Artigo Original

Recebido em: 10/10/2022 | Aceito em: 21/12/2022

Evaluation of the *Mais Médicos* (More Doctors) Program from the perspective of users

Avaliação do Programa Mais Médicos da perspectiva dos usuários

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Abstract
Introduction: The More Doctors Program (PMM) contributed to expand the coverage of Primary Health Care (PHC). Objective: To analyze, according to the experience of users, challenges and benefits of pmm. Method: Evaluation research of concomitant mixed method conducted in Tangará da Serra - Mato Grosso, with users registered in the area of coverage of family health units that had in their team doctors of the PMM, during the period from 2016 to 2018. For quantitative data, descriptive analysis was generated using IBM SPSS® software version 21. Qualitative Solutions Research NVivo® 10 software was used for thematic analysis, which provides presentation in two categories, "PMM: from distrust to recognition through medical practice" and "User-friendly practice and bonding: two-way". The mixing of the data explored the completeness of the information collected. Results: 1036 users participated, in favor of the Program, reporting overcoming language communication; recognition in improving access to medical consultation with decreased waiting time. There is satisfaction with the practice of the professional, arouses mutual contributions between users and the professional, expanding possibilities of co-responsibility with health in the territory. Conclusion: It is revealed subsidies from the PMM in the municipality, which designed the expansion of coverage with recognition of its users, greater possibility of effecting attributes of PHC and fostering the organization of a care network, at the same time the challenge of sustainability of this proposal due to the dependence on cooperation of the Program.
Keywords: health policy; primary health care; program evaluation; health management; health human resource evaluation

Resumo
Introdução: O Programa Mais Médicos (PMM) contribuiu para ampliar a cobertura da Atenção Primária a Saúde (APS). Objetivo: Analisar, segundo a experiência de usuários, desafios e benefícios do PMM. Método: Pesquisa avaliativa de método misto concomitante realizada em

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Tangará da Serra – Mato Grosso, com usuários cadastrados na área de abrangência de unidades de saúde da família que tinham na sua equipe médicos do PMM, durante o período de 2016 a 2018. Para os dados quantitativos a análise descritiva foi gerada por meio do *software* IBM SPSS® versão 21. Para a análise temática dos dados qualitativos foi utilizado o software *Qualitative Solutions Research NVivo*® 10 que oportunizou apresentação em duas categorias, "PMM: da desconfiança ao reconhecimento por meio da prática médica" e "Prática acolhedora ao usuário e o vínculo: via de mão dupla". A mixagem dos dados explorou a completude das informações levantadas. Resultados: Participaram 1036 usuários, em maior frequência a favor do Programa, relatam superação quanto à comunicação do idioma; reconhecimento na melhoria do acesso à consulta médica com a diminuição do tempo de espera. Existe satisfação com a prática do profissional, desperta contribuições mútuas entre os usuários e o profissional, ampliando possibilidades de corresponsabilidade com a saúde no território. Conclusão: Revela-se subsídios do PMM no município, que projetou a ampliação da cobertura com reconhecimento de seus usuários, maior possibilidade de efetivar atributos da APS e fomentar a organização de uma rede de atenção, ao mesmo tempo o desafio da sustentabilidade dessa proposta pela dependência de cooperação do Programa

Palavras-chave: política de saúde; atenção primária à saúde; avaliação de programas e projetos de saúde; gestão em saúde; avaliação de recursos humanos em saúde

Introduction

In the Unified Health System (SUS), Primary Health Care (PHC) has become the main level of care to recognize the needs and problems of the population, but also to coordinate the organization of health care in health care networks (HCN). The Family Health Strategy (FHS) has been the main model of PHC in the country[1], but its progress depends on policies that strengthen the infrastructure, the allocation of personnel, the guarantee of material resources, as well as the constant qualification of the work process, especially in those places that are originally disadvantaged of health services and that face difficulties to establish health teams, especially physicians with training for work in PHC.

In 2013, the federal government of Brazil created the *Mais Médicos* (More Doctors) Program (MDP), which proposed to reduce inequities, particularly in PHC services, in order to face the problem of heterogeneous distribution of physicians in Brazilian states. Planned actions were taken to expand short-term vacancies of physicians, providing emergency provision for more vulnerable areas, with support for qualifying the infrastructure of health units, and for long and medium term strategies were agreed to expand the number of vacancies in undergraduate and residency courses[2].

