

Programa Mais Médicos and the scientific medicine, Luc Boltanski's perspective

Programa Mais Médicos e a medicina científica na perspectiva de Luc Boltanski

Programa Mais Médicos y la medicina científica desde el punto de vista de Luc Boltanski

Priscila Lube Moraes¹ , Edson Theodoro dos Santos Neto¹ , Tatiana Breder Emerich¹ , Adauto Emmerich Oliveira¹ 

¹Universidade Federal do Espírito Santo, Postgraduate Program in Public Health – Vitória (ES), Brazil.

Abstract

Introduction: The implementation of the Mais Médicos (More Doctors) Program provided a favorable response to the inequality of access to health care in Brazil. **Objective:** This is a study that shows the implementation of the Mais Médicos (More Doctors) Program in two different scenarios in Espírito Santo, both of which were in areas of extreme poverty. **Methods:** 23 interviews were conducted with managers who worked from 2013 to the end of 2016. A content analysis technique was used after full transcription. **Results:** Four categories of empirical material emerged, and the results reiterate the possibility of access to medical services from the permanence of the professional in the communities. **Conclusions:** Showed the needs of personnel policies, the professional bond with the community which allows better communication, in addition to sociocultural interaction reinforce the debate about Brazilian medical training.

Keywords: Primary Health Care; Unified Health System; humanization of assistance.

Corresponding author:

Priscila Lube Moraes
E-mail: prilube@ibest.com.br

Funding:

No external funding

Ethical approval:

CAAE: 63949516.7.0000.5060

Provenance:

Not commissioned.

Peer review:

external.

Received: 11/18/2021.

Approved: 10/01/2022.

How to cite: Moraes PL, Santos Neto ET, Emerich TB, Oliveira AE. *Programa Mais Médicos and the scientific medicine, Luc Boltanski's perspective*. Rev Bras Med Fam Comunidade. 2022;17(44):3287. [https://doi.org/10.5712/rbmfc17\(44\)3287](https://doi.org/10.5712/rbmfc17(44)3287)



Resumo

Introdução: A implementação do Programa Mais Médicos propiciou uma resposta favorável na redução da desigualdade de acesso à saúde no Brasil. **Objetivo:** O estudo visou compreender a implantação do Programa Mais Médicos em dois cenários distintos no estado do Espírito Santo demarcados pela situação de extrema pobreza. **Métodos:** Foram realizadas 23 entrevistas com gestores que atuaram no período de 2013 até o fim de 2016. A técnica de análise de conteúdo foi empregada após a transcrição na íntegra. **Resultados:** Emergiram quatro categorias do material empírico e os resultados reiteraram a possibilidade de acesso aos serviços médicos com a permanência do profissional nas comunidades. **Conclusões:** Demonstrou-se a necessidade de políticas de recursos humanos, reforçando que a proximidade do vínculo profissional-comunidade possibilita melhor comunicação, conforme abordado por Luc Boltanski, além de a interação sociocultural reforçar o debate sobre a formação médica brasileira.

Palavras-chave: Atenção Primária à Saúde; Sistema Único de Saúde; humanização da assistência.

Resumen

Introducción: La implementación del *Programa Mais Médicos* dio una respuesta favorable a la desigualdad de acceso a la salud en Brasil. **Objetivo:** Este estudio pretendió comprender la implementación del *Programa Mais Médicos* en dos escenarios distintos en el estado de Espírito Santo, marcados por la situación de extrema pobreza. **Métodos:** Se realizaron 23 entrevistas con gestores que actuaron desde 2013 hasta fines de 2016. Después de haber transcrito el material en su totalidad, se empleó la técnica de Análisis de Contenido. **Resultados:** Del material empírico surgieron cuatro categorías y los resultados reiteran la posibilidad de acceso a los servicios médicos con la permanencia del profesional en las comunidades. **Conclusiones:** Mostraron la necesidad de políticas de personal, reforzando que la proximidad del vínculo profesional-comunidad posibilita una mejor comunicación, según lo abordado por Luc Boltanski, además de que la interacción sociocultural remarca el debate sobre la formación médica brasileña.

Palabras clave: Atención Primaria de Salud; Sistema Único de Salud; humanización de la asistencia.

