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Doctors for Brazil Program: first results

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Abstract *Access to medical care is essential to achieve quality primary health care (PHC). In Brazil, access difficulties still persist. The Doctors for Brazil Program (PMpB in Portuguese) aims to expand the offer of medical services in places of difficult provision or high vulnerability. It innovates insofar as it prioritizes smaller and rather isolated cities, by selecting professionals through an isonomic process, offering them training in Family and Community Medicine and a chance to build their first federal medical career in PHC. The program offers competitive salaries, progression and financial incentives that value long-term commitment and performance. The PMpB is rolled out by the Agency for the Development of Primary Health Care (Adaps), which allows better management of public policies. The first nine months of the program showed promising results, as approximately 23,000 candidates seeking to join the program through its selection process, i.e., 97.1% vacancies were filled and retention rate after admittance was 95.4%. These results show to what extent PMpB has improved in quality compared to previous policies, as well as how essential it is to keep implementing the program so that it may reach its full PHC coverage potential within the Brazilian public health system.*

Key words *Primary health care, Health policy, Family and community medicine, Access to health services*

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Introduction

Well-implemented primary health care (PHC) is fully able to solve most health issues reported by people and in this scenario, the physician's work is fundamental[1]. However, access to medical care varies greatly in Brazil and access has been one of the most challenging aspects involved in structuring PHC[2]. Regarding availability of medical care in PHC, this inequality is currently rather due to the distribution of doctors across Brazil than to the total number of doctors in practice. Smaller cities with a predominance of rural population have less availability of doctors when compared to large cities. Cities in the interior of the North and Northeast Regions of Brazil show a density of 0.2 physicians per thousand inhabitants, while the capitals of the Southeast Region count over 13.7 physicians per thousand inhabitants[3].

Government initiatives aiming to improve access to medical care in Brazil were first launched in the 1970s[4]. Their success varied but supply of medical services in PHC increased, although not in a consistent way throughout Brazil. Access is still a challenge in certain parts of the country, as well as retention of professionals in municipalities and the quality of care offered in PHC[4-6]. It is essential to improve retention and professional qualification to obtain better indicators of long-term care, as well as comprehensiveness and coordination of care, which are essential to effectively establish PHC[1].

The Doctors for Brazil Program (PMpB)[7] was created to address that situation. It aims to increase the provision of PHC medical services in places that are either hard to provide for or highly vulnerable and to promote training of doctors in family medicine. The main guidelines of the Program include: definition of locations eligible for federal medical provision and the respective size of the medical workforce based on technical criteria associated with the difficulty of medical provision and individual vulnerability of people; selection and training of doctors fully skilled to work in PHC; offering doctors a federal medical career with better working conditions and health results to people served.

The program is the current perennial federal medical provision strategy in PHC and is rolled out by the Primary Health Care Development Agency (ADAPS), which was set up to put the PMpB into practice, among addressing other matters.

PMpB doctors took up their work in April 2022. This article presents the first program results.

Results and discussion

Creation and implementation of ADAPS

ADAPS was founded as part of the Doctors in Brazil Program, after an extensive debate in the National Congress involving interested parties from civil society. ADAPS, a public interest and non-profit institution, is legally an autonomous social service (SSA) that aims to develop PHC within the Brazilian Public Health System (SUS) under the terms of the agreement concluded with the Ministry of Health and under the supervision of the institutions in charge.

According to studies that analyze actual cases of institutions of this legal nature and their respective applications, adopting the SSA model aimed to tackle the rigidity of the Brazilian public administration[8]. ADAPS was created by Federal Decree no. 10.283/2020[9] and started to operate in October 2021 under supervision of the Ministry of Health. In less than 100 days after its implementation, ADAPS was already performing large-scale operations, such as a selection process launched to hire almost 2,000 physicians throughout Brazil[10].

Its agile management is due to the fast definition of goals and strategic results in organizational planning, mapped and standardized organizational processes, contracting of digital solutions that allowed, e.g., the simultaneous digital admission of a large volume of doctors, and a dedicated website that publicizes the steps required to select, summon and hire doctors.

Therefore, ADAPS emerges as a powerful innovative model in the scenario of SUS' management[11], aiming to make it more agile without disregarding the principles of public administration. It is committed to strengthening SUS and to the search for solutions that focus on people first[12].

