

## Service users' perceptions of the *Mais Médicos* (More Doctors) Program in the Municipality of Mossoró, Brazil

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**Abstract** *The Mais Médicos (More Doctors) Program (MMP), which was launched in 2013, sought to provide doctors to work in primary health care in priority areas within the Brazilian Unified Health System (SUS). This article analyzes the perception of MMP service users through the results of a qualitative study that consisted of interviews with service users of the Family Health Strategy (ESF) in which doctors from the MMP worked. The service users who were interviewed had a positive view of the MMP because it had expanded access to health care, although there still remained organizational and technical problems that limited the use of services. The performance of foreign doctors was well viewed, with an emphasis on a humanized relationship between doctor and service user, which was characterized by listening, attention and dialogue. In terms of communication with these professionals, some service users referred to language as being a barrier, which was ameliorated by the use of communication strategies within the ESF. The MMP offered a quick and satisfactory resolution to the historical problem of difficulty of access to doctors in Brazil. However, the effectiveness of the Brazilian health system requires that weaknesses are overcome, such as access to specialized services, organizational problems and the implementation of service production models that are centered on illness.*

**Key words** *Primary health care, Health policy, Medical care, Human resources, Personnel management*

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## Introduction

According to the World Health Organization (WHO), the shortage of health professionals is a global problem that undermines the establishment of national health systems; this problem is worse in regions with higher incidence of diseases<sup>1</sup>. In order to meet the challenges arising from epidemiological and demographic transitions, and the redistribution of failure loads, there is need change these systems, as well as the profile of professionals and their training<sup>2</sup>.

In Brazil, the following federal government initiatives have been launched to attract and retain health professionals in remote regions of the country: the Program to Internalize Health and Sanitation Actions (PIASS - 1976); the Program to Internalize the Unified Health System (PISUS - 1993); the Program to Internalize Health Work (PITS - 2001); and the Program to Value Primary Care Professionals (PROVAB)<sup>3</sup>.

Despite these initiatives and the construction of the Unified Health System (SUS), which was accompanied by a significant expansion of health services<sup>4-6</sup>, other problems still compromise the guarantee of universal access to health care, including the unequal distribution of doctors. This results in a lack of health professionals in municipalities that are more distant from the large urban centers in Brazil<sup>7-9</sup>.

Consequently, on July 8, 2013, through the enactment of Provisional Measure No. 621, the Brazilian government established the *Projeto Mais Médicos* (More Doctors Program), which was designed to reduce the shortage of doctors in Brazil, strengthen the SUS, reorganize national medical training and strengthen ongoing health education policy<sup>10</sup>. The *Mais Médicos* Program was changed by Law 12,871 on October 22, 2013, which reorganized the availability of medical courses and vacancies for medical residencies. It also created new parameters for Brazilian medical training and launched the *Projeto Mais Médicos para o Brasil* (More Doctors for Brazil Program), which was intended to allow the emergency provision of doctors to work in primary health care in priority areas of the SUS<sup>11</sup>.

The *Mais Médicos* Program recruited doctors to work in primary health care and compose teams working within the Family Health Strategy (ESF), which led to the hiring of medical staff from abroad after the *Mais Médicos* Program's first call for staff resulted in a low level of interest from Brazilian doctors<sup>12</sup>. These staff are hired for a period of three years and they act under the su-

perision and mentoring of Brazilian universities to provide improvements in basic health care<sup>13</sup>. They have been deployed in areas that are considered to be a priority due to restricted access to health services, difficulty in providing doctors, and the increased vulnerability of the local population, according to criteria defined by Ordinance No. 1377, June 2011<sup>14</sup>.