The municipality of Tangará da Serra – Mato Grosso benefited from two MDP axes, that of emergency provision of physicians to compose FHS teams and qualification of the infrastructure of health units, both for construction and/or renovation, and for expansion. It is noted that the federal induction of the MDP was decisive for the expansion of PHC in this municipality, which in addition to expanding coverage in the urban area, provided a greater presence of medical work in the rural area, in indigenous territories, districts and settlements.

PHC coverage in Tangará da Serra from 2013 to 2018 was 47.61% in 2013, reaching 98.3% in 2016 and 83.99% in 2018[(3)]. The expansion required health management strategies both to qualify and expand the infrastructure, as well as to train a staff of professionals for the family health teams, in addition to a study of the territory to map and define areas of expansion.

The fact that the MDP provides greater access to medical consultation at the primary level, the look of users assisted in daily life in health units can contribute to

capture the understanding of the experience of the Program, especially if this proposal is made after a period of implementation, which justified the period selected for this study. In this sense, this research was guided by the following questions: what are the considerations of family health users about the MDP? In the users' perception, was the MDP able to expand access to the PHC in Tangará da Serra, consequently, was it also able to expand the medical consultation? Thus, this study aimed to analyze, according to the experience of users, challenges and benefits of the MDP.

Materials and Methods

This is an evaluative research[4] of concomitant mixed method (Quanti+quali), carried out through a cross-sectional study and qualitative data approach. It was held in the municipality of Tangará da Serra, located in the state of Mato Grosso, in the middle northern region of Mato Grosso, 240 kilometers from the capital, with an estimated population of 107,631 people in 2022 [5].

The city was chosen because it is of medium population size; it has a care network composed of different types of services (PHC units, specialized services and hospitals, of public and private nature), in addition to being a regional reference in the agreement of services in the health region; it has difficulty fixing physicians in PHC, despite being geographically located near the state capital, which has medical training centers; and that after joining the MDP there was a significant increase in PHC coverage through FHS teams, with a strong presence of exchange physicians. According to the data[6], during the period from 2014 to 2018, of the 54 physicians who passed in the MDP, 57.4% were foreigners and of these 90.3% Cubans.

In the period from 2016 to 2018, by convenience sampling, registered users in the area covered by family health units that had physicians from the MDP in their team were invited to participate in the research. The users who were being treated with scheduling on the day the researchers visited the health units were taken into account for participation. The inclusion criterion was that they had been followed by physicians for at least three months in consultations/monitoring and/or diagnosis and that they were scheduled on the day of the interview for medical consultation, and cannot be spontaneous demand. Patients under 18 years of age, bedridden in home treatment and companions of users were excluded.

To provide opportunities for the participation of different groups of users, an agenda was established with the health services. The team that integrated the research had no link with the health services, was trained and calibrated to carry out the data collection. On different days of the week in the two periods, morning and afternoon, interviewers approached and invited users who were scheduled for medical consultation. The inclusion criteria were verified and the invitation to participate in the research was made after the medical consultation. Upon acceptance of the user, the signing of the Informed Consent Form was requested, the interviews took place at the health unit, in a reserved space and distant from the other users. In the case of changing the medical professional of the unit, for any reason, it was decided to return to the unit after six months of work of the new professional, being justified to ensure better reliability of the data. There was no collection during the physician's vacation period, and the research was returned to the unit after one month that the professional had resumed his duties.

The structured script contained variables organized in three parts: socioeconomic characterization; opinion regarding the MDP and medical conduct. At the end of each part there was a space that asked users to comment on aspects that they

considered relevant about the items addressed in the questions asked. These items were repeated to the users at the end of each part. A pre-test was performed. The data were filled in the script and the open questions, referring to the completion of each part, were audio recorded. For the quantitative data there was double typing in an electronic spreadsheet. The interviews were transcribed by the interviewers of the research. After completion of the transcription, the researcher included, in parentheses, additional information from the field diary. This stage was checked by three coordinators who followed the field research. To ensure the anonymity of the participants, it was identified by the letter "U" of the user, for example: U1, U2, U3. The material composed a database saved in a Word document.

