Mais Médicos Program, improving SUS and democratizing health: an analytic balance of the program

Programa Mais Médicos, aperfeiçoando o SUS e democratizando a saúde: um balanço analítico do programa

Oswaldo Gonçalves Junior
Universidade Estadual de Campinas. Faculdade de Ciências Aplicadas. Administração Pública. Limeira, SP, Brasil.
E-mail: osgoju@gmail.com

Gustavo Bonin Gava
Universidade Estadual de Campinas. Instituto de Economia. Campinas, SP, Brasil.
E-mail: gustavo.bgava@gmail.com

Murilo Santos da Silva
Universidade Estadual de Campinas. Faculdade de Ciências Aplicadas. Administração Pública. Limeira, SP, Brasil.
E-mail: silva.smurilo@gmail.com

Correspondence
Oswaldo Gonçalves Junior
Rua Pedro Zaccaria, 1.300, 2 andar, sala UL37. Limeira, SP, Brasil. CEP 13484-350.

Abstract

This paper aims to analyze the *Mais Médicos* program (PMM) as a public health policy, describing some of its main characteristics and presenting data that allow an insight into its performance, bringing to light, among other aspects, the discrepancy between the results achieved and the opposition placed by the Conselho Federal de Medicina and the Conselho Regional de Medicina do Estado de São Paulo – medicine councils from the federation and from the state of São Paulo. Taking as reference the public policies cycle, the study focuses on the formulation and implementation stages. Using the analytical reference the concepts of bureaucratic insulation and window of opportunity, it is argued that the PMM has instigating aspects, either because of the insulated characteristics that mark its formulation process - which leads one to believe that the program has been maintained disregarding the external pressures of this initial phase -, or because of the favorable environment created by the days of June 2013, marked by popular manifestations that paved the way for the federal government to launch the clearly controversial initiative. These characteristics, associated with the significant social impact of the program, provide reflections that can contribute to the improvement of the knowledge on public policies processes.

Keywords: Public Policy; Formulation and Implementation; SUS; Bureaucratic Insulation; Opportunity Window.

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Resumo

Este trabalho visa analisar o Programa Mais Médicos (PMM) enquanto política pública da saúde, descrevendo algumas de suas características principais e apresentando dados que permitam uma visão sobre seu desempenho, a fim de trazer à luz, além de outros aspectos, a discrepância entre os resultados alcançados e a oposição feita ao programa pelo Conselho Federal de Medicina e pelo Conselho Regional de Medicina do Estado de São Paulo. Tomando como referência o ciclo de políticas públicas, o trabalho trata com especial ênfase as etapas de formulação e implementação. Utilizando como referencial analítico os conceitos de insulamento burocrático e janela de oportunidades, argumenta-se que o PMM possui aspectos instigantes, seja pelas características insuladas que marcam seu processo de formulação – levando a crer que o programa se manteve alheio a pressões externas durante essa fase –, seja pelo caráter oportuno gerado pelas chamadas Jornadas de Junho de 2013, que criaram condições necessárias para o governo federal lançar uma iniciativa claramente polêmica. Essas características, associadas ao significativo impacto social do programa, propiciam reflexões com potenciais aprendizados para processos envolvendo políticas públicas.

Palavras-chave: Políticas Públicas; Formulação e Implementação; SUS; Insulamento Burocrático; Janela de Oportunidades.

Introduction

In 2011, the Institute of Research and Applied Statistics presented the results of the survey "Social Perception Indicators System", whose objective was to diagnose users' perception of services offered by the Brazilian National Health System (SUS). This survey also included questions related to the system of private health insurance plans. The most positive assessments were for the Family Health Strategy (*Estratégia Saúde da Família* - ESF): 81% of the sample described the service as good or very good, and only 5.4% of respondents considered the service bad or very bad. The survey has also addressed the main problems of SUS pointed out by the respondents, with lack of medical professionals being the most frequent, with 58.1% (Brazil, 2011a).

In 2013, Brazil had around 400,000 physicians, corresponding to a rate of approximately two physicians for every one thousand inhabitants. The highest density of physicians was concentrated in the richest and most developed regions of the country, with the Southeast presenting the highest rate of physicians, 2.67 per 1,000 inhabitants, while the North region only has 1.01 physicians per one thousand inhabitants (Scheffer, 2013).

This geographical inequality in the distribution of medical professionals fomented the movement called "Where is the doctor", led by the National Front of Mayors, in 2013. That same year, social movements have gained the streets, in the so-called June Days, which, made up by various claims, pressed the Government for solutions in numerous areas, such as: urban mobility, education, public safety, minorities' rights, democratization of the media etc. The movement also revealed the popular dissatisfaction regarding the quality of public health services, with this theme being featured in numerous mass media newspapers and magazines (Macedo et al., 2016; Pinto et al., 2014). With Brazil experiencing an environment of preparations to host the FIFA World Cup, the protestants demanded the same "FIFA standard" to various social demands, argument that became the main slogan of the popular mobilizations.

Presented in July 2013, through the Provisional Measure no. 621, and consolidated by Law no.