The premise is that the criteria for evaluating health reforms and their corresponding policies must come not only from managers and specialists but also from health workers, service users and other sectors of society<sup>15</sup>. Approaches that are guided by the perceptions of service users made possible the understanding of basic subjective aspects of healthcare, which, together with methodological rigor performed under new paradigmatic bases, especially comprehensive and dialectic, have led to their consolidation and growing scientific legitimacy<sup>16,17</sup>. Possible limits to these approaches have been highlighted, such as the unrepresentative nature of samples, the susceptibility of findings as to how data is collected, and the "otherness" of researchers in relation to the understanding of phenomena<sup>18</sup>, partly arise from a lack of understanding regarding other discursive fields, such as biomedicine, in relation to the ontological and epistemological nature of these approaches and, in part, they contain internal challenges regarding this investigative field<sup>19</sup>. Thus, this research set out to analyze the perceptions of service users regarding the *Mais Médicos para o Brasil* Program.

## Methods

This qualitative study<sup>16</sup> was performed in the city of Mossoró, which is situated in the state of Rio Grande do Norte, Brazil. In April 2014, 14 exchange doctors from Cuba made up about 25% of the local ESF teams<sup>20</sup>. The studied sites were the territories of the Basic Health Units (BHUs) that received these doctors.

The research subjects were residents of the territories served by the ESF teams that included the exchange doctors and who met the following criteria: they were aged over 18; they had resided for at least one year in the locality served by the ESF and that they had used the health services of the ESF where an exchange doctor was working. The exclusion criteria were the following: they did not have a minimum time of 30 minutes to conduct the interview; and they had direct kinship, an affinity relationship, or emotional in-

volvement with an exchange doctor or any other professional working in the BHU where the research was conducted.

For the selection of the service users, firstly a territorial criterion was applied: an ESF was chosen with a foreign doctor in each of the five regions of the city (north, south, east, west and central), with priority being given to complete teams. Subsequently, the participants were selected from the territories where the health teams operated and an attempt was made to interview at least one per person from each micro-area of the area covered by a community health worker (ACS). An attempt was made to diversify the profile of the respondents according to age, gender and socioeconomic profile, so long as the inclusion criteria were respected.

The size of the sample was based on theoretical saturation<sup>21</sup>, which is used in qualitative studies, so there was a total of 25 respondents who were attended by six ESF teams covering all the regions of the city.

Individual semi-structured interviews<sup>22</sup> were used to collect the data in an attempt to allow the interviewees to express themselves freely. The interviews were held in the homes of participants or in the health unit, when there was an appropriate place, according to the convenience of the respondent and ensuring the privacy and confidentiality of the information that was obtained.

The material was submitted to thematic analysis that involved the following methodological procedures: categorization (decomposing the analyzed material into parts and distributing them into categories); description (making a description of the results of categorization); inference (making inferences of the results); and interpretation (interpreting the results with the help of the adopted theoretical approach). In terms of practice, questions were formulated which aimed to find out the content of messages, without prior intervention and seeking to learn<sup>22,23</sup>.

The analysis culminated in the establishment of the following three categories, from which the presentation of the results was structured: the views of service users about the *Mais Médicos para o Brasil* Program; access to primary health care: changes and continuities, and the perceptions of services users regarding the work of the foreign doctors.

This study followed the ethical principles set out in Resolution No. 466/2012 of the National Health Council; it was submitted to the Ethics Committee of the State University of Rio Grande do Norte (UERN) and approved.

## Results and discussion

### The views of service users regarding the *Mais Médicos para o Brasil* Program

The profiles of the service users who expressed their views about the *Mais Médicos para o Brasil* Program were based on the criteria of gender, education and age. In all, there were 25 research participants: 18 women (72%) and seven men (28%); 23 had middle or elementary school education (92%), one was illiterate (4%) and one had higher education (4%); four were aged over 60 (16%), 10 adults were aged between 30 and 60 (40%) and 11 young people were aged between 18 and 30 (44%).

The *Mais Médicos para o Brasil* Program was seen by these service users as an important governmental strategy to address the lack of doctors in BHUs and to improve access to doctors in primary health care, principally through the influx of foreign doctors. In less than a year the *Mais Médicos para o Brasil* Program recruited and allocated 14,462 doctors in 3,785 municipalities, of which there were 12,616 foreign doctors from 49 participating countries; of these 11,429 were Cuban doctors<sup>3</sup>.

