Evaluation of the More Doctors Program: experience report*

Avaliação do Programa Mais Médicos: relato de experiência

Wallace Dos Santos[1], Yamila Comes[2], Lucélia Luiz Pereira[1], Ana Maria Costa[3], Edgar Merchan-Hamann[1], Leonor Maria Pacheco Santos[1]

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ABSTRACT The universal and equitable access to health is established in the Brazilian Federal Constitution of 1988 and must be guaranteed by the Brazilian Unified Health System – the Sistema Único de Saúde (SUS). The lack of professionals and the large regional differences in the distribution of human resources, mainly physicians, are factors that contribute to the non-fulfillment of the SUS principles. This article reports the experience of evaluation of the More Doctors Program (PMM) by a multidisciplinary team composed of 28 researchers, based on field work in 32 municipalities with 20% or more of the population in extreme poverty selected in all regions of Brazil (remote areas, far from capitals, and rural maroon communities), as well as analyzes of the 5,570 Brazilian municipalities based on the Ministry of Health databases. The research resulted in a vast scientific production, pointing out important results, such as broadening of access to health and reducing of avoidable hospitalizations. The reflections brought here show that the PMM contributed to the implementation and consolidation of the SUS principles and guidelines, and guaranteed access to health, especially for the poorest populations, small municipalities and remote and distant regions.

KEYWORDS Health manpower. Health services. Primary Health Care. National health programs.

RESUMO *O acesso à saúde de forma universal e equitativa está preconizado na Constituição Federal de 1988, devendo ser garantida pelo Sistema Único de Saúde (SUS). Dentre os diversos fatores que contribuem para a não efetivação dos princípios do SUS, destacam-se a insuficiência de profissionais e as disparidades regionais na distribuição de recursos humanos, principalmente médicos. Este artigo relata a experiência de avaliação do Programa Mais Médicos (PMM) por uma equipe multidisciplinar composta por 28 pesquisadores, a partir de trabalho de campo em 32 municípios com 20% ou mais da população em extrema pobreza selecionados em todas as regiões do Brasil (áreas remotas, distantes das capitais e comunidades quilombolas rurais), além de análises sobre os 5.570 municípios brasileiros baseadas em bancos de dados do Ministério da Saúde. A pesquisa resultou em vasta produção científica, apontando importantes resultados, como ampliação do acesso à saúde e redução de internações evitáveis. As reflexões aqui trazidas permitem concluir que o PMM contribuiu para a efetivação e consolidação dos princípios e diretrizes do SUS e garantiu acesso à saúde, especialmente para as populações mais pobres, municípios pequenos e regiões remotas e longínquas.*

PALAVRAS-CHAVE *Recursos humanos em saúde. Serviços de saúde. Atenção Primária a Saúde. Programas nacionais de saúde.*

*Have also contributed to the manuscript: Hilton Pereira da Silva, João Paulo Alves Oliveira, Ximena Pamela Diáz Bermudez, Felipe Proenço de Oliveira, Josélia Souza Trindade and Carlos André Moura Arruda.

[1] Universidade de Brasília (UnB) – Brasília (DF), Brasil.
wallaces@unb.br

[2] Organização Pan-Americana da Saúde (Opas) – Brasília (DF), Brasil.

[3] Escola Superior de Ciências da Saúde (ESCS) – Brasília (DF), Brasil.

