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Articles

Federal management of the More Doctors Program: the role of the Ministry of Education

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The More Doctors Program (PMM) has three axes of action and is grounded on the pedagogical guidelines of Permanent Education. Considering the Program's scope, which ranges from the emergency supply of doctors to the expansion of the number of seats in undergraduate and medical residency courses, its management is interministerial, as the Ministry of Health and the Ministry of Education share responsibilities for its full operation. This article reports on the construction of the Ministry of Education's experience of managing PMM, which includes the structuring of a new Directorate and new ways of doing management in this Ministry. It also points out the main difficulties and facilities throughout the process, and reflects on the perspectives and challenges for the Program's continuity and sustainability.

Keywords: More Doctors Program. Management. Education. Health. Primary care.

Introduction

The More Doctors Program (PMM) was created by Law no. 12871[1] on October 22, 2013, grounded on the pedagogical guidelines of Permanent Health Education, with the objective of assisting the population in the primary care services of the Brazilian National Health System (SUS), based on educational modalities of teaching, research and extension. The Program has three axes of action: I - reorganization of the offer of Medicine courses and medical residency seats, prioritizing health regions with a low ratio of seats and doctors per inhabitant, and with a health service structure that is able to offer a sufficient and high-quality field of practice to students; II - establishment of new parameters for medical education in the country; III - promotion of qualification for doctors in primary care in the SUS' priority regions by means of teaching-service integration, even through international exchange.

The Program's scope is large, ranging from the emergency supply of doctors in areas with shortage of these professionals and/or difficulty in retaining them to the increase in the number of seats in undergraduate and residency Medicine courses. In view of this, its management is interministerial: the Ministry of Health (MS) and the Ministry of Education (MEC) share responsibilities for its full operation.

In the perspective of fulfilling the purposes related to the educational axis and aligning with the Program's legislation, a new management configuration was instituted in the sphere of MEC. The organizational structure of the Higher Education Department (SESu) was altered by means of Decree no. 8066/2013, which created the Directorate of Health Education Development (DDES) with two coordination offices: the General Coordination Office of Health Residencies (CGRS) and the General Coordination Office of Health Education Expansion and Management (CGEGES).

SESu is the unit of MEC responsible for planning, guiding, coordinating and supervising the process of formulation and implementation of the National Higher Education Policy in Brazil. In addition, SESu is in charge of maintaining, supervising and developing the Federal Higher Education Institutions (IFES) and of supervising the Private Higher Education Institutions, according to the National Education Guidelines and Framework Law (LDB).

The following competencies were assigned to DDES: I - to evaluate the managerial performance of health education programs; II - to supervise the qualification of professionals in the More Doctors Program and in the other health programs in the sphere of higher education; III - to monitor the implementation of courses in the area of health; IV - to coordinate the implementation, monitoring and assessment of the Project More Doctors for Brazil (PMMB), in the sphere of the federal government's More Doctors Program, in a joint action with the MS; V - to propose criteria to the implementation of educational and strategic policies, aiming to implement health residency programs; VI - to develop special programs and projects to foster teaching, aiming to provide training in health residency programs; VII - to coordinate the activities of the National Medical Residency Committee (CNRM) and of the National Multiprofessional Health Residency Committee (CNRMS); VIII - to grant and monitor scholarships for health residency programs in the IFES; IX - to propose national curricular guidelines for education in health residencies; X - to coordinate the creation and implementation of the national system for the assessment of health residency programs; XI - to establish criteria and monitor whether the institutions where the health residency programs will

take place comply with them, and to establish the system for the periodic accreditation of programs; XII - to prescribe general norms for the operation of health residency programs, according to social needs and to the principles and guidelines of SUS; XIII - to certify teaching hospitals, in a joint action with the MS.

