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## The More Doctors Program: elements of tension between the government and medical associations

Maria Martins Alessio<sup>(a)</sup>

Maria Fátima de Sousa<sup>(b)</sup>

(a) Secretaria de Saúde do Distrito Federal. Setor de Áreas Isoladas Norte, SAIN – Asa Norte, Bloco B, Brasília, DF, Brasil. 70086-900; maria.alessio@gmail.com

(b) Faculdade de Ciências da Saúde, Universidade de Brasília. Brasília, DF, Brasil. fatimasousa@unb.br

In 2013, the first physicians arrived for the More Doctors Program. The process of implementation was engulfed in legal disputes and ideological conflicts sparked by Brazilian physicians and their representative associations. The initiative to create the program was seen by the medical associations as a unilateral measure of the federal government, lacking in planning and designed to win votes. This paper presents the historical process that gave rise to the program, highlighting the tension between the government and medical associations. It is an exploratory study with biographical and documental research. Through analyzing data and national and international trends, as well as statements from physicians and their representative associations, it can be inferred that the program is not understood in its entirety, which goes beyond the immediate provision of physicians. In addition, the regulatory role of the State, in its responsibility to comply with the Federal Constitution, is being misinterpreted as undermining the autonomy of the medical profession.

*Keywords:* Public health policies. Health human resources. Demography, provision and distribution. Internship and residence. Health Planning.

### Introduction

For more than three decades, the need has been recognized for discussion and planning regarding human resources for health. Based on a decision by the 8<sup>th</sup> National Health Conference (CNS) in 1986, the first National Human Resources for Health Conference was held that same year. Since then, the theme of human resources has been on the agenda of all the health conferences<sup>1</sup>, with the 9<sup>th</sup> CNS, in 1994, suggesting the creation of a National Human Resources Policy<sup>2</sup>.

Shortly before the release of the official notice for cities to join the More Doctors for Brazil Project (MDBP), the first notice was published in July 2013, calling for physicians for the project. The demand of municipal managers for physicians to work on family health teams generated 15,460 positions<sup>3</sup>. They were filled, not only by physicians trained in Brazilian universities or whose diplomas had been recognized in the country, but, as set forth in the legislation<sup>4</sup>, physicians educated in foreign universities were also invited to supply this need. Other cycles of calls for physicians were established in order to achieve the goal of meeting the demand of all the managers, in accordance with the basic care ceiling for each city. One year after the launch of the More Doctors Program (MDP), there were 14,462 physicians working in 3,785 cities in all the states of Brazil, caring for around 50 million people<sup>c</sup>. For the first time, there were physicians working continuously in the regions covered by all 34 Special Indigenous Health Districts. Among these more than 14,000 physicians, only 1,846 were Brazilian<sup>6</sup>.

The MDBP is one of five chapters of the law that instituted the More Doctors Program which, in turn, identifies a range of short- and long-term actions, based on three fundamental principles: (i) expansion and improvement of the infrastructure of health units; (ii) emergency supply of physicians for unattended areas; and (iii) training of human resources for the Brazilian National Health System (SUS)<sup>4</sup>. Therefore, the participation of foreign physicians in basic care is part of the MDP, but is not all there is to it.

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<sup>c</sup> The National Basic Care Policy establishes that each Family Health Team should be responsible for a maximum of 4,000 people, with a recommended average of 3,000.<sup>5</sup>

The medical associations accused the government of launching the program as a way to win votes<sup>7, 8</sup> and placate the masses who had manifested their discontent in relation to different social themes in the form of massive street protests in June 2013. After issuing Provisional Measure No. 621/2013, the government succeeded in passing Law No. 12871 of 2013 establishing the MDP<sup>4</sup>. In April of that same year, in a meeting with municipal managers in Brasilia<sup>9</sup>, President Dilma was clear about the possibility of foreign physicians being hired by the federal government, having received a petition from the movement “Where are the Doctors?”, organized by the National Front of Mayors in January<sup>10</sup>.