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Introduction

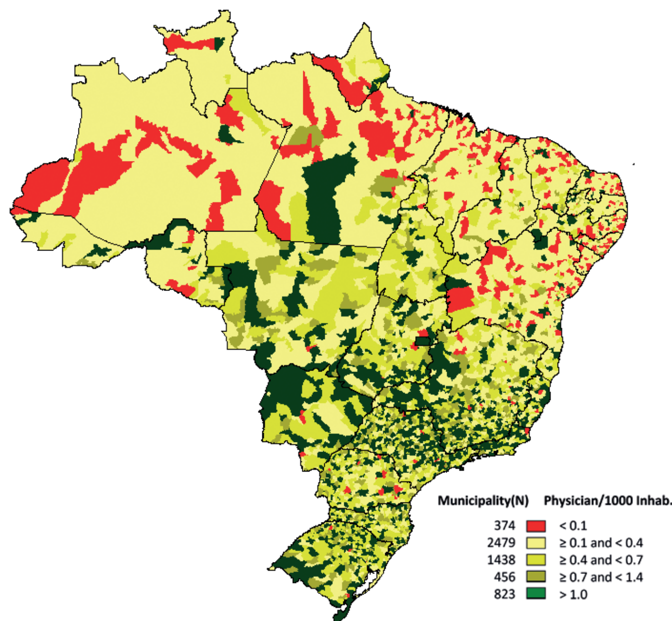
The health-disease balance is a process determined by factors of social, economic, cultural, environmental and biological/genetic origin. The social determination of health is linked to the quality of life of the population which, on the other hand, is influenced by social, economic, cultural and environmental policies and by the political model itself of a State/nation[1,2]. Thus, the health guarantee represents the commitment to the social justice of the nation, that is, it reveals how the Country tries to promote social rights and guarantee equity among the different social groups in a situation of inequality. For this purpose, it is fundamental to create strategies and offer actions to different groups of individuals to guarantee important rights, such as health protection[3,4].

The provision of universal health services constitutes an essential factor in the social determination of health; and from this perspective, the capacity of sufficient supply of health professionals gains importance. In Brazil, rural, remote and peripheral areas of large urban areas, with significant social inequalities, are unable to attract and retain health professionals, especially physicians[5].

The distribution of physicians in the Country marks the enormous regional inequalities and access to health and becomes even greater in relation to specialties. This is a clear limitation for the universalization of the provision of health services according to the Unified Health System (SUS) created by the Federal Constitution, whose guidelines are based on universalization, comprehensiveness and community participation, assuming equal rights and the search for equity[6,7].

Scheffer[7], in the study 'Medical Demography in Brazil', 2013, showed a concentration of physicians in the private sector and classified the Brazilian regions with the highest number of physicians per thousand inhabitants that provided services for the SUS: Southeast (1.35/thousand inhab.); South (1.21/thousand inhab.), Central-West (1.13/thousand inhab.), Northeast (0.83/thousand inhab.) and North (0.66/thousand inhab.). According to the same study, repeated in 2018, Brazil had a density of 1.85[7] in 2013 and 2.24 in 2018[8], a still low figure compared to Canada (2.54 in 2015); to the United Kingdom (2.83 in 2016); and Australia (3.50 in 2015)[9]. For international comparison purposes, the minimum of one physician per 1,000 inhabitants is used. *Figure 1* shows the distribution of the total number of physicians per municipality (public and private sector) in 2013, evidencing the inequality of distribution of these professionals. Only 823 municipalities (out of 5,570) reached one or more physicians per thousand inhabitants; at the other extreme, in 374 municipalities there was less than 0.1 physician per thousand inhabitants.

Figure 1. Municipal distribution of physicians per thousand inhabitants. Brazil, 2011



Source: Adapted from Pereira et al., 2016[12].

From the situational diagnosis, which clearly demonstrated the areas with health care gaps, there was a political articulation of the National Front of Mayors, with the Federal Government, mediated by the National Council of Municipal Health Secretaries (Conasems). The Federal Government, whose priority was the universalization of Primary Health Care (PHC), was struggling to expand its goals in the lack of medical professionals to compose the PHC teams, thus instituting the More Doctors Program (PMM) through Provisional Measure nº 621, of July 8, 2013[10], converted into Law nº 12871, of October 22, 2013[11]. The PMM has the purpose of providing professionals; training human resources in the medical area for the SUS with strategies that prioritize the regions to be served; the strengthening primary health care services; for the improvement of medical training in the Country. Other purposes include strengthening of the policy of permanent education; the promotion of the exchange of knowledge and experience among Brazilian health professionals and physicians trained in foreign institutions; and stimulating research conducted on SUS[6]. The program was designed to operate in three axes: 1) infrastructure, involving reform and construction of basic units to ensure the necessary structure; 2) readjustment and expansion of medical education, through new curricular guidelines and consequent revision and adjustment of curricula of the universities, broadening the approach in collective health and PHC, besides increasing, decentralizing and internalizing the offer of medical courses; and 3) emergency provision of physicians to municipalities to supply immediate demand.