These changes in the sphere of MEC are part of the context of investments in social policies that the country started to develop in the second half of the 2000s[2]. As the More Doctors Program presents actions that lead to the strengthening of SUS, it is also considered a policy of reduction in Brazil's social inequalities, for it universalizes the access to health of populations living in remote areas and in peripheries of large cities. That is why the standpoint of public policies management in the federal level is important, independently of conjunctures.

In view of the importance of recording the management or implementation process of the More Doctors Program and in light of the relevance of sharing experiences by means of a report on the lessons learned and an institutional analysis, this article presents a brief report on the federal management of PMM performed by MEC. The objective is to reconstitute the history of DDES since its creation in 2013 until its evolution in 2016, when a parliamentary coup caused a rupture of democracy in Brazil, highlighting the potentialities and weaknesses of MEC's management process of PMM in this period.

It is important to explain that this work systematizes reports of agents who participated in the Program's formulation and management in the sphere of MEC during the period mentioned above. Thus, the subjects-authors of this work have a trajectory in the federal management of PMM in MEC, both in the administration of DDES and in the coordination and technical team of CGEGES. Therefore, they are involved in the policy in question and in the movements triggered by MEC during the Program's implementation and management.

The content presented here is based on the following sources: reports on subjects' experiences and documents produced during the Program's management in MEC, like annual management reports, normative and technical documents, minutes and other records of meetings. To facilitate the organization of the subjects' reports, some guiding questions were used, namely: a) How did the process of creation of DDES and CGEGES happened?; b) What negotiations and agents were involved in the process of creation of DDES and CGEGES?; c) How was DDES organized? What structure was constructed?; d) How is the creation of DDES related to the More Doctors Program?; e) How did the implementation of the More Doctors Program happen in the sphere of MEC?; f) What were the difficulties and facilities experienced during the implementation and management of PMM in MEC between 2013 and 2016?; g) What changes, gains and losses can be attributed to the process of impeachment (or parliamentary coup) that occurred in 2016?; h) What are the perspectives and/or expectations related to the sustainability of PMM after the political changes that occurred in 2016?

All the material used as source of information for the production of this article was systematized and analyzed using the content analysis technique proposed by Bardin[3], respecting the three stages: pre-analysis, exploration of the material and treatment of the results (inference and interpretation). Thus, we aimed to understand the information provided by the subjects, comprehending the meaning of the communication and interpreting the information so as to search for other significations, in order to

produce reports on the historical facts that took place in the period under analysis. The findings are presented in sessions, considering their chronology and themes.

The emergence of DDES in the genesis of the More Doctors Program and its interface with primary care

In Brazil, Primary Care is understood as a set of individual, family-based and collective health actions that involve promotion, prevention, protection, diagnosis, treatment, rehabilitation, damage reduction, palliative care and health surveillance, developed by means of integrated care practices and qualified management, performed with a multiprofessional team and targeted at the population in a delimited territory, over which the teams assume health responsibility. The Family Health Strategy (ESF) is the main strategy for the expansion and consolidation of the Brazilian primary care[4].

Since its creation in 1994 as Family Health Program, many challenges have been faced so that a significant degree of effectiveness can be achieved and so that the policies can have an impact on the organization of the services and on the improvement in the Brazilian population's health status[5]. Some of these challenges are the insufficient financing of actions[6], the difficulty in hiring and retaining health professionals - mainly doctors -[7-10], workers' inadequate qualification to deliver public health[10,11], the budgetary competition with the medium and high complexity sectors[12,13], and the low symbolic capital to the population[13].

In an attempt to overcome the scarcity of doctors in Brazil and to reduce the inequitable distribution of these professionals across regions and localities[14], in 2013, the federal government created the More Doctors Program, structured by three axes of action: (i) investment in the enhancement of the healthcare networks' infrastructure; (ii) expansion of the offer of courses and seats in Medicine, including a curricular reform in undergraduate and medical residency courses; and (iii) implementation of the Project More Doctors for Brazil (PMMB), characterized by the emergency supply of doctors in primary care at SUS' priority areas.

