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Primary care in Brazil, and the *Mais Médicos* (More Doctors) Program in the Unified Health System: achievements and limits

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Abstract *An historical analysis of Brazil's policies in Primary Healthcare, with emphasis on the Family Health Strategy (FHS), and the Mais Médicos Program (PMM). Studies were made of documents and secondary official data, and the bibliography that has been produced on this theme.It was found that primary healthcare has been established and successfully consolidated as an option in healthcare for a great part of the population of Brazil. There have, however, been structural hurdles, which have tended to compromise the effectiveness and sustainability of this policy.It was identified that these obstacles arise principally from insufficient financing and from inefficient modes of planning and management. The Mais Médicos Program has widened care coverage and made the distribution of primary healthcare doctors more equitable, although it has not resolved the structural problems of the public system.*
Key words *Primary Healthcare, Family Health Strategy, Mais Médicos Program, Health policy*

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Introduction

This paper makes an historical analysis of Brazil's policies on Primary Healthcare, with emphasis on (i) the Family Health Strategy (FHS) and (ii) the *Mais Médicos* Program (PMM), taking as a normative reference[1], for interpretation of documents and events, the directives, concepts and experiences of what we may call National Health Systems based on Primary Healthcare.

The World Health Organization (WHO) uses the expression "National Health Systems based on primary healthcare" to designate a particular ordering of health policies able to ensure the universal right to health[2]. These recommendations by the WHO summarize concepts on methodological strategies for functioning of primary healthcare as part of health systems. In this paper, we will take as guiding analytical categories for primary healthcare the following strategies and directives originating from this cultural field: Primary Care Network integrated to the health systems; Primary Care coverage tending to universality (80% to 100% of the population); integrality, and expanded conception of the health/care process; management and planning based on health vulnerabilities and needs – the 'equity directive'; a care model that integrates knowledge and practices of health promotion, clinical practice and rehabilitation; integrated training of professionals; practices in various scenarios – territory, institutions, family and each person; interdisciplinary teams; coordination and regulation of therapeutic projects; longitudinality and continuity of care, creating bonding; health responsibility; humanization, and sharing of management and care practices with users[3,4].

Implementation on Primary Care in Brazil's Single Health System (SUS)

Shortly after the publication of the Organic Laws that regulate the SUS[5,6], Brazil's Health Ministry launched two programs that can be considered as the first systematic policy for primary healthcare in Brazil: the *Community Health Agents Program* (PACS), in 1991[7]; and the *Family Health Program* (PSF), in 1994[8,9].

The strategy for implementation of Primary Healthcare in the SUS can be classified as an 'inductive method', in which effort is made to create demand for new programs through financial stimulus, and through propaganda on the health merit of the new proposal. There was no systemic planning: the programming of funding took place as and when estimated numbers of interested municipalities joined the program. In this context it was not possible to implement Primary Healthcare progressively obeying the directive of equity, that is to say, electing priorities according to populations and regions that are more or less vulnerable. In the *Practical Guide to the Family Health Program*, issued by the Health Ministry in 2002[10], the comment is made that "it is up to individual mayors to make the political decision to adopt the Family Health Program". In part, the choice of this type of strategy was due to the federated nature, based on municipalities, of the Brazilian State, and also to the directive for decentralization of the SUS, which gave rise to the processes of municipalization of responsibilities and of services that were previously state, or federal.

In reality, the Family Health Program was presented by the federal government as an offer that each city or state could accept or not, as it chose. The principal inducement factor was co-financing, that is to say, the possibility of the municipalities receiving federal funds depending on the number of family health teams in activity. Since the growth of the services depended on each municipality joining, the process took place without the possibility of allocation of priorities to vulnerable territories or populations.

The *Basic Operational Rules* (NOB) in 1996[11] instituted the first rule governing financing of Primary Healthcare in Brazil. These rules created the 'Basic Care Floor' (PAB); and transferred from the federal government to the municipalities a per capita amount equivalent to the number of inhabitants in the municipality, so that this process should ensure 'assistance' for health in primary healthcare. The same rules created the *Incentive for Family Health Programs and Community Health Agents*, linking new funding to a decision by the municipality to join these two programs. These mechanisms were continuously improved, and are now known as the fixed PAB and the variable PAB.

The construction of a primary healthcare network with wide access, organized according to the conceptions described above, was an institutional and cultural reform of major proportions. In general, these reforms have caused conflicts and resistance from groups that consider themselves to be harmed by the changes. Further, this dimension of health reform caused a domino-effect series of changes, and affected various institutions. Primary healthcare depends on radical changes in training and health and in medical education, which has in particularly traditionally

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been centered on specialties. It also implies redefinition of the role of hospitals and specialized services, instituting a more rational use of medications and procedures, and also inducing the population to use the health system according to a different logic from the traditional one, in which access for users was controlled by financial conditions and not by a Primary Health team.

