

# The regional distribution of the provision of training in the Multi-professional Residency in Health modality

## *A distribuição regional da oferta de formação na modalidade Residência Multiprofissional em Saúde*

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**ABSTRACT** The Multi-professional Health Residency (RMS) programs provoke reflections on daily work, the relationships and the work process, and have the potential to modify not only the perspective of the graduated individual, but also the spaces in which they develop, strengthening the continuous process of permanent education in health. Studies that investigate how the multi-professional residency programs supported by the Ministry of Health (MS) have been structured are timely and relevant, given the contributions of these initiatives to the Unified Health System (SUS). This work analyzes the RMS, with the goal of identifying how the programs funded by the MS are distributed regionally across the country. An exploratory documentary research was carried out using edicts and ordinances published by the MS in the period from 2009 to 2015. The majority of the approved programs are concentrated in the Southeast region, mainly in São Paulo, followed by the Northeast and South regions. The North and Midwest regions were the least representative in the total amount of the selected programs. On the other hand, the Northeast region presented an increment of programs induced by the priority given in the published official notices. There was an attempt to organize the distribution and a tendency to increase of programs submitted and approved.

**KEYWORDS** Health human resource training. Internship nonmedical. Education, continuing.

**RESUMO** Os programas de Residência Multiprofissional em Saúde (RMS) provocam reflexões sobre o cotidiano, as relações e o processo de trabalho e têm potencial de modificar não apenas a perspectiva do indivíduo formado, mas os próprios espaços em que se desenvolvem, fortalecendo o contínuo processo de educação permanente em saúde. Estudos que investiguem como tem se estruturado os programas de residência multiprofissional apoiados pelo Ministério da Saúde (MS) são oportunos e relevantes, ante as contribuições dessas iniciativas para o Sistema Único de Saúde. Este trabalho analisa as RMS, com o objetivo de identificar de que maneira os programas financiados pelo MS encontram-se distribuídos regionalmente pelo País. Realizou-se uma pesquisa documental exploratória utilizando-se editais e portarias publicados pelo MS no período de 2009 a 2015. A maioria dos programas aprovados se concentrou na região Sudeste, principalmente em São Paulo, seguida pelas regiões Nordeste e Sul. As regiões Norte e Centro-Oeste foram as menos representativas no total de programas selecionados. Já o Nordeste apresentou um incremento de programas induzido pela prioridade dada nos editais publicados. Observou-se uma tentativa de organização na distribuição e uma tendência ao aumento dos programas apresentados e aprovados.

**PALAVRAS-CHAVE** Capacitação de recursos humanos em saúde. Internato não médico. Educação continuada.

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## Introduction

The heterogeneity of epidemiological situations in the regions of the country and the coexistence of chronic conditions with communicable diseases require a health policy that can deal with the various ongoing transitions, which includes directing the training of human resources for these different scenarios (ARAÚJO, 2012). Moreover, the Brazilian reality is characterized by the lack of provision of health professionals in several regions, in addition to the difficulty for establishing these, especially in regions of economic deprivation and lower access to cultural, educational and technical-scientific assets (CECCIM; PINTO, 2007).

In this environment, the demands for different profiles of professionals aiming at full care make discussions regarding multi-professional training increasingly relevant (PIERANTONI, 2012).

The current technical and assistance model has been migrating from centrality in medical procedures and technical dressing to multi-professional procedures with the participation of users in the conduits (CECCIM; PINTO, 2007). This context points to the potential inducement of Multi-professional Residences in Health (RMS) that were consolidated as specialization in the health area, aiming to promote transformations in the training of professionals in relation to the medical-assistance model (SILVA ET AL., 2015). It is a context of challenges and dilemmas for the institutionalization of RMS.