*The lack of doctors is getting a little better with these foreign doctors arriving; mainly in the health centers* (Interviewee 3).

As well as increased ease of access to health services, the attention and respect given to service users by Cuban doctors were highlighted in this study as contributing to a positive evaluation of the *Mais Médicos para o Brasil* Program.

*It's great because where they [Cuban doctors] are people say they are wonderful* (Interviewee 5). *Excellent, especially the Cuban [doctor], because he attends you well* (Interviewee 2). *I liked it very much. I think they [Cuban doctors] are better prepared because they have a conversation with you. They are very relaxed and treat people very well* (Interviewee 18). *It is a sign that the country is in need of doctors* (Interviewee 19). *I liked it because previously we came [to the health center] and had no doctor* (Interviewee 20).

Some service users felt that the reason why foreign doctors were required was due to the fact that Brazilian doctors preferred to work in private practice rather than in the public SUS:

*Brazilian doctors often don't want work for the SUS. Cuban doctors find it hard to work in their own country so they come here and they work for the SUS. Most Brazilian doctors complete their studies and when it comes to put their learning into*

*practice they open a private clinic. But they [foreign doctors] don't; they accept to come here (Interviewee 10).*

This is a complex issue. On the one hand, it involves the fact that the “unselfishness that characterized the beginning of the modern medical profession has long since been replaced by the professional ideology of valuing ultra-specialities, high personal incomes, and the transformation of health centers into microenterprises inserted within a competitive business market”<sup>24</sup>.

On the other hand, the issue relates to the precariousness of work and the lack of investment in the work conducted by the SUS. The current situation regarding the labor market affects the production of health services, resulting in the degeneration of links, including the denial or omission of the constitutional rights of workers; the precariousness of work-related environments and conditions<sup>25</sup>; the heteronomy of salaries; differentiated and unequal labor; the absence of planning regarding functions, careers and wages (PCCS); the absence of guidelines and technical/institutional principles in the hiring process due to clientelism; and the absence of a permanent education policy<sup>26</sup>.

Although they were less significant, there were also negative perceptions on the part of service users regarding the arrival of foreign doctors, which reflected concerns and uncertainties regarding the training of these professionals and the viability of communication with patients. There was an understanding that there should be greater investment in Brazilian doctors and that they should receive higher salaries

*It's shameful on the part of the federal government, why? Because we have doctors all over Brazil! So they have to bring doctors here from abroad? Are they really trained doctors? (Interviewee 9). I think this implies that the service is not good, it is not efficient; firstly, because he [foreign doctor] does not understand the language, I did not understand what he said. I see this assistance from abroad as a problem and it is unnecessary (Interviewee 12). I think it would be much easier for them to pay more to our own doctors (Interviewee 13).*

Allocating doctors to remote areas goes beyond the issue of salary: “the unattractive nature of regions with the worst social indicators and inadequate working conditions, excessive working hours and low pay hinders the hiring of doctors, and better salaries alone cannot compensate when doctors are subjected to professional isolation and a low quality of life for themselves and their families”<sup>25</sup>.

It should be stressed that within the *Mais Médicos para o Brasil* Program “the following were eligible to participate: Brazilian doctors who graduated in Brazil or abroad, and foreign doctors, regardless of the place of graduation, so long as they came from countries where the number of doctors per capita was above 1.8 per thousand, which corresponded to the number of doctors per capita in Brazil before the implementation of the *Mais Médicos para o Brasil* Program”<sup>3</sup>. The program eventually included 1,846 Brazilian doctors, which showed that there was relatively little interest in the program on the part of the latter<sup>3</sup>.

### **Access to Primary Health Care: changes and continuity**

In Brazil, access to health services within the SUS should be prioritized by primary care needs<sup>27</sup>. Ensuring access to health care is complex because it covers factors that are political (agreements between bodies, social control), economic and social (public investment, service user income), organizational (service flow, regulation, reference/counter-reference), technical (reception, quality of care), symbolic (culture, beliefs, values) and geographic<sup>28</sup>.