When implementing a research project to verify if the PMM has contributed to the consolidation of the constitutional SUS, an immense volume of information and experiences stimulated the elaboration of this article, with the objective of reporting and describing the experience of the team.

Material and methods

Organization of the multicenter study and multidisciplinary team

The project 'Analysis of the effectiveness of the PMM in implementing the universal right to health and in consolidating Health Services Networks' was carried out by researchers from the five regions of Brazil. Coordinated by the University of Brasília (UnB), it counted with participation of the Federal Universities of Bahia, Ceará, Pará, Minas Gerais, Rio Grande do Sul, Campina Grande, as well as the Oswaldo Cruz Foundation – CE, from the State University of Ceará and the Foundation of Education and Research in Health Sciences of the Federal District.

The multiprofessional team consisted of 28 researchers: seven physicians, five public health professionals, three nurses, three nutritionists, two biologists, psychologist, anthropologist, pedagogue, social worker, economist, pharmacist, veterinarian and a pathologist as the coordinator. Analysis of several databases was carried out such as well as an in *locus* visit to evaluate the PMM where the Program actually took place. The broader group met face-to-face on three occasions over five years, and smaller groups participated in various workshops of methodological harmonization.

Field study

For the selection of the municipalities to be visited, the following inclusion criteria were used: 20% or more of the population living in extreme poverty; enrolled in the first or second cycle of the PMM, with less than five physicians and less than 0.5 physician per thousand inhabitants before the program (June 2013). The selection of the sample was random with division proportional to the number of municipalities with the characteristics described previously.

When the inclusion criteria were applied, lists with random numbers were generated to select 32 municipalities from all regions of Brazil, 14 in the North, 12 in the Northeast, three in the Southeast, two in the Central-West and one in the South. In total, 16 Brazilian states were visited.

Results: report of the experience

Field work: getting to know the wide Brazil

The sample of 32 municipalities with 20% or more of the population living in extreme poverty led the team to visit remote areas, carrying out, inclusively, ethnographic research in rural marron communities in the North and Northeast Regions. Numerous trips were made in speedboats and motorboats through the Amazonian rivers, as well as facing floods on the back roads in Minas Gerais and connections in dirt roads in the Central-west region. However, it was certainly unforgettable the experience of one of our teams when boarding a single-engine airplane in a precarious state of conservation in the Western Amazonia, in a situation where the owner of the airplane was the pilot, mechanic and flight controller (visual flight) and landed, with mastery, on the main street of the municipality.

Plan for publications, scientific production and knowledge management

A key initiative was the participatory elaboration of a publication plan from the start, in order to encourage scientific production, stimulate collaboration and avoid authorial disputes. The plan was monitored and reviewed quarterly. This way, 18 original scientific articles were published in national and international journals between 2015 and 2018 and six theses/dissertations were defended at UnB (3), Federal University of Bahia – UFBA (1) and Federal University of Pará – UFPA

(2), obtained from national database analysis, pieces of legislation and field research in 32 municipalities of the five regions. Part of these results will be summarized below, and some of the field experiences and publications can be seen on the websites <http://maismedicospa.blogspot.com/> and <https://www.youtube.com/watch?v= 3_yr56apnTE>.

The research group was concerned with knowledge management, so much so that every six months it requested hearings with managers of the PMM at the Ministry of Health to present preliminary results. The activity took place as planned in the project, from December 2014 to December 2017. There was a presentation at the national congress of Conasems (which convenes municipal health secretariats) and three congresses of the Brazilian Association of Collective Health (Abrasco), aiming to give visibility to the results and focus on planning and implementation of the PMM.