Sousa and Mendonça<sup>1</sup> comprehensively present the collectively built historical episodes in the evolution of Brazilian health care that, inevitably, led to the MDP. Their account contradicts the opinions of many actors in civil society and, more decisively, those of the medical associations, that the launch of the program was the result of a reckless, unplanned and authoritarian act by the federal government<sup>11-13</sup>.

Parallel to what Brazil was undergoing at that time, Mundo discusses the theme of the crisis in human resources for health<sup>14,15</sup>.

This paper is part of a dissertation for the professional master's degree in the collective health program at the University of Brasilia. This work sought to capture moments from the historical process, apart from the protests of June 2013, that gave rise to the MDP, in addition to highlighting the elements of tension generated in this process between the government and civil society, particularly the medical associations. This was an exploratory study that used non-systematic bibliographic research and document analysis, in which official documents, papers from journals, official presentations and newspaper articles in an electronic medium were examined. All the sources consulted were open to the public and it was not necessary to receive approval from the Ethics Committee.

### **Conditions of access to medical training and services in Brazil**

The MDP was announced during a year of political upheaval in the country, when street protests were sweeping through various Brazilian cities. Even though it was not very organized, heterogeneous or cohesive, the movement of June 2013 expressed "discontent with the actions of the executive and legislative branches of government at the municipal, state and federal levels"<sup>16</sup>.

Among others, the theme of "health" frequently cropped up in these protests. In February 2011, the Institute for Applied Economic Research (Ipea) had already released a study indicating that a shortage of physicians was one of the main problems identified by the population, whether or not they were users of the Brazilian National Health System<sup>17</sup>.

In fact, in December of that year, the Federal Council of Medicine delivered a study on medical demographics to the Ministry of Health. It revealed unequal distribution of physicians in Brazil, and between the public and private health systems<sup>18</sup>.

A 2010 study by the Observatory of Human Resources for Health of Minas Gerais had already presented results in relation to the construction of an index to measure the intensity of the shortage of physicians. Although the study identified an average ratio of around one practicing physician registered in Brazil for every 540 inhabitants (1.8 physicians per 1,000 inhabitants), "approximately 25% of Brazilian cities had a ratio of one physician for more than 3,000 inhabitants"<sup>19</sup>.

In April 2011, the Ministry of Health sponsored the National Seminar on the Shortage, Supply and Retention of Health Professionals in Remote and Highly Vulnerable Regions. The objective was to "discuss and provide input for the formulation of proposals and political and technical feasibility that would ensure universal access to health care services [...]"<sup>20</sup>. It was attended by institutions and bodies representing the legislative and executive branches of government; health, education and labor sectors; public control over government; and federative entities from the state and municipal levels.

In February 2012, the Strategic Committee for Improving the Quality of Training of Health Professionals and for Studies on the Need for Health Professionals and

