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The *Mais Médicos* (More Doctors) Program in Mato Grosso State, Brazil: implementation analysis

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Abstract *Although the 224 health professionals engaged by the More Doctors for Brazil Project (*Projeto Mais Médicos para o Brazil, *PMMB) to strengthen the National Primary Health Care Policy (*Política Nacional de Atenção Básica, *PNab) in 104 municipalities of Mato Grosso (MT) State have encountered significant problems in the work process, important advances have resulted in the health of populations served by the More Doctors Programme (*Programa Mais Médicos, *PMM). This article analyses the implementation and development of the PMM in MT, from 2013 to 2015, on the basis of primary data from focus groups and interviews of social stakeholders at the institutions involved and secondary data from reports by supervisors, tutors, managers and institutions on the MT State Coordinating Committee (CCE) of the PMM. Despite political difficulties in managing implementation, the results show that the endeavour was beneficial in that it surmounted previous obstacles, afforded users greater access, prompted discussion of the problem and proposed and experimented with ways to strengthen primary health care. We conclude that there is a need for broader academic discussion of the provision and training of doctors, of the model of care and of human resource capacity-building by continuing professional development with integration among teaching, service and community.*

Key words *More Doctors Programme, Primary Health Care, More Doctors for Brazil Project, Health policy*

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Introduction

Health policy is understood as the social response (action or omission) of an organisation (such as the State) to individuals' and populations' health conditions and their determinants, as well as to the production, distribution, management and regulation of goods and services that affect human health and the environment[1].

In January 2013, the National Front of Mayors (*Frente Nacional dos Prefeitos*, FENAP) launched the campaign "Where's the doctor?" (*Cadê o médico?*). In July that same year, grassroots movements called for changes in health care, as reported in the editorial of the journal *Revista Saúde em Debate*[2]. Until then, Brazil had 1.8 doctors/1000 population, a lower rate than Argentina (3.9) and Uruguay (3.7). The rates were even lower in municipalities with populations in poverty situations, low human development indices (HDIs), indigenous populations and difficulties in retaining health personnel (MoH)[3].

In August 2013, the federal government issued Provisional Order No. 621 (later enacted as Law No. 12.871) instituting the *Mais Médicos* programme. As explained by the Ministry of Health (MoH)[3], this programme to provide doctors was an opportunity to effect changes to strengthen primary health care (PHC) in Brazil. Accordingly, *Mais Médicos* was structured in three dimensions: a) PHC infrastructure; b) organisational or educational changes; and c) emergency provision of doctors, the *Projeto Mais Médicos para o Brasil* (PMMB), with the following goals: to reduce the scarcity of doctors in priority regions of Brazil; reduce inequalities in access to health care; strengthen PHC; improve medical training; increase the number of trainee doctors working in PHC; strengthen the policy on continuing professional development (CPD) by integrating education and service; foster sharing of knowledge and experience between Brazilian health personnel and doctors trained abroad; improve doctors' training for working in the public health policies of the unified national health system (*Sistema Única de Saúde*, SUS); and encourage SUS-related research.

The PMM project allocated 18,240 doctors to 4,058 municipalities and 34 Special Indigenous Health Districts (*Distritos Sanitários Especiais Indígenas*, DSEIs). Mato Grosso State, which previously had 1.10 doctors per 1000 population, the lowest rate in the Mid-West Region, received 224 doctors, who were allocated to 104 of the total of 141 municipalities, according to MoH figures[3]. Set up in November 2013, the Mato Grosso State Coordinating Commission (CCE-MT) is the body responsible for coordinating the *Mais Médicos* for Brazil Project (PMMB) in the territory of Mato Grosso. This article examines the scenario and process in which the PMMB was implemented as a public policy in Mato Grosso State from 2013 to 2015.

Methodology

Qualitative analysis of implementation of the PMM examined the means and funding available to that public policy, following Donabedian[4]. Project reports were consulted in order to follow and monitor the process systematically, as described by Sulbrandt[5]. Analysis of the policy's implementation, which Viana & Baptista[6] consider to be one of the five phases in the social policy cycle, focussed on the context, goals and strategies set out explicitly in the documentary sources.