The Ministry of Health (MS), in accordance with the legislation, takes up the role of ordering the formation of human resources (Federal Constitution, article 200, item III), and it must take into account the priorities according to the epidemiological and demographic profile of the Brazilian regions. Since 2003, the creation of the Secretariat of Labor Management and Health Education (SGTES) of the MS and, later, the approval of the National Policy of Permanent Education

in Health (PNEPS) has allowed numerous projects, aimed at training human resources in health, to be made feasible, aiming to make the public health network a field of teaching-learning in the exercise of work (ROSA, LOPES, 2010).

The Inter-ministerial Ordinance No. 1,077/2009 created the National Program of Scholarships for Multi-professional Residences and Professional Health Area (BRASIL, 2009). The MS assumed the role of regulating RMS by creating vacancies for the specialization of health professionals in priority areas for the Unified Health System (SUS), thus reorganizing the provision of this type of training. Therefore, in addition to acting in the institutionalization and recognition movement of RMS, the MS became responsible for the broad line of financing of these programs (BRASIL, 2011). In addition, the MS, in conducting the evaluation and monitoring of the residences that it finances, bases the establishment of guidelines for the continuation of the investment in this modality of formation.

While the Ministry of Education finances the scholarships of institutions of the federal public higher education system such as university hospitals, the MS is responsible for scholarships linked to strategic programs in its area. The states and municipalities directly fund the programs developed in hospitals and institutions of their respective networks, as well as the private maintainers are responsible for the payment of residence scholarships in hospitals and private health institutions (BRASIL, 2011).

The National Scholarship Program for Multi-professional Residences and Professional Health Area aims to consolidate these Residences as strategic fields of action for SUS. It is funded with the resources of the budget programming of the MS and is developed in partnership with the General Coordination of Residencies of the Department of Hospitals and Residencies of the Secretariat of Higher Education of the

Ministry of Education (DHR/Sesu/MEC), which together make the call for notices. Scholarships are awarded directly to residents, and no longer by agreement (ARAÚJO, 2009). Thus, the MS affirms its role in financing and legitimating RMS, guaranteeing its continuity through selection calls (BRASIL, 2011).

Knowing that the actions relative to the provision and fixation of health professionals in universal and free health systems is the responsibility of the State (BRASIL, 2012), studies that aim to know the effects of governmental incentive strategies become timely. From this perspective, the distribution of the supply of RMS programs induced by the MS's calls for proposals in the Country, from 2009 to 2015, is analyzed.

## Material and methods

This is a descriptive documentary research (GIL, 2010), using a qualitative approach.

The convocation notices and the homologation orders of the RMS programs, financed by the MS in the period from 2009 to 2015 and published in the Official Gazette (DOU) at <http://portal.in.gov.br/>, were analyzed. Although the funding of the RMS grants comes from different sources, only the MS-funded programs were considered through calls for proposals.

In the homologation orders of the selection process, the relationship between the approved programs and their distribution in the regions and states was analyzed. The calls for proposals renewal of existing programs starting in 2016 were excluded, since they were published after the period defined for the analysis of this study.

## Results and discussion

In the period from 2009 to 2015, 320 programs were approved. The first implementation experience dates back to 2010,

through a call notice published in 2009 by MS/SGTES. In that year, 59 new programs were approved in the different regions. All the other ordinances studied presented the list of selected projects for the granting of resident scholarships, jointly contemplating new programs and expansion of vacancies in RMS and in the Professional Health Area.

The Southeast region was the most contemplated area throughout the period, with 148 approved programs, representing 46.3% of the total approvals (*table 1*). In the first ordinance published in 2010, the Southeast region was responsible for 47.5% of the selected projects; And in 2012 and 2013, more than 50% of the approvals came from that region. In 2013, the Southeast had 54.2% of all projects selected.

This finding reflects the status of the Southeast region, which, due to its economic performance, is configured as the dynamic center of the health labor market in the country, corresponding to some extent to the distribution of installed capacity and health jobs in this region (VIEIRA; AMÂNCIO; OLIVEIRA, 2004). The poor geographical distribution of service providers is a persistent situation that has resisted the most varied strategies adopted by the Brazilian governments (CAMPOS; MACHADO; GIRARDI, 2009). Such aspect requires greater coordination between health systems and higher education institutions that, in addition to providing qualified and sufficient professionals, must pay attention to the diversity and serious inequalities of the country in relation to health indicators, with a view to overcoming them (DAL POZ; VARELLA; SANTOS, 2015).