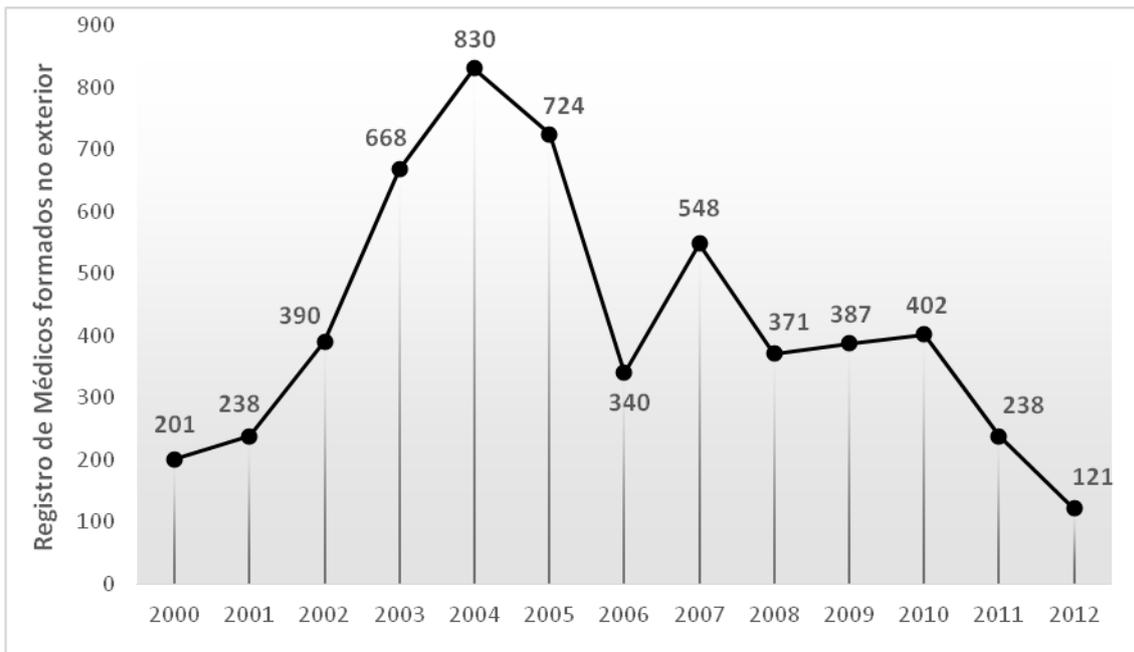
Specialists for the SUS was created; it involved the participation of representatives from professional and educational associations, as well as health managers<sup>21</sup>. In October 2013, the WHO Third Global Forum on Human Resources for Health took place in Recife, Brazil; the theme was “Rising to the grand challenge of human resources for health.” Earlier versions of the Forum were held in Kampala (Uganda) in 2008 and Bangkok (Thailand) in 2011, both of which addressed the issue of the crisis of human resources for health around the world<sup>14</sup>. A recent paper in *The New England Journal of Medicine*<sup>15</sup> raised important questions about the crisis of severe reductions in and clearly poor distribution of health professionals in different countries that are at varying levels of social and economic development.

Whereas Law No. 12871/2013, in Article 30, limits the number of foreign physicians in the MDBP to 10% of the total number of physicians registered in Brazil, 25% of the medical workforce in the United States is composed of foreign physicians (or those who were educated abroad), 28.3% in England, 23.1% in Canada, and 26.5% in Australia. Over 50% of physicians with foreign diplomas in the United States and England (60.2% and 75.2% respectively) came from low-income countries, such as the Philippines and India<sup>22</sup>. By the end of 2012, there were 388,015 physicians registered in Brazil<sup>d</sup>; only 1.75% of them were foreigners or Brazilians who had studied abroad<sup>23e</sup>. *Revalida* is a national exam for recognizing the diplomas of physicians educated abroad and is currently one of the main instruments in the country for this purpose. The exam has existed since 2011, but approvals have been dropping, as seen in Graph 1. In addition, it has not been “leveled” with Brazilian graduates, which prevents determining if it is an inclusive evaluation in terms of the average knowledge of Brazilian physicians or a test that is exclusive in nature.

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<sup>d</sup> The study by the Federal Council of Medicine considered the population of practicing physicians according to each registration. Therefore, if a physician is registered in two different states, they will count as two. Of the 388,015 registered physicians, 93.6% were only registered in one state.<sup>23</sup>

<sup>e</sup> There are conflicting figures in the study in question; for this paper, the total of foreign physicians working in Brazil in 2012 is considered to be 6,822.<sup>23</sup>



\* In 2012, registrations up to the month of July were tabulated.

Registration of physicians educated

**Graph 1** – Registration of physicians educated abroad from 2000 to 2012

Source: CFM: Medical Demographics Study in Brazil, 2013.

