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Where now for the *Mais Médicos* (More Doctors) Program?

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It was with great pleasure that I read the article by Gastão Wagner de Sousa Campos and Nilton Pereira Júnior. We are currently experiencing a serious crisis that requires us to defend the social advances made by the Unified Health System (SUS), whilst at the same time reflecting on political practices in general, including those derived from the Brazilian government. The authors discuss major changes in the approach to primary healthcare in Brazil, which is perceived as a strategic space with the potential to (re)order the care networks (RAS) of the SUS.

The first observation I wish to make is to recognize the manner in which the authors use different sources and references to construct a comprehensive narrative about the implementation of the Family Health Strategy (ESF) in Brazil from the 1990s to the present; they demonstrate the progress and limitations of this process and provide a critical analysis of the *Programa Mais Médicos* (More Doctors Program, PMM). Despite broadly agreeing with the authors, I would like to explore some other aspects that I consider to be highly relevant.

The PMM and the challenges facing the SUS

Despite its numerous advances, we know that the SUS faces important challenges to its consolidation, which include funding, work and education management, the creation of regionalized healthcare networks, changing models of care and management, as well as the supporting structure of the system[1]. These challenges also have an impact on primary care.The PMM is an unprecedented policy that has partially met the challenge of reorganizing medical training and activities, which has put it into conflict with historical forces. This program has enabled the provision of some 18,000 doctors for primary care in areas of great social vulnerability where it had previously been difficult to attract doctors, thereby producing a significant increase in coverage and access and, possibly, a re-ordering of the labor market. In addition, it has redefined the normative foundations of medical graduation and residency. In spite of the aforementioned impact, it is obviously impossible for the PMM to resolve the inherent structural problems in the SUS. However, perhaps the PMM could create more pressure or new impetus to face the challenges confronting the SUS (for example, in terms of primary care and in relation to other networks and management). In this respect, the questions and conclusions of the authors regarding the potential of the PMM to redefine the SUS is rather surprising.

Health and Primary Care Policies

As the authors of this article point out, the last few decades have been marked by a significant growth of the ESF throughout Brazil, which now accounts for the coverage of more than 50% of the population. As with other national policies, financial backing was the main feature used by the government to implement the PMM.

Despite the limits of this process, it should be noted that the ESF is more accessible to the most vulnerable social groups, in other words, the program has provided an element of social equity[2]. Moreover, even though its federal funding is subject to fragmented logic, the Basic Care Fund (PAB) and its components, unlike most programs and services funded with medium and highly-complex resources (MAC), overcame the logic of funding based on the production of procedures.

The following three major issues became central to the review process of the National Basic Care Policy (PNAB) in 2011: the need to qualify and to make formal coverage a reality; increased funding; and the need to solve the difficulties encountered by municipalities in hiring doctors, under the threat of setbacks in the coverage that had been achieved to that point. The first two of these issues were prominent in the agenda of the Ministry of Health during that year, with such initiatives as the 'Requalifica UBS', (or Primary Healthcare Unit Training, a program that incorporated reforms, extensions, construction, information technology and telehealth) and the Program to Improve Access and Quality (PMAQ), as well as other changes contained in the PNAB (for example, allowing the growth of family health support centers). The 'Requalifica UBS' and the PMAQ have received increased federal funding for primary care in recent years[3], which covered a number of municipalities, teams and larger units that were larger than the PMM (which was created two years later), but without achieving the same public impact of the PMM.

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The relevance of these two programs, which preceded the PMM by two years, is that they also entered the battle against the medical profession and the media, and they demonstrate the technical-political argument that the PMM was not an isolated policy. This draws attention to the fact that the authors of this article did not consider these two programs in their analysis (although they do quote some of their evaluation data). For example, to what extent was the prospect of managerialism present in the PMAQ? What were the local effects of this program in relation to its objective of encouraging the improvement of access to and quality of healthcare? How were the PMAQ and the 'Requalifica UBS' linked to the PMM?

Taken together, these three programs demonstrated different degrees of the prioritization of primary care in the government's agenda and they also influenced different actors (particularly managers, health teams and universities).

Some challenges to the PMM as a strategic component of primary healthcare within the SUS

The PMM was created in 2013, in the third year of the Dilma Roussef government, against a backdrop of widespread urban demonstrations in Brazil. Some of the main effects of the PMM so far have been the increased retention of doctors in basic health units (UBS) and the growth of the ESF, which have represented significant improvements in access to primary healthcare. Perhaps one should also consider the reconstruction of the social sense of medical practice in primary healthcare, which is represented by the often-mentioned contrast between the posture of Brazilian and Cuban doctors. Furthermore, the PMM has highlighted and created an important opportunity for family and community medicine, as well as providing the basic network to be utilized as a central space for large-scale training in medical schools and residencies.

Nevertheless, professional careers continue to be a major failing and there is a problem in employing trained doctors for the future. Moreover, considering the training and practice of doctors (including those from Cuba) it is not clear to what extent the issues of biomedicine and medicalization[4] are addressed by the PMM; inquiring if the suffering, demands and life potential of people are more central than professional practices, risks, diseases and prescriptive requirements. For example, conditions such as mental health, alcohol and drug dependency, and adherence to treatment could act as analyzers[5] with the potential to shed more light on this issue.

Primary healthcare is not only constructed through formal management and important macro-actions, in the sense that the health work process has a relative degree of autonomy and is also a space for the co-production of realities on the micro-political level[6,7]. The daily work in a UBS is fraught with challenges. Thus, echoing the argument of the authors of this article, the supervision provided by the PMM limits itself to focusing on doctors and not teams. The PMM was able to involve universities as supervisory institutions responsible for this process, which has strengthened it; however, the relationship between the supervision provided by the PMM and the support actions aimed at management and health teams is insufficient. Considering the capillarity that the supervising doctors have in Brazilian UBSs, that supervision could be an opportunity for intensive support in relation to the local work processes of teams and care management. The supervision by the PMM would be far better if it were re-thought from the perspective of institutional support, lifelong learning, matrix support and lateral cooperation.

Finally, when thinking about the sustainability of the PMM it is important to consider various normative-legal political, temporal, financial, symbolic and subjective dimensions. Despite the limitations of this program, the significant progress it has produced, and the challenges that it faces in relation to its sustainability and strategic role, require that the PMM (and other components of primary care) are defended in the face of the threats to the SUS at the macro and micro levels.

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