

The More Doctors Program: documentary analysis of critical events and positioning of social actors

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One of the challenges in consolidating primary health care, which is a priority strategy for reorienting the healthcare model in Brazil, is the difficulty of supplying and retaining health professionals, especially physicians, throughout the country. This study consists of a documentary analysis of the formulation and implementation processes of the More Doctors Program from 2013 (time of publication of Law No. 12871/2013, which created the MDP) to 2015. Through the selected publications, it was possible to map critical events, interests and identification of divergent positions among social actors (allies, opponents or indifferent) involved in the stages of formulating proposals and implementing the program. The analysis indicated that the MDP generally represented a step forward in providing expanded access to health in Brazil.

Keywords: More Doctors. More Doctors Program. Primary Health Care.

Introduction

In Brazil, the restructuring of primary health care was part of the health reform movement, with the objective of reorganizing care models¹⁻³. Over the history of

primary care, initiatives have been implemented to attract and retain health professionals in remote regions, such as: the Program for the Expansion of Health and Sanitation Initiatives (PIASS – 1976), the Program for the Expansion of the Brazilian Health Care System (PISUS – 1993), and the Program for the Promotion of Primary Care Professionals (PROVAB – 2011)⁴⁻⁶.

Nevertheless, unequal distribution of human resources, especially physicians, in the field of health has continued to prevail, creating limitations on continuity of care³ due to factors such as: high turnover and multiple employment relationships of health professionals, who work simultaneously in the public and private sectors; long work weeks; and different pay scales, with priority given to on-duty shifts and predominance of care activities⁷. This set of factors provided the foundation for a proposal from the National Health Council⁸ highlighting the need to formulate policies aimed at a more balanced distribution of health professionals in all regions of the country.

It can be assumed that the protests of June 2013, sparked by demands for social rights⁹, resonated within the Ministry of Health and the Ministry of Education, culminating in the implementation of strategies focused on the supply of primary care physicians¹⁰, reorientation of university education in health¹¹⁻¹³, publication of new policy guidelines^{10, 14-16} and creation of the More Doctors Program (MDP)^{17,18}. However, various studies have indicated that the MDP implementation process was permeated with polemical opinions, in the absence of analysis of critical events and the positions of the different social actors^{16,19-21}. This study sought to identify and map the main critical events and positions of the social actors during the MDP formulation and implementation process in Brazil from 2013 to 2015.

Methodology

This was a documentary analysis of the implementation process of the More Doctors Program from 2013 (time of publication of Law No. 12871/2013, which created the MDP) to 2015.

The literature search was done by accessing digitalized databases, in addition to an integrated search in the Virtual Health Library (LILACS, MEDLINE and COCHRANE) and Virtual Health Library of the Ministry of Health. Searches were also conducted in journals in the area of collective health (Interface, Saúde em Debate, Saúde Coletiva and Ciência e Saúde Coletiva); institutional repositories (UNICAMP, UFBA, UERJ, UFPR, UNB and UFRGS), in order to retrieve dissertations and theses; and digital pages of governmental and non-governmental organizations (Brazilian Health Studies Center, Brazilian Collective Health Association, Federal Council of Medicine, Ministry of Health and Ministry of Education). The inclusion of databases, journals and websites enabled mapping actors and initiatives adopted, in relation to ease, difficulty, opportunities and threats during the formulation and implementation stages of the MDP. A search was also done of papers referenced in the selected texts, due to the scarcity of documents on the theme.

The Boolean keywords and operators, “mais médicos” OR “programa mais médicos” in Portuguese (“more doctors” OR “more doctors program”) were used. The data collection took place from September to December 2015, ranging from technical and regulatory documents (laws, ordinances, decrees, technical management reports) to scientific papers and master's degree dissertations.

A total of 160 documents were submitted to a selection and analysis process and systematized, based on the following inclusion criteria: publications from 2013 to 2015; abstract available (scientific papers); and the theme of the object of study is discussed. This information was then entered into an Excel® database.

After reading the titles and abstracts, seven documents were excluded. After then reading the texts in full, 43 documents were excluded, since they did not address the theme. The review included fifty documents, analyzed by consensus between two researchers.