In various other countries, such as Spain, Portugal, Canada and the UK, there had been synchronization between implementation of the national system and constitution of a national primary care network. In just a few years, the majority of these countries succeeded in guaranteeing access to more than 80% of their populations.

The induction-based mode of constitution of the primary healthcare network in Brazil, which was not highly committed to support and management, enabled the Health Ministry to reduce its responsibility to the preparation and dissemination of the Family Health Program, and definition of the standards of co-financing. The responsibility of the 27 states to the Family Health Program was not defined – enabling them to opt between supporting, or not, the cities involved with this change. Various studies on the cost of the Family Health Strategy indicate that the municipality bears a major part of the running cost – which probably increased mayors' caution about the program, careful as they were not to make an excessive commitment to health from the municipality's budget[12,13].

Further, no nation-wide planning was carried out to coordinate systematic provision of the main resources that are indispensable for setting up a wide primary healthcare network, able to alter the care model of the SUS and function as an entry point. There was always an important degree of uncertainty and in-definition on regular supply of personnel, medications, infrastructure and equipment by the federal and state governments to those responsible for execution of the program – the municipalities. Until the *Mais Médicos* Program[14], in 2013, no strategies had been set for mass training of doctors, nurses and other professionals for the Family Health Strategy (FHS).

Thus, the Brazilian way of implementing an integral Primary Care Network, based on economic inducement and the operational initiative of each municipality, has been producing paradoxical effects. While the Program, later called the Family Health Strategy (FHS), was well received in the Northeast, this was not the case in the Southeastern Region. According to the National Health Survey[15], held in 2013, 53.4% of Brazilian families were registered with Family Health Units (34.8 million households). The coverage was greatest in the Northeast (64.7%), and lowest in the Southeast (46%). This same survey reported that 47.9% of Brazilians are accustomed to seeking out a Primary Healthcare Unit when they need care.

According to the Primary Care Department of the Health Ministry[16], between 1994 and 2002 a total of 16,698 Family Health teams were put in place, in 4,161 municipalities, covering 31.87% of the Brazilian population; and between 2003 and 2012 a further 16,706 teams were put in place, making a total of 33,404, and expanding the coverage to 54.84% of the population in 5,297 municipalities. These indicators of installed capacity and of use of services indicate the growing importance of primary healthcare in Brazil.

Over these first 22 years of the SUS, new National Primary Healthcare Policies (PNAB), have been prepared, one in 2006 and another in 2011[17,18], both apportioning value to primary healthcare. The 2006 PNAB[17] altered the program concept to that of a Strategy, in view of the consideration that growth and continuing improvement of primary healthcare would be vital for consolidation and sustainability of the SUS. Based on this new formulation the support from the federal level for training of personnel for primary healthcare began to be considered as fundamental – both through reformulation of the undergraduate health courses, and also by expansion of the medical residency and multi-professional programs centered on work in primary care. As from that time, the Health Ministry instituted enumerable processes, courses and seminars of permanent education, offered to professionals of the states and municipalities.

The 2011 PNAB[18] strengthened the creation of Family Health Support Centers (NASFs), created in 2008[19], widening the spectrum of professionals that operate in primary care with the aim of increasing the possibilities of intervention in certain social and subjective determinant factors of the health process, thus increasing the capacity to resolve the populations health problems. Also, the concept of primary care network of the SUS was widened, to include not only teams structured according to the criteria of the FHS, but also 'Basic Units', referred to as 'traditional units', organized usually according to the logic of Health Programming or First Aid. It was recommended that these services should gradually be reformulated to approximate to the logic of

functioning of the FHS. The inclusion of these traditional services had the effect of raising the 'administrative status' of the official coverage of primary care in the country.

This PNAB enabled part of the weekly workload of team members (up to 8 hours/week) to be used in other areas: the municipality's emergency network, a specialization course in Family Health, a multi-professional residency and/or Family and Community Medicine, or activities of permanent education and matrix support. It thus enabled teams to be brought together with a more varied composition than the previous requirement of a doctor with 40 hours/week dedicated. It became possible to have two doctors registered in the same team, with weekly work over 30 hours, or even 20 hours. In the latter case, the funding from the federal government to the municipality was lower. Effort was made to diversify the care offered in primary healthcare, considering specific populations, such as the 'Street Consulting Offices' and the Family Health teams to supply care for the riverside populations of the Amazon Region and of the Pantanal wetlands in the state of Mato Grosso do Sul.