In 2009, the first year of the convocation notices, the North, Northeast and Midwest regions were considered as priorities for funding. However, only the Northeast region presented a significant number of selected programs, just behind the Southeast region, with 20.6% of approvals throughout the period. In 2010, 2011 and 2013, the Northeast was the second region with more programs

in operation, being surpassed in 2014, when the number of residences approved was increased to 25.5% in the South region.

The MS edicts of 2009 and 2014 considered the financing of RMS programs in the North and Midwest as a priority; however, these regions were the least approved projects, representing only 10% and 4.4% of all the programs offered in the period, respectively. The region with the lowest performance in the period was the Midwest, which in the year 2014 presented only 2.9% of the programs approved in the country.

This finding is in line with the offer of higher education in Brazil, which historically focuses on large urban centers, predominantly the South and Southeast axis. As for the distribution of enrollments in presential higher education courses in the country's public and private networks, the Midwest and North regions accounted respectively for 9.4% and 6.9% of enrollments in 2013, while the Southeast region concentrated 47.2%, followed by Northeast (20.9%) and South (15.6%) (BRASIL, 2014; SEMESP, 2015).

Table 1. Quantitative of RMS programs that have been approved and funded by the MS in the years 2010 to 2015 by regions and states in Brazil

Region / States	Year											
	2010/2011	%	2012	%	2013	%	2014	%	2015	%	Total	%
<b>North</b>	<b>1</b>	<b>1,7%</b>	<b>6</b>	<b>20,0%</b>	<b>7</b>	<b>8,4%</b>	<b>8</b>	<b>7,8%</b>	<b>10</b>	<b>21,7%</b>	<b>32</b>	<b>10,0%</b>
AC	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%
AP	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%
AM	0	0,0%	0	0,0%	2	2,4%	2	2,0%	4	8,7%	8	2,5%
PA	0	0,0%	6	20,0%	4	4,8%	1	1,0%	2	4,3%	13	4,1%
RO	1	1,7%	0	0,0%	1	1,2%	0	0,0%	3	6,5%	5	1,6%
RR	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%
TO	0	0,0%	0	0,0%	0	0,0%	5	4,9%	1	2,2%	6	1,9%
<b>Northeast</b>	<b>16</b>	<b>27,1%</b>	<b>4</b>	<b>13,3%</b>	<b>14</b>	<b>16,9%</b>	<b>24</b>	<b>23,5%</b>	<b>8</b>	<b>17,4%</b>	<b>66</b>	<b>20,6%</b>
PE	7	11,9%	0	0,0%	3	3,6%	11	10,8%	4	8,7%	25	7,8%
CE	4	6,8%	1	3,3%	5	6,0%	7	6,9%	1	2,2%	18	5,6%
BA	2	3,4%	2	6,7%	5	6,0%	2	2,0%	2	4,3%	13	4,1%
PB	0	0,0%	0	0,0%	0	0,0%	2	2,0%	0	0,0%	2	0,6%
PI	1	1,7%	0	0,0%	0	0,0%	1	1,0%	0	0,0%	2	0,6%
RN	1	1,7%	0	0,0%	0	0,0%	1	1,0%	0	0,0%	2	0,6%
SE	1	1,7%	0	0,0%	1	1,2%	0	0,0%	0	0,0%	2	0,6%
MA	0	0,0%	0	0,0%	0	0,0%	0	0,0%	1	2,2%	1	0,3%
AL	0	0,0%	1	3,3%	0	0,0%	0	0,0%	0	0,0%	1	0,3%
<b>South-west</b>	<b>28</b>	<b>47,5%</b>	<b>16</b>	<b>53,3%</b>	<b>45</b>	<b>54,2%</b>	<b>41</b>	<b>40,2%</b>	<b>18</b>	<b>39,1%</b>	<b>148</b>	<b>46,3%</b>
SP	14	23,7%	10	33,3%	25	30,1%	35	34,3%	9	19,6%	93	29,1%
MG	9	15,3%	5	16,7%	15	18,1%	2	2,0%	4	8,7%	35	10,9%
RJ	4	6,8%	1	3,3%	5	6,0%	4	3,9%	3	6,5%	17	5,3%
ES	1	1,7%	0	0,0%	0	0,0%	0	0,0%	2	4,3%	3	0,9%