The analysis was carried out based on the theoretical contributions proposed by Teixeira²² and the stages of building strategic agendas (formulation and implementation). Also included were the adaptations of Teixeira²² to the theoretical proposal of Carlos Matus²³ regarding the mapping of social actors, classifying them as

governmental actors (representatives of institutions and agencies directly and indirectly involved in the political guidance of health actions in different government spheres) and non-governmental actors (representatives of civil society and/or non-governmental organizations that participated in the implementation of health initiatives in regions and states of the country). The positions of the central, secondary and supporting actors in the process were characterized as allies (actors that support the political proposals of the central actor), opponents (actors who oppose the political proposals of the central actor) or indifferent actors (those with no defined position who can be won over through persuasion or recruitment)²².

Results and Discussion

Of the 58 documents examined, 70.9% came from medical associations, 20% were scientific papers and 9.1% were monographs, dissertations and regulatory documents. Among these, 40.9% discussed the MDP formulation stage (formulation and analysis of proposals) (Table 1) and 59.1% addressed the MDP implementation process (creation of strategies, formulation of policies and operationalization of the program) (Table 2).

STAGE	CATEGORIES	DOCUMENT EXCERPTS	AUTHOR/YEAR
FORMULATION	Formulation of proposals	<ul style="list-style-type: none"> - Massive street protests demanding health care improvements. - MDP – simple measure with great popular appeal. - Ministries of Health and Education create strategies to respond to the demands in the streets. - MDP represents a strategy purely for winning votes in the election. - MDP generates discussion between government representatives and medical associations, especially the Federal Council of Medicine. - "Where's the Doctor?" campaign, by the National Front of Mayors. - Diagnosis of shortage of physicians in the country and research about strategies in other countries to solve shortages of physicians. - Analysis of initiatives: PIASS – 1976, PISUS – 1993, PITS – 2001 and PROVAB – 2011. - Competition between cities for few physicians, generating high turnover. - MDP is an emergency and supplementary program. - MDP does not guarantee labor rights: Federal Council of Medicine criticizes the program because it does not include signed working cards, the guarantee fund for length of service (FGTS), annual Christmas bonus or even paid holidays. - There are no strategies in the public health sphere for creating an SUS career plan, for nurses, dentists and physicians. - Creation of civil servant careers for physicians. - MDP, regardless of its results and the intentions of the federal government, trampled on state, city and regional processes for adequate supply of the SUS networks. - MDP – an initiative clearly aimed at greater regulation of the medical profession by the state. - It would be wiser to invest in public universities. 	<p>OLIVEIRA et al.⁶; PINTO et al.¹⁰; MOLINA et al.¹⁹; GONÇALVES⁶¹; CARAMELLI⁶²; SALLES⁵⁵; ANGOTTI NETO⁴; TORRES⁵⁸; SCHANAIDER³⁸; CUETO et al.⁶⁴; SANTOS¹²; SILVA²⁰; FERREIRA³⁹; CFM⁴¹; D'AVILA⁴²; CUNHA⁴⁸; CFM⁴⁷; CFM⁴³; CEBES⁶³; SANTOS³⁴; COUTO¹⁶</p>

	Analysis of the proposals	<ul style="list-style-type: none"> - The priority regions were defined according to a combined set of criteria. - The program established a period of five years for primary healthcare units to obtain quality equipment and infrastructure, and to serve as learning centers for undergraduate students and residents. - MDP requires measures to expand the training of preceptors in health services. - Law requires that courses of medicine tailor their curricula to the new national curriculum guidelines and determines that implementation would be subject to assessment and audit by the Ministry of Education. - Law stipulates universal medical residency and regulates access to the programs. - Law requires the creation, within two years, of a specific biannual evaluation for undergraduate courses in medicine. - Professional registration of physicians trained abroad will be issued by the Ministry of Health. - Main mistake of the federal government program is the arrival of foreign physicians whose diplomas have not been recognized through Revalida (an obligatory exam). 	<p>KAMIKAWA E MOTTA⁴⁹. BRITO⁵. CFM⁴⁷. MORAIS et al.¹⁵. CFM⁶⁵. CAMBRICOLI²⁷</p>
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Table 1. Systematization of critical events from documents in reference to the formulation stage of the MDP, from 2013–2015.

SOURCE: Prepared by the authors.