Quantitative data analysis was performed using descriptive statistics, using IBM SPSS® software version 21 and the data were presented in tables with their absolute values and respective percentages. For the categorization of qualitative data, exhaustive readings of the content and extraction of information pertinent to the analysis and attached in the format of documents were carried out, which allowed coding of the "Nodes", identifying the terms and categorization, aided by the Qualitative Solutions Research NVivo® 10 software.

The coding process was performed by two researchers separately. To ensure greater reliability, the data were cross-referenced. The content analysis technique of the thematic categorical type was used [7]. The results were organized, from the codification into two categories: "MDP: from distrust to recognition of medical practice" and "Embracing practice to the users and the bond: two-way path".

The study was approved by the Human Research Ethics Committee CAEE: 49419315.3.0000.5166.

Results

From 2016 to 2018, 2694 users were invited to participate in the study, of which 1872 met the inclusion criteria and 1036 users agreed to participate in the study. Table 1 shows the socioeconomic profile of the participants. The highest frequencies were women, the age group was 30 to 44 years, the skin color was white, married with children, some had government assistance from the Bolsa Família program, the housing condition was financed and lived in the urban area (Table 1).

Table 1 - Socioeconomic characteristics of users of family health units, Tangará da Serra - Mato Grosso, Brazil, 2018

	N	%
Sex		
Number of women interviewed	843	81.4
Number of men interviewed	193	18.6
Age group (years)		
18 I--- 30 years	177	17.1
30 I--- 45 years	303	29.2
45 I--- 60 years	295	28.5
60 years over	261	25.2
Skin color		
White	952	91.9
Black	24	2.3
Yellow	20	1.9
Brown	36	3.5

Indigenous	04	0.4
Marital status		
Single	78	7.5
Married/Cohabitation	878	84.8
[ ] Divorced/Separated	52	5.0
Widowed	28	2.7
Children		
Yes	981	94.7
No	55	5.3
Government aid		
Bolsa Família (Family Allowance)	110	10.6
Health insurance		
Yes	21	2.0
Housing		
Own house	85	8.2
Financed house	728	70.2
Rented house	209	20.2
Given house	14	1.4
Zone		
Urban	997	97.2
Rural	29	2.8

Source: Research Database, 2018.

The MDP: from distrust to recognition of medical practice

Most users reported that they knew the MDP and said they were in favor of the Program (Table 2).

Table 2 – Knowledge and evaluation of family health users about the MDP, Tangará da Serra - Mato Grosso, Brazil, 2018

	N	%
Are you familiar with the *Mais medicos* (More Doctors) Program (MDP)?		
Yes	789	80.8
No	172	17.5
Does not know	17	1.7
Are you for or against the More Physicians Program?		
I'm in favor of the MDP	695	71.3
Indifferent	204	20.8
I'm against the MDP	35	3.5
I do not know what is the MDP	27	2.7
I don't know the MDP	17	1.7

Source: Research Database, 2018.

Some users reported that, initially, they distrusted the physicians of the MDP. There are statements about communications in the local media or in the comments of physicians who already worked in the municipality, that the MDP physicians *"they are not doctors"* U37, they were *"improved nurses" U106, "they do not have a degree in medicine" U178, "they came to take a course to graduate here" U191, "it is illegal for them to exercise the profession because they did not have the registration with the Regional Council of Medicine"* U239.

Another aspect mentioned by the participants was the position of the local medical professional category in linking the information that the MDP physicians, especially Cubans, did not have the ability to work, as can be seen in the statements: "*the doctor who used to work here at the post told me that I could not accept the change, especially if it was a Cuban*" U58 and *"the doctor who assisted me said that Cubans are not trained as physicians, they do not know how to prescribe medication. You have to be careful if you receive instruction for medications from them"* U146.

However, after the time of contact with the physicians of the MDP there are reports of users who changed their position. For example: *"at first I was suspicious of coming here to be seen by him, but my neighbor came and spoke very well of him, so I came and liked him"* U356, *"in fact I was afraid, yes. I brought my son for a consultation, he gave us very good assistance and all was fine. At my son's consultation he gave me medical care too. He suspected that I had high blood pressure and after the exam he confirmed that I am hypertensive. He is good"* U791.

With the increase in PHC coverage, users more frequently recognized easier access to medical consultation, with a time of three to seven days to schedule the consultation, if it was not an emergency demand. Considering the relation to waiting time, they affirm that it did not take long; they feel satisfied with the waiting for care at the health unit and the waiting time for the consultation at the unit (Table 3).