Doctors for Brazil Program (PMpB)

Redistribution of vacancies

The PMpB presents new criteria to allocate vacancies in municipalities, which is one of the features of the improvement of national strategies for the provision of medical services. Priority is given to remote municipalities and their most vulnerable areas. For this purpose, primary criteria (with greater weight) and secondary criteria[13] are applied. Primary criteria are defined by Program Law and constituted according to the typology of the municipality, as defined by the Brazilian Institute of Geography and Statistics

(IBGE)[14] and by the number of people in socially highly vulnerable situations. Those data were obtained by surveying the number of people registered by family health teams and the beneficiaries of the Bolsa Família Program, continuous cash benefit (BPC) or social security benefit up to a maximum amount of 2 (two) minimum wages. Prioritization of remote areas and/or areas containing populations in a situation of social vulnerability favors provision of PHC in areas with greater demand for health services and in those which have greater difficulty in attracting physicians. The secondary criteria[13] used to deepen the analysis and count the number of vacancies by location included municipal tax collection per capita, municipal population dependent on SUS, hospitalizations due to conditions sensitive to PHC in the municipality and municipal coverage of the Family Health Strategy.

Changes in criteria increased the number of vacancies in the North and Northeast regions, which now account for 56% of the vacancies, and to rural municipalities that lie far from large urban centers. By way of comparison, the More Doctors Project (PMM) allocated 48% of its vacancies to the North and Northeast regions.

The PMpB forecasts 21,527 vacancies, an increase of approximately 20% in relation to the 17,977 vacancies made available by the PMM (Table 1). PMM vacancies are distributed in 3,873 municipalities, while the PMpB should cover 5,233 municipalities. Change in criteria for distributing vacancies clearly benefits indigenous localities and remote municipalities.

Attraction and selection of doctors

The PMpB hires doctors for two different kinds of positions: family and community physician (MFC) and medical tutor. Doctors need to be registered with the Federal Council of Medicine and pass a written test for both positions. Candidates who apply for the position of Medical Tutor need to be specialize in either Family and Community Medicine or in Internal Medicine. Candidates to the MFC position need to complete a two-year training course and pass a final exam to qualify as MFC specialists, acknowledged by the Brazilian Medical Association. Medical tutors, in addition to support the PHC team they join, need to help instruct doctors in training.

Two PMpB recruitment processes have already taken place, the first one in December 2021 and the second one in September 2022. Between the 2021 and 2022 processes, improvements were made, such as changes in the rules for indicating the place of interest and taking the test online. The program attracted more candidates, the time between the start of the recruitment process and results homologation diminished, and the bank of qualified candidates apt to start activities increased (Table 2).

Career path

The PHC medical career is an innovation by the PMpB[15]. Doctors employed by ADAPS are hired under a CLT agreement (The Consolidation of Labor Laws – Portuguese: Consolidação das Leis do Trabalho, CLT –, officially Decree Law no. 5.452, is the decree which governs labor relations in Brazil.). Their career comprises four levels of progression, salaries are above market average for MFC and progression takes place every five years. Additional performance enhancement incentives[16] were implemented as well. Performance evaluation is based on assessment of care quality indicators, development of professional skills and performance of continuing education activities.

Medical Tutors receive specific incentive for this assignment. Physicians working in either rural or remote municipalities, as well as in Special Indigenous Health Districts (DSEI) also receive supplemental wage. Performance indicators need to be aligned with those that apply to all teams within the scope of the performance component of PHC's federal funding.

Thus, efforts are combined and result in synergistic effects on program managers, teams and physicians in their effort to improve monitoring of chronic diseases and other frequent conditions in PHC. Doctors may also be transferred to other municipalities, prioritizing those who have been part of the program for a longer period of time, who work in places that are more difficult to provide with staff and who present a better performance evaluation.

All these features aim to retain physicians and to value those who present better performance, work in places that are rather difficult to provide with staff and those in charge of training new MFC doctors[17].

Occupation and professional retention

Physicians who passed the selection process were gradually invited to fill the 5,000 vacancies made available by the PMpB in 2022[18], according to selection process grades and the workplace they had chosen. There were 22 calls in the first nine months, average time between calls was approximately 12 days, totaling 12,126 doctors called.

Table 1. Comparison of distribution of vacancies by type of municipality between PMM and PMpB.

Location typology	PMM	PMpB	Relative difference
DSEI	372	711	+91%
Rural remote	643	1,404	+118%
Rural adjacent	4,424	7,463	+69%
Intermediate remote	235	509	+117%
Intermediate adjacent	1,603	1854	+16%
Urban	10,700	9,586	-10%
Total	17,977	21,527	+20%

PMM = More Doctors Project; PMpB = Doctors for Brazil Program; DSEI = Special Indigenous Health District.