Table 2. Systematization of critical events from documents in reference to the implementation stage of the MDP, from 2013–2015

STAGE	CATEGORIES	DOCUMENT EXCERPTS	AUTHOR/YEAR
IMPLEMENTATION	Strategy design	<ul style="list-style-type: none"> - The intention is to create 11,500 openings in undergraduate courses of medicine by 2017 as well as 12,400 medical residency openings to train specialists by 2018, with a focus on enhancing the importance of primary care in the Family Health Strategy and SUS priority areas. - These dilemmas affect medical residency programs. The Ministry of Education's announcement that an opening for specialization will be provided for each graduating student is unenforceable. There are not enough prepared hospitals or preceptors to guide future specialists. 	DURCAN E TARGA ²⁰ . CEBES ²⁴ . CEBES ²⁸
	Formalization of Policies	<ul style="list-style-type: none"> - To make the PAHO/WHO technical cooperation agreement official, a cooperation agreement (TC 80) was signed between the Ministry of Health of Brazil and PAHO/WHO, as well as successive adjustment agreements. - Labor agreement between the Ministry of Health, PAHO, the government of Cuba and Cuban physicians is unfair. - More Doctors Program - two years: more health care for Brazilians. 	CAMPOS ⁵¹ . MOLINA ⁵⁰ . MENDES ³⁶ . PINHO ⁵² . MARTINS ⁵³ . CFM ⁵⁴ . FERREIRA ⁶⁸
	Operationalization of the program	<ul style="list-style-type: none"> - Through the emergency supply of physicians, the project expanded primary care in poor regions. - Enabled Brazilian physicians to share experiences with foreign physicians. - MDP has specific inadequacies related to the execution of supervisory and tutoring activities. receiving and training professionals. decisions of local managers to replace contracted physicians with visiting physicians, penalties on Cuban physicians who have their families with them in Brazil. - The main criticism of the auditors from the Federal Court of Accounts targeted the weaknesses of the supervisory and tutoring system of the program. - Expand the number of undergraduate openings, without depending on the market - It is necessary to ensure that students from lower income neighborhoods and rural, indigenous and quilombola communities have an opportunity to occupy places in courses of medicine. - Initial number of cities that joined the program was 4,025 and 16,631 physicians were requested. 1,878 priority cities joined the program. Along with 2,147 in other locations. - Most of the news coverage was negative. Some journalists and readers saw positive aspects in the implementation of the More Doctors Program. 	SCHEFFER ⁷ . CFM ⁵⁴ . BRASIL ²⁵ . CYRINO et al ²⁶ . CARVALHO ²⁹ . CHIORO ³⁰ . AQUINO ³¹ . CAMPOS ⁵¹ . CFM ⁶⁵ . GOMES ⁶⁶ . FERREIRA ⁶⁸ . CFM ⁶⁹ . CFM ⁷⁰ . CFM ⁷¹ . CFM ⁷² . CFM ⁷³ . CFM ⁷⁴ . FORMENTE AND ROSA ⁷⁵ .

		<ul style="list-style-type: none"> - SUS requalification. - Inspections by the Regional Council of Medicine of Rio de Janeiro (CREMERJ) and other regional councils of medicine found no supervision or tutoring. There were physicians from the MDP seeing patients alone who had difficulty communicating in Portuguese. - The audit performed by the Federal Court of Accounts (2014) showed that 49% of the first locations served by the program dismissed previously hired physicians after the arrival of the physicians from the MDP. Consequently, around one year later, these locations had fewer professionals registered in the public health network. - Of the 42 cities that established medical schools between 2013 and July 2015, 60% (25) did not meet the criterion of five SUS beds per enrolled medical student. 	
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SOURCE: Prepared by the authors.

Formulation and analysis of the proposal

With respect to problems, the documents indicated unequal distribution of physicians as one of the main challenges to fully putting the SUS into practice^{21,24,25}. They also mentioned competition for manpower between certain cities, based on attractive compensation (high wages), which generated high turnover among these professionals and discontinuity in health initiatives^{6,10,16,26-32}.

This situation sparked various discussions. In April 2011, the Ministry of Health sponsored the National Seminar on the Shortage, Supply and Retention of Health Professionals in Remote and More Vulnerable Areas, in order to "discuss and provide input for drafting political and technical feasibility proposals to ensure universal access to healthcare services [...]"³³. The seminar brought together representatives from: different branches of government; the health, education and labor sectors; and organizations that monitor the actions of federal, state and municipal governments.