12,871, of October 22 of the same year, the *Mais Médicos* program (PMM) [More Doctors Program] can also be understood as an consequence of this process, a response from the Federal Government to the claims of population concerning health. In its general provisions, PMM has as objectives: (1) reduce regional inequalities concerning the shortage of physicians; (2) strengthen actions and primary health care (PHC) services throughout the territory; (3) improve medical training; (4) expand the insertion of physicians in training in SUS service units; (5) strengthen the permanent education policy; (6) promote the exchange of knowledge and experiences between Brazilian health professionals and physicians trained in foreign institutions; (7) improve the medical staff to act regarding public health policies; and (8) stimulate the carrying out of research applied to SUS (Brazil, 2013b).

From the guideline of decentralization of SUS, in 1990, and the understanding that the municipalities are the agents responsible for the management of primary health services in their territory, there was a gradual growth of the so-called Basic Attention or Primary Health Care. Characterized by a set of individual and collective actions, PHC aims to develop integral care, which impacts the health situation and autonomy of people, as well as health determinants and restrictions, bringing the population closer to the services provided by SUS (Matta; Morosini, 2008).

In 2006, the Ministry of Health launched the National Policy for Primary Care (Brazil, 2006, 2011b). This policy states that the Family Health is the priority strategy for expanding, qualifying, and consolidating PHC in the country, to broaden case management and impact on the health situation of individuals and groups, in addition to providing an important cost-effectiveness relationship considering the resources needed for its implementation.

The expansion of the Family Health Strategy (ESF), name that dates back to 1994, as the Family Health Program (*Programa Saúde da Família* - PSF), began when the Ministry of Health developed the Community Health Agents Program (*Programa de Agentes Comunitários de Saúde* - Pacs), in 1991. From this milestone, the family began to be understood as a programmatic health unit, and the notion of area of coverage or scope (per family) was introduced. According to Rosa and Labate (2005), as predecessor of the PSF, Pacs also introduced an alternative view regarding health interventions: not to "wait for a demand" to intervene, but act on it preventively, thus being a concrete instrument to reorganize the health care demand. That way, ESF is dedicated to healthcare coverage in areas of greatest social risk, to reorient the assistentialist model and define a new dynamic in the organization of health services.

ESF works through multiprofessional teams, family health teams (*Equipes de Saúde da Família* - EqSF), consisting of a physician, a nurse, a nursing technician or assistant, and four or even six community health agents. In some cases, the teams also have professionals deal with oral health, such as dentists, dental hygiene technicians, and dental surgeon assistants. The EqSF work in Family Health Units (FHU), which operate in defined geographical areas with populations described in a minimum number of 600 and a maximum of 1,000 families per team (Brazil, 2011b).

According to Pinto et al. (2014), PMM was developed at a time of great change in Brazil, in which PHC was prioritized, in contrast with programs focused on specialized medicine. The *Mais Médicos* program also had the prerogative of extending and expanding ESF, which was demonstrating difficulties of retaining and also of attracting physicians for teams in remote regions, distant from major urban centers.

This paper aims to analyze PMM as a public health policy, describing some of its main characteristics and presenting data that allow an insight into its performance, bringing to light, among other aspects, the discrepancy between the results achieved and the opposition placed by the *Conselho Federal de Medicina* (CFM) and the *Conselho Regional de Medicina do Estado de São Paulo* - medicine councils from the federation and from the state of São Paulo. In addition, it seeks to focus on PMM by taking as reference the public policy cycle, with particular emphasis on the formulation and implementation stages, due to interesting aspects to an analytical perspective and for learning that the case may bring in the field of public policy.

Attraction and retaining initiatives of healthcare professionals in the country: a brief historic panorama

Over the decades, various initiatives were undertaken with the objective of taking, attracting and/or retaining medical professionals in municipalities with low social and economic development. In the military period (1964-1985), two programs were created: the Rondon Project and the Interiorization of Health and Sanitation Actions Program (*Programa de Interiorização das Ações de Saúde e Saneamento* – Piass). The first contemplated, mostly, municipalities located in the North, Northeast and Midwest macro-regions. According to Maciel Filho (2007), the participation in the project was voluntary, involving university students from different courses, with the aim of executing actions specific to each area. Specifically in the area of health, vaccination campaigns to combat endemic diseases, nursing services, and medical and dental care.

In 1976, Piass was created, the first program that aimed to deploy in communities of up to 20 thousand inhabitants a basic structure of public health and contribute to improve the population's health level. There was, during the period from 1975 to 1984, a 1,255% increase of the outpatient network (Mendes, 1993 apud Maciel Filho, 2007). With the process of redemocratization and expansion of interest groups in the development of a universal health system (SUS), Piass began to lose importance.

As highlighted by Oliveira et al. (2015), with the implementation of SUS and its decentralization to municipalities from the mid-1990s, three programs can be listed as initiatives from the Federal Government to promote attraction and retaining of physicians in small towns: (1) Interiorization of the Brazilian National Health System Program (Pisus), in 1993; (2) Interiorization of Work in Health Program (Pits), in 2001; and (3) Primary Care Professionals Appreciation Program (Provab), created in 2011 and still in force.