All these new formulations of the federal policy on basic healthcare did not change the Health Ministry's approach to planning and management, which continued with mechanisms that did not have strong power for inducement and stimulus to municipalities and states.

Since its origin, the Family Health Plan adopted a widened view of the process of health and care, and recommended the approach based on integrality, based on possible and necessary actions on the various plains of this process. It was also argued that integrality would depend on multi-professional composition of the family health team and, later, of the NASFs (Family Health Support Centers – *Núcleos de Apoio à Saúde da Família*).

However, one observes that in practice there was heterogeneity in the actual form of operating these teams. Since the actual management is exercised by the municipalities, and since the health departments have very different capacities for management and availability of funds, a heterogeneous result was produced in the performance of basic healthcare services. Great difficulty was found in administration of personnel, in particular doctors. There were problems with salaries, in discipline at work and corporative opposition against a large part of the primary healthcare directives. The number of teams with doctors specialized in family and community health was always low, and there was still difficulty in recruiting and fixing these professionals in regions of great social and health vulnerability. In practice, it was found that there was local discontinuity of services, with three basic types of functioning of the Family Health Strategy being identified: some basic units organized as if they were first aid services with low capacity to resolve problems; others functioning in a bureaucratic manner, according to a programmatic logic due to the influence of this model in the Brazilian health culture; and another group, finally, operating according to the directives of the PNAB (National Primary Healthcare Policy).

Results obtained in the evaluations of the *Program to Improve Access and Quality in Healthcare* (PMAQ-AB)[20] showed that while 93% of the Family Health Teams stated that they reserve spaces in their agendas for same-day treatment, thus meeting spontaneous demand, 16.5% of the teams said that they make the scheduled appointments only for users linked to the programmatic actions, a percentage which increases to 21.5% in smaller municipalities. If on the one hand, 73% of the teams say they carry out urgent and emergency care, on the other hand 35% of the users interviewed alleged that they do not seek out the primary healthcare units for urgent or emergency care for two main reasons: they say that these units do not provide urgent or emergency care, or that the units were closed when they sought to use them[21]. As to the dimension *bonding*, one of the directives of both primary care and the Family Health Strategy, the results indicated that 65% of the users state that they are always served by the same doctor, while 19% say this happens the majority of the time and 17% never or almost never[22]. As to 'welcome and acceptance', the results show a wide capillary spread of this practice in Brazil. While 80% of the teams said that they have put the 'Acceptance' system in place, thereafter carrying out listening and evaluation of the whole of their demand, only 47.8% showed the existence of protocols of risk and vulnerability assessment to orient this evaluation[23].

In experiences of primary healthcare in other countries, adoption of management models have been seen that combine an important degree of autonomy of the professionals with strategies of control centered on users and on participative systems of evaluation of results[24,25]. In Brazil, particularly (but not only) in cities where primary healthcare is outsourced through Social Organizations (OSs), two phenomena were found to exists that are polar opposites, but equally

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damaging: either (i) management processes with low capacity for governability of the networks and, principally, of the medical work; or (ii) institution of rigid systems of definition of targets centered on procedures, constituting a mistaken practice known locally as 'management-ism' (*gerencialismo*)[26-28].

We have admitted the impossibility of the municipalities, in isolation, succeeding in developing a personnel policy that is adequate for primary healthcare. This impossibility, we argue, arises from financial restrictions, that have their effect on the capacity for recruiting and fixing of personnel, impeding constitution of careers and a retirement system. Summing up: it seems to us to be an insufficient and limited approach to build policies for training of personnel, and even for permanent education, on the basis of autonomous effort by the municipalities.

There was also difficulty in making primary healthcare function in an integrated services network with services which have different complexities and which play different roles. As a result, the capacity for coordination and regulation of doctors and teams of basic healthcare is also reduced. This shortcoming is probably related to the impossibility of organization of the Health Regions as instances of planning and management of the SUS. In spite of the recent legislation that instituted the Public Service Organization Contract (*Contrato Organizativo de Ação Pública*)[29,30], little progress has been made in integration of thematic networks and services by Health Region. Another factor that leads to the low capacity of coordination of the FHS is the low governability of the SUS over its own hospital network, contracted network and the universities. In various state capitals and medium and large cities one can frequently see two systems of management and regulation, for the hospital network and for the primary network. In general, the primary network is directed by municipalities, and the hospitals are under the control of the state – and, rarely, municipal regulation. Also, the primary healthcare policy in Brazil was initially conceived as being a program – a term which shows the point of view that the Family Health Strategy would be organized in a vertical mode, as a network isolated from other thematic modes of the SUS.