INTRODUCTION

The More Doctors Program (*Programa Mais Médicos* – PMM) was instituted in June 2013 in order to solve, in an emergency and resolute way, one of the main shortcomings of the Unified Health System (*Sistema Único de Saúde* – SUS): the retention of medical professionals.¹ It is a public policy that aims to combat inequality in access to health services, given the shortage of medical professionals in SUS² and the inequalities in the distribution of doctors in different regions of the country.¹ In the state of Espírito Santo (ES), this inequality becomes evident with a ratio of 12.27 doctors per thousand inhabitants in Vitória, the state capital — the highest proportion among Brazilian capitals — and a ratio of only 1.43 doctors in the countryside.³

The implementation of the PMM provided a favorable response in relation to access to health, aiming to meet the needs of the most vulnerable Brazilians.⁴ Despite the coverage achieved by Primary Health Care (PHC) over the years, some challenges mark the segmentation of public health in Brazil,⁵ enhanced by the imposition of social stratification, as a result of the highly competitive capitalist system, which generates great inequalities in the country.⁶

The implementation of the PMM has improved the access of riverside and rural communities to health and to the figure of the doctor, embedded in health teams and full-time in vulnerable areas, which allowed the expansion of resolution and the exchange of experiences with the team and between Brazilian and foreign professionals, providing a more comprehensive and resolute PHC.⁷

Thus, the PMM made it possible to provide medical services mainly in rural, remote, more vulnerable, and *quilombola* areas, in addition to reducing hospitalizations for preventable causes, providing more humanized medical care and better adherence to treatment, resulting in greater satisfaction from the population and health managers.⁸

Furthermore, the PMM sought to resolve the social inequalities that determine the health-disease process.⁹ It is known that social inequalities are determined by power interactions, a reflection of the history and political experience of each society,¹⁰ not only overcoming material differences, but also being present in everyday experiences in the region of residence, in the workplace, and in daily relationships.¹¹ These inequalities are revealed in the lack of equal distribution of income, in poverty, and in the precariousness of resources and inputs,¹² also translating into health inequalities.¹³

On these aspects, the work of Luc Boltanski¹⁴ carries out an approach that permeates the relationship of the imposition of society and the practices of scientific medicine to the detriment of the social classes of patients,¹⁴ which refers to the context of sociological analysis in the face of the changes experienced through the PMM, as in the case of this study. In this sense, this research aimed to understand the implementation of the PMM in two different scenarios in Espírito Santo, marked by the situation of extreme poverty, from the perspective of Luc Boltanski.¹⁴

METHODS

This is a qualitative study with face-to-face and individual interviews that used a semi-structured guide script and were recorded, transcribed, and analyzed using the content analysis technique.¹⁵

1. Based on one of the criteria of Ordinance No. 1.369, of July 8th, 2013,¹⁶ the most vulnerable populations living in extreme poverty were taken as a reference, to verify which municipalities in the state of Espírito Santo had the highest and lowest percentages of the population in extreme poverty, based on data provided by *Instituto Jones dos Santos Neves* (IJSN).
2. The municipalities chosen to carry out the interviews with the managers were the one that had the highest percentage of population in extreme poverty in the state in 2016 and the one with the lowest percentage of population in extreme poverty, participants of the PMM, in order to investigate the different nuances in the implementation process.

On the one hand, the municipality of Brejetuba has an area of 342,509 km² and an estimated population of 12,797 inhabitants. It is located in the countryside of the state, 147 km from Vitória, Espírito Santo, and is known as the national capital of coffee.¹⁷ Its human development index (HDI) in 2016 corresponded to 0.656, and its percentage of population in extreme poverty was equal to 18.08% in the same year, representing the municipality with the highest percentage of population in extreme poverty.

1. On the other hand, Vitória is the capital of Espírito Santo, formed by an archipelago made up of 33 islands and a continental portion, with a total area of 93.38 km² and an estimated population of 359,555 inhabitants.¹⁸ Its HDI in 2016 corresponded to 0.845 and its percentage of population in extreme poverty was equal to 1.54% in the same period, equivalent to 33,737 inhabitants; the city therefore has the lowest percentage of population in extreme poverty.
2. Only the municipalities in Espírito Santo that had received medical professionals for the PMM were selected.