Pisus had the objective to offer a health unit and a minimum team for each municipality. Minimum teams were formed by a physician, a nurse, and a health community agent. According to Maciel Filho (2007), Pisus was set to be implemented in the North region, covering 398 municipalities, with possibility of extension to other regions with the same socioeconomic development characteristics. The program was implemented before the elections of 1994 and its duration did not reach a full year. For Maciel Filho (2007, p. 107), two prerogatives contributed to the failure of Pisus: (1) the program was developed only within States, therefore the municipalities were left out of the process of implementation; and (2) the proposal was inherited from another office, thus suffering from lack of political support and being affected by the logic of partisan disputes.

With the restructuring of the health care model from the creation of SUS, the development of PHC in Brazil was developed with the creation of the PSF, in 1994 (Fausto; Matta, 2007). However, given the difficulties to attract and retain professionals in these poor municipalities, the Federal Government proposed Pits. As highlighted by Maciel Filho (2007), in addition to physicians, the program also had the goal of attracting and retaining nurses through educational and economic incentives, for example, offering specialization courses in Family Health and scholarships. Approximately 300 municipalities, the majority concentrated in the North (45.22%) and Northeast (46.32%) regions, were covered by Pits in its three years of duration, from 2001 to 2004. According to Maciel Filho (2007, p. 125), most covered municipalities (41%) had between 10 and 20 thousand inhabitants and low population density, with 51.1% of them having only 10 inhabitants per km².

Since 2011, Provab has the prerogative of allocating health teams (physicians, dentists, and nurses) to work in remote and extreme poverty areas (Oliveira et al., 2015). According to Pinto et al. (2014), in 2013 the program had 3,579 physicians, for which, as a way of attracting and stimulating, Provab provided additional scores in tests of medical residency and scholarships.

Therefore, since the 1960s, Brazil has formulated policies of attraction and retaining of health professionals towards the interior of the country. However, none of these initiatives was able to effectively solve the problem. As argued by Oliveira et al. (2015), with the creation of PMM, in 2013, the

country allocated, in just a year, 14,462 physicians in 3,785 municipalities. The great novelty of this program was allowing the hiring of foreign physicians, mainly from Cuba, through international agreements.

Mais Médicos: design and characteristics

Brazil has unique territorial and population dimensions, a complexity that is increased when we consider regional inequalities. As part of SUS, the formulation and implementation of a program along the lines of *Mais Médicos* should observe the right to health in its universality, integrality, and equity.

To meet the needs that motivated its creation, PMM featured three guiding axis, contemplating actions to be developed in the short, medium, and long term:

- **Axis 1 – Emergency Provision**: immediate hiring of physicians. In 2015, in the balance of two years of PMM, the program had 18,240 physicians in the 4,058 municipalities, thus, covering 73% of Brazilian cities and 34 Special Indigenous Health Districts, ensuring medical assistance to approximately 63 million Brazilian citizens (Brazil, 2015).
- **Axis 2 – Education**: with the implementation of the program, there was a profound restructuring of Brazil's medical training. Law no. 12,871/2013, which created the PMM, determined that the National Council of Education began to require from medical schools, until 2015, to adapt to the new national curriculum guidelines for the undergraduate courses of Medicine1, a demand that substantially modified the training of physicians and experts. This axis aims to face permanently the lack of physicians and finally solve the deficit of professionals in the country. To this end, inside PMM is an expansion plan of undergraduate courses and medical residency. Until 2017, the Federal Government established the goal to create 11.5 thousand new vacancies for undergraduate courses and 12.4 thousand vacancies for residency.Until 2015, over 5 thousand undergraduate vacancies and 5 thousand medical residency vacancies had already been created (Brazil, 2015).
- **Axis 3 – Infrastructure**: through the construction, extension, and renovation of basic health units. Until 2015, over R$ 5 billion had been invested to finance 26 thousand construction works, in approximately 5 thousand municipalities. It is important to highlight that 45 of these works are of river Basic Health Units (UBS), i.e., they have the purpose to take physicians to places they were unable to reach before. Of all required infrastructure, according to official data of the program, until 2015, approximately 10,500 works were ready and other 10,000 were in implementation phase (Brazil, 2015).

From the three axes, it is possible to verify that PMM aims to broadly change the entire structure in force, bypassing the medical training in the country, the immediate hiring of professionals, and also providing the necessary infrastructure to enable the desired universalization of the right to health.

These measures are also expressed in the opportunity to overcome the problem of attraction and retaining of physicians in the ESF teams, faced with PHC, the entrance preferred by SUS, through which the system seeks to ensure to users access to other services of the health network, thus being present in all Brazilian municipalities (Brazil, 2015, p. 15-16).

When PMM was formulated, Brazil had a ratio of physicians per inhabitants far below the needs of SUS. Professionals were poorly distributed throughout the national territory, with the poorest and most vulnerable regions being those fewer physicians. Between 2002 and 2012, the country graduated only 65% of the demand for physicians, with the deficit reaching the level of 53 thousand professionals in the period. Chart 1 summarizes these data.

1 Requirements of law no. 12,871/2013 to the new curriculum in medicine. Available at: <http://maismedicos.gov.br/o-novo-curriculo>. Access on: Nov. 22, 2017.