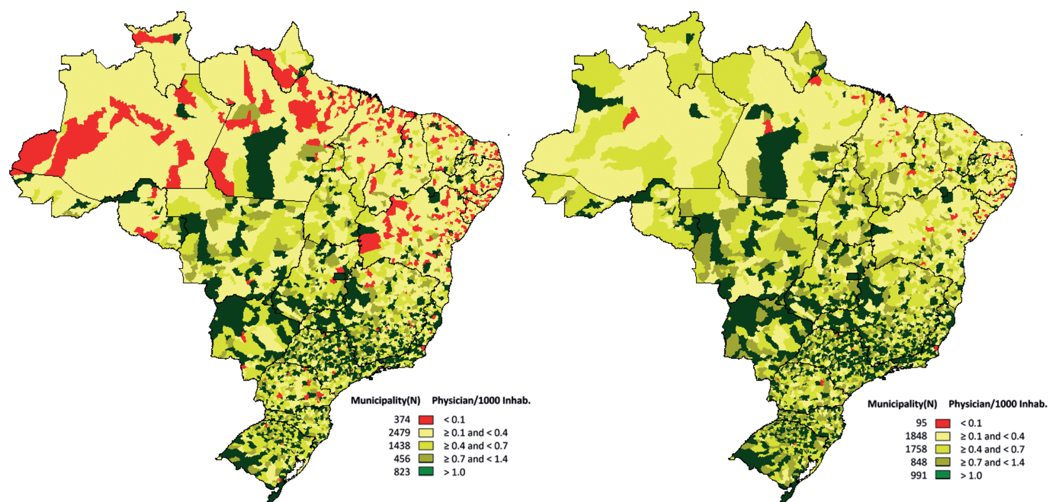
Contributions to reduce inequalities

In this scenario, it is important to disclose the scientific evidence produced by the More Doctors Research Group of the UnB, which evaluates the program since its inception in August 2013. The research with official databases of the Ministry of Health, together with the fieldwork in 32 municipalities in the five regions of the Country, has been unfolding in a series of studies with meticulous methodologies, aiming to analyze the achievement of the objectives and mission of the PMM. Experiences lived in the field and the results already published, some of which are described below, speak for themselves.

The PMM made a unique contribution in attracting and retaining physicians in areas of difficult access (rural, remote and of high vulnerability)[12]. In its first public call, in July 2013, there was accession of 3,511 municipalities that requested 15,460 physicians. Although the PMM prioritizes Brazilian physicians, only 1,096 with register in the Regional Council of Medicine (CRM) have applied and were hired along with 522 other foreign physicians. The agreement of international cooperation with the Pan American Health Organization (PAHO) was established for the arrival of Cuban physicians. In 12 months, the program recruited 14,462 physicians (79% Cubans, 16% Brazilians and 5% of other nationalities), meeting 93.5% of the demand of the municipalities enrolled.

The parameter recommended by the Ministry of Health was that there should be one physician per thousand inhabitants. The study[12], however, has revealed that, before the PMM, only 823 municipalities reached this goal; already a year later, there were 991 municipalities (20% increase). In the comparison made in *figure 2*, it is observed that, in a one-year period, there was a reduction of 75% in the number of municipalities with less than 0.1 physician per thousand inhabitants (from 374 to 95). Of the total number of physicians, 3.390 were allocated to municipalities where there were certified rural marron communities. In addition, the PMM sent 294 physicians to work in the 34 Indigenous Health Districts (100% coverage), ensuring the presence of physicians in all Districts, a fact that had never been possible since the creation of the subsystem of Care to Indigenous Health in the SUS.

Figure 2. Municipal distribution of physicians per thousand inhabitants in 2011 (left) and 2014 (right), before and after the implementation of the PMM, respectively*



Source: adapted from Pereira et al., 2016[12].