The *Mais Médicos* Program

The *Mais Médicos* Program (PMM), begun in 2013, at the same time meant a continuation of the effort to consolidate the National Primary Health Program, and also had elements that broke with this tradition.

The first qualitative change of the PMM was the greater interference by the Health Ministry in Primary Healthcare, a competency almost exclusively of the municipality. The PMM has been and is being put in place in articulation with municipalities, but the protagonism at the federal level is greater in various dimensions. For this program, finally, the Health Ministry carried out national planning, taking responsibility for execution of a large part of the actions defined in the plan.

The first of these dimensions of direct intervention by the Health Ministry was in recruiting, distribution, remuneration and training of doctors, carried out directly by the Health Ministry, even if with some degree of negotiation with the federal entities. Through a nationwide selection process, the Health Ministry succeeded, in the very short space of two years, in including more than 18,000 professionals in the SUS and Primary Healthcare. A large proportion of these doctors was recruited through 3-way international cooperation between the Pan-American Health Organization (PAHO), the government of Cuba, and the Brazilian government, after a period of inscription for doctors trained in Brazil and in other countries, in which the need for professionals has not been met. The doctors originating from Cuba, unlike the majority of the Brazilian doctors that work in primary healthcare, had specific training and experience in primary healthcare and family and community medicine.

These professionals have had a large influence on the daily work of Brazilian primary healthcare, principally because they adopt a standard of health responsibility which has led them to construct a link, and interaction, with users. An evaluation[31] in 32 municipalities taking part in the program found that 94.1% of the users interviewed evaluated the consultation with a doctor of the program as "very good" and "good"; 98.1% stated that the doctor heard all their complaints with attention, and 87% reported that they understood the explanations and indications that the doctors supplied about the illness and the treatment. The authors of this study said that "the users were surprised, positively, to find that the Cuban doctors visit their home to check their living conditions and thus better understood the social determinants of health"[32].

However, this decision to contract foreign doctors without the qualification revalidation

examination, aggravated by the fact that most of them came from Cuba, generated a strong political and ideological conflict, in which medical entities assumed the position of radical opposition to the government of President Dilma Rouseff, who was the person responsible for the PMM[33,34].

Another qualitative difference of the PMM was exactly this disposition of the federal government to redefine the relationship of the SUS with the medical profession, both in relation to the fact referred to above, and also in relation to the changes arising from reorientation of medical training that Law 12787/2013[14] ordered for all medical schools, new and existing, public and private. It also orders changes in the logic of the expansion of vacancies for graduation in medicine. The demand is now regulated and planned by the State, as a function of the social need for supply of medical education. The new logic goes toward interiorization of the courses (directing of a greater weighting in their activity to the interior of the country and of the states), and a more equitable distribution between the regions of Brazil, seeking to reduce the regional differences in proportions of doctors and graduation vacancies, per capita. However, it has been observed that this expansion has been taking place principally through private medical schools, with costs that are inaccessible for most families, which would indicate non-explicit objectives of exercising control of the medical labor market through the increase in supply of professionals.

Ratifying the *Mais Médicos* Law, the National Education Council approved the new *National Medicine Graduation Course Curriculum Directives*[35], in 2014, which orders reformulation of the medical curriculum, with expansion of the fields of knowledge and practice in Collective Heath, Mental Health, Urgent and Emergency Treatment, Primary Healthcare and Family Health. It orders that at least 30% of the residency (which must comprise at least two years of the graduation course) must take place in primary healthcare and in urgency services of the SUS. This change, if it comes to take place in fact, articulated with the insertion of students since the beginning of the course in primary healthcare units and other services, in the logic of integration between teaching, service and community, would result in an approximation with the health system, that would be necessary for acquisition of the competencies, skills and attitudes that are appropriate to a medical practice aiming to serve the needs of the population. This legal component of the *Mais Médicos* Program has been suffering strong resistance from the majority of the medical movement and other conservative sectors.

Also, the Law restricted the control of the medical specialty associations over medical residency programs. Until the PMM, construction of the SUS had not produced any explicit conflict with a large proportion of the doctors and of their entities. Part of this conflict was attenuated by the institution of a points system (positive discrimination) in the competitions for residency for doctors that had been in the PMM or in the Provab for at least one year[36]. Another component of this conflict with the specializations and medical entities arises from the need for the Brazilian State to build conditions to plan and regulate the quantity of the training of specialist doctors. The PMM Law created the National Registry of Specialists, which makes it possible to centralize information about training and distribution specialists throughout Brazil – data which, strangely, no organ of the federal government possessed until that moment[37].

