacionais de saúde: o caso brasileiro*. Rio de Janeiro: IMS – Instituto de Medicina Social; UERJ; 2007.
14. Pinto HA, Sales MJT, Oliveira FP, Brizolara R, Figueiredo AM, Santos JT. O Programa Mais Médicos e o fortalecimento da atenção básica. *Divulg Saúde Debate*. 2014; (51):105–20.
15. Schimith MD, Weiller TH. PROVAB: potencialidades e implicações para o Sistema Único de Saúde. *J Nurs Health*. 2014;3(2):145–56.
16. Ministério da Saúde (BR). Pacto Nacional pela Saúde Mais Médicos. [Internet]. Brasília: Ministério da Saúde; 2016 [citado 29 Mar 2016]. Disponível em: [http://bvsms.saude.gov.br/bvs/publicacoes/pacto\\_nacional\\_saude\\_mais\\_medicos.pdf](http://bvsms.saude.gov.br/bvs/publicacoes/pacto_nacional_saude_mais_medicos.pdf)
17. Conselho Regional de Medicina do Estado de São Paulo (CREMESP). Estudo de Projeção “concentração de Médicos no Brasil em 2020”. [Internet]. São Paulo: CREMESP; 2016 [Citado 29 Mar 2016]. Disponível em: <http://www.cremesp.org.br/?siteAcao=NoticiasC&id=2528>.

18. Frente Nacional de Prefeitos. Petição Cadê o Médico? [Internet]. Brasília: FNP; 2013 [citado 25 Jan 2016]. Disponível em: <http://cadeomedico.blogspot.com.br/p/peticao.html>.
19. Denzin NK, Lincoln YS, Giardina MD. Disciplining qualitative research 1. *Int J Qual Stud Educ*. 2006;19(6):769–82.
20. Poupart J. A entrevista de tipo qualitativo: considerações epistemológicas, teóricas e metodológicas. In: Poupart J, Deslauriers JP, Groulx LH, Laperrière A, Mayer R, Pires A. Organizadores. *A pesquisa qualitativa: enfoques epistemológicos e metodológicos*. Petrópolis: Vozes; 2008. p. 215–53.
21. Bardin L. *Análise de conteúdo*. Edições 70; 2011.
22. Muhr T. *ATLAS.ti. Versão 1.0.36 (129)*. Berlin: Scientific Software; 2013.
23. Campos FE, Machado MH, Girardi SN. A fixação de profissionais de saúde em regiões de necessidades. *Divulg Saúde Debate*. 2009;1(44):13–24.
24. Estação de Pesquisa de Sinais de Mercado (EPSM). *Construção do índice de escassez de profissionais de saúde para apoio à Política Nacional de Promoção da Segurança Assistencial em Saúde*. Belo Horizonte: Universidade Federal de Minas Gerais, Faculdade de Medicina, NESCON; 2010 [citado 18 Dez 2015]. Disponível em: <https://www.nescon.medicina.ufmg.br/biblioteca/imagem/2443.pdf>.
25. Estação de Pesquisa de Sinais de Mercado (EPSM). *Identificação de áreas de escassez de recursos humanos em saúde no Brasil: Relatório final de atividades* [Internet]. Belo Horizonte: EPSM/NESCON/FM/UFMG; 2012 [citado 18 Dez 2015]. Disponível em: [http://epsm.nescon.medicina.ufmg.br/epsm/Relate\\_Pesquisa/Identifica%C3%A7%C3%A3o%20de%20%C3%A1reas%20de%20escassez%20de%20RHS%20no%20Brasil.pdf](http://epsm.nescon.medicina.ufmg.br/epsm/Relate_Pesquisa/Identifica%C3%A7%C3%A3o%20de%20%C3%A1reas%20de%20escassez%20de%20RHS%20no%20Brasil.pdf).
26. Ministério da Saúde (BR). *Programa mais médicos – dois anos: mais saúde para os brasileiros*. Brasília: Ministério da Saúde; 2015. p. 128.
27. Tomasi E, Facchini LA, Thumé E, Piccini RX, Osorio A, Silveira DS, et al. Características da utilização de serviços de Atenção Básica à Saúde nas regiões Sul e Nordeste do Brasil: diferenças por modelo de atenção. *Cienc Saude Colet*. 2011;16(11):4395–404.
28. Leal MC, Theme-Filha MM, Moura EC, Cecatti JG, Santos LMP. Atenção ao pré-natal e parto em mulheres usuárias do sistema público de saúde residentes na Amazônia Legal e no Nordeste, Brasil 2010. *Rev Bras Saúde Materno-infantil*. 2015;15(1):91–104.
29. Lopes JMC. Princípios da Medicina de Família e Comunidade. In: Gusso G, Lopes JMC, Organizadores. *Tratado de Medicina de Família e Comunidade: princípios, formação e prática*. Porto Alegre: Artmed; 2012. p. 1–11.
30. Engel GL. The need for a new medical model: a challenge for biomedicine. *Science*. 1977;196(4286):129–36.
31. Caprara A, Rodrigues J. A relação assimétrica médico-paciente: repensando o vínculo terapêutico. *Ciência Saúde Colet*. 2004; 9(1):139–46.
32. Bustamante Alfonso LM. La educación en valores en trabajadores de la atención primaria de salud en Cuba. *Rev Cuba Med Gen Integral*. 2010;26(1):138–46.

33. Mendes EV, Minas G. Os fundamentos para a construção e os elementos constitutivos das Redes de Atenção à Saúde no SUS. Minas Gerais Escola de Saúde Pública do Estado de Minas Gerais Implantação do Plano Diretor da Atenção Primária à Saúde: Oficina I-Redes de Atenção à Saúde. Belo Horizonte: ESPMG; 2009. p. 50-6.

34. Mattos RA. Cuidado prudente para uma vida decente. In: Pinheiro R, Mattos RA, organizadores. Cuidado: as fronteiras da integralidade. Rio de Janeiro: CEPESC\UERJ, ABRASCO; 2006. p. 119-132.

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