Tabela 1. (cont.)

<b>South</b>	<b>10</b>	<b>16,9%</b>	<b>3</b>	<b>10,0%</b>	<b>13</b>	<b>15,7%</b>	<b>26</b>	<b>25,5%</b>	<b>8</b>	<b>17,4%</b>	<b>60</b>	<b>18,8%</b>
RS	4	6,8%	2	6,7%	8	9,6%	12	11,8%	4	8,7%	30	9,4%
PR	3	5,1%	0	0,0%	4	4,8%	6	5,9%	2	4,3%	15	4,7%
SC	3	5,1%	1	3,3%	1	1,2%	8	7,8%	2	4,3%	15	4,7%
<b>Midwest</b>	<b>4</b>	<b>6,8%</b>	<b>1</b>	<b>3,3%</b>	<b>4</b>	<b>4,8%</b>	<b>3</b>	<b>2,9%</b>	<b>2</b>	<b>4,3%</b>	<b>14</b>	<b>4,4%</b>
DF	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%	0	0,0%
GO	1	1,7%	0	0,0%	3	3,6%	1	1,0%	2	4,3%	7	2,2%
MT	2	3,4%	1	3,3%	0	0,0%	2	2,0%	0	0,0%	5	1,6%
MS	1	1,7%	0	0,0%	1	1,2%	0	0,0%	0	0,0%	2	0,6%
<b>Total</b>	<b>59</b>	<b>100,0%</b>	<b>30</b>	<b>100,0%</b>	<b>83</b>	<b>100,0%</b>	<b>102</b>	<b>100,0%</b>	<b>46</b>	<b>100,0%</b>	<b>320</b>	<b>100,0%</b>

Source: Ordinances approval of RMS programs released by MS/SGTES in the years 2010-2015.

Although it is argued that the creation of the SUS, with its decentralized institutional arrangements, was the great factor that drove the advances in the interiorization and improvement of the distribution of health services (CAMPOS; MACHADO; GIRARDI, 2009), the country still faces problems in terms of the geographic distribution and fixation of health professionals. Different countries across the world share the challenges of providing and securing health professionals. Experts even claim that this will be an even bigger problem in the future. For this reason, the World Health Organization (WHO) has established, as one of its goals, the correction of the deficit and maldistribution of health professionals (BRASIL, 2012).

In the Brazilian case, there is a consensus that the distribution problems have made it difficult to consolidate the SUS, the expansion and qualification of the Family Health Strategy (ESF), which plays a central role in the reorientation of the model of care and improvement of health care networks (OLIVEIRA, 2009).

Given this situation, actions focused on the need to provide and fix health professionals to promote quality access to health care services for the entire population become

essential (BRASIL, 2012). In a large country such as Brazil, the health needs presented are the most diversified, requiring managers and policy makers in order to provide adequate guidance to meet social demands.

In the field of health, the training of workers must align the specific needs of each profession with the context in which it is inserted, considering the problems experienced by the population assisted, in addition to those related to work organization. The extreme inequalities in the concentration and supply of health services are represented by the saturation of physicians and other health professionals in the great cities and richest regions of the country – and situations of extreme deprivation in remote, poor and peripheral regions (CAMPOS, MACHADO, GIRARDI, 2009).