Chart 1 – Distribution of physicians in the regions by thousand inhabitants, Brazil, 2013

Regions	Population 2012	Total of physicians	Physicians per thousand inhabitants
North	15,945,589	14,394	0.9
Northeast	54,949,170	59,671	1.1
Federal District	2,741,213	9,494	3.5
Midwest	11,692,888	16,091	1.4
Southeast	82,880,900	206,238	2.5
South	28,316,533	53,803	1.9
Total	196,526,293	359,691	1.8

Source: Adapted from Ministry of Health, 2015, p. 28.

To achieve the goal of 2.7 physicians for every 1,000 inhabitants, planned for the year of 2026, Brazil would need to have trained, by 2013, 168,424 more physicians. That is, there was already a serious problem concerning the lack of physicians in the country at the time of formulation of the program (Brazil, 2015, p. 27).

To attract adherence to PMM, several public notices were released, which allowed any municipality to participate to receive the program resources, the selection being conditioned by priority criteria, such as: "areas with high percentage of population in extreme poverty; low human development index or very poor regions; semi-arid and Amazonic regions; areas with indigenous and *quilombola* population; places with great difficulty to attract and retain professionals; among others" (Brazil, 2015, p. 43).

PMM has a list of priorities for the recruitment of professionals, and Brazilian physicians with training and registration in the Regional Council of Medicine had precedence to participate in the program, but due to the historical deficit of professionals with degrees in Medicine, it was necessary to opt for other alternatives.

> It is important to highlight that physicians, Brazilian or foreign, who were trained or worked in countries with a proportion of physicians per inhabitants lower than Brazil could not enroll in the Program. That is, Brazil practices a rule of international equity and solidarity, seeking to attract physicians only from countries that have more professionals than Brazil itself, not exacerbating those with a lower average. For this reason, physicians who were trained or work in countries such as Bolivia, Paraguay, Ecuador and most neighboring countries in South and Central America cannot apply for the program. (Brazil, 2015, p. 44-45)

According to the Ministry of Health (Brazil, 2015, p. 49-52), only attracting professionals without at least providing the necessary work conditions shall not achieve satisfactory results. Thus, investments in infrastructure were increased, from R$1.7 billion in the first year to R$4.9 billion in 2015. PHC never made investments of resources in the dimensions that PMM have been directing, both for infrastructure and professional qualification.

The need for immediate hiring of physicians and of improvement of the infrastructure of basic health units were key items so that the program could answer to the problems in the short and medium term; while its second axis, education, focuses on the long-term measures, to minimize the historical deficit of physicians in the country.

> Law no. 12,871/2013 determined important changes on reorientation of training, which should be observed by all Schools of Medicine, new and existing ones, public and private, and also changed the logic of expansion of vacancies in Brazilian Medicine undergraduate courses. (Brazil, 2015, p. 53)

According to the Ministry of Health (Brazil, 2015, p. 54) the law determined that the National Council of Education should develop new guidelines for the undergraduate course in Medicine. These guidelines should intend to update medical training and give students a leading role, teaching them to "learn how to learn", as well as bring together and direct training to the needs of the population and of SUS, training professionals with a more complete and contemporary view regarding health, users, and medicine.

All physicians who participate/cooperate with the program are required to participate in improvement activities, which seek to articulate teaching and service. The length of stay of professionals in PMM is three years, renewable for another three (Brazil, 2015, p. 45-48).

Numbers and views on implementation

According to Girardi et al. (2016), between the beginning of the implementation of the PMM until September 2015, 14,256 physicians were hired. The North region had the largest participation of physicians in the program (23.7%), followed by the Northeast (with 18.1%). Therefore, the distribution of professionals was directed towards areas with more needs.

The participation of physicians in PMM in municipalities with up to 10 thousand inhabitants was of 22.2%, as highlights Girardi et al. (2016, p. 2679): "Smaller municipalities were the ones who better organized themselves around the offer of family health physicians, instead of other specialties, and were the more vulnerable in terms of health care". The impact of relative participation of physicians in the PMM in cities with over 100 thousand inhabitants, in addition to capital and metropolitan regions is smaller, since the professionals who work in the private sector fill this gap, among which are mainly general practitioners and pediatricians.

In addition to Girardi et al. (2016), other authors (Campos; Pereira Junior, 2016; Miranda et al., 2017; Oliveira; Sanchez; Santos, 2016; Oliveira et al., 2015) reinforce that PMM enabled the population, especially the population of poorer municipalities, to access health, a right that is present in the Constitution of 1988 and is the foundation of the construction of SUS.

For Silva Junior and Andrade (2016), the Education axis allows for, in addition to changes in medical training, an incentive for the creation of undergraduate courses in small cities. The authors highlight, for example, that in the state of Rio de Janeiro most vacancies were made available by private institutions in municipalities in the interior of the state. However, as the authors point out, the privatization of education "undermine the stability of this process and the necessary relationship of these schools with the public health service network" (Silva Junior; Andrade, 2016, p. 2671). In addition, the interiorization of the medical residency should advance further into the municipalities with greatest needs.