The service users attended by *Mais Médicos para o Brasil* Program doctors commented on access to services in terms of organizational and technical elements. Firstly, they pointed out that these doctors were more physically present in the UBS and, therefore, they differed from their Brazilian predecessors. Consequently, there was less uncertainty as to whether service users would be attended. In the *Mais Médicos para o Brasil* Program, doctors are expected to devote 32 hours per week to PHC work and eight hours to theoretical studies, which are subsequently evaluated<sup>3</sup>.

*The doctor is very punctual (Interviewee 3). The Brazilian [doctors] came on the day that they wanted (Interviewee 5). The system for seeing the Cuban doctor is easier than trying to see the other doctor. Everybody says that the Cuban doctor always comes (Interviewee 12). It's good because it used to be so difficult to see a doctor here but now the situation has improved 100% (Interviewee 24).*

Service users reported increased access to medical consultations and a reduction in the waiting time between scheduling and the consultation itself, which previously had sometimes taken months. However, the old system of making appointments (issuing tickets on a first-come

first-served basis) still persisted, which resulted in queues at the UBS, even at dawn.

*You have to come very early in the morning to get a ticket and sometimes you still aren't attended (Interviewee 1). It's much better now because you know that you will be seen. I take a ticket and I know that I will be seen tomorrow. The best situation would be to take a ticket and be seen on the same day (Interviewee 6). You go to the health center on a Friday and you can make an appointment for the following Monday or Tuesday (Interviewee 13).*

The literature shows that this is still a widely used method in Brazil to organize access to medical consultations in terms of PHC. Studies of UBSs within the ESF in the Brazilian states of Ceará<sup>29</sup>, Pernambuco<sup>30,31</sup> and Bahia<sup>32,33</sup> have shown the reproduction of this model, which is associated with delays of up to 15 days from making an appointment to the consultation. A 2012 study based on the external evaluation of the data from the National Program to Improve Access to and the Quality of Primary Care (PMAQ) showed that more than 50% of service users in Brazil take a ticket in a UBS as a way to schedule their appointments and more than 30% of them have to queue at a UBS before it opens<sup>34</sup>.

This traditional and ineffective model forces service users to queue at the doors of health units, which organize fixed days and/or times for people to schedule medical consultations that are usually performed at the reception desk of the UBS by staff who are unqualified to exercise that function. When this model is performed correctly the scheduling of appointments is performed by a UBS health professional who screens service users before forwarding them to the appropriate doctor<sup>35</sup>. Regarding waiting time, although *Mais Médicos para o Brasil* Program service users mentioned a reduction in waiting time and increased access to services, it was still not possible to guarantee medical attention on a specific day, which was of major importance for service users.

In general, service users were positive about the performance of the new doctors in the UBS to which they were referred. However, they also pointed to barriers that compromised the resolution of their health problems such as access to medical specialties, medicines and examinations.

*Is very difficult because, for example, you need a doctor, a specialist, you go to the health center and they give you a referral. You wait almost three months to get a consultation with a specialist, an ophthalmologist, a gynecologist (Interviewee 12). The lack of medicines is terrible (Interviewee 3). I needed some examinations, an MRI in August, and*

*I finally had it yesterday after five months! (Interviewee 22).*

Access to medical specialties is an aspect of great importance to providing an integral form of primary health care<sup>6</sup>. The analysis of an external evaluation conducted by the PMAQ in 2012 revealed that 61.2% of service users in Brazil had to wait up to 30 days to access a specialized consultant after being attended in PHC<sup>34</sup>. Although regulatory structures have been set up within municipal health departments in Brazil in order to integrate PHC services and specialized attention in recent years<sup>36</sup>, other studies suggest that the waiting time is actually much higher than reported in the external evaluation performed of the PMAQ, which reinforces questions about the validity of this finding<sup>34,37,38</sup>. It is noteworthy that this waiting time also varies due to socio-economic inequalities: it is generally higher for individuals with lower levels of economic power and education<sup>39</sup>.