*Figures 1 and 2 used the study 'Medical Demography', which does not present data for all Brazilian municipalities, especially for those of smaller population size. In this case, 28% of the cases were allocated with the regional median values for each population size of the municipalities. It was verified that the imputation hardly changed the distribution of values in the states.

In the first year of the PMM, it was verified, as well, that 2,377 priority municipalities for the SUS joined the program, and the Northeast Region presented the highest number of municipalities with 20% or more of the population living in extreme poverty enrolled, as well as the largest number of municipalities enrolled in general (1,318). In the same period, among the 1,834 physicians with CRM enrolled in the PMM, only 20% (965) were allocated in the Northeast Region. Thus, of all physicians who were displaced to meet the demand of this Region, 76% were Cubans. In the Northern Region, which has populations living in even more extreme situations, Cuban physicians accounted for 81.1%[13].

In this regard, the PMM contributed to the fact that a greater number of municipalities in the North and Northeast Regions could approach the minimum amount of physicians per thousand inhabitants. In the Northern Region, for example, it was observed that among the 363 municipalities that joined the PMM in the first year, 58 had less than 0.1 physician per thousand inhabitants, and 204 had low density (≥0.1 and <0.4) of physician. With the increase of physicians of the PMM, there was a reduction from 58 to 2 in the number of municipalities with very low physician density and an increase in the number of municipalities with bordering density (≥0.7 and <1.0)[14].

Thus, the PMM contributed to ensuring greater equity in the access and use of health services, since the internalization of the actions and the better distribution of physicians enabled the professionals to be provided in areas with historically unassisted populations, such as indigenous populations and rural maroon communities[12].

The various professionals who make up the family health teams, in which a Cuban physician was inserted, affirm that the PMM collaborated to offer care with greater quality and completeness not only by increasing access of

people, but also by the effective availability of physicians to meet the needs of the population. It improved reception, bonding and respect with the users due to the appreciation of the human condition of the users with the sensitive responsibility that these professionals present in solving the health problems of the people. Also, according to the users, the characteristics of these physicians in relation to the availability to solve the problems are especially highlighted; and, as a result, the work carried out by them was decisive for the progress of the networks coordinator role for PHC. It is also worth noting that, within the teams, Cuban physicians have integrated into the multiprofessional work process, favoring the strengthening of primary care[15].

Training of physicians and requalification of Basic Health Units

Little publicized by the mainstream media, the medical training components and the expansion and reform of Basic Health Units (BHU) have been implemented since the creation of the PMM. The first one aims to ensure an adequate number of physicians for PHC that is able to respond to SUS needs. In addition to the immediate provision actions of physicians, initiatives were also developed to expand undergraduate courses in medicine and medical residency positions.

The available evidence allows to affirm that the PMM, in its first years of implementation, reached a set of important results in the axis of change in medical education. In a research that analyzes the impact of the creation of medical courses in the interior supported by the PMM, the social representations about the work in the PHC of the students in the 'new' courses and in the 'traditional' courses were compared. A script of free evocation was applied; after the ranking of items, results show that the social representations of medical students in 'new' schools are more in line with the PHC guidelines. Emphasis was placed on the evocation of terms such as 'responsibility', 'bond', 'community' and 'care'. In the 'traditional' courses, the most prominent terms were 'devalued' and 'precariousness'[16]. However, from 2016 onwards, actions on the training axis no longer receives investments, making the creation goals of 12 thousand graduation positions and 11.5 thousand medical residency positions not be reached.

Although there is evidence that health is not only practiced through physicians, these professionals are fundamental for the adequate provision of this constitutional right, especially with the exclusive attributions of this professional category in the current legislation. By 2015, the number of physicians in the Country grew by 3% a year, a figure notoriously insufficient to meet the demands of the nation[17]. However, according to the Federal Council of Medicine (CFM), between 2013 and 2018, growth in the number of professionals was on the order of 21.3%, that is, higher than the Brazilian population growth[14]; even though there was previously a low proportion of professionals in relation to the population and the latter had the perception of an absence of physicians[17,18]. What is occurring, in fact, is a poor distribution of these human resources by the services and regions of the Country – mainly in the rural areas, in the North and Northeast Regions, in urban areas in conflict –; and in services there is a shortage and/or high turnover of professionals, seriously compromising PHC.