The managers who were coordinators of the Basic Health Units (*Unidades Básicas de Saúde* – UBS) from the second half of 2013 to the end of 2016 participated in the study, a period that corresponded to the first cycle of the PMM, in the two selected municipalities, provided that the managers had remained in office for at least one year. The manager responsible for primary care in each municipality and the person responsible for primary care in the state, in the same period, were also interviewed.

The set of actors consisted of 23 interviewed subjects, as follows: five interviews (four UBS managers and one manager from the municipal health department) in the countryside; 17 interviews (14 UBS directors and three managers from the municipal health department) in the capital city; and an interview with the state management of the PMM in the state of ES. Not all actors contacted accepted to participate, with three refusals.

The selected individuals were contacted by e-mail and/or telephone, for scheduling according to availability, allowing participants to choose their preferred location.

The interviews were conducted face-to-face by the researcher in charge and analyzed through content analysis, according to the following steps:

1. reading the material;
2. categorization of excerpts;
3. discussion of results.¹⁵

The excerpts were categorized using the MAXqda 11.0 qualitative data analysis software in order to ensure a more accurate, organized, and transparent analysis.

The theoretical framework of Luc Boltanski was used.¹⁴ In this perspective, the perception of the existence of human beings, the construction of their identity and their experience in society are based on the reactions and relationships that individuals build with their encounters.¹⁹ Despite Luc Boltanski¹⁴ using the term “*médecin-malade*” (in French), we will adopt “doctor-community”, since the theoretical assumptions of extended health consider health not only as the absence of disease.²⁰

The research was approved by the Research Ethics Committee (*Comitê de Ética em Pesquisa – CEP*) — Presentation Certificate for Ethical Assessment (*Certificado de Apresentação para Apreciação Ética – CAAE*) 58948516.5.0000.5060. It was also authorized by the State Health Department (*Secretaria de Estado da Saúde – SESA*) of Espírito Santo and by *Escola Técnica e Formação Profissional de Saúde* (ETSUS) of Vitória. All respondents consented by signing the Informed Consent.

RESULTS AND DISCUSSION

In the period of interest to the study, 2013–2016, the municipalities had 100% PHC coverage. The municipality in the countryside had five Family Health Strategy (FHS) teams in place and the one in the capital had 77 of these teams.

In interviews with managers, four categories emerged: possibility of access to medical services; appeal to the figure of the scientific doctor; proximity *versus* distance in the doctor-community relationship; and sociocultural interaction of exchange physicians.

It is worth mentioning that, despite the high percentage of coverage found, it is clear that regional disparities are present, demonstrating the influence of geographic location on the poverty index of each municipality due to the difficulty of interest and retention of these professionals.²¹

Possibility of access to medical services

It is known that the retention of medical professionals determines the access to health services, since the insufficiency of existing doctors in PHC and the high turnover rate of these professionals cause competition between municipalities, either through the negotiation of the wages, either by reducing the working hours, which directly interferes in the reduction of access by the population.²²

The stimulus to individual competition and commercialization within capitalist society, in the very relationship between people, determined the transformation of power and conflict relations, since, while some people profit, others receive different wages that influence differences and social inequalities, stimulating the accumulation of capital, prestige, and material goods,²³ which also impacts the health of the population.

In this context, the amount of the salary paid to the professional directly interferes with the permanence in the job. As a result of the salary proposals imposed by the capitalist system, competition between municipalities is strengthened, combined with the autonomy of the salaried worker to refuse to work depending on some conditions,²³ since the municipality that pays more and has better work conditions will be more likely to retain doctors.

In this way, the lack of regular staffing by the federal government marks the heterogeneity in the management practiced by the municipalities and by the health secretariats and corroborates the difficulty of managing²¹ the decentralization and fragmentation imposed by SUS, as well as the integration of health services, not considering the difficulties of each region.²⁴ In this sense, the proposition of personnel policies exclusively dedicated to SUS, valuing professionals, would contribute to the achievement of quality primary care.²⁵ The above assumptions, discussed by Boltanski and Chiapello,²³ are well regarded in medical practice, corroborating the difficulty of retaining this professional, as could also be observed in the present research:

“The implementation of the PMM certainly favored it, because there was always a shortage of doctors in primary care, mainly because of the salary. So many didn’t stay on account of that” (manager — capital).