Qualitative analysis, argues Minayo[7], permits a fuller understanding of political and institutional structures, which were given special attention in this study. The point of departure was to examine secondary data obtained from 115 first-impression reports, 138 first-visit reports and two on-site regional supervision reports, all of which were available in the UNASUS system. Once categorised, these data served as the basis for an analytical situational description of the study object.

This was followed by primary data collection by semi-structured interviews applied by the lead author of the study, and by focal groups. Data comparison provided the necessary complementarity for the analysis, which was extensive and integrative, as proposed by Novaes[8]. The study subjects were 8 members of the CCE-MT (4 men and 4 women, predominantly around 40 years of age), 10 supervisors (6 women and 4 men, average age 38 years), 2 academic tutors (aged approximately 63 years), 20 doctors on the PMM (17 men and 3 women, aged around 43 years) and 6 health managers (3 men and 3 women, mean age 39 years).

In Focal Group 1, comprising eight members of the CCE-MT, consensus and conflict were observed as regards the participation by each study participant's institution in the CCE-MT. The session was recorded, transcribed and the transcription analysed using the S.W.O.T (Strength, Weakness, Opportunities and Threats) methodology, a structure, notes Travassos[9], that permits

analysis of institutions' structures and relations.

In Focal Group 2, comprising ten supervising doctors and two tutors, consensus and conflict were identified among these subjects as regards the process of monitoring and academic support in the context of the programme. The group proceedings were recorded and transcribed and the transcription subjected to thematic content analysis. Lastly, in Focal Group 3, comprising twelve doctors on the PMM, consensus and conflict were observed as regards their experiences in the municipalities and DSEIs. As in the previous focal group, the work was recorded, transcribed and the transcription subjected to thematic content analysis.

The dynamic of the focal group process made it possible to interlace data on practical experiences and subjective considerations, to constitute assessments with qualitative information, as in Kitzinger[10]. In this way, dialogue was possible among the various actors, making the research broader, by virtue of the varied methodological instruments and the diversity of subjects/actors/protagonists of this policy.

As this study involved research with human subjects, it was submitted to the Ethics Committee of the Júlio Muller University Hospital (HUJM-UFMT) and authorised.

Results

In the process of data analysis, the following categories were observed to emerge: *Institutional Scenario*; *Local Support*; *Health support*; and *Work Process,* as described below.

Institutional scenario

Implementation of the PMM-MT was influenced by the national political scenario, as exemplified by the manifesto by doctors' representative institutions repudiating the programme:

"The Federal Board of Medicine (*Conselho Federal de Medicina*, CFM) vehemently condemns the irresponsible decision by the Ministry of Health which, by causing Cuban doctors to come here without due revalidation of their diplomas and without their demonstrating command of the Portuguese language, violates Brazilians' human rights and places their lives at risk, especially those living in poorer and more distant areas" (CFM)[11].

In the same way, a lack of support for the PMM predominated during implementation in Mato Grosso as, for example, in the formal position taken by the School of Medicine at Mato Grosso Federal University (FM-UFMT). This undermined the programme activities and goals, as one interviewee explained: *if it had not been for the lack of interest in, and opposition to, the PMM on the part of the School of Medicine (FM-UFMT) and the Institute of Collective Health (ISC-UFMT), there would have been better results in integration between teaching and service and continuing professional development in the state*. The interviewee also stated that there was minimal support for the PMM from the State Health Department (*Secretaria Estadual de Saúde*, SES) and recalls that *the SES has relegated PHC to third- or fourth-place importance* (Interview 1). As regards the lack of SES support for PHC, another interviewee stated:

We have monitored health care activities in Mato Grosso for years and, despite good managers, we have never seen the SES acting to grant due value to PHC. There is a lack of political interest and understanding on the part of managers of the benefits of PHC to the SUS. This has caused major fragilities in the system in the state.... The SES does not make actions and technical personnel available for proper integration with the PMM. As PHC does not yield political laurels, it is being consigned to secondary importance... (Interview 2).