The inequity in the regional distribution of undergraduate and postgraduate courses in health also contributes to this situation. The Southeast region accounted for 46.5% of undergraduate and 66.3% of postgraduate courses in the country, in 2010 and 2008 respectively. The North region, on the other hand, accounted for only 7.3% and 1.2% respectively. The Midwest region offered 8.9% of undergraduate health courses, and

the Northeast 18.5%. The South region had 18.5% of graduations and 15.1% of post-graduations in health.

The offer of vacancies in undergraduate courses in this area is in a similar condition. The Southeast region accounted for 55.7% of the vacancies available in the country in 2010, while the North and Midwest regions accounted respectively for 5.2% and 10.1% of health graduation vacancies. The Northeast region offered 16.5% of vacancies this year, while the South region offered 12.2%. Although the offer of vacancies in undergraduate health courses has increased in recent years (316% in the period between 2000 and 2010), there is still an uneven distribution of them, also observed in residence courses (ESTAÇÃO DE TRABALHO IMS/UERJ, 2012; BARATA, 2008).

Other situations besides the offer of professionals, such as means of transport in peripheral regions, costs of displacement and adequacy of the local epidemiological profile, are factors that influence the access of the population to health services. This intense geographical concentration of the professionals and services offered makes it difficult to achieve the principles that govern the SUS, particularly with regard to universalization, integrality and decentralization (MACIEL FILHO, 2007).

When considering the Residency as a factor of fixation of these professionals, the calls for proposals of the National Program of Scholarships for Multi-professional Residences and in the Professional Health Area assume the function of regulating the offer for areas considered as priorities for SUS. This policy seeks to redistribute the supply of vacancies; in spite of this effort, the analysis of the data in *table 1* shows that the redistribution of the RMS programs by the Country is still not very expressive, mainly in the North and Midwest regions.

The analysis of the distribution of the RMS programs approved by states has shown that the condition of the State of São

Paulo, as being the most economically developed in the country, contributes to preserving the inequality of this training modality, even in its region. São Paulo approved 29.1% of the programs from 2010 to 2015, followed by Minas Gerais with 10.9% of the selected projects. Rio de Janeiro approved 5.3% of the programs and Espírito Santo only 0.9%, and from 2012 to 2014 no selected projects were observed in this state (*table 1*).

For Ceccim and Pinto (2007, p. 273),

The imbalance in the provision of training and professional practice generates serious distortions in terms of the satisfaction and technical security of the individual workers and in the quality and guarantee of efficient assistance to users.

In response, the internalization of work must associate offers to professionals, mixing periods of learning and study between services, places and regions. It should also regulate permanent health education on a locoregional basis, in addition to constantly mobilizing multi-professional and interdisciplinary practices in order to broaden the care of users in their diversity and the resolution of individual or collective health problems (CECCIM; PINTO, 2007).

All Northeastern states approved projects with RMS grants, and in 2014 there was the highest frequency in the period with 24 projects. Pernambuco approved the largest number of RMS programs from 2009 to 2015 with 7.8% of all programs offered in this region. The state of Ceará participated with 5.6%, and Bahia with 4.1%, both with programs in operation in the years studied. On the opposite side, Maranhão and Alagoas had the lowest representation with only 0.3% of approvals in the period.

Rio Grande do Sul approved the majority of programs in its region with 9.4%, followed by Paraná and Santa Catarina, both with 4.7%. In 2014, there was an increase in new programs throughout the South

region, indicating a greater distribution, although Rio Grande do Sul concentrated 11.8% of the approvals.

In the North, in 2012, six new programs were approved by the state of Pará, implying an increase in the status of this region, making it the second with the highest offer of RMS programs in the year (20%). In the year of 2013, Amazonas contributed 8.4% of the programs financed by the MS, and in 2014, five new residence programs were approved by Tocantins, in addition to two in Amazonas and one in Pará. In 2015 the North became the second region with the largest number of programs (21.7%), with the states of Amazonas, Rondônia, Tocantins and Pará being the most representative in the period analyzed.