In January 2013, a campaign entitled "Where's the Doctor?" was carried out by the National Front of Mayors^{16,25}. In June, there were street protests demanding better means of access to health services and the inclusion of priority actions on the government's agenda^{10,15, 34}.

This process helped consolidate the situational analysis and provided input for prioritizing problems and creation of strategies by the Ministry of Health, the Ministry of Education, and the Ministry of Planning, Budget and Management. The ministries were represented by their ministers, who submitted to the president the Inter-Ministerial Presentation of Motives (EIM) No. 24/2013-MS-MEC-MP, which listed priority actions³⁵. This document was used to draft Provisional Measure No. 621/2013 in July¹⁷.

The ministers estimated a ratio, in 2012, of 1.8 physicians per thousand inhabitants^{5,14,36} based on data from the Brazilian Institute of Geography and Statistics (IBGE) and the Federal Council of Medicine^{11,12}. However, Silva²¹ said that this figure was questioned by the Federal Council of Medicine, which calculated 2 physicians per

thousand inhabitants. In contrast, data from the World Health Organization indicated that Brazil had a low ratio³⁷.

Given the lack of an international parameter to measure the ideal ratio of physicians in a country, it was agreed to use the parameter from the United Kingdom (2.7 physicians per thousand inhabitants), since that country has a universal health system. However, considering the number of students graduating in medicine, without an effective intervention to raise this figure²¹, this goal would only be reached by 2035.

According to Mendes³⁶ and Schanaider³⁸, merely increasing the number of physicians would not solve the problem of allocation in more vulnerable regions, since these professionals could opt for more attractive work options. Scheffer³⁹ noted the imminence of intensified competition in areas that already had a high density of physicians.

Some advocates of the MDP discussed proposals to modify the national curriculum guidelines for undergraduate courses in medicine, medical residencies, and the training of specialists¹⁰. As an alternative to the precariousness of medical work and insufficient policies for inland expansion of care, Silva²¹, Ferreira⁴⁰ and the Federal Council of Medicine⁴¹ suggested the creation of civil servant careers for SUS physicians. D'avila⁴² also proposed structuring an SUS career plan for nurses and dentists.

However, the Federal Council of Medicine pointed out that of the 12,000 places offered in 2013 for the medical residency program, 3,000 were not used because of disorganization in some programs⁴³. It also emphasized that the proposal to create a forum to regulate health professions, contained in the Provisional Measure (which was later deleted altogether), could alter the competencies of the professions, especially those solely related to physicians, and the duties of the national and regional councils of medicine⁴⁴.

To defend and justify these positions, the Federal Council of Medicine and other medical associations prepared a document entitled "Provisional Measure 621/2013: Technical and legal weaknesses that place the health of the population at risk." It was afterwards sent to lawmakers⁴⁵; the document pointed out statistical divergences related to the distribution of professionals in Brazil.

After the publication of Provisional Measure No. 621/2013, the National Congress appointed an integrated mixed commission, composed of senators and federal deputies, to issue an opinion on the standard. Senator João Alberto Souza (PMDB/MA) acted as chairman, Federal Deputy Francisco Escórcio (PMDB/MA) as vice-chairman, Federal Deputy Rogério Carvalho (PT/SE) as rapporteur, and Senator Mozarildo Cavalcanti (PT/RR) as rapporteur-reviewer^{16,46}. Considering the heterogeneous makeup of the commission, it was a forum for numerous debates and a lot of controversy generated by the proposals of the program.

The lawmakers submitted 1,376 proposed amendments to the MDP, involving all the foundations of the program and representing many political parties: Democratic Party (DEM), Communist Party of Brazil, Democratic Labor Party, National Ecologic Party, Brazilian Democratic Movement Party (PMDB), Progressive Party, Socialist People's Party, Party of the Republic, Brazilian Republican Party, Social Christian Party, Social Democratic Party, Brazilian Social Democracy Party (PSDB), Workers' Party, Brazilian Labor Party and Green Party. A large number of proposals were filed by the PSDB, PMDB and DEM, with 160, 125 and 114 amendments, respectively¹⁶.

Provisional Measure No. 621/2013 covered many polemical issues, such as lengthening undergraduate courses in medicine by two years. This particularly disturbed medical students, educational institutions and medical associations that had suggested changes to the original bill, in terms of implementing new courses of medicine based on the new national curriculum guidelines^{10,16,17}.