When assessing the implementation of PMM in 104 municipalities in the state of Mato Grosso, Mota and Barros (2016) argued that, even with the numerous difficulties present in the state, such as the lack of medicines, inputs, equipment, and shortage in the physical infrastructure of health units, the hiring of physicians was decisive to assist the approximately 900 thousand inhabitants, as it significantly decreased the inequalities of access to health actions and services. Still according to the authors, another objective provided for by *Mais Médicos* was achieved in the state of Mato Grosso: the exchange of experience between the foreign professionals and Brazilian physicians, due to the fact the foreigners have as characteristic the humanization of care and creating bonds to their patients, thus enriching treatment and execution of actions of promotion and prevention in the context of PHC.

The contribution of PMM in more vulnerable municipalities can be observed in Bruna Silva et al. (2016), who dealt with the implementation of the program in the Vale do Ribeira, an area that covers part of the states of São Paulo and Paraná, housing 544,042 inhabitants, and that has great socioeconomic and cultural diversity, with a portion of the population in extreme poverty (7.77%) and living in the rural area (25.94%).

According to the authors, there was an increase in the number of appointments to the adult population and care for STD/Aids patients, with reduction of the appointments carried out outside the scope of the ESF, reflecting as greater access of this population to PHC services and actions. In the words of Bruna Silva et al. (2016, p. 2902): "there was a sudden drop in hospitalizations for other causes, demonstrating the ability to produce services and respond to the health needs of a given population".

In the city of Mossoró, state of Rio Grande do Norte, Tiago Silva et al. (2016) conducted a qualitative research, interviewing users of Basic Health Units that received physicians from Cuba. According to Tiago Silva et al. (2016, p. 2863): "In addition to ease of access, the attention and respect showed to users by Cuban physicians were evidenced in the survey as elements that contributed to a positive assessment of the project".

Interviews carried out with administrators and beneficiaries of *Mais Médicos*, available on the home page of the program, help reflect on the changes that occurred after its implementation, highlighting important elements that support the vision of Tiago Silva et al. (2016).

In surveys conducted by the Ministry of Health (Brazil, 2015), 95% of users declared to be satisfied or very satisfied with the performance of the program's physicians. The most cited aspects by users were: "increase in the number of appointments", "now having the possibility of having appointments with physicians every day", "more considerate physicians", "who spend more time with patients", and are "capable and competent". These perceptions help qualitatively complement the view on a program whose numbers are equally impressive.

Insulation and opportunity window: elements for a discussion

As a State policy, not even the exchange of Governments, from Dilma Rousseff (PT) to Michel Temer (PMDB), resulting from the vociferous impeachment process in 2016, interrupted the PMM. There have been adjustments in scholarships and benefits to participant and cooperative physicians. Another important measure was the renewal of the cooperation with the Pan American Health Organization (PAHO) until 2019, to ensure that the Cuban physicians are able to fulfill their contracts by the predicted end. However, the goal is to expand the participation of Brazilians in the 4 thousand vacancies that today are filled by the international agreement.

Despite the setbacks, resistance, and limitations existing in PMM, the results indicate a successful public policy, opposed to many trade union and media discourses made since its launch.

The non-interruption of the program even with the exchange for presidents, but rather its expansion, is also accompanied by a performance that is beyond common, especially when considering the public policy cycle and the challenges involving the developments between the phases of formulation and implementation, i.e., between what is planned and what is actually performed (Arretche, 2001, p. 45). In the well-known text by Arretche (2001), "Uma contribuição para fazermos avaliações menos ingênuas" [A contribution to make less naive assessments], the author draws attention to the fact that:

> Public policies evaluation manuals taught us that the evaluation of the effectiveness, efficiency, or effectiveness of public programs must systematically take into account the objectives and implementation strategy defined by the policy makers of these programs. However, assuming that a public program can be implemented entirely in accordance with the design and means envisaged by its formulators shall also lead to a negative conclusion about its performance, as it is virtually impossible for this to occur. The distance between what is planned and what is actually carried out is an implementation contingency, which can be largely explained by the decisions made by managers, within the economic, political, and institutional context in which they operate. Thus, to overcome a naive conception of the evaluation of public policies, which would necessarily lead the evaluator to conclude for the failure of the program under review, it is prudent, wise, and necessary

> to admit that implementation modifies public policies. (Arretche, 2001, p. 45-46)

The numbers provided and the testimony of managers and users about the program show a successful implementation, with a degree of consonance between formulation and implementation that clashes with the warnings of the theory. This finding of success raises concerns before a scenario often marked by frustrations and revisions of targets of public programs. In other words, which would explain the performance of this initiative?

When analyzing the trajectory of *Mais Médicos*, a first aspect draws attention and emerges as a possible explanation: the insular form of its formulation. This characteristic is linked to the concept of bureaucratic insulation, which can be defined as a way of protecting technical institutions of the State against political interference. Bureaucratic insulation is considered a technocratic process associated with the strengthening of the technical core of bureaucracy, aiming to avoid interference from political and social systems. It is, therefore, a process marked by low or no political and social control, thus being understood as a dysfunction (Xavier, 2006).