According to the legal framework instituted for the Program, the axes (ii) and (iii) have an educational character and, due to this, demanded the MEC's involvement to develop them adequately. Thus, in the same year of 2013, a new organizational structure was instituted by Decree no. 8066/2013: the Directorate of Health Education Development (DDES), responsible for the management of the Program's educational aspects

This Directorate, created in the sphere of SESu, was structured in articulation with others that already existed in MEC, like CGRS and the Department for the Regulation and Supervision of Higher Education (Seres). CGRS was created in MEC together with the General Coordination Office of University Hospitals (CGHU) in 2007, within the Directorate of University Hospitals and Health Residencies (DHR), which was instituted through Decree no. 6320 in December 20, 2007. CGRS was responsible for managing multiprofessional and uniprofessional medical residency programs, and also for coordinating the works of the National Medical Residency Committee (CNRM) and National Multiprofessional Health Residency Committee (CNRMS). When the Brazilian Company of Hospital Services (Ebserh) was created, in 2011, it absorbed CGHU and CGRS gained a Directorate status, linked directly to SESu. Thus,

when DDES was created, CGRS was positioned inside MEC again and started reporting hierarchically to the new Directorate, together with CGEGES, and absorbing new responsibilities, which were established after the creation of PMM. The goals related to the expansion of medical residency programs and seats were assigned to CGRS, while the actions referring to the expansion of seats and undergraduate courses in Medicine, as well as the actions regarding PMMB's educational cycle, like the Embracement and Assessment Modules and the provision of academic supervision to the doctors, were assigned to CGEGES.

It is important to highlight that the conception of PMM, as well as its management and operationalization, occurred under the strong articulation and partnership between MS and MEC. In the sphere of the MS, the articulation with SESu was performed by the Management Department for Work and Education in Health (SGTES), especially through the Planning and Regulation Division for the Supply of Health Professionals (Depreps) and through the Division of Health Education Management (Deges).

The management team of PMM in MEC: new profiles and new structures

In the context of the restructuring of MEC and with the emergence of DDES, the management was assumed by a professional with experience in SUS and higher education, who remained in the function from December 2013 to March 2016. The description of this profile leads us to highlight that, in this report on historical facts, we start from the premise that the difficulties or failures in the implementation of changes in MEC did not originate in the design of the public policy; rather, they derived from the reflection that the moment of their implementation requires a specific field of analysis[15].

When DDES was integrated into MEC, besides directing actions under the responsibility of CGRS, whose team was already organized, the central management team was structured in CGGES, subdivided into two fronts: one to manage the expansion process of public Medicine schools in Brazil, in consonance with the National Expansion Policy of Medical Schools[16], and the other to manage supervision actions in the sphere of PMMB. The coordination of CGEGES was assigned to a career manager of MEC with a higher education degree in the area of health.

The majority of the members of the technical team structured in CGEGES had degrees in the areas of health (Physiotherapy, Psychology, Dentistry, Social Work, Nursing, etc.) and education (Pedagogy), and had experience in health management and/or healthcare and in the management of education and health education. This team was responsible, in the beginning of the structuring of CGEGES, for the construction of an important regulatory framework in MEC for the management of PMM, for the articulation with other partner institutions, like the Open University of the Brazilian National Health System (UNA-SUS), Ebserh and Fundação Oswaldo Cruz (Fiocruz), and for the definition of the new Coordination Office's process and organization flows.

It is important to mention that the Program, which would initially supply four thousand doctors to the Brazilian primary care, was substantially expanded, supplying more than eighteen thousand doctors to four thousand Brazilian cities (approximately

73% of the Brazilian cities) until December 2016. This increase generated the need to amplify the MEC's management team, operationalized by means of the strategy of decentralized institutional support. Institutional support is a management tool usually employed by the MS, but not by the MEC, to create, implement and execute projects and public policies and, at the same time, to support the construction of individual and collective subjects. Furthermore, it can be incorporated by organized groups without the need of an external agent[17].

