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Mais Médicos (More Doctors) Program – a view from England

Programa Mais Médicos – um ponto de vista desde a Inglaterra

Matthew Harris [1]

Abstract *The Programa Mais Medicos (PMM) is a national strategy to increase the numbers of Brazilian trained doctors entering primary care and is possibly the most significant human resource intervention in Latin America in recent years. From an English perspective, there are clearly opportunities to learn the PMM. First, PAHO's role in the PMM provides an exemplar for an overarching human resource migration and recruitment role throughout the EU. The role of the WHO in influencing and overseeing the recruitment of doctors throughout the EU could be an opportunity for improved distribution, avoiding a reliance on market forces. Secondly, a centrally-coordinated and governed process following well-established criteria and guidance laid out in law has helped to ensure that doctors are allocated to regions of the greatest need. Finally, the deployment of primary care doctors to ensure that the needs of the whole population are met, including in hard-to-reach areas. However, Brazil should not fall into the trap of doing much, and evaluating little. Brazil is in an exciting position to conduct robust before-after studies regarding the improvement in access, outcomes and equity that the ESF has already been credited with. Evaluation must include the impact of the PMM on Cuba.*

Key words *Human resources for health, Brazil, England, Programa Mais Medicos*

Resumo *O Programa Mais Médicos (PMM) é uma estratégia nacional para aumentar o número de médicos brasileiros formados entrando na área de cuidados primários e é, sem dúvida, a intervenção de recursos humanos mais importante na América Latina nos últimos anos. De uma perspectiva inglesa, é evidente que existem oportunidades para aprender com o PMM. Em primeiro lugar, o papel da OPAS no PMM fornece um exemplo para um modelo de migração de recursos e recrutamento humano global em toda a UE. O papel da OMS em influenciar e fiscalizar o recrutamento de médicos em toda a UE poderia ser uma oportunidade para melhorar a distribuição, evitando a dependência nas forças de mercado. Em segundo lugar, um processo centralmente coordenada e governada de acordo com critérios bem estabelecidos e as orientações constantes da lei tem ajudado a garantir que os médicos sejam alocados em regiões de maior necessidade. Por fim, a implementação de médicos de cuidados primários garante que as necessidades de toda a população sejam atendidas, incluindo em áreas de difícil alcance. No entanto, o Brasil não deve cair na armadilha de avaliar pouco. O Brasil pode fazer estudos robustos sobre a melhoria do acesso pelos resultados e equidade com que a ESF já foi creditada. A avaliação deve incluir o impacto do PMM em Cuba.*

Palavras-chave *Recursos Humanos para a Saúde, Brasil, Inglaterra, Programa Mais Médicos*

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Introduction

The Programa Mais Medicos (PMM) is a significant national strategy to increase the numbers of Brazilian trained doctors entering primary care and is possibly the most significant human resource intervention in Latin America in recent years. It is significant because of its size but also because of the approach it has used, which includes the PAHO-mediated emergency deployment of Cuban doctors to fill gaps in primary care provision, alongside an increase in residency programmes. Under the provisions of the PMM, doctors with foreign qualifications are exempt from revalidating their diplomas on the condition that they work in the Estrategia Saude da Familia (ESF), with supervision and continuing professional development training in primary care from an affiliate local higher education institution.

Despite the significant expansion of the ESF, now covering 160 million people, ongoing labour market failures in Brazil have led to a gap in the supply of primary care doctors in remote, rural areas, deprived areas, and indigenous populations. A somewhat toxic scenario has developed whereby doctors may have multiple jobs in urban areas, whereas many municipalities are offering small fortunes to attract clinicians, and not succeeding. Primary care has been chronically undervalued from a professional perspective, and residency programmes in primary care have struggled to fill their vacancies. Some policies had already been implemented as part of the ESF to entice doctors into the specialty, such as ensuring a forty-hour working week and continuous professional development opportunities in primary care and public health. But Brazil would need around sixty-seven thousand ESF doctors for full coverage of Brazil's population of over two hundred million inhabitants[1]. Brazil has only 1.8 doctors per 1000 inhabitants, less than that recommended by the WHO, and eighty per cent of States are below the national average[2]. Forty-two per cent of municipalities have less than one doctor per four thousand inhabitants. The PMM represents a to-date investment of R$4bn to bring the doctor-patient ratio up to 2.7 per 1000 inhabitants[1].