Deficiency in access to PHC is primarily present in populations in Brazil who live in regions further away from capital cities, with difficult geographic accessibility and on the outskirts of large cities,²⁶ configuring inequities in access to health services. With the implementation of the PMM, access to health services through the figure of the doctor resulted in the creation of a bond, in the reception and in the integrality of care as positive achievements for PHC.⁷ These approaches could be experienced by the management of the PMM in Espírito Santo, contributing to the solution of the high turnover of professionals, which constituted one of the barriers to access:

“A crucial factor of Mais Médicos was the expansion of access. Places of difficult access, that couldn’t retain a doctor, that a doctor would visit once a week [sic], once every fortnight, once a month, and then there was a doctor there every day, that was a very important difference...” (manager — capital).

However, it is known that there is no single recipe to promote the establishment of medical professionals in remote and underserved areas. Although the salary attribute was mentioned at almost all times, research shows the need to combine non-financial incentives, such as flexibility, time off from work, workplace infrastructure and opportunities to take courses, thus obtaining quality commitment and personal involvement of employees, valuing collective benefits and professional engagement.²³

Appeal to the figure of the scientific doctor

Medicine, culturally, is seen as sovereign, holder of the knowledge and techniques that provide health. In this sense, Luc Boltanski,¹⁴ in his research with 128 people in France between 1967 and 1968, already demonstrated the hegemonic differences with regard to medical-scientific knowledge and the

medical-community relationship. Through medical-scientific knowledge, scientific techniques are imposed to the detriment of the disease itself, the body and popular knowledge. In terms of medical-community knowledge, people, mainly from the most vulnerable classes, have the possibility of speaking and listening; thus, the so-called doctor can be complemented, which makes the relationship less hierarchical and more consistent with the individual reality of each person, representing the different perceptions according to the place of residence and the experiences lived throughout life.¹⁴

The theoretical assumptions discussed by Luc Boltanski¹⁴ in the approach to differences between medicine and other professionals — since doctors work on sick bodies, and not on the disease in isolation — were also addressed in the implementation of the PMM:

“[...] in relation to the mental part of the patient, the human part of the patient, this, for me, was their special feature. And that made a lot of difference [...]” (manager — countryside).

In this regard, the professional action on a person is different from other actions, since the doctor often needs to manifest the official medical practice through his interventions and prescriptions, to the detriment of other possible knowledge that may exist or be manifested.¹⁴ These approaches, discussed by Luc Boltanski¹⁴ in relation to medical practice, were observed in the present research:

“[...] when a medical professional arrived, for us it was a party. ‘Cause then, Brazilians have a centered medical culture, one of medicalization. So, they want medicine, they want a doctor. And the only one who can prescribe the medicine is the doctor, you know? So, for them, it’s about having a doctor, wherever he is from, whatever the program, they want the doctor, the figure of the doctor” (manager – capital).

From this perspective, the existing centralization in the search for medical care represents a major obstacle to the integrality of services,² as exemplified by a manager:

“[...] we couldn’t get a doctor to come to the countryside, because it’s very difficult... we were a little faulty, a little understaffed... When the Programa Mais Médicos came, it solved everything for us... It was able to solve the population’s demand” (manager — countryside).

In this context, the PMM emerged as an attempt to redistribute doctors in Brazil, to reduce inequities in access to PHC.²⁷

Proximity versus distance in the doctor-community relationship

Health interventions must be individualized, as well as possible techniques that can be implemented in health care, through the prevention, treatment and recovery of diseases,²⁸ enabling the construction of mediations between the subjects involved.¹⁹

When considering the relationship between the medical profession and health promotion, Gadamer²⁹ emphasizes the importance of humanizing these professionals. He defends the need to develop sensitivity toward the patient’s cause, in order to consider not only the biological situations in question, but also the physical, psychological, and social integrity involved. This was reinforced by the actors interviewed:

“[...] they’d paid a lot of attention to the patient. I think that’s what they liked, that sometimes he said that others wouldn’t [sic]. So they paid a lot of attention to the patient, their participation, their humanity, is to try to look at the patient as a whole. So, I think this is the difference, because they are attentive. And the population seeks that, attention” (manager — countryside).