After establishing the priorities, the commission proceeded to formulate the program based on three areas of action: 1) investments to improve the infrastructure of the health network, especially primary healthcare units; 2) expansion and curriculum reform for undergraduate courses in medicine and medical residencies in the country; 3) the More Doctors in Brazil Project (MDBP), which entailed emergency supply of physicians in vulnerable areas of the country^{15,18}.

Implementation of the MDP

Operationalizing the MDP required inter-sectoral coordination between the health and education sectors and the three levels of political and administrative organization of the country (federal, state, and municipal), through state and municipal departments of health, and the participation of public and private universities^{15,35}.

The criteria for allocating physicians and defining priority regions took into consideration six profiles: capital cities; metropolitan regions; G100 (100 cities > 80,000 inhabitants and high social vulnerability); poverty (cities with \geq 20% of the population living in extreme poverty); Special Indigenous Health Districts; and other locations^{5,10,15,18,25,28,36}.

The cities that were classified joined voluntarily and signed an agreement that they would ensure housing, food and transportation for the physicians; keep the primary healthcare units in good operating condition; implement or support residency programs for family and community medicine; and provide professionals with the time needed for improvement activities. Physicians were solicited after the agreements had been signed²⁵.

In the first year of the MDP, official notices were published inviting physicians registered in Brazil, followed by calls for Brazilian physicians educated abroad but not registered in the country, until most of the available openings were filled^{5,21}. The length of time physicians could work in the program was three years, renewable for another three years^{47,48}.

To assist with hiring foreign physicians whose diplomas were not formally recognized in Brazil, the Ministry of Health signed a cooperation agreement with the Pan American Health Organization (PAHO), interlinked with the World Health Organization (WHO), specifying the technical and financial requirements for the components of the program^{19,36}.

PAHO/WHO also signed a cooperation agreement with the Ministry of Public Health of Cuba in order to recruit Cuban physicians, fill available openings and encourage the sharing of primary care experiences, based on the work of professionals in other countries^{19,25,36,39}.

Physicians who were not registered with the Federal Council of Medicine obtained a special registration through the Ministry of Health that allowed them to work in activities defined by the MDP^{5,16,21,36,49}. Dispensing with the formal process for recognizing the diplomas of these physicians upset some of the medical associations, which alleged state interference in the autonomy of the federal and regional councils of medicine. They also considered the measure a risk to the population due to the lack of clear rules and criteria for the selection of physicians^{40,47}.

The Federal Council of Medicine insisted that, even if registrations were not issued, the MDP coordinators should provide a list of physicians and their places of work, because even with temporary registration, these professionals were still subject to the laws in effect regarding professional, civil, criminal and ethical liability⁴⁴.

As an alternative, visiting physicians were required to participate in an orientation process to assess their proficiency in Portuguese, communication skills and qualifications, in order to provide a deeper theoretical and practical understanding of the principles and guidelines of the SUS, through monitoring and evaluation by academic tutors^{16,29}.

Another issue discussed was the recruitment of a large contingent of foreign physicians from Cuba to fill the first set of places in the MDP selection notices, due to the technical cooperation agreement^{19,25,36,50}. Campos⁵¹, Pinho⁵², Martins⁵³ and the Federal Council of Medicine⁵⁴ considered the following aspects to be unfair: partial payment of the stipend to the professionals and travel restrictions on the family members of physicians working in Brazil. Some authors viewed the cooperation agreement between the countries as representing collusion with the oppression of citizens in Cuba^{51,53}.

However, the rights of visiting physicians were guaranteed according to international agreements¹⁶ and Brazilian physicians were given the right to register for Social Security. Objections by the Federal Council of Medicine to these professionals being hired under the rules of the CLT (Brazilian labor law) and concerns about possible increases in federal government spending were dismissed⁵⁵.

Scheffer⁷ and Ferreira⁴⁰ noted that inspections by various regional councils of medicine found that Brazilian physicians were repeatedly being replaced by visiting physicians.

Cambricoli²⁷ questioned the allocation of certain physicians from the program, because almost one-quarter of those who were selected either worked or would work in capital cities or metropolitan regions. In contrast, data from the Ministry of Health (2014) indicated that there were an additional 14,090 physicians covering a population of 48.6 million people (in priority regions) in 3,866 cities and 33 indigenous districts. Seventy-five percent of them were in the semi-arid region of the Northeast, on the outskirts of major urban centers (with a low or very low Human Development Index), or in cities and regions with a quilombola population (descendants of Afro-Brazilian slaves who escaped from the slave plantations that existed in Brazil and live in hinterland settlements)¹⁹.