In March 2014, a team of state supporters from MEC started to be structured for PMMB. The team's main responsibility was to mediate the relationship between the institutions that supervise and tutor the participant doctors and the federal management of PMMB. These supporters, whose number increased from four to forty in an interval of six months, had degrees and experience in the health area, and their work process was organized in light of the framework of Popular Education and Permanent Health Education. This experience is reported by Almeida et al.[18].

Besides the relationship with the MS and with institutions that tutored and supervised the PMMB doctors, CGEGES built institutional articulations with Ebserh, which supported the Coordination Office in the payment of scholarships to tutors, supervisors and evaluators of the Committee for the Monitoring of Medical Schools (Camem); with UNA-SUS, which developed an electronic system to monitor supervision actions (Webportfolio), to which reports on the supervision of the Program's doctors were uploaded; and with Fiocruz, especially the Foundation for Scientific and Technological Development in Health (Fiotec), which supported MEC in the logistic processes of tutors' and supervisors' transportation to the Family Health Units where the Program's doctors were working.

With the expansion of the Program and the need to guarantee the supervision process to all doctors, in compliance with the regulations, an important institutional articulation was also constructed with the Ministry of Defense, which supported MEC in relation to the transportation of supervisors and tutors of the Special Supervision Group[19], responsible for supervision in indigenous areas and regions difficult to be reached in the Northern states of Pará, Amazonas, Roraima and Acre. This articulation was fundamental to enable the supervision in these regions, and it was important to build institutional bonds between two historically distant ministries.

Considering that PMM was the highlight of Dilma Roussef's government in the field of public health, a relevant articulation was structured with the Office of the President's Chief of Staff, mainly with the Evaluation and Monitoring Division, which was responsible for monitoring the Program's actions and stipulated goals.

This process was fundamental to place MEC in an outstanding position in the management of PMM and to redirect its organizational and functional structure, so that it could effectively contribute to the fulfilment of the Program's objectives. Nevertheless, the restructuring of MEC and the consolidation of PMM did not occur without popular participation. Social control was always a great challenge in the Program. First, because social control has a stronger character in the health sector. Second, the debate about medical education never had an articulation with the health councils. However, the PMM team always strove to build articulations with the National Health Council (CNS) and the state and municipal councils, in order to hear their analyses and suggestions for the Program's improvement. It also welcomed the dialog with

entities representing the students' movement in the medical area (especially DENEM). The team also asked the National Education Council for advice, regarding the implementation of public education policies.

It is important to mention that this process was considerably important to reduce the distance between the Ministries of Health and Education. Although they were created in 1930 as "siblings", the split of the former Ministry of Education and Public Health, in 1953, brought a significant degree of dispute between the ministries that lasts until the current days. Either because of budget disputes or because of ideological disputes, both Ministries have, in their history, moments of fraternity and rupture. In the sphere of PMM, the main disputes were over the academic management of the Embracement and Assessment Modules, over the management of the opening of new medical schools and expansion of seats in Medical Residency Programs, and over the management of the Education-Health Public Action Organizational Contracts (Coapes).

In spite of oscillations in this interministerial relationship, the PMM governing teams in both Ministries had previous personal relationships and similar trajectories in the field of work and militancy in SUS, and this fact was fundamental to overcome institutional challenges (instituted or instituting) and to construct a fraternal relationship marked by solidarity and collaboration, which substantially contributed to the Program's good performance.

Challenges and perspectives for PMM from 2016 onwards

With the rupture of the Brazilian democratic process, consolidated in August 2016 through the impeachment of President Dilma Roussef (or political, parliamentary and juridical coup), an extensive reform was implemented in the federal government. Practically the entire governing and technical body of all the Ministries was modified and the whole government project was reformulated when Michel Temer became the President of Brazil.