In Focal Group 1 (CCE-MT), the lack of SES support was identified as one of the greatest difficulties in implementing the PMM. Other important difficulties mentioned were that management was excessively centralised in the federal government and alignment was lacking among programme actions in the municipalities. One interviewee described precarious relations among levels of management:

I was in the coordination of the [PHC personnel programme] *PROVAB.* [...] *Communication was always poor between the state and the ministry. Information was conflicting. A lot of confusion in that early phase of the PMM.* [...] *Implementation could have been better if there had been planning. Managers would have been made more aware, shown these doctors' profile and their potential to make a difference in PHC* (Interview 3).

The interviewee explained that the MoH's centralisation of the PMM affected the SES and that, while the MoH formulated and drove the provision of doctors, the SES treated the PMM technically and bureaucratically.

At no time did management manage look to integrating the PMM with the SES. For the state management, it was just another MoH programme.

The SES did not know what direction or proportions the PMM was to take in the state. MT state needs the PMM; many municipalities have difficulties in engaging and retaining doctors. [...] *Municipal managers and the communities welcomed the PMM.* [...] *The MoH should grant autonomy for the necessary measures; the state should lead the process. The MoH simply ignores the CCE's recommendations. Neither the state government nor the commission were ever called on to discuss the PMM with the central government. That shows the fragility of the dialogue, which has been perpetuated over time* (Interview 3).

Another interviewee saw the PMM as "imposed" on the states, which posed the need for the programme's national coordination to give clarifications on the deadlocks created.

...on the one hand, the Brazilian doctor is demonised; on the other, the government is bringing in foreign doctors like good angels... That brought on a war, where the states had to go along... there was no actual planning of monitoring in MT. [...] *If the government effort to bring in the PMM doctors – like cheap labour, investing in a dictatorship – had been invested in a basic career in the SUS, we would have better responses in the medium term* (Interview 4).

Even though the strong criticisms were politically aligned with the institutions of the medical profession, documents exchanged between the CCE-MT and the SES show that, if there had been proper planning and political will, there would not have been so many divergences. Not only dialogue, but the will to dialogue, was lacking, as can be seen in this passage from an official letter from the CCE, which, lacking coordination, requests a position from the SES:

"It is fundamental that the SES be more involved in, and committed to, the PROVAB and *Mais Médicos* programmes. (...). We request support from the SES/MT to strengthen the CCE and the PROVAB and *Mais Médicos* programmes in Mato Grosso State (...) Appointment of a coordinator for the PROVAB/*Mais Médicos* CCE. (...) Physical space, structure (computer, printer, telephone) and most importantly an executive secretary exclusive to the CCE. (...) Support from the PHC team and the Regional Offices for actions and activities involving the PMM. (...) Logistic support and autonomy for the CCE coordinator to be able to meet the demands from the programmes (car, mobile phone, *per diem* for visits to the municipalities) (...) and facilitate fund execution (...) of the PROVAB/*Mais Médicos* CCE 2014". (Document 1)

At another point, the CCE-MT – now with a coordinator appointed by the state health department – forwards the following observations to the MoH:

"The CCE/MT (...) is encountering difficulties, for lack of guidance and/or responses from this national coordination, which is leading to conflicts and complaints from the municipalities. (...) The main problems are: 1. Requests for Doctor Reassignment/Exclusion; 2. Moral Issues (harassment) over which the CCE has no governance; 3. Participation by representatives of the DSEIs on the CCE/MT; 4. The CCE has not received the necessary information on Indigenous Health. There is a lack of direct contact with the SESAI [Special Secretariat for Indigenous Health]; 5. Request for a PAHO representative in the state; 6. Prescribing errors by doctors; 7. Issues relating to the code of ethics; 8. Lack of criteria in provision of doctors has caused problems; 9. Lack of planning in MoH joint activities with the CCE/MT – information not conveyed in time; 10. Systems problems in adhesion by the municipalities, in applications for travel costs, in the SGP and SCNES [systems]; 11. Lack of decentralised MoH support personnel; 12. Lack of legal support for the PMM/UFMT tutor (...), who is being taken to court by the CRM [regional board of medicine] (...) with regard to the PMM". (Document 2)

The lack of order and coordination in actions by the federal government towards MT, and by the state government towards the municipalities, was regarded as a considerable threat, which was causing discontinuity in, and weakening, the programme. Lacking robustness and precariously aligned, the PMM reached the municipalities with failures in management, work process and continued professional development, in addition to the doctors' encountering just as many weaknesses in a system still in the process of implementation.