With respect to medical training, Law No. 12871/2013 enabled structural changes through promoting the reformulation of the national curriculum guidelines for courses in medicine, with a focus on healthcare networks, active teaching and learning methodologies, early insertion in health services, and aligning medical training with the new requirements and needs of the population and the SUS^{25,26}. The federal government proposed the creation of 11,500 undergraduate openings in medicine by 2017 and 12,400 in medical residencies by 2018, with a focus on primary care and the Family Health Strategy^{18,20,26}.

The Federal Council of Medicine highlighted the need for more strictness in relation to opening new courses and surveillance of already existing ones. It pointed out that of the 42 cities that set up medical schools from 2013 to July 2015, 60% (25) did not meet the SUS requirement of five beds per enrolled student, as per the guidelines from the Ministry of Education⁴³. It also reported the existence of unfilled openings, lack of structure in the programs, and inadequate working conditions⁴³.

Through an acceptance agreement, local managers were required to provide the necessary structural conditions for undergraduate courses in medicine to operate effectively²⁶. Remodeling, expansion and construction of primary healthcare units

through the Primary Healthcare Unit Requalification Program⁵⁶, increased expenditures related to the computerization of these units, implementation of a new primary care information system and the e-SUS strategy, with electronic medical records for health services²⁵, were considered essential to boost the effectiveness of primary care¹⁹. The law also referred to the creation of Public Health Organizational Contracts in education and health^{14,25}. However, some professionals continued to claim that working conditions were inadequate⁴⁸.

In 2015, the ministries released an analysis entitled "More Doctors Program – two years: more health care for Brazilians", addressing the motivations and context for the creation of the program. However, the uncertain political and social situation pointed toward termination of the program, even though a provisional measure had been enacted to extend the program for another three years²⁵.

Mapping and position of social actors

This document analysis allowed the identification actors that hindered and/or influenced the definition of actions and strategies, as well as understanding of how the public policy was designed and implemented²².

The positions and management of government resources by social actors triggered a series of divergent "initiatives" in the local, regional and national implementation of the MDP. It was also possible to identify secondary actors, classifying them as allies, opponents or indifferent actors in relation to the central actors (Ministry of Health and Ministry of Education)^{6,10,16,26-32,57}. Table 3 systematizes the mapping of the positions.

Table 3. Identification of documents and positions of social actors in relation to the formulation and implementation stages of the MDP

TYPE OF ACTORS	POSITION	ACTOR	DOCUMENTS
GOVERNMENTAL	Central Actors	Ministry of Health; Ministry of Education	OLIVEIRA et al. ⁶ ; PINTO et al. ¹⁰ ; COUTO ¹⁶ ; CYRINO et al. ²⁶ ; CAMBRIOCOLI ²⁷ ; CEBES ²⁸ ; CARVALHO ²⁹ ; CHIORO ³⁰ ; AQUINO ³¹ ; CARVALHO ³²
	Allies	PAHO; WHO; Municipal Department of Health of Rio de Janeiro; Isabel Emilia Prado da Silva (supporter of the MDP in the Ministry of Education); Federal Attorney's Office; Central Única dos Trabalhadores (CUT - national trade union); National Front of Mayors; National Council of Municipal Secretaries of Health (CONASEMS); National Association of Public Prosecutor's Offices for Defense of Health (AMPASA)	BRITO ⁵ ; COUTO ¹⁶ ; MOLINA et al. ¹⁹ ; DURCAN AND TARGA ²⁰ ; SILVA ²¹ ; MOLINA ⁵⁰
	Opponents	Ronaldo Marques Gomes (Department of Health of Rio de Janeiro); Robespierre Costa Ribeiro (Minas Gerais Hospital Foundation); Federal Deputy Marcus Pestana (PSDB-MG); Leader of the DEM, Mendonça Filho (PE); Federal Deputy Ronaldo Caiado (DEM-GO); Cyro Miranda (PSDB-GO)	GOMES ⁶⁶ ; CFM ⁷⁰
	Indifferent	Public Prosecutor's Office for Labor (MPT); National Coordinating Committee for the Fight against Labor Irregularities; Federal Court of Accounts; Members of the Mixed Commission (Chairman - Senator João Alberto Souza (PMDB/MA); Vice-chairman - Federal Deputy Francisco Escórcio (PMDB/MA); Rapporteur - Federal Deputy Rogério Carvalho (PT/SE); and Rapporteur-Reviewer - Senator Mozarildo Cavalcanti (PT/RR))	BRITO ⁵ ; COUTO ¹⁶ ; CFM ⁷¹ ; CFM ⁷² ; CFM ⁷³ ; FORMENTI AND ROSA ⁷⁵
NON-GOVERNMENT	Central Actors	-	-
	Allies	Mário Scheffer (USP); Gastão Wagner de Sousa Campos (UNICAMP); CEBES; Lourdes Mann, Cuban physician; CEBES; Central Única dos Trabalhadores (CUT); Conectas - Nongovernmental Organization for the Defense of Human Rights; Association for Holders of Bachelor's Degrees of Brazil	COUTO ¹⁶ ; SCHEFFER ³⁹ ; CAMPOS ⁵¹ ; FERREIRA ⁶⁸