The awareness of the need for better integration and communication between the medical professional and the patient was raised by Luc Boltanski¹⁴ in his approach, when dealing with a relationship that is often presented with authoritarianism and superiority by the professional.¹⁴

From the implementation of the PMM, the condition of having a full-time medical professional in vulnerable areas allowed for the expansion of resolution, in addition to having achieved a change in the medical attitude toward patients and greater commitment of professionals with the community:

“[...] so I think that the results of the implementation of the PMM were this approximation with the community. This strengthening that we wanted with the family health strategy. We managed to make a lot of progress in those basic clinics” (manager — capital).

“[...] it is a relationship with the community. And it’s not just with that family, it’s getting to know that territory, that alley, that place. [...] So, he knew his territory, he knew the situations of greatest vulnerability there. Before, it was a very dogmatic relationship: the knowledge is mine, I say it has to be that way and the user has to do what I tell them to do” (manager – capital).

It was also reported that the exchange of experiences with the team and between Brazilian and foreign professionals provided a more comprehensive and resolute primary care:

“[...] the doctor who came from abroad, he had a relationship due to training issues, cultural issues, he had a better relationship with the community” (manager — capital).

“[...] Because of the easy access we had to them, because they were not only resolute, but also easy to negotiate” (manager — capital).

In this context, the reflection defended by Luc Boltanski¹⁴ mentions the existing distance between the professional and the community. The greater this distance, the lower the understanding, memorization, and replication of medical discourse, especially among the lower classes, compared to members of the upper classes, who normally belong to the same social class as their doctor.¹⁴ In this way, it is observed that the PMM contributed to the formation of a bond between the professional and the community.

Sociocultural interaction of exchange doctors

Due to the service with better communication, the population showed greater satisfaction in receiving a treatment that goes beyond the barrier of bodies with diseases, finding space to listen to stories and desires, since humanization allows professionals to provide care that goes beyond pharmacological control. It is also considered that the expertise of Cubans in the art of looking, listening, and touching can be an indication for the implementation of the culture of humanized care and prevention as a priority.¹³

The interviews in the ES scenario corroborate this understanding in relation to exchange doctors:

“[...] I noticed something that I didn’t notice in other doctors, a different look, which I think counted a lot. The touch, which I think also counts a lot. At least I think that here, because our municipality is very humble, with very poor people. So, I realized that sometimes patients were satisfied with that... I think that made a difference” (manager – countryside).

“[...] the cooperative doctors, through their look and attention in primary care, managed to bring to society a look and a welcome that we do not have, unfortunately, in the culture of the Brazilian doctor” (state manager).

It is understood that improving communication, regardless of socioeconomic or cultural origin, implies minimizing health inequities.⁹ We live in a linguistically constructed world, in which the communication process differentiates and unites groups through the understanding of verbal, body, and gestural language, added to the communication difficulty existing in the doctor-community relationship.¹⁴ Thus, it is clear, in the present study, that the possible difficulty of exchange professionals with regard to language was not a confirmed event, much less restricted to them, since that the communication practiced by Brazilian medicine proves to be difficult due to the technical terms used:

“At first, I’m not going to lie, it scared me a little. Everyone [she thought] ‘ah, Cuban, I don’t know what, they come to Brazil, speak another language’. The population was a little scared. But, after having contact with them, we could see that they are wonderful people, very good professionals... they are very qualified” (manager — countryside).

Boltanski¹⁴ emphasizes that the existing doctor-community relationship builds anxiety, especially for the lower classes, as there is no easy communication in this relationship, since there is no clear transmission of information about the disease. This can create a barrier between the doctor and the community itself, since the existing specialized vocabulary intensifies this linguistic distance, which was not constant in the PMM.

To date, the PMM has undergone reformulations in its design. In December 2019, through Law No. 13.958, the *Programa Médicos pelo Brasil* came to replace the PMM, having as a way of hiring the work card in the search for a more attractive, stable employment relationship with salary progression.³⁰ These new policies reiterate the relevance of studies like this one, which may contribute to new reformulations.

FINAL CONSIDERATIONS

This work showed that the implementation of the PMM in Espírito Santo, both in the countryside and in the capital, was permeated by the positive aspects that this program brought to needy and underserved populations in the perception of managers. These benefits were listed by the interviewees and discussed based on the four categories of analysis proposed based on the theoretical framework of Luc Boltanski¹⁴ in his discussions on medical practice.