Under the logic of command, opting for insulation finds motivation on the understanding that:

> any political interference could harm the achievement of the goals, either due to the slowness of the process of negotiation or preservation of the rational content of the public policy. In agreement with this logic, in fact, what is sought with bureaucratic insulation is to reduce the scope of relations and the political space of the public organization. (Xavier, 2006, p. 1)

Such a vision, when placed under the public policy cycle, reveals that Governments would be seeking, with bureaucratic insulation, to limit:

> the management of public organizations with technicist bases, to concentrate, centralize, and close the decision making regarding the formulation and implementation of public policies in the bureaucratic rationality. [...] This invisible shield created by insulation around governmental organizations makes the public administration completely immune to society's control and to the political system, often generating questions about the democratic system itself. (Xavier, 2006, p. 1-2)

When we consider PMM in light of this perspective, a paradox is revealed, since the clear social function of the program focuses precisely on the main criticism regarding insulation concerning the democratic dimension: the lack of legitimacy.

The democratizing dimension is reinforced when we consider that the insulated formulation of PMM made the program assertive in its goals of reviewing a historically rooted structure, facing interests (and lack there of), effectively focusing on a difficult to solve problem, central to public health: the lack of professionals in small towns and distant areas, unattractive when compared to wealthier areas, but not unrelated to a monopolist view from a representative part of the medical profession.

In addition to these points is the fact that the implementation did not deconfigure the policy formulated, even though the participant agents of these steps are not the same. This finding adds another unusual aspect, because one of the striking characteristics of insulation is, precisely, the ability to, in the more intense cases, make decentralized agencies assume one single role of makers and implementers, thus permanently avoiding social control and withdrawing from legitimacy towards society (Xavier, 2006). In this scenario, the structure designed during formulation was able to create the necessary mechanisms so that implementers – front line bureaucrats – could execute the policy without being "perverted" by its discretion.

The formulation process, the success of the policy, and its social scope bring intriguing elements to think about in a recurrently addressed aspect: the existence of a controversial trade off between efficiency and democracy. For some, it is clear that the higher participation, the lower the efficiency – "there is an improvement in in agility, but a loss in democracy" –, for others, on the other hand, in defense of democratic practices, there would be no

loss of efficiency that justified less participation of social actors in public processes.

In the case of *Mais Médicos*, the lower participation of actors from management character in the formulation resulted in a program rooted mainly in democratic and inclusive values. This finding, therefore, adds to the two poles mentioned a third possibility: exclusion with democratic gain. It is excluded in the process, but is included in the materialization of the policy, highlighting the quality and coverage of public services provided with the successful implementation of PMM.

This fact calls further attention when considering that:

> Health policies in the context of the SUS were developed in scenarios permeated by ambiguity, uncertainty, and conflict between values and interests of groups in the public choice [...]. The correlation of forces are present in most of these decisions, in complex health organizations, in which multiple actors interact, with heterogeneous identity and preferences [...]. In view of this, and not by chance, the option for processes agreed upon in political arenas of SUS, set in deliberative and specific advisory forums, assume increasing prominence and relevance in the process of democratization of public health policies in Brazil. (Gottems et al., 2013, p. 511)

While the program was formulated in this insulated way in bureaucratic back offices of the federal government, with the Ministry of Health taking the lead, in collaboration with the Ministries of Education and Planning, Budget and Management, to society and to the public opinion,PMM did not exist yet. It was only in the second half of 2013 that PMM emerged as a program ready to be put into action. In this sense, the top-down characteristic - policy defined from the top of the management pyramid down -, which determines the formulation, may never be confused with improvisation, a fact confirmed by statements such as that of the Cuban physician Tania Sosa. In an interview, Sosa presents an external view that is surprising if we consider the ignorance of society and national public opinion on the subject: "This program is not improvised. We are have been getting ready for it for a year, learning the language and studying Brazil's characteristics" (Carvalho, 2013). Another source reports that the agreement to import Cuban physicians was concluded before the announcement of *Mais Médicos*, on April 26, 2013, i.e., almost three months before the provisional measure that created PMM (D'Amorim; Johanna, 2013).

When we analyze the Brazilian context and the political power exercised historically by physicians, either as a professional association and individuals, with long tradition of having important public positions, through elections or not, in the national public life, it is possible to understand the hidden logic that marks the insular nature of the formulation process of *Mais Médicos*. In other words, no special gifts are required to anticipate the enormous resistance that a program with such characteristics would face from a significant part of physicians.

Schraiber (1993) discusses autonomy as an aspect of an intricate process that encompasses the techniques of medical practice (inner dimension) and participation in the formulation of health policies (outside dimension). To the author, this process would be paradoxical, "since, the medical thought shall participate, as a form of manifestation in support of technical autonomy, of health policy formulations" (p. 171). It is, therefore, a strategy of power aiming to "keep to the profession what its predecessors managed to conquer, i.e., full control over the work process" (p. 173). The author explores a number of aspects that help understand the complexity that involves medicine, stating the traces of a story that makes it, at the same time, "so divided and so cohesive; diversely practiced and, nevertheless, revolving around a common ideal" (p. 149). This dynamic is revealed in the view, according to which:

> Physicians, as people, are not immediately and absolutely responsible, and that does not mean that the professional category is not. However, this is not constant. There is great distance between the common and the intellectual physicians on the ideological and political participation for

> the formulation of the project of organization of Medicine. (Schraiber, 1993, p. 174)

In this sense, the critical view here undertaken does not disregard this multifaceted and complex universe in which, under common aspects and a cloak of uniformity, dwell divergent views on PMM.