On the other hand, Brazil has approximately 7.6 graduates in medicine for every 100,000 inhabitants, as opposed to 6.91 in the United States (Table 1). This has caused medical associations to argue against increasing the number of places in medical schools in Brazil, going back to campaigns such as the one launched by the Regional Council of Medicine of São Paulo (CREMESP) in 1999: "New courses in Medicine are prejudicial to health"<sup>24</sup>. However, it does not appear to be the case that the U.S. has fewer places in medical schools because it has enough American physicians being trained in the country, but because of the option to import physicians rather than invest in opening up more places in medical schools. Other examples are not uncommon, such as an article in the newspaper *Folha de São Paulo*, where Abramczyk notes the opposition of the Brazilian Medical Association, the Paulista Association of Medicine and other medical associations to the creation of new medical schools<sup>25</sup>. On the CFM website, Brandão says that opening new courses in medicine will

not solve the "chaos in healthcare"<sup>26</sup> and, in 2012, the Federal Council of Medicine criticized the government's announcement about opening up new places in courses of medicine, alleging that there was no shortage of physicians in Brazil<sup>27</sup>.

**Table 1** – Ratio of medical school graduates per 100,000 inhabitants

Country	2008	2009	2010	2011
Australia*	11.24	10.89	12.08	13.48
Canada*	6.37	6.94	7.18	7.35
United Kingdom*	11.12	11.30	11.31	11.43
United States	6.42	6.70	6.62	6.91
Brazil**	5.71	6.20	6.81	7.61

Source: \* OECD.StatExtracts, ([s.d.]); \*\* Martins, Silveira and Silvestre (2013) and IBGE.

In another analysis, the Federal Council of Medicine pointed out that Brazil has 197 medical schools compared to 137 in the United States, which has a larger population than Brazil<sup>28</sup>. Therefore, it also seems inappropriate to compare countries by the absolute number of medical schools, since this does not indicate the number of places in these courses. An example that illustrates the bias in such comparisons is the State University of Maringá (PR), which offers 40 places per year in medicine,<sup>29</sup> and the University of Minnesota Medical School (U.S.), which has 230 per year<sup>30</sup>. This latter parameter, in turn, cannot be used in comparisons between countries without taking into account the policy for importing physicians or the particular needs in health-disease processes and demographic growth.

Looking back over the last 15 years, Brazil has tried out certain strategies to deal with the challenge of supplying health professionals in the country, especially in areas outside the main cities, and this is therefore not something new in the current administration of the federal government (Chart 1). A paper entitled, "Continuity and change in human resources policies for health: lessons from Brazil"<sup>31</sup> suggests that there have been three main constraints on the development of the SUS since the mid-1980s:

"(i) Insufficient skills of staff, limited access to training of health workers, and maldistribution; (ii) Low capacity to deal with local HRH management issues; and (iii) absence of linkage between the education and training sectors (universities) and health services. It was also recognized that the health system could not wait for the education system to prepare for new roles on its own.

**Chart 1** – Federal initiatives to address themes related to the supply of health professionals and professional reorientation in health since the year 2000 (continues)

Year	Program	Legal framework	Description
2001	PITS	Presidential Decree No. 3745, of 5 February 2001	Creates the Program for Inland Expansion of Work in Health. Closed in 2004, 4,666 physicians enrolled were enrolled in the program during the four years it operated, but only 469 started working in the cities (Maciel Filho, 2008).
2001	FIES	Law No. 10260, of 12 July 2001.	Creates the Fund for Financing University Students.
2002	PROMED	Interministerial Ordinance No. 610, of 26 March 2002	Institutes the National Program to Encourage Curricular Changes in Medical Schools, with the objective of promoting changes in training processes, generation of knowledge and provision of services to communities, through curricular innovations, based on the Curricular Guidelines for Courses in Medicine.
2003	SGTES	Presidential Decree No. 4726, of 9 June 2003	Creates the Secretariat for Management of Work and Education in Health of the Ministry of Health, formed by the Departments of Management of Work in Health and Management of Education in Health.
2005	Pró-Saúde	Interministerial Ordinance	Institutes the National Program for Reorientation of Professional Training in Health for

		No. 2101, of 3 November 2005	undergraduate courses in medicine, nursing and dentistry. The program seeks to encourage changes in the training process, generation of knowledge and provision of services to communities, for an integral approach to the health–disease process.
2007	CIGES	Decree No. 20/2007	Creates the Interministerial Commission for Management of Education in Health, with an advisory role in relation to the organization of training human resources in the field of health.
2007	Subcommittee for the Study and Evaluation of the Needs of Medical Specialists in Brazil	Joint Ordinance No. 1, of 23 October 2007	CIGES creates the Subcommittee for the Study and Evaluation of the Needs of Medical Specialists in Brazil.
2009	Pet–Saúde	Interministerial Ordinance No. 1802, of 26 August 2008	Institutes the Educational Program for Working with Health, which seeks to help train health professionals and instill a profile tailored to the country's health needs and policies, raising awareness and preparing these professionals to adequately cope with the different realities of life and health of the Brazilian population, among other aspects.