Table 3– Opinion of family health users regarding access to medical consultation, Tangará da Serra - Mato Grosso, Brazil, 2018

	N	%
Do you think that with the MDP the number of consultations increased and the waiting time for medical care decreased?		
Yes	1015	98.0
It continues in the same way	10	1.0
I do not know	11	1.0
Was it easy to schedule this medical consultation?		
Yes	997	96.2
No	39	3.8
Number of days to schedule the consultation		
Up to 3 days	94	9.1
3 7 Days	612	59.0
7 days or more	330	31.9
Regarding the time to schedule the medical consultation, you think that:		
It took way too long	50	4.8
It took long	32	3.1
It took a while	47	4.5
It did not take long	907	87.6
Regarding the waiting time to be consulted, you feel:		
Very satisfied	265	25.6
Satisfied	695	67.1
Dissatisfied	34	3.3
Very Satisfied	42	4.1
How do you see the waiting time for a consultation at the health unit		
It took way too long	02	0.2
It took long	22	2.1
It took a while	967	93.3
It did not take long	45	4.3
How do you feel about the waiting time during the assistance at the health unit		
Satisfied	1010	97.5
Dissatisfied	24	2.3
Very satisfied	02	0.2

Source: Research Database, 2018.

In the opinion of the users, the contribution of the MDP to the access to medical consultation was evident, as can be seen in the statements: *"before that, I had to wake up at dawn to go to the central post to try a ticket for place in the cue, now I have a doctor in the neighborhood"* U65, *"the consultation was not like this here in the neighborhood, I have lived here for 27 years and never had a health unit in my neighborhood, it has been two years since it opened and now I can schedule it faster" U247, "I have been without medication for pressure because I could not schedule the consultation at the other post, I often went and had already filled the quota of people outside their area"* U849.

The waiting time for consultations was considered satisfactory for most of the users, who reported *"it used to be more difficult to get a consultation, it took longer, because the doctor only came here once a week"* U138 *"now I come to the unit every month to control my blood pressure"* U67, *"this prenatal I'm doing right, because in the first I went only three times, there was no vacancy in the other unit"* U459 *"if there is no vacancy for the day I come, they already schedule me for another date, it has already occurred that a patient missed the consultation and the receptionist called me to come before my date"* U345, *"I never waited more than three days to be seen if there was no vacancy"* U762.

The highest frequency of users who participated in the study had already consulted with a MDP physician, and the foreign variable was the most reported, reaffirming the protagonism of this segment. Regarding the comprehension of the language, the highest frequency reports being understandable and that there was no communication difficulty, not bothering them because they did not pronounce the Portuguese language correctly, not having an influence on the development of the consultation. The users more frequently trusted the physician, verbalized cordiality and attention to the reason for the consultation, with an interest in evaluating and clarifying the health status of the user in the consultation, showing in a way an attempt by the medical professional to adapt the best language for the users to understand his evaluation, being considered that they were satisfied with the explanations. The users showed confidence in the practice of the physician and in his prescription/recommendations in face of their demand, checking that there is no doubt about the competence of the professional. The time of up to 20 minutes of consultation was more frequently recorded, stating that the demand was solved, considering the good service (Table 4).

Table 4 – Characteristics of the medical profile, medical consultation and the feeling of family health users in the face of care, Tangará da Serra - Mato Grosso, Brazil, 2018

	N	%
Have you ever consulted with another physician in PHC health units?		
Yes	821	79.2
No	215	20.8
The physician who attended you is:		
Foreigner	809	92.7
Brazilian	227	7.3
If foreign: How well do you think the doctor's speaks Portuguese?		
Speaks well	186	22.9
It is not understandable	13	1.6
It's understandable	610	75.5