Local support

In the municipalities of Mato Grosso, the doctors of the PMM were received with expressions of public support, as described by one doctor interviewed:

[foreign accent/faulty Portuguese] *I got to my municipality on a rainy Saturday, scared and worried about how the local people in this very remote place would react, but I was really very surprised, because even in that rain, I was received by the local people who were anxiously waiting for the doctor in front of the hotel where I was going to live for*

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a few months. Soon the radio press arrived. I never imagined my reception would be that good, so it was as if I was in Cuba, as if we were all family. My reception at the health post was just the same: part of the community was waiting for the new Cuban doctor. I remember one woman remarked to another 'She's very young' and the other one said 'They're the best'... (Report 1).

The arrival of these health professionals contributed to improving access to health, because *the PMM managed to get organised and to reach the municipalities where there were no doctors, such as Rondolândia (MT) and so many others. That improved access to medical services and brought more health care to the population* (Interview 5).

Although supervisors felt a need for support from the municipal managers, reports describe this as being weak as regards transport, accommodation, meals, Internet, CPD and most importantly in adjusting the teams' work process. One of the doctors interviewed declared that *the municipal managers often did not support our work, particularly the preventive work, because they continue to practice curative medicine, which has done so much harm to the communities* (Interview 5).

The consensus on the CCE-MT was that, during implementation of the PMM, commitment from the managers was tenuous, as evidenced by the lack of support and party political interest, lack of knowledge of the principles of the SUS, failure to comply with PNab guidelines and, most importantly, the weak state primary healthcare policy (Focal Group 1).

The work process

There is a lot of user satisfaction; they have been treated differently. The doctors value their activity of care for the community. They stay on there for 8 hours. It's a different kind of care, because of their training for the community. It's a another logic, another power relation. The doctor lives in the community, forms part of the community, makes home visits, give guidance and monitors the treatment of users. The doctor is very concerned with health promotion. The user trusts and bonds with the doctor, feels valued. The results are good and the managers press us for the programme to continue, because they are being pressed by the community. We have to value that in training our health personnel (Interview 6).

In spite of the difficulties at the start of the PMM, recognition for the humanised bond and the focus on comprehensive care for the community is a consensus in the model to be followed for PHC, as reported by one interviewee:

I think that the programme reached distant and remote communities, even in indigenous districts that never had a doctor. That is new and should be valued by managers and by the state government. The Cuban doctors' commitment is an important difference. That is due to the humanised training Cuban doctors were given after the revolution, including training in ethical and humanitarian principles, putting the human person first rather than money. Mercantile medicine hinders bonding and caring for the whole person and the whole community (Interview 7).

Most of the supervisors considered the work process followed by the teams to be inappropriate. Over the course of implementation, the practice of the PMM doctors was anchored in care for the family and community, in a broader understanding of the process of health and disease and in the socio-environmental context, and their practice was not restricted just to curative measures. Accordingly, they prioritised health promotion and health education activities. As one interviewee described the model encountered at the start of the PMM:

the lack of suitable physical structure at the facilities, lack of organisation in the team work process, [...] *people ended up being seen simply 'on demand', which is not what is proposed by the family health strategy (ESF) policy. Little practical continued professional development activity. Little state support – either financial or technical – for improving the quality of primary care. Manager turnover hinders continuity in actions proposed by the team the doctor works with, as does lack of knowledge of the municipalities' duties to the programme* (Interview 6).