**Chart 1** (continuation) – Federal initiatives to address themes related to the supply of health professionals and professional reorientation in health since the year 2000

Year	Program	Legal framework	Description
2009	PRÓ–	Interministerial	Institutes the Program to Support the Training of

	RESIDÊNCIA	Ordinance No. 1001, of 22 October 2009	Medical Specialists in Strategic Areas. It finances medical residency scholarships for medical residency programs in specialties and regions that are a priority for the SUS. Of the 21,110 places in the first year (R1) in 2014, the Ministry of Health provided funding for 5,125. Before the program, this ministry only funded a few places in isolated projects.
2010	FIES Basic Care	Law No. 12202, of 14 January 2010	Institutes an extended grace period for physicians that opted for medical residency programs in areas of priority for the SUS, in addition to debt reductions for physicians who work in basic care in priority regions of the country.
2013	MORE DOCTORS PROGRAM	Provisional Measure No. 621, of 8 July 2013 – transformed into Law No. 12871, of 22 October 2013	Creates the More Doctors Program and amends Laws No. 8745, of 9 December 1993, and No. 6932, of 7 July 1981, among other provisions.
2013	DPREPS and DDES	Presidential Decree No. 8065, of 7 August 2013	Creates the Department of Planning and Regulation of the Supply of Health Professionals, within the scope of SGTES/Ministry of Health and the Board of Development of Education in Health, within the scope of SESU/Ministry of Education.

Source: Author

### **Tensions resulting from interests defended by the medical associations and public responsibility**

Despite the history of public health policies being shaped and discussed with extensive participation of different actors, the medical associations essentially focus on four key arguments to oppose the MDP. These appear in various documents, such

as an open letter to physicians and the Brazilian population, "Physicians fighting to protect public health,"<sup>32</sup> a petition to annul the MDP drafted by the Brazilian Medical Association and filed in the Supreme Court,<sup>33</sup> and a statement released by the federal and regional councils of medicine on the federal government's analysis of the first year of the MDP<sup>34</sup>:

1. *Foreign physicians working without their diplomas having been recognized by Revalida.* Discussions that mix concern about the freedom to practice medicine with concern for the public that will be served by professionals without certified qualifications.
2. *Opening of new medical schools.* A mixture of concern about the quality of training of new medical schools and concern about the depreciation of medical professionals if there starts to be a surplus of these professionals in the market.
3. *Career plans for physicians are lacking.* They emphasize the importance of the role of a career for providing and retaining medical professionals, but omit the constitutional roles of each federative entity of the country in this issue.
4. *There is no shortage of physicians, but they are unevenly distributed in the country.* Discussions that ignore the urgency of providing medical care in places where there is none and the fact that the mere existence of physicians – of a wide range of specialties – in the country does not necessarily make them available to work in basic care.

It is common knowledge that basic care has an impact on hospitalization indicators, as demonstrated by a study by Mafra<sup>35</sup> and reinforced by the 2013 National Health Survey, which showed that, between 2008 and 2012, the coverage of the Family Health Strategy increased from 49.2% to 55.3%, while hospitalizations for conditions responsive to basic care dropped from 35.8% to 33.2%<sup>36</sup>.

Between December 2013 and April 2014, there was an " increase of 33% in the monthly average of consultations in the cities that received the program<sup>37</sup>, and fewer hospitalizations for systemic hypertension and diabetes<sup>38</sup>." Even so, after one year of the MDP, CREMESP published an article saying "the MDP completed its first year on October 22, registering new health risks to patients. [...]. It is clear, therefore, that the More Doctors Program is unlikely to help Brazil overcome its deficiencies in health

care<sup>39</sup>." The author's main arguments in relation to the risks resulting from the program focused on the requirement for recognition of the diplomas of physicians who graduated in foreign institutions and the fact that continuous and ongoing medical supervision of these professionals is not occurring as it should.