The research reiterates the possibility of access to medical services with the permanence of the doctor in the communities, both in the capital and in the countryside, demonstrating not only the importance of this professional by appealing to the figure of the scientific doctor for the population, but also the need for articulation with popular knowledge, as listed by Luc Boltanski.¹⁴ In addition, it reinforces the need for discussion about proximity *versus* distance in the doctor’s relationship with the community, since the bond

guarantees better communication between them. This was evidenced in this study by the sociocultural interaction of exchange physicians, enabling a new experience in the history of primary care through humanized experiences and practices.

Thus, the research reinforces the debate on the construction of human resources policies in health, which will allow the establishment of professionals in SUS.

AUTHORS' CONTRIBUTIONS

PLM participated in the planning and writing of the manuscript, analysis and interpretation of data; ETSN participated in the design, planning, and final approval of the manuscript; TBE participated in the conception, planning, and writing of the manuscript; AEO participated in the drafting and final critical review of the manuscript.

REFERENCES

1. Brasil. Lei n.º 12.871, de 22 de outubro de 2013. Institui o Programa Mais Médicos, altera as Leis n. 8.745, de 9 de dezembro de 1993, e n. 6.932, de 7 de julho de 1981, e dá outras providências [Internet]. Brasília: Diário Oficial da União; 2013. [cited on Apr. 3, 2018]. Available at: http://www.planalto.gov.br/ccivil_03/_Ato2011-2014/2013/Lei/L12871.htm
2. Tesser CD, Norman AH, Vidal TB. Acesso ao cuidado na Atenção Primária à Saúde brasileira: situação, problemas e estratégias de superação. *Saúde Debate* 2018;42(Spe 1):361-78. <https://doi.org/10.1590/0103-11042018S125>
3. Scheffer M, coord. Demografia médica no Brasil 2018 [Internet]. São Paulo: Departamento de Medicina Preventiva da Faculdade de Medicina da USP, Conselho Regional de Medicina do Estado de São Paulo, Conselho Federal de Medicina; 2018. [cited on Aug. 20, 2019]. Available at: [http://www.epsvj.fiocruz.br/sites/default/files/files/DemografiaMedica2018%20\(3\).pdf](http://www.epsvj.fiocruz.br/sites/default/files/files/DemografiaMedica2018%20(3).pdf)
4. Oliveira FP, Vanni T, Pinto HA, Santos JTR, Figueiredo AM, Araújo SQ, et al. "Mais Médicos": a Brazilian program in an international perspective. *Interface (Botucatu)* 2015;19(54):623-34. <https://doi.org/10.1590/1807-57622014.1142>
5. Neri M, Soares W. Desigualdade social e saúde no Brasil. *Cad Saúde Pública* 2002;18(Supl.):S77-87. <https://doi.org/10.1590/S0102-311X2002000700009>
6. Rocha MPC. A questão cidadania na sociedade da informação. *Ci Inf* 2000;29(1):40-5. <https://doi.org/10.1590/S0100-19652000000100004>
7. Comes Y, Trindade JS, Pessoa VM, Barreto ICHC, Shimizu HE, Dewes D, et al. A implementação do Programa Mais Médicos e a integralidade nas práticas da Estratégia Saúde da família. *Ciênc Saúde Colet* 2016; 21(9):2729-38. <https://doi.org/10.1590/1413-81232015219.15472016>
8. Santos W, Comes Y, Pereira LL, Costa AM, Merchan-Hamann E, Santos LMP. Avaliação do Programa Mais Médicos: relato de experiência. *Saúde Debate* 2019;43(120):256-68. <https://doi.org/10.1590/0103-1104201912019>
9. Barata RB. Como e por que as desigualdades sociais fazem mal à saúde. Rio de Janeiro: FIOCRUZ; 2009.
10. Medeiros M. Medidas de desigualdade e pobreza. Brasília: Universidade de Brasília; 2012.
11. Euzébios Filho A, Guzzo RSL. Desigualdade social e pobreza: contexto de vida e de sobrevivência. *Psicol Soc* 2009;21(1):35-44. <https://doi.org/10.1590/S0102-71822009000100005>
12. Schenkel MA. O papel da política de saúde sobre as desigualdades nas regiões do Brasil. *Guaju* 2017;3(2):104-21. <http://doi.org/10.5380/guaju.v3i2.55105>
13. Santos JBF, Maciel RHMO, Lessa MGG, Maia ALLN, Guimarães EPA. Médicos estrangeiros no Brasil: a arte do saber olhar, escutar e tocar. *Saúde Soc* 2016;25(4):1003-16. <https://doi.org/10.1590/S0104-12902016163364>
14. Boltanski L. As classes sociais e o corpo. 3ª ed. São Paulo: Paz e Terra; 2004.
15. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
16. Brasil. Portaria nº. 1.369, de 8 de julho de 2013. Dispõe sobre a implementação do projeto Mais Médicos para o Brasil [Internet]. Brasília: Ministério da Saúde; 2013 [cited on Aug. 29, 2018]. Available at: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/pri1369_08_07_2013.html
17. Prefeitura Municipal de Brejetuba. Conheça Brejetuba. [cited on Dec. 10, 2019]. Available at: <https://www.brejetuba.es.gov.br/pagina/ler/1044/conheca-brejetuba>
18. Prefeitura Municipal de Vitória. História de Vitória. [cited on Dec. 10, 2019]. Available at: <https://www.vitoria.es.gov.br/turista/historia-de-vitoria>
19. Ayres JRCM. Cuidado e reconstrução das práticas de saúde. *Interface (Botucatu)* 2004;8(14):73-92. <https://doi.org/10.1590/S1414-32832004000100005>
20. Campos GWS. Clínica e saúde coletiva compartilhadas: teoria paidéia e reformulação ampliada do trabalho em saúde. In: Campos GWS, Bonfim JRA, Minayo MCS, Akerman M, Drummond Júnior M, Carvalho YM, org. Tratado de saúde coletiva. 2ª ed. São Paulo: Hucitec; 2012. p. 41-80.