The problems mentioned by this interviewee coincide with those most cited by supervisors with regard to the work process, during the first visits to the doctors on the programme: incomplete teams, without health agents or nurses; gaps in coverage; care work overload; lack of PHC planning; scarce meetings with teams; precarious planning between team and management; managers insisting on the traditional model of care and emergency care; and facilities without user registers and without properly defined territories.

Structure and health support

In Mato Grosso State, in the 2013-2014 PMAQ-AB [PHC quality and access programme], according to the SES[12], the structure

available to more than half (55.45%) the teams was classified as average or less than average. Of the 527 facilities assessed, 224 of a total of 662 family health teams received doctors under the PMM. The physical conditions of the rural facilities, where 50% of the PMM doctors worked, were mostly adapted or improvised facilities with PHC structure in need of improvement. As explained by one of the doctors interviewed:

The PHC facility functioned in an improvised manner in a room of the community centre where a flour mill operated, offering no proper privacy for gynaecological sample taking. The room is divided by a cupboard separating one environment, where the doctor conducts the session, from another environment where all other types of procedure are carried out (pre-appointment, vaccination, dispensing). Medicines are not properly stored, there is no refrigerator for storing insulin (Focal Group 2).

Nearly all the first visit reports point to insufficient supply, irregular distribution and inappropriate storage of medicines. One doctor on the programme declared *There are no materials for a simple suture* (threads, sterile gloves, forceps, drapes etc.) *and there are none of the basic medicines at the PHC centre that could solve many of the community's disorders* (Focal Group 3).

The supervisors in Focal Group 2 reported failures and overloads in the care system. The system was characteristically fragmented, indecisive and ineffective. This complaint voiced by the supervisors has been recurrent among the doctors, especially in small municipalities distant from the larger centres. *The lack of diagnostic support and the restrictions on complementary examinations limit therapeutic outcomes. Medium- and high-complexity services exist only in larger cities, but access is restricted and waiting times are long* (Focal Group 3). The process of referrals and counter-referrals is practically non-existent in the interior of the state.

Discussion

Despite the lack and poor distribution of doctors, implementation of the PMM as a public policy is characterised by lukewarm support and heterogeneous involvement of health institutions. The MoH pressed hard for the PMM to be implemented quickly, in spite of opposition from institutions representing the medical profession and the short planning period, as argued by Oliveira et al.[13]. At that stage, the support of the State Council of Municipal Health Secretaries (*Conselho de Secretários Municipais de Saúde*, COSEMS-MT) was decisive in dealings with the 104 municipalities that joined the programme. In spite of the major effort by the federal government, the centralised planning and failures in coordination with the state government led to precarious policy alignment between the MoH (proponent) and the SES (implementer). The differing policy positions, with differing degrees of commitment and/or opposition to implementation of the policies, as described by Viana & Baptista[6], associated with a lack of integration of the PMM with the state's regional health offices (*Escritórios Regionais de Saúde*, ERS-SES), undermined the capillarity and monitoring of implementation in the municipalities. The managers were tasked, as explained by Lobato & Giovanella[14], with implementation, re-establishing political arrangements, oversight, evaluation and monitoring of the activities.

Although the agents responsible for driving implementation were not politically coordinated with the proponent institutions, implementation of the programme brought to the municipalities 224 doctors who mention exceptional acceptance on the part of the population, which created an environment favourable to the programme's community-oriented actions. It was to be up to the state managers, as established in the PNab, to provide institutional support for implementing, monitoring and improving the quality of PHC; making available technical and teaching instruments for the process of training and continued professional development of the doctors; and to foster sharing of experiences to spread technologies and knowledge directed to improving PHC services. Nonetheless, this 'driver' agent did not provide the support necessary for proper implementation of the policy. One possible consequence is that managers' support for the doctors on the programme was limited or insufficient in 30% of the municipalities.