In the 1990s, only 1% of Brazilian clinicians identified themselves as family doctors or generalists[3] so that there are now over 30,000 is a significant development for Brazil. Brazil has implemented many strategies in the past to promote entry into primary care such as the PROESF, PNAB and PMAQ, and for several years the Ministry of Health and the Ministry of Education have worked closely together through the SGETS department to reform medical school curricula and criteria for entry. However, given that this is alongside one of the most far-reaching health sector reforms promoting the expansion of universal healthcare based on a comprehensive primary care system with primary care doctors as gatekeepers to the SUS, what explains the persistent lack of primary care professionals in Brazil and will it now be resolved by the PMM?

Some of the barriers to recruiting and retaining primary care doctors in priority municipalities are beyond the reach of government to change, such as whether the general environment is appealing to raise a family in. However, many of the elements of the PMM do align well with established policy strategies for health workforce recruitment, as detailed by Ono et al.[4]. The PMM, for example, has encouraged the expansion of residency programmes in rural areas, therefore attracting medical students from these backgrounds, and who may be more likely to remain in these areas. In addition, the PMM regulates, at least to some extent, the location where the doctor can practice in and therefore is able to ensure a more equitable distribution of doctors into priority municipalities.

According to Ribas[1], the PMM seems to have had some early effect in a relatively short period of time. PMM doctors are distributed quite broadly – 73% of Brazilian municipalities received at least one PMM doctor. PMM doctors have been distributed to where they are most needed – between 65-83% of the doctors have been allocated to priority municipalities. PMM doctors have supported an expansion of the ESF - 82% of the PMM doctors were placed into ESF units, leading to an expansion of the ESF by 15.7% (10-25%) of the population covered in the two years since the PMM started[1]. Finally, the fundamental aim of the PMM, to encourage Brazilian-trained doctors to move more into primary care, seems to be being addressed given that the most recent intake wave was entirely composed of Brazilian-trained doctors. This is encouraging and needs to be sustained.

One of the unique aspects to the PMM is the bilateral arrangement between Cuba and Brazil. Less a usual workforce migration issue, and more a bilateral trade agreement, Brazil has imported over fourteen thousand Cuban primary care doctors as an emergency measure to plug the gaps in provision in hard-to-reach or deprived municipalities. Mediated through PAHO, the importing

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of Cuban doctors was established to provide access to primary care in hard-to-reach areas, until the professional training and recruitment infrastructure had expanded sufficiently to redress the imbalance. The controlled placement of PMM doctors seems to have enabled a more equitable allocation of resources but there is some evidence to suggest that it is mostly the Cuban doctors that are going to the hard-to-reach areas. Eighty-eight per cent of the PMM doctors that were sent to priority municipalities were Cuban, and all except 8 doctors that were sent to indigenous populations were Cuban[1]. To what extent will these areas remain no-go areas for Brazilian trained doctors? There is a concern that the PMM may not be addressing this underlying workforce issue i.e. that the shortage of Brazilian primary care doctors in priority municipalities may in fact be 'unwillingness' to work there[5].

England's experience

In the European Union (EU), doctors, nurses, midwives, dentists and pharmacists trained in the EU are able to seek employment, work and settle down in any Member State[5]. However, in the EU, such free mobility can lead to inefficiencies because it is not possible to control the employment choices of the incoming health professional. Some EU States suffer as a result and Bulgaria and Romania have high levels of outward migration for all health workers[6]. European cooperation in the area of recruitment and retention remains underdeveloped. England is a signatory of the WHO Global Code of Practice on the International Recruitment of Health Personnel and has developed its own set of guidelines for the ethical recruitment of foreign-trained medical professionals, particularly from low- and middle-income countries. However, because recruitment takes place at the local level, interpretation of the Code of Practice may not be fully under the control of central government. Blacklock et al.[7] noted that between 2001 and 2003, Hospital Trusts doubled the number of professional registrations of doctors that had been trained in Africa and south Asia (from 3105 to 6343 registrations). This was due to the new recruitment targets that the Hospital Trusts were required to meet as part of the NHS Plan. Falls in this type of recruitment only occurred when other factors, such as the creation of specific Memoranda of Understanding with specific countries and new visa or immigration laws, were put in place[7].