Important studies have discussed the repercussions of choosing a health system based on basic care: lower cost of care; less use of medication, better levels of health, higher satisfaction of users and even reduced social inequality<sup>40,41</sup>.

The Federal Constitution of 1988, in Articles 196 and 197, institutes the concept of the responsibility of the state to ensure the right to health; evidently, the MDP is not considered a strategy for the immediate guarantee of this right.

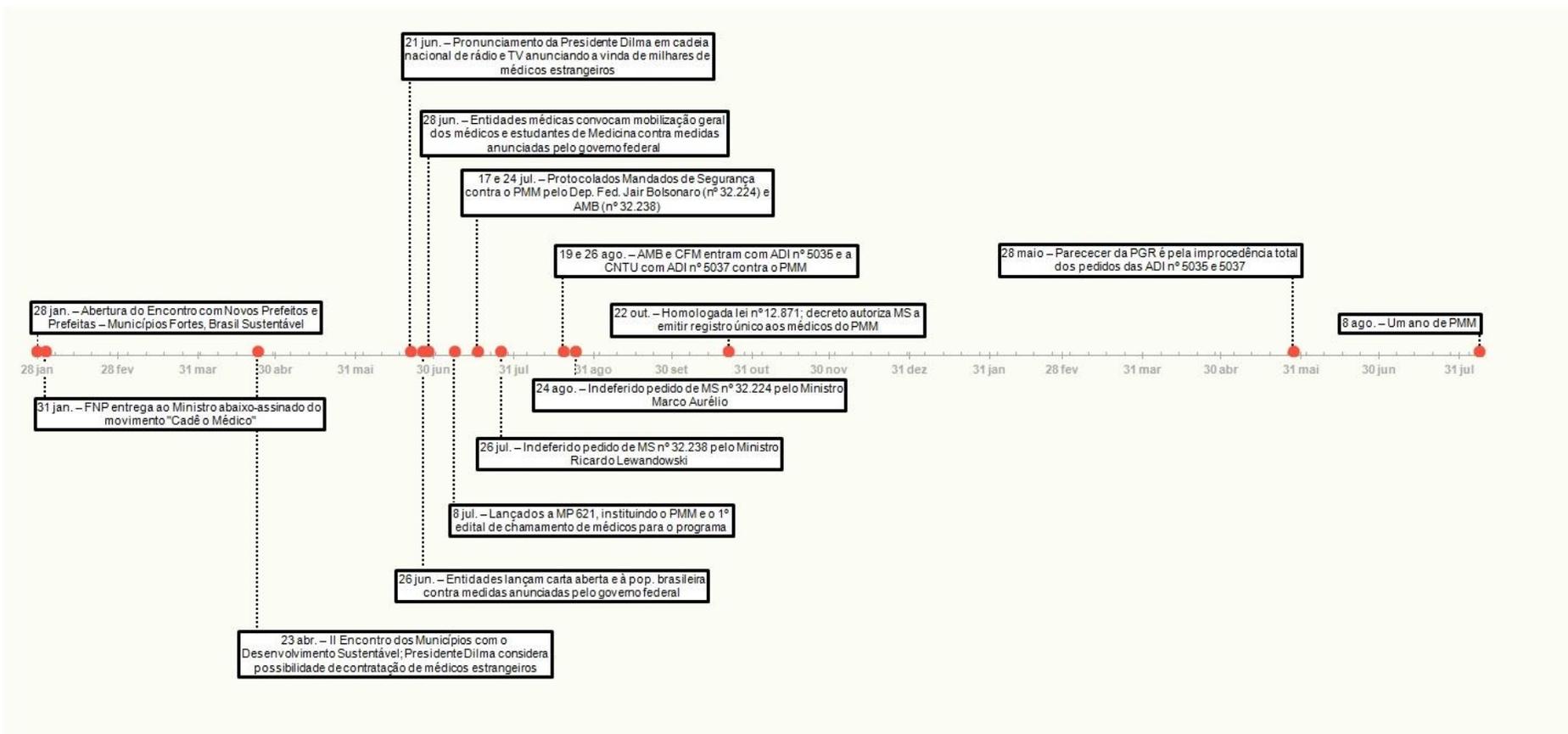
The fundamental conflict is considered to be between two sets of values. One is the right of the state to ensure universal access to health care, as set forth in the federal constitution. The other is the perception that the intent of such policies is to interfere with the freedom to carry out the profession, as conceived in the construct of liberal-private initiative action described by Ceccim et al.<sup>42</sup> in a paper that examined the constructs found in the training of health professionals in relation to regulation and exercise of the profession. An excerpt from a paper published on the website of the Federal Council of Medicine clearly illustrates this perception; the author describes the MDP as an "[...] unconstitutional and authoritarian measure, wholly stemming from a left-wing mentality that believes that the individual (in this case, the physician) should exist for the purpose of society [...]"<sup>43</sup>.