There is, therefore, no shortage of physicians[9], just as there is no need for more physicians – in addition to infrastructure and inputs[18,19]. The challenge, then, is to understand why these two sides of the same problem do not meet. One of the potential explanations is the distribution of schools and medical residences, currently concentrated in large urban centers, a situation that began to change after the implementation of the PMM[17]. A complementary explanation is the type of training received at faculties, which until recently did not focus on the training of generalists, qualified to provide comprehensive care and solve

the most prevalent problems in the population, nor did it consider local diversity, encouraging the entry of socially and economically groups vulnerable in the medical career[17].

In the training field, therefore, through a more equitable distribution of faculties, transformation of the curricular structure and inclusion of more ethnic and social diversity in the medical courses resulting from the PMM, one can envisage securing not only more, but better physicians to the needs of the Country[17].

The performance of the cooperated physicians

People using the SUS (users), who were cared for by Cuban physicians, report that the PMM increased their satisfaction with PHC and the responsiveness of services. Many adult users reported that for the first time in their lives they had access to a medical appointment; before there was no regular medical care in the municipality, which only managed to hire temporary physicians and who were present punctually. It was observed, in the narratives of the users, satisfaction with the attention and availability of Cuban physicians, their sensitivity, respect and humanized care and treatment, characteristics that can be summarized in the concept of dignity in care. In a detailed way, service responsiveness aspects were evidenced in the organization of schedules, the inclusion of spontaneous demand, home visits and the reduction of waiting times until the medical consultation[20].

Traits of 'humanized care', so valued by users, are central to the model of care that the cooperated physicians brought from Cuba and are a fundamental element of medical training and practice in that country. The responsibility that these professionals have with the bond and trust of the population is favored by their permanence in the municipality to which they were designated by the PMM. The commitment to the population is expressed both in the availability and in the physician-patient relationship with empathy, as well as in the effective resolution of the problems. Medical care is established through closer and more affective horizontal relationships between users and professionals; and by the recognition of the person, user or patient, in the aspects of empathy in listening, looking, examining, finally, taking care[21].

The health councilors of the studied municipalities, understood as representatives of the actors that operate and work in the SUS (managers, professionals and users), were also interviewed and brought a very positive view of the PMM, reporting that it improved the quality of local PHC. Counselors registered advances in the health of the rural population, since it was incorporated as a scenario of PHC, even though they are isolated or far from the urban zone. Regarding the medical consultation, they again reported the same dimensions as team members and users: love, attention, care. There was an intuitive appreciation of the counselors when reporting that there was a decrease in the need for urgent consultations, due to the constant presence of physicians in BHU[22]. In fact, chronic patients, especially hypertensive and diabetic patients, when well monitored and controlled by PHC, no longer present acute attacks of their diseases and no longer need hospitalizations or other more invasive and expensive procedures.

The Cuban physicians of the PMM were also interviewed and described the activities performed: spontaneous demand consultations and scheduled consultations, home visits, educational activities, health programs and participation in regular meetings to plan the actions with the teams. The regular involvement of physicians in this range of activities, although foreseen in the National Primary Care Policy (PNAB), had never occurred in most municipalities. They dedicate a longer consultation time than the population was accustomed to, and although they have received some complaints from users, physicians justify that time is needed to work with detail on the user and their context. In home visits, they have a comprehensive view of the patient, the

family and the environment, in which they observed the prior lack of medical care in the communities. They also noted with concern the great consumption of drugs, especially psychotropic drugs without proper control; were able to refer patients for follow-up with specialists, when necessary. They stated that they had succeeded in working as a team and maintaining good relations with municipal managers[23].