Goiás received 50% of the programs approved between 2010 and 2015. Mato Grosso presented 1.6% of the approvals; and Mato Grosso do Sul, 0.6%. In this last state, the programs only worked in the years of 2010, 2011 and 2013. The Federal District did not present approval in the period.

Given that the RMS programs have the guiding axes of decentralization, regionalization and internalization of health work, it is identified that these are a training proposal with the potential to fix professionals in regions where there is a restricted supply of health services, strengthening the responsibility of links with communities. It is understood, as Oliveira (2009) affirms, that such training can be a powerful strategy since it has a more equitable spatial distribution.

Regarding the deconcentration movement of residence programs to the North, Midwest and Northeast, Pierantoni, França and Varella (2003) point out that this is in line with the disparity between supply and demand, both in the educational sector and in the assistance model, present in these regions, highlighting the imbalances in job openings for training and job provision. This reality, difficult to be modified in the short and medium term, is directly related to the heterogeneous profile of the country's

conformation, due to its wide geographic area, population density, differences in economic development, among other aspects (PIERANTONI; VARELLA, 2003).

The orderly investment of these programs is crucial for their survival and for the affirmation of RMS as a fundamental part of a health workers' education policy for the SUS. In this perspective, it should be noted that, between 2006 and 2008, 133.5 million of the SGTES were invested in RMS, financing the training of 1,487 professionals and increasing from 11 to 24 the number of states contemplated (ARAÚJO, 2009; HADDAD, 2009). There was an increase in the resources destined to this modality of formation contributing to its consolidation.

The expansion of supply comprises two dimensions: the increase in the number of vacancies and the deconcentration of supply, through better distribution in the five Brazilian regions and in urban and rural areas (BRASIL, 2014). The proposed analysis revealed that there was an attempt to organize the distribution of the RMS programs that were financed by MS in the national territory, since in the edicts there was an effort to overcome regional inequalities in order to intervene in the different epidemiological realities. There was also a tendency to increase the programs offered.

However, the analysis made it possible to note that the distribution of MS-funded residency programs kept the trend of concentration of health professionals in large centers and regions (Southeast and South). Pierantoni, França, and Varella (2003) warn that this movement serves mainly political and economic interests that do not always reflect the needs of the population.

In this environment, it is assumed that normative frameworks, while limiting the process of creating programs, end up contributing to the legitimization process as an important training strategy for health workers. In carrying out the evaluation and monitoring of the residences it finances, the

MS accumulates support capable of basing new guidelines for the continuation of the investment in this type of training.

## Final considerations

Originating from a historical context of great disputes about the implementation of a counter-hegemonic health model, the RMS encountered several manifestations of resistance until they were consolidated as part of an education policy for SUS workers. These have been increasingly considered as an important training alternative for professionals in the arrangement of new techno-assistance drawings.

Most RSM programs approved in the Ministry of Health were concentrated in the Southeast region, especially in the state of São Paulo. This fact corroborates the scenario of regional inequalities, both in the offer of graduations and post-graduation, and in the provision of services to the population and, consequently, the availability of professionals.

The MS, through its call notice, proposes

to encourage the provision of new programs and the continuation of those already existing in areas outside the axis of the large centers, considering the Northeast, North and Midwest regions as priorities for financing. The latter two were the least representative in the total number of programs selected. However, the Northeast region presented an increment of RMS programs induced by the priority given in the published edicts.

RMS programs are offered in a challenging context, given the growing need to redress the population's health problems through proportionately limited resources. Training through work qualifies professionals for a high solvability and power transformation of the local reality (FIORANO, 2015).

When considering the RMS as training spaces with potential questioning of the instituted and as permanent education devices, its definition as an important strategy within a state training policy for health workers implies not only pedagogical debates, but political legitimacy, with constant mobilization, including the use of legal instruments, for the sustainability and expansion of programs. ■



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