Although the doctors engaged to strengthen the PNab[15] encountered considerable difficulties in relation to the work process: irregular supply of materials, medicines and equipment, plus deficiencies in the care network, including geographical factors which, as argued by Travassos and Castro[16], conspire towards precarious access to health care, these professionals surmounted various other obstacles to provide medical care to approximately 900,000 users across Mato Grosso State. Accordingly, it was found that one of the main goals of the PMM – reduction of inequalities in access to health care – is being attained to a significant extent.

The fact that most (72%) of the municipalities joined the programme and that, by 2015, only two (1.9%) of the 104 municipalities served by the PMM had left, attests to the good results achieved in provision of doctors. The benefits were mentioned by managers in smaller municipalities, who reported a high degree of satisfaction with the results obtained. In Mato Grosso, 80% of the municipalities served by the programme are located in rural areas and have populations of fewer than 20,000. Retaining doctors in these communities, as noted by Oliveira et al.[13], fosters improved access to health care for vulnerable populations, resulting in highly beneficial impacts in regions with similar vulnerabilities across Brazil.

In the supervisors' view, in addition to assuring supply and retention of doctors, the PMM contributed to structuring PHC, especially in the smaller municipalities, stimulating continued professional development and organising the teams' work process model, all of which helped strengthen PHC. It should be mentioned that another goal of the programme, the sharing of experience between foreign and Brazilian doctors, has enriched the spectrum of technical procedures and instruments used for PHC. The supervisors acknowledge these doctors' humanised bonds with users and the comprehensive kind of care they offer the community, even though support has been weak and from few managers, hindering the doctors' activities, particularly as regards the process and organisation of team work. Martinelli[17] writes that the great majority of municipalities in Mato Grosso are small and do not have purpose-trained health managers; these are often party appointments, with no training for the position. The lack of knowledge of, or regard for, the principles of the SUS, the guidelines of the PNab and ESF, and tenuous commitment to the programme, the state's fragile PHC policy, the (lack of) party political interest, the lack of support from managers, are all factors that jeopardise implementation of the PMM and threaten the intended results. The work process was considered inappropriate in 86% of the supervision reports. The care practised in the family health programme should involve a multi-professional approach, an extended understanding of the process of health and disease, be directed to the family in its socioenvironmental context and, accordingly, not be restricted to curative practices (MoH[18]). Brazil's family health strategy emphasises disease prevention and health promotion, which gain differential importance in the model of work organised on the basis of using instruments and equipment designed specifically for the purpose (MoH[15]). However, the model often adopted by managers is more traditional, fragmented, doctor-centred, to the detriment of the comprehensive, interdisciplinary care proposed by the family health strategy, as observed by Araujo e Rocha[19]. In order for changes to be made to the work process, managers have to be persuaded and teams trained. The CCE-MT considered that this investment, if integrated with the state's regional health offices and the School of Public Health, could encourage the needed changes in the teams' work process.

Physical conditions were inappropriate and structural improvements needed at most of the rural facilities, where 50% of the doctors on the PMM work. Law No. 12.871 of 2013 (BR[20]), drafted by the Office of the Chief of Staff of the Presidency, allows the SUS five years to provide primary health care facilities with quality equipment and infrastructure, because without appropriate premises and a minimum of support for the teams' activities, efforts to strengthen PHC in the SUS are undermined.

In spite of the difficulties in implementing the PMM in Mato Grosso, many of the goals were attained and others may yet be. For PHC to be strengthened, better planning and institutional and political adjustments are needed, in addition to policy monitoring and evaluation, and new, complementary policies need to be developed to strengthen PHC and the other levels of care in the SUS. Appropriate political alignment and integration among the proponent bodies (MoH), implementers (SES) and municipal health departments (*Secretarias Municipais de Saúde*, SMS) for the good of this public policy will contribute to achieving the goals of the PMM.

In spite of the difficulties in implementing the PMM in Mato Grosso, many of the goals were attained and others may yet be with better planning and institutional and political fit. This political alignment and integration among the proponent bodies (MoH), implementers (SES) and municipal health departments (*Secretarias Municipais de Saúde*, SMS) for the good of this public policy will contribute to achieving the goals of the PMM.