In the sphere of PMM, both the MEC's and the MS' teams underwent significant changes that caused substantial modifications in the Program itself. In MEC, the adjustments in the management of DDES after the parliamentary coup did not occur immediately. They happened gradually, through the dismantling of public management processes and procedures. Four months after the arrival of the new Administration, an "outsourced" model of management was installed, as well as a model of clientelism. The 'new management model' reverberated positively among collaborators with a technical-bureaucratic profile who did not have an ideological bond with the Program. In addition, many collaborators desired to assume positions in the team. This format of conduction of public management, added to the will of outsourcing the Administration's responsibilities, was a memorable encounter for the personal interests of the people involved, but it brought losses to PMMB.

The first challenge that this team faced was the understanding of the Program and of the Project. This only occurred through pressure from the Presidency of the Republic and from the control and supervisory bodies of the federal government and of the MS. The team was, then, hurriedly structured, based on criteria that did not take into account the necessary skills and competencies for the development of PMM. Secondly,

the management team had to deal with the termination of the partnership agreement between MEC/Ebserh and Fiocruz, which maintained not only the team, but all the PMM actions under the MEC's responsibility.

With difficulties in negotiating the continuity of PMMB, the CGEGES coordination proposed a temporary arrangement to Fiocruz that lasted until September 2017. The difficulties in maintaining the partnership agreement were caused by financial issues - the new value that MEC proposed to Fiocruz was not compatible with the previous budgetary planning - and also by competition among projects - the priorities of the new management were not aligned with the PMM needs. Thus, according to institutions that supervise PMMB, this deadlock paralyzed the academic supervision during three months. While the negotiations did not reach a consensus, part of the More Doctors Program remained illegal due to non-compliance with what is set forth in the law, which is the maintenance of the regular and periodic supervision of all the participant doctors. Changes in the institutional supporters' profile also occurred, as the positions were filled by non-technical supporters. Before, they acted under a perspective of institutional support, and today they have a more bureaucratic character.

Regarding the Policy for the Expansion of Medical Schools, as well as the actions related to the curricular reform of Medicine courses and the actions referring to medical residencies, the ongoing agendas were paralyzed: the process of opening new schools and increasing the number of undergraduate and medical residency seats was interrupted, and there was an intense movement around the reversion of changes in the Curricular Guidelines that had been brought by PMM.

The agenda defended by the majority of the medical entities, historically contrary to the Program, was resumed, and a space was opened to the dismantling of the advances that had been achieved until then. Even the traditional biomedical model of education, doctor-centered, was resurrected.

Concerning supervision, the relationship with the MS became distant again, and severe losses were reported in the Embracement and Evaluation Modules, not to mention the abandonment of projects for the qualification of supervisors and tutors. The interruption in the activities of the Special Supervision Group was also reported - in 2017, the group delivered only one face-to-face supervision to doctors working at remote and indigenous areas -, as well as difficulties in fulfilling the Program's presuppositions regarding regular and longitudinal academic supervision and tutorship.

In light of what was described here, the future perspectives for PMMB do not seem much encouraging in the current conjuncture. The commitment to the collective cause and to the population's universal access to high-quality healthcare, as set forth for the SUS users, does not seem to be included in MEC's agenda of concerns for health education management.

Finally, there has been a regression in MEC's management levels deriving from the macro-management change. The current management in DDES presents strong indications of public administration vices, something that so many people combat nowadays, leading to the deconstruction of public policies in the areas of health and education - medical education. This will have a great impact on future generations. There must urgently be more involvement and action on the part of social control and participation levels, both in the field of health and in that of education, as well as a greater protagonism on the part of the teaching institutions involved in supervision

processes, in order to guarantee the Program's continuity and sustainability and, above all, the fulfilment of the entire population's right to high-quality healthcare.

Authors' contributions

All the authors participated actively in all the stages of the preparation of the manuscript.