Complementing the proposals for changes in the Medicine graduation course, the PMM brings in significant changes in the orders and guidelines for training specialists. The main one of these is the priority given to the specialty *Family and Community Medicine* (now called MGFC or General Family and Community Medicine). The *Mais Médicos* Law establishes that this residency will give access to all the specialties that do not have direct access (which are only ten). That is to say, for the doctor to enter most of the residency programs currently available, he/she must do one or two years of residency in Family and Community Medicine. By placing family medicine as the central specialty in the training of specialists, the Brazilian State comes closer to the majority of countries that have public health systems, worldwide[38-41]. Concomitantly, it guarantees, for the medium and long term, the supply of family and community doctors (trained and in training) in the majority of the primary health units, which today do not have doctors with this training.

Another important aspect of this program was the possibility of planning the distribution of the new doctors into primary healthcare according to criteria of equity, social vulnerability and specific populations. Even 20 years after the approval of the principles and directives of the SUS in the Federal Constitution, several obstacles prevent its being put into effect, mainly when we look at the social inequities and regional inequalities[42,43]. Surveys show that populations living in areas of extreme poverty, whether distant from large centers,

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or in the peripheral regions of large metropolises, areas of difficult access, indigenous populations, riverbank dwellers, Quilombo dwellers, people of the field and the forest, in general have much greater difficulty in finding healthcare, including primary healthcare services[44,45].

The SUS has been and continues to implement policies for promotion of equality, with the objective of reducing the vulnerabilities to which certain population groups are most exposed, resulting from the social determinants of health such as schooling and income, living conditions, access to land, water and water services, food and nutritional security, intercultural conflicts and prejudices such as racism, homophobia and machismo – among others[46].

However, the challenge persists of access to the health network, including primary healthcare. The emergency supply of doctors to Brazil's most vulnerable locations and those historically most underprovided with doctors has a significant impact in the reduction of inequities in health. Results obtained from the evaluation of the government and research groups show this reduction of inequalities. If on the one hand quantitative data for municipalities' joining the program show the real need for doctors, at the same time qualitative data on users' satisfaction shows the efficacy of the actions, the impact that they have had on people's care. The scope of the Program is that 18,240 professionals are in 81% of Brazil's municipalities, in all the 27 state capitals, in all the 34 Special Indigenous Health Districts (DSEIs), in 87% of the municipalities of metropolitan regions, and 82% of the municipalities with the largest proportion of people in extreme poverty[37]. One of the studies that highlights the reduction of the inequities, which sought to hear Quilombo communities of the states of Rio Grande do Norte and Pará, reports that the changes most highlighted by the Quilombo users related to the constant presence of the doctors in the primary healthcare unit, the greater ease in scheduling consultations, the increase in household visits and the differentiated characteristics of the clinical practice. For the users, there is now a greater organization of the scheduling of appointments, and the medical consultation is different from that of other doctors that operated previously in the primary healthcare units. Several participants highlighted that the arrival of the doctors in the primary healthcare units made the process of return visits, and the accompaniment of chronic diseases, more agile. They also report participation in groups of prevention, which did not exist before[47].

Limits of the Mais Médicos Program

However, in spite of the positive impact of the PMM on the expansion and qualification of primary healthcare in Brazil, it has not succeeded in affecting certain structural hurdles in the National Healthcare Policy: (i) because the PMM has a provisional nature, it depends on being renewed every three years; and (ii), because a type of work contract has been constructed that is also precarious, in which the doctors are remunerated by grant (set at an attractive amount), which required that the contract established would be a mixture of work and space for education. Those in receipt of grants are obliged to do a distance learning course, and receive supervision and tutorship from doctors with experience in primary healthcare. Unfortunately, the system of supervision and tutorship was directed only to the 'students' and not to the whole team of which these doctors are a part. One sees that there was a certain lack of care taken on management models which, by recognizing health work as a practice, combine strategies of ensuring autonomy and devolved responsibility.

The PMM also does not make any proposal to change the isolation of primary healthcare and, thus, the low capacity for exercise of regulation and coordination of the doctors and teams over the health system. In spite of the expansion of the investment in infrastructure, it is still insufficient and very dependent on the municipalities' capacity for management.

Nor has it made progress in the definition of careers for the SUS. The professional turnover of health workers appears to be mainly caused by precarious and unstable employment links and outsourcing of management of health services. The challenge also remains of expanding the view beyond medical care alone, seeking inter-professionalism and inter-sectoriality, change in the "management-ist" models of supervision and care, and focusing more attention on expanded clinical care, and promotion of health.

Defense of the PMM, thus, depends on facing these structural obstacles.

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