In addition to monitoring and evaluation of this policy, there is a need to develop new, complementary policies to strengthen PHC and the other levels of care in the SUS.

In spite of the fragmentation in management, the deficient people policy of the SUS, the dilu-

tion of state and federal responsibility (as mentioned by Campos[21]), implementation of this policy in MT has stimulated PHC measures in the municipalities. Despite a culture of improvisation and immediacy, and of precarious user care, the process of implementing this public policy, which is treated simplistically and inadequately, has produced effects on the related infrastructure, equipment and model of service and care. In this scenario, considering the right to citizenship and the principles of the SUS, the results of this study are evidence that implementation of the PMM in MT contributed to strengthening PHC, improving health service quality, improving supply of doctors and significantly improving the population's access to health services.

Although this study does present important data on implementation of the PMM, limitations were encountered in both data collection and analysis, suggesting a need for further research to assess impact from the outcomes of this policy, in addition to addressing other stakeholders, such as users, in order to evaluate the degree of satisfaction of the populations served. While, on the one hand, in the role of researcher and tutor on the programme, I was afforded greater access to data and information, I must confess to a major effort to be impartial and considered in analysing the data and writing the article. Accordingly, the study findings should be reassessed in due course, because the historical process will throw new light on this programme, which by 2015 had brought some 13,000 foreign doctors to Brazil (11,429 of them Cuban cooperating doctors), to whom I must express my gratitude.

Conclusions

Notwithstanding the political complexity of the moment in Brazil, the heterogeneous involvement and institutional fragilities in the health sector, the lukewarm support given to implementation of the PMM in Mato Grosso State, the short period and centralisation of related planning, the great haste in implementing this policy, the precarious political alignment among the institutions involved, the insufficient monitoring of programme actions by SES managers, the precarious conditions the doctors encountered at PHC facilities, the lack of support from some municipal managers, the limited structures at the facilities, the lack of material, equipment and medicines, the inappropriate work process and the inadequate health care network, nonetheless, the PMM has resulted in provision of 224 new doctors to Mato Grosso State, improvements to access, integration between doctors and team personnel, continued professional development activities, changes in the work model, team capacity-building, policies with a social commitment to strengthening PHC as a space for care, respect and civic dignity, in addition to new possibilities for the SUS as a space for social gains.

On this shifting field of veiled or explicit struggles and inequalities, there has undeniably been greater access to health care, especially in vulnerable municipalities and areas and, as a result, the overall set of individual and collective social and political rights has been extended to more people. Health, as an instrument of participatory citizenship, can be seen to attenuate differences, fostering a society with more justice and solidarity. A properly structured health network is not enough without social commitment, just as it is not enough to implement yet another health policy, because what is needed is healthy struggle for policies that promote the right to life.

Despite the complexity of the issue, an effort has been made here to reflect on the process of implementation of the PMM as an innovative public policy that prioritises access to health care by vulnerable populations as a citizens' right. Far from exhausting such subjects, this article seeks to prompt academic discussion, given the principles of universality and of primary health care as the main gateway to the SUS, which are often undermined by political lack of interest.

Collaborations

RG Mota the lead author of this article, which resulted from doctoral research, was responsible for the literature and documentary review, and preparation and application of instruments, data recording and analysis and drafting of the article. NF Barros the doctoral supervisor, was responsible for academic support, bibliographical and methodological guidance, supervising preparation of instruments, monitoring of data analysis, supervisory guidance and discussion of the findings.

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In the role of tutor on the PMMB during two years of its implementation, the lead author had the opportunity to share experience in close contact with the doctors, both in urban consulting rooms and on Amazon indigenous lands. There, these doctors' arrival could be seen to have brought not just professionals with the technical competence for primary health care, but persons committed to the ideals of social justice and solidarity. Trained in a different academic scenario, concerned for the wellbeing of the communities where they live, these doctors pursue their activities with an admirable sense of responsibility in caring for people and modestly honour us with their presence. I would like to express my gratitude for their selflessness and timeliness, especially to the Cuban doctors, who left their families and country to plunge deep into the inner reaches of this Brazil.

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