References

1. Presidência da República (BR). Casa Civil. Subchefia para Assuntos Jurídicos. Lei nº 12.871, de 22 de Outubro de 2013. Institui o Programa Mais Médicos, altera as Leis nº 8.745, de 9 de Dezembro de 1993, e nº 6.932, de 7 de Julho de 1981, e dá outras providências. Diário Oficial da União. 23 Out 2013.
2. Madeira LM. Avaliação de políticas públicas. Porto Alegre: UFRGS/CEGOV; 2014.
3. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2009.
4. Ministério da Saúde (BR). Portaria nº 2.436, de 21 de Setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Brasília: Ministério da Saúde; 2017.
5. Observatório de Análise Política em Saúde. Atenção Primária à Saúde em 2016: avanços, desafios e resultados [Internet]. Salvador; 2016 [citado 27 Dez 2017]. Disponível em: http://analisepoliticaemsaude.org/oaps/noticias/?id=58f51333a319ff1adc256 e5205e4e372&pg=1
6. Silva IB. Desafios do financiamento da atenção primária à saúde: revisão integrativa. Rev Bras Promoc Saude. 2017; 30(1):110-7. doi: 10.5020/18061230.2017.p110.
7. Ney MS, Rodrigues PHA. Fatores críticos para a fixação do médico na Estratégia Saúde da Família. Physis. 2012; 22(4):1293-311.
8. Lopes EZ, Bousquat AEM. Fixação de enfermeiras e médicos na Estratégia Saúde da Família, município de Praia Grande, São Paulo, Brasil. Rev Bras Med Fam Comunidade. 2011; 6(19):118-24.
9. Ministério da Saúde (BR). Secretaria de Gestão do Trabalho e da Educação na Saúde. Seminário nacional sobre escassez, provimento e fixação de profissionais de saúde em áreas remotas de maior vulnerabilidade. Brasília: Ministério da Saúde; 2012.
10. Carvalho MS, Sousa MF. Como o Brasil tem enfrentado o tema provimento de médicos? Interface (Botucatu). 2013; 17(47):913-26.
11. Batista KBC, Gonçalves OSJ. Formação dos profissionais de saúde para o SUS: significado e cuidado. Saude Soc. 2011; 20(4):884-99.

12. Coronel ALC, Bonamigo AW, Azambuja MS, Silva HTH. Sistema Único de Saúde (SUS): quando vai começar? Int J Health Educ. 2016; 1(2):83-90.

13. Santos FAS, Gurgel Junior GD, Pacheco HF, Martelli PJL. A regionalização e financiamento da saúde: um estudo de caso. Cad Saude Colet. 2015; 23(4):402-8.

14. Girardi SN, Van Stralen ACS, Cella JN, Mass LWD, Carvalho CL, Faria EO. Impacto do Programa Mais Médicos na redução da escassez de médicos em Atenção Primária à Saúde. Cienc Saude Colet. 2016; 21(9):2675-84.

15. Lima L, D'Ascenzi L. Estrutura normativa e implementação de políticas públicas. In: Madeira LM, organizador. Avaliação de políticas públicas. Porto Alegre: UFRGS/CEGOV; 2014.

16. Ministério da Educação (BR). Portaria Normativa nº 15, de 22 de Julho de 2013. Diário Oficial da União. 23 Jul 2013.

17. Pereira Júnior N, Campos GWS. O apoio institucional no Sistema Único de Saúde (SUS): os dilemas da integração interfederativa e da cogestão. Interface (Botucatu). 2014; 18 Supl 1:895-908.

18. Almeida ER, Germany H, Firmiano JGA, Martins AF, Dias AS. Projeto Mais Médicos para o Brasil: a experiência pioneira do apoio institucional no Ministério da Educação. Tempus. 2015; 9(4):49-66.

19. Ministério da Educação (BR). Portaria Normativa nº 28, de 14 de Julho de 2015. Dispõe sobre a criação e organização do Grupo Especial de Supervisão para áreas de difícil cobertura de supervisão, no âmbito do Projeto Mais Médicos para o Brasil, e dá outras providências. Diário Oficial da União. 15 Jul 2015.

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