Regarding access to medicines, studies have indicated that there is now a much higher supply within PHC: approximately 70% of prescribed medicines are dispensed in the UBSs<sup>34,40</sup>. However, there is other evidence of the lack of medicines, which indicates the need for further research regarding pharmaceutical services within PHC<sup>41</sup>.

From the perspective of service users, the implementation of the *Mais Médicos para o Brasil* Program has resulted in PHC that is more accessible in terms of medical consultations. However, it is important to note that barriers still remain that limit the ability to provide effective and timely health actions and services, which are associated with low levels of funding for health, technical and administrative limitations, poor organization and inefficiency in offering services, all of which are required to provide an integral service<sup>42</sup>.

### **Opinions of service users about the work of foreign doctors**

The work of the foreign doctors was perceived from the point of view of the doctor-service user relationship, the effectiveness of the medical consultation, and the communication with service users. The doctor-service user relationship emerged as a central issue. Respondents reported that they felt welcomed and encouraged to actively participate in their medical appointments. In general, they declared that they were satisfied

and they praised the attitudes of the doctors for the way in which they were treated and the fact that they were given an opportunity to speak.

*That's what I said, how he [the doctor] treats you, how he attends you. Do you understand? He doesn't have that attitude of being in a hurry. You don't have to talk if you don't want to, he gives you time (Interviewee 3). He is very attentive with us, he really looks at us. Some doctors just write notes when you are with them. 'What's your problem?' He's not like that. He looks; he listens, just as I am talking to you here. He looks in your eyes and asks you what your problem is (Interviewee 6).*

The theme of the humanization of healthcare practices has guided the need for health care that is capable of combining technical and scientific knowledge with the recognition of the rights, culture and subjectivity of service users<sup>42</sup>. The aim is to overcome the over-valuation of the technical dimension in the management of the morpho-functional mechanisms related to disease at the expense of its human dimension, which sidelines sociocultural and emotional issues and excludes the reality of life and the knowledge and experiences of service users from medical therapy<sup>43-45</sup>.

This model of relationships, which is enshrined in health practices, was influenced by social medicalization, which hid the social character of illness, i.e. the medical-industrial complex that directed professional attention to machinery and equipment; the social determinations of life and health work; the generators of dehumanizing contexts; and the establishment and organization of health systems that submit professionals to increasingly routine and uncritical dynamics<sup>46</sup>. Examples of this are the quantitative pressure for consultations and procedures, increases in the implementation of routines and protocols, and the precarious nature of professional conditions, stability and ties<sup>41,47</sup>.

This dehumanization compromises the practical success of interventions, resulting in a failure to improve health conditions, which is promised by the potential of technical and scientific advances<sup>45</sup>. Moreover, there is a sense that medical work has been overshadowed by the idea of personal fulfilment to the detriment of its social dimension<sup>47</sup>, which may be associated with the dissatisfaction and distrust of some service users regarding the behavior of health professionals, which in turn undermines the possibility of a good relationship between doctors and service users.

Another aspect highlighted in this study was the perceptions of service users in relation to the

degree of resolution of their medical problems by the foreign doctors, which has also been commented on in a study of Brazilian doctors<sup>48</sup>.

*All I ever need, she [the doctor] always solves. She gave me a prescription, I needed a few examinations, she sent me to another doctor, the appointment was made and I went to see the other doctor. What I mean is that every time that I have needed something she has solved it (Interviewee 17). What if I had had to live with that headache forever? That headache, what was it? My diabetes is not extreme. Why me? So I started taking the medicine, and today I feel better. I think that she was sent from God to help me with that headache (Interviewee 5).*

The resolution of health issues is one of the main expectations of service users when they seek the help of health professionals, and the role of the doctor is particularly important because they are the professionals most sought by those requiring PHC<sup>49</sup>.