Santos and Merhy<sup>44</sup> defined regulation as the capacity to intervene in processes for provision of services, altering or orienting their execution. In health, they viewed the regulatory process as the "intervention of a third party between the demand of users and the actual provision of health actions through health services."<sup>44</sup> It appears that many physicians and medical associations do not understand the need for regulation by the state, in order to ensure the provision of services and the consequent delivery of care promised by the applicable laws.

Since the initial announcement of the arrival of foreign physicians to Brazil in June 2013, the medical associations have been heavily criticizing the MDP and

engaging in campaigns against the program aimed at the medical community and Brazilian society as a whole, as well as frequently resorting to legal measures.

**Figure 1** – Timeline with the main milestones of tensions between the government and medical associations



Source: Author Alessio MM

However, this is not the first time that the medical associations have expressed their opposition to government policies in Brazil and the world that regulate the medical workforce. Recent examples of the reactions of associations and physicians occurred in Venezuela, in 2003, during the implementation of “Misión Barrio Adentro” – a program similar to the MDBP. Campaigns denigrating foreign physicians and denial of care and referrals made by these physicians for secondary care or pharmaceutical care took place there as they did here<sup>45-47</sup>. Brazilian physicians even subjected foreign colleagues to summary public judgments by exposing their prescriptions, which were identified on social networks and blogs<sup>f</sup>, denying them the right to an adversary system and investigation and judgment by the competent authority, in this case, the Regional Councils of Medicine.

These Councils, in turn, went to court, seeking not to be obliged to provide foreign physicians in the program with temporary registration. However, in its ruling denying this request, the court signaled its understanding that such denials seek to preserve a hold on the market for physicians trained in Brazilian universities or those whose diplomas have been recognized in the country, and victimize the sick and users of the public health system<sup>48</sup>.

The most forceful actions against the program by the medical associations were injunctions requesting immediate suspension of the MDP approximately ten days after it was announced and Direct Challenges of Unconstitutionality against Provisional Measure No. 621/2013. All the legal measures questioned the urgency of the health situation that would require issuing a provisional measure as provided for in the Federal Constitution. The justification for the urgency to suspend the program, on the other hand, apparently lies in the “irreparable or difficult-to-repair damage to the health of the Brazilian people”<sup>33</sup> the longer it takes for the decision to suspend Provisional Measure No. 621/2013. The requests were studied and rejected<sup>11</sup>.

Therefore, it is possible to perceive the major conflicts between medical associations and the federal government in relation to the MDP. The feeling that this program represented a personal attack on Brazilian physicians, blaming them for

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<sup>f</sup> <http://www.perito.med.br/p/cubanadas-na-saude-do-brasil.html>

insufficient health services and minimizing the value of Brazilian professionals compared to foreigners, was also an idea widely disseminated by the associations among physicians. Health managers saying that foreign physicians were necessary at this time because there weren't enough Brazilian physicians interested in working in specific areas of the country was also interpreted by the associations as showing that such choices were viewed by the government as a matter of character. Therefore, if the government's premise is that there is a shortage of professionals in the market, the understanding is that physicians would not be available to respond to an invitation by the program, since they would already be practicing medicine in other specialties and occupying positions other than basic care.

