DOI: 10.1590/1413-81232015219.07582016

Beyond the *Mais Médicos* (More Doctors) Program

Mário Scheffer [1]

This article situates the *Mais Médicos* (More Doctors) Program (PMM) at a historical point between the "continuation of consolidation" and the "breaking with tradition" of primary healthcare policies in Brazil. The authors present "changes and qualitative differences" attributed to the program, as well as the challenges it has faced and its limitations.

The model chosen by countries to identify health demands and needs, the manner in which they seek to explain them and are organized to face them, as well as decisions about what should be done, are all formulations by governments that may or may not be mediated by the participation of society, which requires submission to vigorous mechanisms regarding health democracy.

Because there are various ways to structure health systems, which means that there are also variations in the results of the health outcomes that are obtained, in order to better understand the implementation of a program and to evaluate its performance it is worth considering the motivations of the individuals and organizations who are mobilized in a specific institutional and policy framework.

Although it has defined guidelines and principles, a legal and normative basis, and extensive operational experience[1], the Unified Health System (SUS) is threatened by fragile political and economic sustainability and does not possess an articulated research agenda in its favor.

An excessive number of evaluative studies about specific health programs have failed to use the same resources and determination to address complex issues, such as assessing the performance of health systems in the face of financial constraints, or issues arising, for example, from the tensions between universalism and segmentation, which is present in the reinterpretations of the boundaries between public coverage and the licentiousness of private interests within the Brazilian health system.

If there is no evidence on the horizon of material conditions, or political leaders or forces, which are capable of conducting structural measures that can make the health system fully meet the needs of the population, then the emergence of programs tends to be subsumed to a greater degree.

A program can serve the universal system and ensure the technical effectiveness of health policies. In remedial action status, it can ensure priority access to sections of the population. Universalization and focus should be two complementary concepts of social justice[2]. However, the history of the SUS has demonstrated that, although they were anchored in the universal rights guaranteed by the constitution, a number of programs suffered the effects of rushed design and slashed budgets under different administrations.

Health programs are multi-dimensional in nature, with diverse elements that involve a complex process of organizing practices to perform specific objectives[3] that require human, material and political resources for actions that are planned over a defined period[4].

Federal law No. 12,871[5], which was passed in 2013, established the *Mais Médicos* (More Doctors) Program (PMM) and its following three macro-components: 1) the provision of doctors in deprived locations; 2) the expansion of graduate medical course vacancies and residencies; and 3) new guidelines and standards for medical training.

It is essential to clarify which component of the PPP is being discussed and evaluated, and a clear explanation of its scope, objectives and limits are essential starting points.

Driven by a short-term need for legitimacy, the PMM was anchored in a municipal-orientated alliance, in tactics designed to surprise its opponents, and in an a priori assessment of the high positive value of the program.

However, the application of judgment and the first impressions drawn from improvised surveys cannot be confused with evaluation. Evaluation does not lend itself to validating political or technical decisions, but rather to guiding such decisions and to improve the program that is being assessed by appropriating the results of the evaluation process. Every evaluation should consider the principles of utility, ethics and accuracy, making use of scientific and technical parameters, which should not underestimate the political motivations and the social context in which the evaluated program operates.

Among the issues that often contaminate the methodological approaches of assessment are the lack of clarity or overestimation of what is expected as a consequence of the program, and

[1] Departamento de Medicina Preventiva, Faculdade de Medicina, USP. Av. Dr. Arnaldo 455/2º/2166, Cerqueira César. 01246-903 São Paulo SP. mscheffer@usp.br

the desire to immediately measure the effects based on convictions, which are not always confirmed, that the program has been properly implemented. Therefore, an assessment of the implementation process, including its contextual variables, is now a crucial dimension in the evaluation of health programs worldwide[4].

By tracing the evolution of primary healthcare (PHC) in the SUS, and by referring to programs that were implemented in the 1990s, such as the Program of Community Health Agents (PACS) and the Family Health Program (PSF), the authors of this article have chosen to situate the PMM within efforts to implement the National Policy for Primary Care (PNAB) but they also address elements of the PMM that characterize a "break with this tradition".

In fact, there are contradictions. While the PACS and PSF, which were under the umbrella of the Family Health Strategy (ESF), were intended to reorientate the care model from the standpoint of basic care in the context of the expansion of health coverage, the diversification of services, the promotion, diagnosis, treatment and maintenance of health, and democratic management practices rooted in teamwork, the PMM exclusively targeted the supply and training of doctors. Although the PMM provides doctors in deprived locations and increases the amount of doctors in Brazil there remains doubt regarding the insertion and the effect of the program within the upsurge in primary healthcare policies.

Much progress has been made in theoretical terms, and also regarding the organization of health activities, since the historic change from the concept of 'primary curing' (*cuidados primários*), which can be considered to be simple technical and medical procedures, to the notion of primary healthcare' (*atenção primária*), which is seen as the level of care or the portal to a hierarchical and regionalized health system[6]. The gap has been reduced between selective primary care, which is dispensed by a program focused on poor people and poor regions by a restricted 'basket' of consultations and examinations, to ordered and coordinated primary care within an integrated network of attention to health[7].

However, it seems that a balance has still not been achieved regarding the polarity that exists between primary healthcare that denies the essentiality of doctors and another form of that primary healthcare which promotes the exaggerated centrality of doctors in healthcare and in the design of programs or responses to requirements for assistance.