In this study, the concept of resolution expressed by service users was synonymous with the control and treatment of illness, which confirmed the findings of other studies<sup>50</sup>. The service users generally referred to a high level of satisfaction with the services that they used, as was also found in other studies<sup>51,52</sup>, which does not always reflect the quality of the services that are offered<sup>30,53</sup>.

It should be noted that thinking about the issue of resolution in relation to integral PHC and the principles and guidelines of the SUS also implies, in addition to resolving the illnesses and injuries that are traditionally presented by the population, recognizing and addressing broader needs that are related to the determinants of the health-disease process and all the objective and subjective processes that compromise health and which do not find a satisfactory answer within the technical-scientific arsenal of biomedicine<sup>41,54</sup>.

The service users interviewed in this study also spoke about the issue of communication with the foreign doctors. This question generated public debate in Brazil when the importation of foreign doctors was announced; there was some indignation on the part of Brazilian doctors and service users about possible problems related to language barriers, which were seen as a barrier to the quality of services that would be offered

A small number of service users reported that they had experienced no problems regarding the language of the foreign doctors. Most mentioned that they had had difficulty understanding the Cuban doctors; this was mentioned as a negative

aspect, but that it had not made the consultation impossible.

*There was a woman there with him [the foreign doctor], she was from the health center and she explains when we don't understand (Interviewee 1). When I don't understand I ask her [the foreign doctor] what she is saying. She makes gestures and then I understand what she is saying. Sometimes I don't understand and I call the girl to come and explain (Interviewee 15). I didn't have any problems regarding language, I understood everything (Interviewee 17). We were able to communicate. I liked it, I understood. He was patient, when I couldn't understand something he repeated it (Interviewee 20). The way he talks is a bit complicated for us, but when we ask him to explain he goes over it again and then we understand (Interviewee 5).*

Conversation is a process of agreement that implies that both interlocutors are disposed to talk to each other, thereby promoting an exchange of views which culminates in a joint decision. Consequently, the dialogue between doctor and service user should aim to establish a link that promotes interaction between these individuals and that is capable of combining technical and practical success in the relationship that has been established<sup>45,55</sup>.

In the case of the foreign doctors, it is natural to assume that there would be some difficulty in communication during consultations. However, the problem lies not only in understanding the words themselves, but in understanding the message that is being conveyed. Caprara and Rodrigues<sup>44</sup> studied Brazilian doctors working within the ESF and found that 39% of doctors did not explain medical problems in a clear and objective way and that in 58% of cases the professional did not check that the patient had understood the

diagnosis.

Thus, the fact that doctors and service users share the same language does not guarantee that there is effective communication between them, due to the interference of factors such as the use of excessive technical language, different educational levels of service users, and the use of authoritative medical discourse.

It was observed that the fact that doctors were from countries where Portuguese is not the official language did not constitute an impediment to the interaction between individuals, compared to the use of communication strategies such as non-verbal language, speaking slowly and repeating what is said, and the help of other professionals to transmit messages.

### Final considerations

The voices of the service users revealed that the *Mais Médicos para o Brasil* Program represents a breakthrough for the SUS because it has contributed to overcoming a historical and difficult problem, i.e. the expansion of access to health in the most deprived regions of Brazil. This trend aligns itself forcefully with international efforts to provide health staff.

However, the emergency nature of the implementation of the *Mais Médicos para o Brasil* Program merely shifts the challenges of providing doctors, and in the medium and long terms policies are required to simultaneously address problems related to the high turnover of doctors. Consolidating a public and universal health system that is guided by primary health care requires the effort and courage to face other structural problems, such as funding, as well as organizational, management and health care models.

### Collaborations

TRB Silva worked in all stages of research and construction of the article; J Vale e Silva served in the design, guidance and analysis of the research and writing of the article. AGV Pontes participates in the analysis and writing article. ATR Cunha made critical review and drafting of the article.

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