In England, primary care doctors are not public employees, rather autonomous professionals providing services under contract with the NHS. The levers available to influence choice of where to practice are limited to the relatively crude primary care payment mechanism formula, which includes measures of deprivation, to assign overall weighting to patients.

The rurality index is a function of the distance between the patient's home and the surgery[4]. However, since the 2012 NHS Reforms this has been dropped from the payment mechanism formula. According to the Royal College of General Practitioners, the exclusion of the rural adjustment to the formula used to reimburse general practices undermines the support for these practices, particularly given that they are more dependent on locum doctors. To make matters worse, since the 2012 Health and Social Care Act, the cost of locum payments was transferred from the Primary Care Trust (the commissioning organization) to the employing practice[8].

In England, there has been an increase in the number of full-time equivalent GPs over the past ten years, but this represents an increase of only half that of other medical specialties and has not kept pace with population growth. Part-time work has caused long-term sustainability issues and many rural practices are dependent on locum doctors[9]. Government strategy to improve primary care over the last ten years has focussed on improving the efficiency and effectiveness of primary care, through for example integrating care with secondary care services and includes multi-professional integrated community teams, community hospitals, and virtual wards. Practices have been encouraged to merge in to larger centres, and to collaborate in the procurement of services and supplies, administrative capacity and planning. The GP Access Fund and the Extended Hours Access Scheme have both injected financial incentives into the system to extend the number of hours that GP practices remain open (normally from 8-630pm), but this has led to only limited impact on patient satisfaction or attendance at emergency departments[10].

As a doctor trained in the English NHS, but with a revalidated medical degree through the University of Sao Paulo (1999), and several years experience working in the ESF in the State of Pernambuco, it is possible to see there are several areas in which England could learn from the PMM experience. First, there are clearly opportunities to learn from PAHO's role in the PMM regarding an overarching mediation role for human resour-

ce migration and recruitment throughout the EU. The role of the WHO in influencing and overseeing the recruitment of doctors throughout the EU could be an opportunity for improved distribution, avoiding a reliance on market forces. Certainly, the result of the June referendum regarding whether to stay in or leave the European Union will play out in this arena too. Secondly, notwithstanding the political and professional complexity of the PAHO-mediated Cuban recruitment in Brazil, a centrally-coordinated and governed process following well-established criteria and guidance laid out in law has helped to ensure that doctors are allocated to regions of the greatest need. Finally, there are clearly opportunities here to learn from the PMM and ESF in Brazil regarding the deployment of primary care doctors to ensure that the needs of the whole population are met, including in hard-to-reach areas.

Moving forward

The recent WHO Strategy on Health Workforce[2] discusses how the imbalance between demand, need and supply often leads to the coexistence of health worker unemployment in urban areas alongside unmet health needs elsewhere. New models of health worker education and service delivery strategies will be required to positively disrupt this trend[2] and the PMM certainly seems to be an innovative national, indeed international, policy to stimulate entry into primary care and plug gaps in care in a punishingly tight timeframe.

That the expansion of the ESF has led to such significant national-level improvements in health outcomes and equity[11] suggests that when fully staffed, Brazil is likely to enjoy even more significant improvements in health. However, formal evaluations of human resource strategies are rare[6], and Brazil should not fall into the trap of doing much, and evaluating little. Brazil is in an exciting position to conduct robust before-after studies regarding the improvement in access, outcomes and equity that the ESF has already been credited with. Evaluation must include the impact of the PMM on Cuba given that sources also experience positive and negative effects[5]. Cuba might not be considered to be in the same league as most other developing countries with respect to its health workforce, given that it has a net surplus of doctors, but nonetheless it is important to evaluate the impact that the PMM has had on Cuba, whether in terms of the role of remittances or improved skills.

Finally, Brazil must avoid simplifying the medical workforce problem into a numerical shortage of healthcare workers. The target to reach 2.7 doctors per 1000 inhabitants helps to galvanize support, but the problem has management, quality, and location and performance dimensions and is not a simple matter of reaching a target level of doctors per head of population. Buchan and Campbell[12] describe this as the "right staff, in the right place, at the right time, with the right skills". Clear definition of the problem is needed – it is not just about training more doctors[12].

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