Morais et al.<sup>49</sup> did a survey of two major print media outlets regarding the tone of news published on the subject, as well as the social implications for readers, in an effort to analyze the impact of the MDP in the media. It was noted that in both the titles and content of the articles, there was a prevalence of pessimistic or negative connotations.

However, from June to November 2013, Carvalho<sup>50</sup> noted that the press published more information on and fewer statements about the topic. The author cites a survey by CNT/MDA (National Confederation of Transportation/Ministry of Agrarian Development) of July, September and November 2013, where opinions in favor of bringing foreign physicians to the poorest regions of Brazil climbed from 49.7% to 84.3% and those against decreased from 47.4% to 12.8%. "From a Habermasian perspective, one could argue that the needs of the 'lifeworld' in the daily life of the Brazilian people takes precedence over the statements and positions of the medical associations and those who were against the MDP"<sup>50</sup>.

It is nonetheless a cause for concern that most of those who oppose the MDP appear to assume that access to medical care for those who lack it is not truly urgent. They do not question whether it is fair for individuals and families to have to wait years until training centers of excellence are set up close to their locations and career plans are designed and established to attract medical professionals.

## Other elements for discussion

The More Doctors for Brazil Project must be viewed as a self-limited initiative within the More Doctors Program in order to understand and perhaps support it. It is imperative to reaffirm the urgency of investing in the immediate supply of physicians, without negating long-term structural initiatives, since they are complementary and not mutually exclusive. They represent different actions for different problems, and therefore have distinct desired results. Significant federal resources have already been invested in the renovation and construction of new basic health units and emergency care units to enhance health care<sup>51</sup>, but attracting physicians, which does not depend solely on working conditions and pay, continues to be an intense challenge. The strong demand of various health categories for careers that value and confer stability and safety to workers faces difficulties of execution due to the federative arrangement and the different responsibilities and capacities of each federative entity in human resources management at different levels of health care.

The expansion and inland extension of federal universities between 2003 and 2010 is notable<sup>52</sup>, improving the access of young people and adults to higher education. New rules for opening courses of medicine also promise to provide access to the profession to thousands of young people who would never have had the opportunity to move to the capitals where such courses are concentrated, thereby improving the retention rates of physicians in these areas. However, it is important to highlight mentored studies and practice situations as being critical for the success of the program in expanding the number of undergraduate and medical residency openings and making curricular changes, as well as reinforcing the importance of investments in these sectors.

It is necessary to observe the development of the MDP in the collective construction of the SUS to ensure the lasting victories for the Brazilian health system promised by the program, such as improvements in the equipment and infrastructure of the basic health units, effective curricular changes that promote the training of

professionals with a profile to work in the SUS and meet its needs, and the creation of a National Registry of Specialists. Working conditions and quality of the field of practice for students to be properly trained are also indisputable issues for the success of the government's bold proposal, which promises to double the number of places in medical schools and universalize places in medical residency programs in a short period of time. At present, the focus is on the shortage of medical professionals, which must not shift the focus from multiprofessional teams, the greatest characteristic of basic care.

It is suggested that the Ministry of Health formulate an adequate communication plan regarding its government programs, focusing on health professionals who are at the mercy of its professional councils and representations, to provide them with a synthesis – so often distorted by diverse interests to the detriment of collective interests – of national and international events and contexts. This is particularly the case with the MDP, where it must be made clear that Brazilian physicians are not being devalued through the emergency recruitment of foreign physicians for a specific purpose.

### **Collaborators**

Maria Martins Alessio was responsible for the project design, data analysis and interpretation and writing of the paper, in addition to actively participating in the discussion of the results and the review and approval of the final version of the paper.

Maria Fátima de Sousa collaborated with the project design and actively participated in the discussion of the results and the review and approval of the final version of the paper.

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