	N	%
If foreign: Did you have difficulty communicating?		
Yes	195	24.1
No	614	75.9
If foreign: Did this fact bother you?		
Yes	248	30.6
No	561	69.4
If foreigner: Do you think this influenced the consultation?		
Yes	202	24.9
No	607	75.1
Did you feel you can trust the doctor during this service?		
Yes	1012	97.7
No	05	0.5
More or less	19	1.8
Was the doctor friendly when he/she saw you?		
Yes	984	95.0
No	52	5.0
Did the doctor listen carefully to your complaints and the reason for the consultation?		
Yes	978	98.3
No	58	1.7
Has the doctor shown interest in evaluating your case?		
Yes	995	96.0
No	41	4.0
Did you receive information and clarification about your health status?		
Yes	957	92.4
No	79	7.6
Did you understand the language used by the doctor?		
Yes	917	88.6
No	119	11.4
Did the doctor give you an opportunity to express your opinion?		
Yes	994	95.9
No	42	4,1
How do you feel about the doctor's explanations about your need?		
Very satisfied	37	3.6
Satisfied	976	94.2
Dissatisfied	23	2.2
Did you feel you can trust the doctor to solve your problem?		
Yes	998	96.3
Just so so	38	3.7
Did you feel you can trust the prescription/recommendation that the doctor gave you?		
Yes	1018	85.8
No	18	14.2
Do you have doubts about the competence of the doctor who saw you?		
No	1004	96.9
I do not know	32	3.1
How long do you think your consultation lasted?		
5 minutes	69	6.7
10 minutes	153	14.8
15 minutes	123	11.9
20 minutes	658	63.5
25 minutes	33	3.2
At the end of the consultation you think that your demand:		
Was solved	995	96.1
Was partially resolved	25	2.4
Was not resolved	16	1.5
In general, how do you evaluate the care provided by the doctor?		
Excellent	382	36.9
Good	426	41.1

	N	%
Regular	160	15.4
Bad	57	5.5
Very bad	11	1.1
Do you prefer the care of a Brazilian or foreign doctor?		
Brazilian	34	3,3
Foreigner	32	3.0
It doesn't make any difference.	971	93.7
Do you think that there is a difference in care provided by the MDP doctor and the others who already worked in the PHC units?		
Yes	1.017	98.1
No	08	0.8
I do not know	11	1.1

Source: Research Database, 2018.

It was noted that the lack of mastery of the Portuguese language resulted in difficulty in conducting the consultation by the physicians; to overcome this challenge, initially, the work was recorded together with the nurses, until the physician was able to express himself better, as can be seen in the speech stratum: *"At the beginning I did not understand much what he said, but the nurse followed the consultation and what he did not understand he would ask her"* U72, *"the first time I was seen, he did not understand what I said, in other consultations I came together with the nurse, but he was already speaking "portunhol", he saw me alone. We even laughed remembering how it was at the beginning"* U138. However, it was noticed that users pondered between the difficulty in communication and the opportunity to have a physician to see them: *"now I have a doctor and unit, if we need I use Google translator for him to understand"* U149; *"just by having a doctor I'm already happy, the issue of speech we will manage until it works"* U395; *"I can't complain, before I had to go to the central post, wake up early to get a ticket for place in the cue to schedule the consultation, now I schedule here near home, it's very good"*.

The physician's practice was analyzed by the users as satisfactory. It is noticed charisma and cordiality in the service, *""she is very attentive and explains so calmly, I have been to many doctors, but only she had a charisma that won me over"* U647, *"he is always very polite and attentive"* U1012. In the reports, it is possible to verify the anamnesis being guided by questions about food, medication control, investigation to the user's demand and monitoring of the case. *"He asks a lot of questions about how I am, especially about my diet"* U33, "he *asks me to tell him how my sleep is, my scolding at home and my relationship with my children"* U915, *"every time I come he talks about my weight and the diet I need to take care of"* U71, *"he got my blood pressure medication right, before I went to the UPA because I lost control, it has been almost a year that this does not happen"* U785, *"he found out that I have panic disorder, he and the psychologist he referred me to, they are treating me, so I trust him"* U493, *"my son always fainted, it was thanks to him and his persistence in the exams that we discovered a cancer"* U892, *"she does not let me miss the return, I remember once she requested a routine exam and I did not take it to her, she asked to the CHA to go to the house and say that she wanted to talk to me"* U583.

Although the greater frequency of users stated that they did not have a preference for care among Brazilian and foreign physicians, there were differences in the care of the MDP physician with others who already attended the PHC (Table 4), according to the statements, the main comparisons were in relation to the

cordiality and listening of the professionals, punctuality and commitment to the workday: *"I was not used to a doctor who greeted me, who pulled the chair to sit"* U380, *"this doctor is now very polite, he does not shout my name from his office, he comes to the door and calls me. The others were like a thunder and if the patient didn't get in quickly, he would call another one" U749, "our neighborhood was lucky to have a doctor like that, those who went to the central post were completely uninterested" U742, "I come to the unit he is here, different from the old days that there was only one period and look there"* U892, *"the is in the unit, I came when I had no consultation scheduled, at the end of the morning, and he still received me"* U1005.

