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Family and Community Medicine: now more than ever!

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The article "*A Atenção Primária e o Programa Mais Médicos do Sistema Único de Saúde* ("Primary Care and the 'More Doctors Program' of the Unified Health System") reflects on the "More Doctors for Brazil Program" and its impact on the Unified Health System (SUS) and primary health care (PHC). Using an historical perspective regarding the process of the instigation and expansion of PHC in Brazil, this article highlights important challenges in relation to its consolidation, particularly regarding the provision and retention of medical staff.

The development of Family and Community Medicine (FCM) in Brazil began in a pioneering fashion in the 1970s (pre-SUS), with residency programs in MFC held in Rio Grande do Sul, Rio de Janeiro and Pernambuco[1]. At that time, there was little support for these initiatives from health managers and even within academia, which further hampered the robust implementation (from 1994) of the Family Health Program (FHP) due to a lack of professionals with appropriate training. The last few decades have witnessed a lack of cooperation between educational institutions and the SUS regarding the need for and the supply of professionals for PHC. Thus, the implementation of health reform, especially regarding PHC, lasted longer than in countries with PHC-orientated health systems such as Canada, Cuba, Spain and Portugal. In the 1980s and 1990s these countries specialized medical training regarding PHC (medical residency was defined as the gold standard of training), minimum percentages were established for FCM, and compulsory residence was incorporated into the health system[2,3]. In Brazil, one of the obstacles to this international trend emanated from medical schools, which, until recently, insisted on the idea that graduation was the end of the line[4].

One of the difficulties that prevented advances in the implementation of PHC in Brazil was the latent need for doctors to work in PSF teams, especially in relation to training for FCM. When the emergency provision policies of the Federal Government (PROVAB and PMM) were launched, the Brazilian Society of Family and Community Medicine (SBMFC) recognized this as extremely important because for the first time PHC featured on the national political agenda[5]. These initiatives were seen at the time as policies focused on the chronic difficulties regarding the provision of doctors in health teams in cities in the interior of Brazil and in the outlying areas of major cities. However, these strategies could be viewed as a "double-edged sword" because they can provoke dependency: their potential to mobilize educational institutions is weak and, furthermore, those involved in these strategies tend to demand less, with little pressure for better structural conditions[6]. Thus, even at this stage the SBMFC warned that these emergency measures should be accompanied by consistent and effective policies to improve the quality of services, the infrastructure (in this case, the 'Requalifica UBS' or training for primary healthcare units), training of the care network and support services for diagnosis and treatment, and also that there should be similar policies for other health professionals (not just doctors) in order to strengthen all the attributes of PHC.

In three years of operation, the PMM produced real growth of more than 7,000 FHP teams and population coverage of 10%[7]. The number of doctors that were working within the PMM (over 18,000) also replaced doctors in pre-existing teams, and many of them were concentrated in metropolitan areas and regions within the Brazilian coastal zone, which were selected as priority areas. Although it had been shown that the latter regions were lacking in doctors they did not have the historical lack of doctors that was present in the Amazon and the semi-arid region and border regions.

Furthermore, care is needed in interpreting the satisfaction of service users regarding PMM doctors, and in particular Cuban exchange doctors, compared to Brazilian doctors. These differences may be associated with the training profile of FCM, and also the regulation of the program and the supervision and monitoring of the labor process, regardless of the doctor's nationality. We have no knowledge of research comparing doctors who have graduated from residential FCM programs in Brazil and other countries, among those doctors who followed these paths.

With regard to the issue of graduation, the PMM incorporated a re-orientation of curricula,

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with the publication of the National Curriculum Guidelines (2014)[8], which highlighted the role of FCM in medical training, with a minimum percentage of internships, thereby providing a growing practice in PHC services in line with the guidelines of the Brazilian Association of Medical Education (ABEM) and the SBMFC[9]. However, these changes will only be effective in relation to PHC practices in high quality environments under the supervision of FCM teachers/tutors and integrated teaching/service that is consolidated through the Organizational Contract of Public Education-Health Action (COAPES). Induction policies to provide public competitions to apply for vacancies as FCM teachers in medical courses need to be implemented in order to achieve this goal.

While it is necessary to increase the number of places in medical schools, according to previous studies the proposed number of new vacancies in the short-term tends to be at a surplus, thereby running the risk that the majority will be concentrated in private schools[10,11]. Initiatives designed to provide more courses in the interior of Brazil are another positive aspect, however better structuring of the health networks in these municipalities is required. Thus, losing the political momentum for the inclusion of obligatory medical residency (and percentages for FCM) may, in the long-term, increase the number of medical graduates, without necessarily solving the needs of PHC.

The focus on medical residency within the PMM is the most important factor in terms of human resources for PHC within Brazil. The SBMFC supports the process of the universalization of residency positions and the expansion of FCM programs, although there remains continued concern about the quality of such programs. There was a significant numerical increase from 2013-2016, with an increase of more than 1,700 R1 vacancies in FCM. However, this was far short of the desired target, i.e. 40% of direct access to residency positions, which is the case in countries with health systems that are oriented towards PHC, such as Canada[12].

Another important and essential challenge is in relation to the filling of these vacancies; although there has been an increase in the total number of places occupied by R1, there still remains a vacancy rate of around 70%. Regarding this qualification process, in 2015 the SBMFC developed the Curriculum Based on Competencies for FCM residency programs in order to homogenize the training in this area in Brazil, with a subsequent resolution passed by the National Medical Residency Commission (CNRM), which directed training based on this document[13]. In association with this initiative, we consider that projects designed to train preceptors are central to this process, through broadly-based specialization courses and professional master's degrees, both funded by the MS.

Finally, we understand that if the objective of the Brazilian state is to consolidate the SUS, based on strong, robust, versatile and high-quality PHC, the PMM provides a basis for these factors. In order to expedite this process and to provide sufficient FCM, support is required for the following three regulatory pillars of residency-based training: the universalization of vacancies; a percentage of 40% of vacancies to be designated for direct access to FCM; and multifaceted strategies to fill vacancies, especially in relation to the obligatory requirement of residency in FCM for future inflow into Brazilian PHC, with a defined time-frame to take effect in the coming years. Family and Community Medicine: now more than ever!

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