It was also interesting to hear the municipal managers, both Health Secretaries and coordinators of the PHC, who reported the situation experienced in the municipalities before the arrival of the PMM. The shortage of physicians led to the barrier in access and lack of continuity of care, which had repercussions on the quality of services offered. These managers pointed out many contributions of the PMM to the municipality; among them, the improvement of PHC health indicators, such as prenatal visits, home visits, reduced hospitalizations, better access to the network and the humanization of care, as well as health surveillance. Regarding the individual aspects of the Cuban physicians, aspects also reported by users and team members emanated from the narratives of the managers: meticulous attendance, adequate consultation time, improved medical consultation, accomplishment of complete physical examination, rational use of medication, respect and responsibility in case follow-up, concern with patients and problem solving and commitment to meeting the workload. Finally, they pointed out that Cuban physicians work for the prevention and promotion of health, and not only for patients who are ill[24], one of the presuppositions of quality PHC.

The allocation and the permanence of physicians in the BHU in the municipalities made possible the accomplishment of actions of prevention and health promotion and the establishment of bond with users of rural and maroon communities. The Cuban physicians act in a way to secure the service to the users, either in the BHU or in home visits, seeking to respect their specificities, especially, the cultural dimensions. Often, these professionals combine traditional medicine, present in an expressive way in these communities, with allopathic treatment[25]. There was evidence that Cuban physicians seek to respond to the specifics of the rural and/or maroon population through strategies such as: expansion of health education actions, planning of actions with other team members, better organization of the agenda, seeking to contemplate needs of residents living in distant and isolated areas, frequent home visits, greater continuity of health care, bonding, and greater presence in health services. One of the great advantages of the more careful and humanized care offered by Cuban physicians is the fact that the users adhere to the treatment and attend more the BHU for routine follow-ups, avoiding more serious health complications and decongesting the urgent care[22,26,27].

The impact of the PMM on health indicators

In order to verify the possible impact of the PMM on health indicators, a 'quasi-experimental' evaluation was carried out before and after program implementation in the 1,708 municipalities with 20% or more of the population living in extreme poverty and in remote border areas. Density of physicians, coverage of primary care and avoidable hospitalizations at enrolled municipalities (n=1,450) and non-enrolled (n=258) in the program were compared. It is a robust study design for impact assessment, in which the non-enrolled counterfactual group is not allocated by the researcher, but, rather, occurs randomly (in this case, it was the municipal manager who did not request the application). The results indicated that, among the 1,708 municipalities studied, those with one or more physicians per thousand inhabitants increased from 163 in 2013 to 348 in 2015. Primary health care coverage at enrolled municipalities increased from 77.9% in 2012 to 86.3% in 2015; and the

rest remained stable. The avoidable hospitalizations at the 1,450 registered municipalities decreased from 44.9% in 2012 to 41.2% in 2015, but remained unchanged in the 258 control municipalities. This was one of the first studies to provide evidence on the impact of the PMM on health[28]. This result shows that, in spite of the small number of cooperated physicians in relation to the total number of physicians already available in the Country (1.8%) and their higher concentration in coastal areas and in the Southeast and South Regions[29], there was, in fact, an improvement in distribution of intra and interregional professionals, and especially in the access of broad segments of the population previously excluded from regular medical care, even in the more developed regions.

Synthesis of scientific evidence produced

The data collected and analyzed by the project regarding the PMM, and gathered here, indicate:

i. the development of PMM medical care in municipalities where there were previously no physicians;

ii. quality improvement and increase of the number of physicians trained in the Country;

iii. performance of the PMM physicians in rural, remote and more vulnerable areas;

iv. reduction of municipalities with extreme scarcity of physicians (less than 0.1 physician per thousand inhabitants);

v. provision of physician in Maroon community areas and in all Special Indigenous Sanitary Districts (DSEI);

vi. strengthening and an increase in the coverage of PHC throughout the national territory;

vii. significant reduction in hospitalizations due to preventable causes;

viii. creation of a bond between physician and patient, with better accession to treatment;

ix. more humanized medical care;

x. greater satisfaction of the population and of the managers with the health services.