Analyzing the role of the medicine boards throughout the country, we observed a movement of resistance to the program, particularly about the prerogative of foreign physicians working in Brazil without qualifying exams such as Revalida[2]. Moreover, with the approval of the Provisional Measure no. 621, of July 8, 2013, in the Congress, CFM, along with other medical institutions in Brazil, filed an action in the Federal Supreme Court (STF) requesting the unconstitutionality of PMM (Macedo et al., 2016).

"Lack of evidence of proficiency in the Portuguese language by candidates" was one of the arguments that justified the lawsuits (CFM, 2013), pushing for concluding the corporatist character in these propositions. For Scheffer (2013), in the document entitled *Demografia médica do Brasil: cenários e indicadores de distribuição* [Medical demography of Brazil: distribution scenarios and indicators], a measure like PMM would also be unnecessary since, according to the data presented by the document, the country would reach the level of physicians laid down by the program only by taking into account the ratio of trained physicians by population growth. The study made projections until the year of 2050. The only point of view that the document share with PMM refers to the uneven geographical distribution of physicians (Scheffer, 2013, p. 163), as some excerpts indicate:

> According to the projections, in 2020 there will 500 thousand physicians, 2.41 per 1,000 inhabitants. In 2028, the number of women in the work market shall surpass that of men, and in 2050 the total of professionals will be over 900 thousand, with a ratio of 4.24 physicians per 1,000 inhabitants. At least five states from the North and Northeast regions, however, will continue with rates below the current national ratio of 2.00. **The increase of the national rate of physicians per inhabitant will certainly not reduce the inequalities between regions and between the public and private health sectors, if new policies of attraction and retaining of physicians is not adopted, and if no substantive changes occur in the operation of the Brazilian health system**. (Scheffer, 2013, p. 164, emphasis added)

> Finally, as warned in the first volume of this study, **it is certain that the physician's presence cannot be determined by unilateral Government decisions, nor only by managers of the public system or by medical entities, much less by market interests**. Before this, well-founded information and the participation of society need to be discussed with transparency. Hasty diagnosis of this problem can inappropriately guide policies and programs aimed at train or retain physicians, resulting even in irreversible damage to the Brazilian health system. (Scheffer, 2013, p. 165, emphasis added)

These excerpts help to understand that even before the launch of PMM, in July 2013, the report, dated from February of the same year, already presented guidelines contrary to actions which were later completely incorporated and faced by the program. Such vision ratifies the judicialization measures combating PMM by CFM and other related institutions, with the proposed lawsuits being defeated in STF (Mandel, 2013).

One of the initiatives of PMM, perhaps the most criticized one during its implementation, was the cooperation agreement signed with PAHO, a centennial institution linked to the World Health Organization and that for decades has been contributing with Brazil in the area of health. To give the process sequence, Paho signed a cooperation agreement with the Cuban Government, which fit the

2 "The national exam for Revalidation of Medicine Diploma dispatched by Foreign Higher Education Institution (Revalida) was created to guide the recognition of medical diplomas issued by foreign institutions of higher education. To act as a physician in Brazil, the student who graduated abroad need to revalidate the diploma" (INEP, 2017). Available at: <http://portal.inep.gov.br/revalida>

requirements set by PMM and possessed physicians with extensive experience and training in PHC.

For the program, these Cuban physicians are designated cooperators, as they do not come individually, but through the Brazil-PAHO-Cuba cooperation. To allow the full exercise of medicine within the program, the Ministry of Health was authorized to issue a Single Record aimed at replacing the revalidation of the diploma of the participants only during participation in the program (Brazil, 2015, p. 45).

> It is a fact that, at first, there was resistance on the part of some sectors of society, particularly regarding foreign physicians. As the results of the program in the everyday life of users were felt, the doubts and questions raised about the need for more physicians to improve assistance to the population and to expand primary health care across the country were overcome. (Brazil, 2015, p. 9)

Due to the historical deficit of physicians and the difficulties of public health policies to attract and retain professionals in the poorest regions and remote areas of the country, from the launch of PMM until December 2014, 79% of the vacancies were filled by cooperated Cuban physicians. However, in the public notice released in 2015, for the first time, all available vacancies were filled by Brazilians or foreigners trained and with diplomas registered in the country, i.e., foreign physicians or physicians trained abroad without a diploma registered in Brazil were not necessary to meet the needs of PMM (Leal, 2015).

To bureaucratic insulation as a successful strategy for the formulation of the program, keeping it safe from outside pressure and influences, can be added a second characteristic: the opportunity window that impacted its launch as a proper public action, beyond bureaucratic backstages. This aspect is equally interesting from the point of view of an environment conducive to discourage resistors and ensure approval in the Legislative environment, regarding the concrete progress of the policy action plan.