Two weightings were frequent in the statements about the MDP. The first concerns the vacation period of visiting physicians who left the unit for a while without medical care; *"when he went on vacation the unit had not a single doctor for almost three months"* U54, *"on his vacation we could not easily consult because he was a doctor who came once a week and in a single period"* U149. The second concerns the exchange of professionals for completion of the mission, related to Cubans, and leaving the professional for personal reasons, a situation that weakens the bond in PHC; *"two doctors have already been here, when we are getting used to it and having more confidence, they change the doctors"* U82, *"it is bad to have a change of doctor, the old doctor was a love of a person and understood me, this new one is not like her"* U361, "*when change is bad, because we are already used to it, in my case I thought it was bad because this new one does not give so much attention to us"* U659.

Embracing practice to the user and the bond: two-way path

This category explores qualitative data that show the relevance of the PHC work in the territory, contributing to establish a bond, bring the professionals closer to the family and conduct care practices with the family health team. Social representations constructed by professional-user interaction in the daily routine of health services are identified. Mutual exchanges of reception are shown for both actors, based on simple ways of building bonds and health care.

Regarding the issue of language, which would represent a problem, it resulted in a strategic condition of approaching among users and professionals, which may have contributed to increase the bond. There were reports of users who helped physicians with the Portuguese language, *"on Fridays in the afternoon he did not work in the unit so he came here to my house for me to teach him Portuguese" U751, "I am a teacher and thus I wanted to help them, in speech and writing, we set up a group with five doctors and on Saturday mornings they practiced Portuguese"* U394.

Another aspect concerns the proximity and identification that the users had with the daily life of the physicians, in this case more related to Cubans, for example; *"he lives here in the neighborhood, takes the bus with me, it doesn't even seem like he is the doctor"* U53 *"she comes to work in the unit in a bicycle"* U251 *"the doctor of the unit plays ball with my kids on the block of the neighborhood"* U690 *"I invited him to come for lunch at my home and he came"* U774, *"he is far from his country, he is alone. Our group* [seniors] *welcomed him"* U552.

Regarding the space for dialogue during the consultation, the users commented that: *"it is a consultation full of laughter, it is a therapy"* U45, "*she is very smiling, talkative and is always in a good mood, she cheers up the day"* U149, *"I never saw him in a bad humor, only the day*

I said that I did not take the right medicine, but then he opened his smile and told me that I wanted to see him sad" U370.

There were reports that showed the care that the physician had with the monitoring of his user, including external visits to the home environment, including using communication technologies, for example: *"he went to the hospital to see my son hospitalized and wanted to talk to the doctor of the hospital"* U503, *"she accompanied me for six months in my house when I had to stay in bed because of an accident"* U825, "*she called me to check on me, when I went to do chemotherapy"* U569.

Actions of some physicians were reported as motivating for some users in relation to adherence to treatment, reinforcing the use of communication technologies, for example the strategy of using groups on *WhatsApp* with users of care programs was perceived as facilitating communication with the health service and the physicians. The reports express, for example: *"there is a group on WhatsApp and in the morning the doctor always posts a photo so we do not forget that we have to take the medication"* U1005, *"our group of the walk is the most excited and if someone misses the day one pulls the other and looks that the doctor is excited and walks with us"* U772, *"I take medication for leprosy and has to be sure, the doctor made a group on WhatsApp with me and the nurse and the CHA. Every day is someone there asking me how I am?"* U493, *"he put me in the group of people with high blood pressure. Early on, he passes the message telling us to take the medication and not forget to control it in the spreadsheet he gave"*U170; *"our group of pregnant women, in addition to meeting every month, we have WhatsApp that each one posts questions and their experiences or something that we found interesting and if something is wrong, the doctor or the nurse soon tell us not to follow that"* U436.

Users reported that the monitoring of the physician after initial care of a demand was considered important. It is identified that the attention most present in the user's life made it possible to identify the complaint, as it can be verified: *"I started having high blood pressure and headache, she asked me to monitor the pressure in the unit every day and I came every two days to talk to her in the late afternoon, I did this for three weeks and she later told me that it could be anxiety, so I am going to the psychologist to see if it is true, but my pressure has already improved"* U154, *"I came here because of an intimate problem,* [Sexually Transmitted Disease], *he was very attentive and referred me to the TCC* [Testing and Counseling Centers] *after I did the consultation there he went to my house to advise me and my wife about the treatment*" U591.