Source: Primary Health Care Department, 2019.

Table 2. Comparison between the two PMpB selection processes.

Variable	First selection process			Second selection process		
	Medical tutor	MFC	Total	Medical tutor	MFC	Total
Vacancies	595	4.057	4.652	312	2.188	2.500
Candidates	1.872	14.485	16.357	2.511	20.669	23.180
Candidates/vacancy	3,1	3,6	3,5	8,0	9,4	9,3
Approved candidates	724	7.794	8.518	1.666	16.270	17.936
Duration		90 days			60 days	

Source: Authors.

At the end of 2022, 97.1% of all vacant posts had been filled, i.e., 4,855 physicians had started working at that time. Of the 2,835 municipalities offering vacancies to be filled in 2022, 2,777 had been provided with doctors by the program. Of the total number of physicians hired, only 4.6% were dismissed, mainly at their own request. The vacancy occupation target for the first year of the program is 35%, while the target for MFC dismissals is up to 30%[15]. Results point to a high adherence of doctors to the program and a high retention rate, which exceeded goals established by the Ministry of Health through its Management Agreement with ADAPS[18].

The above results show that the right strategies were adopted to retain doctors in the Program. By comparison, 54% of the Brazilian physicians who participated in the More Doctors Project between 2013 and 2017 were dismissed from the program within a year and a half after its start[5].

Professional qualification

As part of the selection process, physicians who are accepted for an MFC position by ADAPS need to attend the Specialization Course in Family and Community Medicine (CEMFC)[19]. The CEMFC is a novel professional training model in Brazil that has been developed specifically for the program, based on the specialty's competencies. It relies on consolidated methodologies that are widely used to train physicians[19]. The course focuses on clinical care and allows doctors to develop all the required skills to offer resolute care at the end of a two-year training course.

Training workload is 60 hours per week (40 hours of practice + 20 hours of theoretical activities). Theoretical activities are performed in an online and asynchronous format. Doctors in training are supervised by the Medical Tutor, who spends one week with them every two months in continuous supervision to support, supervise and evaluate the development of their professional skills. In addition, they are academically tutored by the theoretical component of the training course.

Evaluation of professionals is another important novelty of the PMpB. Physicians are periodically monitored regarding their academic performance and development of clinical and professional skills. Health care quality indicators are also monitored.

Doctors receive a training grant during the entire course, which is concluded with a test for

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professional qualification as specialists in MFC acknowledged by the Brazilian Medical Association. This is the last point of control of training quality; it certifies that quality and increases the number of MFC specialists in Brazil significantly. Approved physicians are automatically hired under ADAPS' CLT agreement.

Final considerations

The first results presented by the PMpB are significant. There was a large and growing demand for the program's selection processes. At the same time, retention rate of contracted physicians point to a promising future in terms of the PMpB's potential as a physician retention policy, an issue that previous provision policies had not been able to address properly[4-6]. In addition, occupancy capacity has proven to be effective due to the fact that ADAPS rolled out the program, which contributes to greater flexibility in organizing procedures to attract, select, call and allocate physicians. PMpB's career plan for doctors, an excellent strategy for professional retention, has only become possible through implementation of its policy by ADAPS.

New public policies emerge to build up on what has been achieved. The PMpB has been developed based on that reality. It corrects shortcomings and flaws of previous provision policies and increases efficient medical provision in Brazil by redistributing vacancies to places with greater access difficulties, improves on attracting and retaining physicians, reduces idle time of unoccupied vacancies and offers better professional training.

However, some challenges still need to be tackled. PMpB needs to be expanded to be able to serve more than 20,000 teams that expect receiving the program's physicians in 5,233 municipalities[13]. Expanding also requires improving its processes for recruiting, selecting, receiving, supporting, retaining and training physicians and offering support to local managers. In addition, no matter how well established mechanisms work, some locations may continue having difficulties to provide PHC. Given this historic difficulties of medical provision in certain locations, ADAPS allows developing innovative solutions to meet the needs of areas that the PMpB cannot cover and which are identified by the agency itself. Telemedicine is a possibility that needs to be considered. Thus, the cycle of planning, implementing, evaluating and improving public policy is restarted.

Finally, ADAPS, as its name implies, was created to implement any kind of actions aimed at developing PHC. Based on the results of its first action, i.e. the PMpB, the agency has become a strategic partner of public administration in offering increasingly better services to users of PHC provided by SUS.

Collaborations

CMJ Santos and L Wollmann contributed with the original conception of the article; all authors contributed to the writing and final revision of the manuscript.

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