The idea of opportunity window is related to decision making, action that shall in fact enable a formulated alternative to become a public policy. The studies by Kingdon (1984) are the reference recurrently cited to understand processes of this type. The Multiple Streams Model seeks to clarify when and how a problem shall be considered or not in the decision-making of a government agenda3. In a systematization of the Kingdon model applied to the analysis of health policies, Baptista and Rezende (2015) remember that the entry of new problems in the decision-making agenda is a result from a combination of independent streams that cross the decision-making structures: problem stream; policy stream; and politics stream. The first refers to social conditions and how each condition awakens the need for action, with the evidence of the problems being unable to individually influence decision-making, requiring an articulation with the other streams. The second comprises proposals routinely prepared by specialists, civil servants, interest groups, among others. In this case, the alternatives and solutions would be available and, when problems arose, they would go through a competitive selection process for effective consideration in the decision-making process of policies (Baptista; Rezende, 2015, p. 230-231). As for the third stream:

> It would be the political dimension "proper", in which coalitions are built from bargains and negotiations. In this stream, three elements influenced the Government agenda: the "climate" or "humor" (e.g.: a a political moment favorable to change given the charisma of a ruler or the political, economic, and social situation);

3 According to the model of Kingdon, in addition to decision-making and government agenda, which corresponds to the list of problems being considered and that will be worked in decision-making, there would be two other: the systemic or non-governmental agenda – list of subjects and issues of the country, placed in society, which for some reason did not arouse the attention of the Government and policy makers at that time and which were waiting for opportunity and jostle to enter the governmental agenda; and the institutional or governmental agenda, in which would be included the problems that get the attention of the Government, but are not yet addressed on the decision table (Baptista; Rezende, 2015, p. 230).

> organized political forces (pressure groups); and changes within the Government itself. For Kingdon, each of these streams has a life of their own and follow their way relatively independently, as the stream or current of a river. However, in a few moments, these streams converge creating "opportunity windows" (policy windows), enabling the formation of public policies or changes in existing policies. That is, a opportunity window presents a set of conditions favorable to changes in Government agendas and decisions as well as to the insertion of new themes in these agendas. (Baptista; Rezende, 2015, p. 233-234)

Considering the Kingdon model, *Mais Médicos*, even still being envisaged, the moment and even the certainty of its release, as in the case of most public policies, would be uncertain and dependent of a confluence of processes. The integration of the three streams – problems, alternatives, and politics –, resulting in the opening of a opportunity window, help us to understand how an initiative with controversial character and potential mechanisms to face with labor interests in its origin array takes shape and is put into practice.

In this sense, the idea of opportunity window seems to contain an essential explanation concerning the reasons that prompted the policy to go from an alternative to a concrete reality. The performance of the program also seems to confirm another identifiable feature: an alternative that survived and, for being successful, triggered a multiplier effect, gaining supporters ("Bandwagon"). The maintenance of PMM as a political agenda, despite the exchange of Governments at the federal level – a critical process surrounded with uncertainty –, confirms this.

The federal Government found in the clamor of the streets and in the claims of the June Days in 2013 the perfect opportunity window to launch PMM. Taking advantage of the timing and entrepreneurial strategy, fundamental aspect to enforce any policy alternative, we might say that, when enacting provisional measure no. 621/2013 (Brazil, 2013a), there was a process of "bureaucratic desinsulation of *Mais Médicos*", which thus followed to the National Congress, where it was intensely debated by the parliamentarians until becoming Law no. 12,871, sanctioned in October 22, 2013, by the then President, Dilma Rousseff (Brazil, 2013b).

The national mood, clearly marked by popular dissatisfaction, configured a favorable scenario for the formation of the agenda. Paradoxically, the atmosphere of popular revolt was able to pacify the political environment between Legislative and Executive powers, to provide a quick and uncontested approval of PMM.

Final considerations

Various public policies were created with the aim of strengthening PHC over the 28 years of SUS history. The implementations of ESF along with the establishment of PMM may be considered the most prominent initiatives to guarantee the universal right to health, the foundation principle of the construction of SUS. Not by chance, PMM quickly consolidated itself as the most ambitious federal policy, aiming to solve the shortfall of the medical work force in the country's most vulnerable municipalities. The studies consulted and the documents made available by the Ministry of Health demonstrate a significant success in the performance of the program, reflected in the satisfaction of the population, especially for those who were underserved and who rarely – if ever – had access to medical professionals.

Other data enable to verify the improvement of service quality, an increase in access to PHC services, as well as the development of exchanges of experience and learning between Brazilian and foreign professionals. Overall, the data and information made available leave no doubts as to PMM being a successful public policy. To these findings we can add, moreover, that the program has an annual cost of about R$2.8 billion (equivalent to approximately 0.05% of 2017 GDP), having as beneficiaries around 63 million people. Such numbers help scale the resources invested in the program and its significant social impact.

From concrete and verifiable elements, it is evident the need to stimulate PMM as a State policy,

guiding the debate so that its actions are magnified and perpetuate a new level for public health in Brazil.

Similarly, these elements help us understand that the controversy generated around the program involving trade associations of physicians find their motivations in elements of moral order, rather than concrete ones.

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Author's contribution

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