21. Campos GWS, Pereira Júnior N. A atenção primária e o Programa Mais Médicos do Sistema Único de Saúde: conquistas e limites. *Ciênc Saúde Coletiva* 2016;21(9):2655-63. <https://doi.org/10.1590/1413-81232015219.18922016>
22. Santos L, Pinto H. A saúde da família de cara nova: a gestão interfederativa do SUS. Campinas: Instituto de Direito Sanitário Aplicado; 2008.
23. Boltanski L, Chiapello È. O novo espírito do capitalismo. São Paulo: Martins Fontes; 2009.
24. Santos MLM, Bertussi DC, Kodjaoglanian VL, Merhy EE. O que pode uma política? Problematizando a implementação do Programa Mais Médicos a partir da experiência de uma cidade brasileira. *Interface (Botucatu)* 2019; 23:e190052. <https://doi.org/10.1590/Interface.190052>
25. Giovanella L. Atenção básica ou atenção primária à saúde? *Cad Saúde Pública* 2018;34(8):e190052. <https://doi.org/10.1590/0102-311X00029818>
26. Santos LMP, Costa AM, Girardi SN. Programa Mais Médicos: uma ação efetiva para reduzir iniquidades em saúde. *Ciênc Saúde Colet* 2015;20(11):3547-52. <https://doi.org/10.1590/1413-812320152011.07252015>
27. Arruda CAM, Pessoa MV, Barreto ICHC, Carneiro FF, Comes Y, Trindade JS, et al. Percepções de gestores municipais de saúde sobre o provimento e a atuação dos médicos do Programa Mais Médicos. *Interface (Botucatu)* 2017;21(Suppl 1):1269-80. <https://doi.org/10.1590/1807-57622016.0235>
28. Ayres JRCM. Organização das ações de atenção à saúde: modelos e práticas. *Saúde Soc* 2009;18(Suppl 2):11-23. <https://doi.org/10.1590/S0104-12902009000600003>
29. Gadamer HG. *Dove si nasconde la salute*. Milão: Raffaello Cortina; 1994.
30. Brasil. Lei nº. 13.958, de 18 de dezembro de 2019. Institui o Programa Médicos pelo Brasil, no âmbito da atenção primária à saúde no Sistema Único de Saúde (SUS), e autoriza o Poder Executivo federal a instituir serviço social autônomo denominado Agência para o Desenvolvimento da Atenção Primária à Saúde (ADAPS) [Internet]. Brasília: Diário Oficial da União; 2019. [cited on Mar. 6, 2020]. Available at: http://www.planalto.gov.br/ccivil_03/_Ato2019-2022/2019/Lei/L13958.htm.