	Opponents	Federal Council of Medicine (CFM); Brazilian Medical Association (AMB); ABEM; FENAM; National Association of Medical Residents; National Executive Board of Medical Students (DENEM); Caroline Reis (UNIMONTES); Bruno Caramelli (USP); Marina Salles (USP); Hélio Angotti Neto (UNESC); Ribas Didier Roberto Torres (Seconci-SP – Social Organization); Alberto Schanaider (UFRJ); Gisele Keiko Kamikawa (UNICESUMAR); Ligia Bahia (UFRJ); Students' Forum of ENSP/Fiocruz; Unicamp, USP and Unifesp; Dr. Maíra Fachini National Medical Association (AMN-MF); National Confederation of Regulated Autonomous University Workers (CNTU).	ANGOTTI NETO ⁴ ; BRITO ⁵ ; SANTOS ³⁴ ; MENDES ³⁶ ; SCHANAIDER ³⁸ ; FERREIRA ⁴⁰ ; CFM ⁴¹ ; D'AVILA ⁴² ; CFM ⁴³ ; CFM ⁴⁴ ; CFM ⁴⁷ ; CUNHA ⁴⁸ ; MOTTA ⁴⁹ ; PINHO ⁵² ; MARTINS ⁵³ ; CFM ⁵⁴ ; SALLES ⁵⁵ ; TORRES ⁵⁹ ; GONÇALVES ⁶¹ ; CARAMELLI ⁶² ; CEBES ⁶³ ; KAMIKAWA AND CUETO et al. ⁶⁴ ; CFM ⁶⁵ ; GOMES ⁶⁶ ; CFM ⁶⁷ ; FERREIRA ⁶⁸ ; CFM ⁶⁹ ; CFM ⁷⁰ ; CFM ⁷¹
	Indifferent	Mônica Sampaio (UNB); Paulo Henrique (Estácio de Sá University); Indyara Morais (UNB); Liege Scremin (UNIBRASIL); Renato Meirelles (Datapopular); Institute for Applied Economic Research (IPEA)	BRITO ⁵ ; MORAIS et al. ¹⁵ ; CARVALHO ³²

SOURCE: Prepared by the authors.

Regarding initiatives to legitimize the MDP, it was possible to identify political, technical and tactical negotiations of the central actors^{5,15,16,35}.

The allied social actors were mapped based on their insertion into the decision-making process. They argued that the shortage of physicians, among other issues, was due to the omissions of previous governments and the corporatism of the medical category⁵⁸ such as PAHO/WHO (which mediated the hiring of foreign physicians, signed the cooperation agreement with the Ministry of Public Health of Cuba, and mobilized Cuban physicians).

Some institutions of higher education, the Federal Attorney's Office and Central Única dos Trabalhadores (CUT – the main national trade union center in Brazil) defended the legality of the work of the contracted physicians, based on the integration of teaching and service. The National Front of Mayors and National Council of Municipal Health Departments defended the need for more physicians in the cities to ensure comprehensiveness in primary healthcare actions. The National Association of Public Prosecutor's Offices for the Defense of Health, the Non-governmental Organization for the Defense of Human Rights and the Association of Holders of Bachelor's Degrees of Brazil were also involved^{16,19-21,50}.