Some users reported the practice of physicians who encouraged the planting of fruit trees and vegetables in the backyard of the houses. It is possible to notice the physician's approach to the user's residence*: "the doctor came home and saw my backyard, he said that in addition to the flower I had to have a fruit tree, you believe he brought a tangerine seedling"* U09, *"the doctor said that I had to plant chayote and lemon balm in the back of the house to also use along with the medication"* U27, in addition to involving professionals and users for this practice in the unit *"he encouraged us to make a community garden here at the bottom of the unit; now we have a lot and we distribute it in the group of collaborators when we can already harvest"* U361.

Discussion

The profile of the participants reflects characteristics of care provided in family health units in the country[8,9]. The higher frequency of housing conditions financed shows a reality of a city with

strong economic growth, in addition to financial induction of the State under construction of housing programs. The record of little presence of men in follow-up consultations can signal gaps in care and follow-up to this population segment, recorded many times due to lack of time and preference for self-medication[10].

The experience of municipalities that had a significant increase in PHC coverage, through the MDP, can reveal several strategies in the conduct of the Program[11] and in the support of the health care model. During the research, in Tangará da Serra, strategies had not been established to extend the working hours beyond the working hours in PHC health units, a situation that may restrict access to a large portion of the population that has a work relationship with working hours at that time. In countries that have strong PHC, for example in the United Kingdom and Canada, the service journey reaches up to 24 hours a day, with support for user communication channels through telehealth[12, 13] and in Spain extended shifts reach up to 21 hours of service[13].

It is worth mentioning that the investment in the strengthening of PHC through the MDP faced intense positions of medical entities in a fierce confrontation for its support, reflecting on different opinions of the media and society, including causing several clashes about the program and its contribution to the strengthening of PHC in the country[15,16]. A fact that happened in Tangará da Serra, but that the users' interaction with the MDP professionals allowed them to demystify many of the uncertainties that surrounded them.

It is noticed that the MDP had a representation for the users built in the interrelationships with the professionals, in the context of the daily work. This fact may signal an evaluation of the Program, due to its ability to involve people who attend health services to understand the quality of care provided, which enhances the evaluation of the service response from the perspective of those who experience the actions of the unit and not those who do not use it[17].

The participants, more frequently, consider that with the MDP contributed to the expansion of PHC, consequently facilitating access to medical consultation, scheduling considering that the waiting time for the consultation did not take long, feeling satisfied. It is noteworthy that the lack or low supply of a primary health service in the territory contributes to a perception of improved access. In the literature, it is possible to verify that the MDP was able to increase medical care in the country and health services in PHC[18,19], as well as contributing to a positive impact on health indicators[20].

With the MDP, from the perspective of the participants, the PHC has become more accessible with regard to medical consultation, but it should be noted that this increase in access causes increased demands on the care network that supports the PHC, especially the network of specialists and diagnosis. The non-restructuring and investment in other levels of care to meet this demand may contribute to greater fragmentation of care, impacting equity and comprehensiveness, in addition to the low resolvability of the health system.

The large portion of the study participants was attended by foreign physicians. In the first years of the MDP there was a greater participation of this medical segment[21,22], and in Tangará da Serra their presence, mainly of Cubans, was expressive. More frequently, the language, in the communication process, was understandable; they did not feel uncomfortable or considered that it influenced the consultation, showing confidence in the physician. Studies[23,24] report communication with foreign physicians was not a major obstacle in the attention to users. The communication difficulties reported because of the

language, especially with Cuban physicians in Tangará da Serra, were overcome by teamwork, mainly with the support of the nurses, who helped for a while to enable the response to the users in the consultation, in addition to registering reports of help from users in the teaching of the Portuguese language during the study period of the physicians and on weekends. It is reaffirmed that the consultation space and the daily life of physicians in the community, for the most part, promoted a moment of exchange of knowledge and experiences.