Current situation of the PMM for Brazil

On November 14, 2018, news about the interruption of technical cooperation between the governments of Cuba and Brazil, through the PMM, were publicized in the national and international mass media. The reaction of the Cuban government stemmed from a response to the statements of the elected president about his intention to modify the criteria of the Agreement of Cooperation of the Program, as well as raising questions about the qualification of the Cuban professionals who integrate it. In this scenario, around 8,500 cooperated physicians left the Program, and the Brazilian government seeks a solution not to leave without health assistance 29 million Brazilians, largely residing in the most vulnerable places in the Country, where these professionals were part of the health teams of the family. According to official sources, open positions for hiring new professionals are being filled by Brazilian physicians with CRM, while gaps still exists, especially in remote areas, including DSEI.

Final considerations

The contributions of the PMM to the implementation and consolidation of the constitutional principles and guidelines of the SUS are, as described in this report, broad, perceptible and meaningful. Therefore, it is fundamental

to study and evaluate the damages and losses for the Brazilian health system with the sudden disengagement of these physicians from the family health teams as well as the legacy they leave for the Country and for the culture of health practices. Even if all 8,300 positions are rapidly filled by national professionals, questions are asked about the degree of temporal accession, permanence and the resolving ability of new physicians as for the population. These questions for future research become even more important because they are economically and socially more unequal and vulnerable areas of Brazil, where, historically, Brazilian physicians have resisted going and staying.

It cannot be expected or attributed to the PMM the solution of all problems and chronic and recognized misfortunes of the SUS, but it is undoubted to credit the advances that the Program has brought to the Country, especially for the socially excluded populations where medical professionals have been provided: the peripheries of large cities, small-sized and poor municipalities and those in distant and hard-to-reach regions. It is very true that the volume of physicians trained in Brazil has been growing – also because of the PMM, which has been active in the growth of schools and positions for medical training. Likewise, it is also known that, in spite of the enormous effort to change the curricular guidelines for medicine, bringing the trained professionals closer to the real needs of the population based on collective health and PHC, still prevails the values that guide the physicians, roughly, to the profitable specialties. The training of physicians in Brazil mostly stimulates a predominant performance in the private market even when the worker of the SUS, who seeks more profitable specialties and dependent on sophisticated technological inputs and who, often, moves for more market-oriented than humanitarian interests.

In his book 'Medicina financeira: a ética estilhaçada' ('Financial Medicine: the shattered ethics', free translation), Dr. Luiz Vianna develops his central thesis that current medicine serves much more to the health insurance market and capital of the industrial medical complex than to patients, and from histories and lived facts, based on classics of the study of ethics, the author demonstrates the reasons that confirm his statement. Painful thesis for a country that lives such inequality and hopes to see consolidated the universal right to health in the way that the Constitution of this nation conceived.

The presence of Cuban physicians around here, in those years, has left strong marks, resulting from a distinct medical culture that is necessary to the Brazilian people. They could have stayed more and consolidated the model of PHC, irreversibly influencing the training of future generations of physicians and the organization of services. Hopefully the Brazilians, who now take over, will also assume the considerable challenge of showing that another healthcare is possible, continuing what has been started; and that, inspired by the Cuban experience, can effectively advance to a resolute, universal, integral and equitable health system.

Collaborators

Santos W (0000-0001-5705-936X)* contributed to the conception and design of the study, data analysis, preparation of the preliminary version of the article, writing of significant intellectual content and review of the article. Comes Y (0000-0002-7745-6650)*, Pereira LL (0000-0001-9722-143X)*, Costa AM (0000-0002-1931-3969)*, Merchan-Hamann E (0000-0001-6775- 9466)* and Santos LMP 0000-0002-6739-6260)* contributed to the conception and design of the study, elaboration of the preliminary version of the article, writing of significant intellectual content and review of the article. ■

*Orcid (Open Researcher and Contributor ID).

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