On the other side, opponents of the MDP reported the existence of implicit electoral interests, categorizing the measure as "populist" and enacted to maintain the government in power^{48,50,59}.

Also in opposition, some medical schools and medical associations, such as the Federal Council of Medicine, argued that the percentage of physicians in the country was compatible with the need and denounced government interference in the autonomy of the councils of medicine, irregularities in the hiring process in relation to Brazilian labor laws, and lack of strictness in the opening of medical schools^{47,48,58}. The National Council of Medical Students argued that the creation of the MDP was fallacious. They considered the main problems of Brazilian health care to be lack of infrastructure and improper management of health units⁵⁵.

Social organizations, the Hospital Foundation of Minas Gerais, and political parties in opposition to the government, such as the PSDB and DEM, were also against

the program. These actors alleged that the MDP was a threat to people's health, because it did not require official recognition of the diplomas of foreign physicians. They also referred to the existence of fragmented human resources policies in the SUS, lack of supervision and tutoring, situations where visiting physicians provided care alone, and communication difficulties (in Portuguese)^{4,5,35,36,38,40-49,52,53,55,59-71}.

Despite the positions of opposition groups and the government coalition, and a diversity of interests in the process, Law No 12871/2013 was passed^{15,16,18,35}. Regardless of the controversy, Kamikawa and Motta⁴⁹ correlated the creation of the provisional measure with efforts to ensure the right of the population to health.

The documents also revealed actors with indifferent or contradictory positions in relation to the MDP, such as certain institutions of higher education; control agencies of the state, such as the Public Prosecutor's Office for Labor (which disagreed with the form of hiring); the National Coordination Office for the Fight against Labor Irregularities (which advocated the insertion of professionals through public sector recruitment exams, in accordance with constitutional requirements); the Federal Court of Accounts; and the Integrated Mixed Commission^{18,54,71-75}.

As for the Integrated Mixed Commission, although numerous amendments were filed, it was not possible to detect that any consensus was reached regarding the priorities that would constitute the strategic agenda, in light of the actions of lawmakers that were designed to serve personal and party interests. This was substantiated by the high number of proposals submitted and the large percentage of amendments rejected by the Integrated Mixed Commission that studied the provisional measure¹⁶.

Indifferent parties also mentioned certain challenges in the MDP formulation stage, such as: high turnover of professionals in the cities⁶¹; the need to review medical training¹⁵; insufficient numbers of places in undergraduate courses in medicine, in all regions of the country¹⁵; allegations that the MDP was an initiative aimed at greater regulation of the medical profession by the state⁵¹; and the low number of Brazilian physicians who joined and worked in the first stage of the MDP^{18,54,71-74}.

Final Considerations

This document review served to list the critical events and motivations and identify the formulation and implementation process of the MDP. This process gave rise to a tug of war that involved "concessions" and "negotiations" based on the interests and positions of the social actors and the premise of prioritizing primary care and expanding the inclusion of professionals with appropriate training to work in public health care. However, it should be emphasized that to maintain a program of this nature, it is necessary to strengthen the development of mid- and long-term strategies related to the training and qualification of physicians.

The MDP was implemented in a politically favorable context, and the preliminary results of some studies indicate that the program was expanded to 65% of the cities and operated in all regions of the country (13% in the North, 35% in the Northeast, 27% in the Southeast, 17% in the South and 6% in the Center-West)⁷⁶, in addition to providing increased access to health services for quilombola users⁷⁷. In spite of that, there was still controversy related to labor issues.

The cooperation agreement with PAHO, although it included physicians from 47 countries, showed that there were differences in the hiring of Cuban physicians. The articles of the agreement revealed low compensation for these professionals, since part of their salary was appropriated by the government, and lack of labor guarantees and rights related to the mobility of the physicians and their family members⁵⁰⁻⁵². This situation generated expressions of discontent and proposals to expand the discussion with society regarding the appropriateness of this hiring process for Cuban professionals.

Last, even though the MDP was subject to many questions and some uncertainties, it has been an important strategy for the regulation of human resources for the SUS and plays a key role in increasing access to health and strengthening primary care in Brazil.

Collaborators

RA Jesus participated in the design, outline, data analysis and interpretation and writing of the paper. MG Medina participated in the design and review of the paper. NMBL Prado participated in the design, outline, data analysis and interpretation, discussion of the results, and review and approval of the final version of the paper.

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