Cordiality and listening to the users was highlighted in the approach of MDP physicians, especially Cubans, in addition to punctuality, commitment to the workload and performance in prevention and promotion actions in the community. This finding was also recorded in other scenarios[17,25,26,27,28]. Listening to the demands, with the users' speech space, showed that the physicians were open to listening to the reason for seeking the consultation, expressing interest in the evaluation of the case presented by the users and presented clarifications on the health status, and the users considered that they understood the language used by the physicians.

In this study regarding the users' preference to be attended by Brazilian or foreign physicians, the highest frequency did not consider preference, but when they analyzed whether there was a difference between the care of these MDP physicians in relation to the previous experience of consulting with other physicians who already worked in PHC, they answered yes. A study[18] that analyzed the quality of PHC in Brazil, associated with the MDP, found that the type of physician did not influence the degree of attributes analyzed, and that as for the MDP was shown to be more associated with access scores, especially in regions with greater socioeconomic vulnerability and shortage of physicians, such as the Northeast, North and Midwest regions. In the Northeast, especially in more vulnerable territories, there was a strong expansion of PHC through the MDP[29].

The consultation time predominated in the interval of 10 to 20 minutes, and at the end they stated that their demands were solved. They considered the physicians' care to be between excellent and good, showing confidence in the physicians and in their recommendations and prescriptions. Regarding the consultation of the MDP physician, there was resoluteness of the assistance sought by the users, in the sense of monitoring and controlling the treatment of the users' demand[25]. However, it should be noted that the resoluteness in PHC goes beyond the reductionist view of the biomedical model and it is expected that the actions of the health teams may be focused on the territories and their relationship with the determinants of the health-disease process.

One point to be discussed is the bond established between users and the health service professionals, including the physicians who collaborate as facilitators in health care [30]. It is noteworthy that the MDP was unable to assume the commitment of longitudinality in the perspective of creating long-term bonds through personal relationships with the medical professionals. Subsequent exchanges were recorded during the MDP, but it still lacks an analysis of medical fixation, especially in the changes that the MDP has undergone since 2017 and after its replacement by the *Médicos pelo Brasil* (Doctors in Brazil) program

In Bahia, managers considered that in order to establish medical professionals in PHC it is necessary to offer good working conditions and employment relationship with social security protection[31]. As for the infrastructure of the units, in Tangará da Serra there was a strong application of incentives for the construction of new units, but at first it was noticed that health units

were improvised to allocate the teams in rented houses. Research conducted in Brazil on the infrastructure of health services that received physicians from the MDP showed that 65% had medium quality infrastructure and 5.8% had low quality infrastructure[32].
In the evaluation of the supply of medical services in the PHC of Tangará da Serra, it certainly was not the same before the expansion of coverage. In Brazil, in many municipalities, organizational barriers to access and flows in the care network were registered before the MDP[33]. This study represents a possibility for the knowledge of the users' opinion about the MDP, from a medium-sized municipality that faced difficulties to expand the coverage of PHC, mainly due to the establishment of medical professionals. The MDP, its contribution and its limits as a project, which proposed greater access to attention through a public policy of human resources induction, slips in its own structural framework designed, project and not public policy, which showed its fragile defense against reforms and management changes.

Conclusion

As for the considerations of family health users about the MDP, it can be said that the incentive of this Program to expand PHC revealed a contribution in Tangará da Serra, that from the perspective of users there were improvements in access to medical consultation, encouragement of promotion and prevention activities and closer links, even if short, in health care actions. It is possible to capture from the lens of users a material that supports the defense of projects that foster the expansion of PHC as an organizer of the care network, in the role of responsible for territorial demands, capable of approaching users who need access, strengthening essential and derived attributes that the PHC model requires to make it resolute. However, it is important to highlight the sustainability challenges of this expansion proposal and induction policies to ensure the network built from the MDP, especially in municipalities such as Tangará da Serra, which invested in cooperation to expand PHC coverage.
An aspect listed as a limitation was the selection criterion of these users, which can hide from those who cannot access PHC due to the workday, in addition to those who necessarily require home care due to their conditions, elements that need to be considered in other studies. However, it is possible to recognize that the results shown here add up to the production on the MDP, reinforcing its contribution to PHC in the SUS.

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How to cite this article:

Gleriano JS, Martins LC, Krein C, Chaves LDP. Evaluation of the Mais Médicos (More Doctors) Program from the perspective of users. Rev. Aten. Saúde. 2023; e20238791(21). doi https//doi.org/10.13037/ras.vol21.e20238791