The authors of this article stress that attitudes towards primary healthcare in Brazil expose regional differences regarding the degree of adherence of those in power and also in relation to the speed of its expansion within Brazil as a whole. The Ministry of Health, which is an economic agent and formulator of policy, maintains a low level of commitment to overcoming the limitations of municipalities in terms of ordering and qualifying PHC networks. Experiences that have had a positive, evaluated impact fail to hide the harsh realities of insufficient personnel and inadequate structures, outsourced management and precarious working relations, of acting without enrolled populations, of acute conditions, and of the lack of coordination of emergency care units, specializations and hospitals[8].

The concealed manner of hiring doctors is one of the limitations of the PMM that is highlighted in the article under discussion, which also mentions the provisional nature of the program, the prioritization of medical assistance, and the absence of professional careers within the SUS. Further limitations of the program include the risk of the unaccountability of municipalities in the regular hiring of PHC doctors, and the potential weaknesses of the basis of the program, i.e. the bilateral agreement between Brazil and Cuba, which is triangulated by the Pan American Health Organization (PAHO).

The authors of this article highlight the induction of the supply and training of doctors as an attribute of the PMM. The literature, and the experiences of countries, demonstrates that the poor distribution and localized shortage of doctors should be addressed by a combination of regulatory measures and incentives, from initial training and recruitment, to the installation and settlement of the professional in the workplace. There is no single or lasting solution and there are few methodologically sound evaluations available to measure and compare the levels of impact and cost-effectiveness of different iniciatives[9]. However, in Brazil, and also worldwide, programs and policies associated with the provision of doctors, which have pragmatic appeal and high political kudos, are designed and implemented even in the absence of relevant evidence.

Although this article highlights the decentralization of medical schools, which was planned in the PMM, it may not have been the main factor that resulted in the influx of doctors to these locations. Furthermore, the PMM accelerated the privatization of medical education in Brazil[10], and the massive increase in the number of private jobs

was accompanied by a quality assurance plan regarding the courses, as well as the democratization of access to medical education.

The PMM certainly differed from previous attempts, especially in terms of scale, in that it staffed many municipalities and provided a significant overall increase in the number of doctors. However, by simply linking these perspectives to the efforts of private institutions and municipal initiatives, this drastically restricted the options for reform in terms of the graduation and the lifetime of the program. Calculated in terms of administrations that only last four years, party political support for the program was given in the form of substantial funds for the network of support, supervision, training, research and advertising.

Although it is plausible to argue that the PMM attempted to take control of the regulation of the total number of doctors in the country, confronted professional corporations (which intensified ideological conflicts), and restricted the control of medical institutions of residential homes and specializations, it is an exaggeration to claim that the PMM "redefined the relationship of the SUS with the medical profession".

There are more than 420,000 doctors in Brazil and they represent a mosaic of identities, profiles and backgrounds, with numerous possibilities of integration within the labor market, which is often juxtaposed and dynamic throughout their working lives. Nevertheless, 73% of Brazilian doctors work within the ambit of the SUS[11] and they interact with the public system and its service users in various ways, with varying degrees of relationship, time, commitment, engagement and response capacity. Taken together, public hospitals and the SUS primary care network are the largest employers of doctors in Brazil.

Inadequate training, elitism and individual choices can result in doctors working outside the public sector, especially in small cities and suburban areas, but what plays a much more decisive role in the shortage of doctors is the structural dismantling of the SUS, which has imploded due to a lack of public finance, as well as the incentives for the growth of the private health market and the subsidized expansion of the private healthcare network. The extensive waiting lists for appointments, examinations and elective surgeries, which are generated by the lack of specialists in secondary care and public outpatient care, due to the fact that these doctors are concentrated in isolated and private clinics, is an eloquent example of the failure of the Brazilian health system.

References

1. Paim J, Travassos C, Almeida C, Bahia L, Macinko J. The Brazilian health system: history, advances, and challenges. *Lancet* 2011; 377(9779):1778-1797.
2. Kerstenetzky CL. Políticas Sociais: focalização ou universalização? *Rev. Econ. Polit.* 2006; 26(4):564-574.
3. Novaes HMD. Avaliação de programas, serviços e tecnologias em saúde. *Rev Saude Publica* 2000; 34(5):547-549.
4. Teixeira C, organizador. *Planejamento em saúde: conceitos, métodos e experiências*. Salvador: EDUFBA; 2010.
5. Brasil. Lei nº 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. *Diário Oficial da União* 2013; 23 out.
6. Mota A, Schraiber LB. Atenção Primária no Sistema de Saúde: debates paulistas numa perspectiva histórica. *Saúde Soc* 2011; 20(4):837-852.
7. Giovanella L. Atenção Primária à Saúde seletiva ou abrangente? *Cad Saude Publica* 2008; 24(Supl. 1):21-23.
8. Mendes EV. *As redes de atenção à saúde*. Brasília: Organização Pan-Americana da Saúde; 2011.
9. Ono T, Schoenstein M, Buchan J. Geographic Imbalances in Doctor Supply and Policy Responses. OECD Publishing 2014: *OECD Health Working Papers*, Nº 69. http://dx.doi.org/10.1787/5jz5sq5ls1wl-en
10. Scheffer MC, Dal Poz MR. The privatization of medical education in Brazil: trends and challenges. *Human resources for health* 2015; 13:96.
11. Scheffer M, Biancarelli A, Cassenote A. *Demografia Médica no Brasil 2015*. São Paulo: DMPUSP, Cremesp, CFM; 2015.