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Debates

Reply

Sustainability of the More Doctors Program as a public policy

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The consistent and thoughtful comments made by Alcindo Ferla, Mara De Sordi, and Tiago Correia (to whom we thank) on our article converge as to the relevance and complexity of the approach and analysis of the education axis to the Brazilian National Health System (SUS) of the More Doctors Program (PMM) as a public policy. They particularly contribute with other potential approaches to the topic and to the need for a deeper analysis. Should they had already been dealt with in the main article, these approaches and analysis would have resulted in a more powerful contribution than the original one.

Our challenge now is to discuss the new issues pointed out by the debaters and to foster elements to a discussion aimed at the sustainability of a policy that is being contested and that will face the challenge of being centrally conducted, as of 2019, by those who were its main opponents in the political scenario in which it was constituted.

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Ferla indicates a dimension of actions and effects of PMM not mentioned in most works, including in our article: the great effect of permanent health education to professionals and teams. According to him, this discussion belongs "to the epistemic field of health education and its recent legislation, which aims at prompting changes in health education and work." He thinks the occupational world is subject to conditionalities and determinations that are more complex than the disciplinary organization of knowledge. This fact ends up attributing to work a unique and necessary pedagogical ability to overcome specialized fragmentations, aggregate dimensions to care practice, and transform the produced knowledge and practice through significant learning.

We agree with Ferla's propositions. Our analysis was based on changes established in legal frameworks, in the condition of "policy statute"[1], related to PMM's axis aimed at the production of changes in education.

This analysis option had at least two biases. The first one was leaving out what was most transversal to the law's text and that is present in the education axis to SUS, but even more so in the supply axis[2]. In this axis, permanent health education[3] shows, once again, all its power as a way of conceiving and implementing public policies in health. The observed (and unprecedented) integrated work between the Brazilian Ministry of Health and the Ministry of Education has caused permanent education to be the prevailing way of work in education and practice of PMM's tutors and supervisors.

The second bias is that the analysis made in the original article is based on a top-down perspective[4]. It is focused on the statute and aims at noticing if the policy was modified and implemented or not. This way of approaching the problem hinders giving light to more perceivable effects in the fieldwork with doctors and their teams, supervisors, tutors, teachers, and local managers. We agree that other studies should focus on this effect that, in our opinion, is indeed absolutely relevant and has brought important innovations that can help qualify several public policies.

Correia brings the heuristic notion of policy cycles and identifies a group of mesotheories (or synthetic theories of the policy analysis, according to John[5]) that can shed light on the emergence of the problem, on its decision and formulation, and on the policy's implementation and assessment. His provocations are valuable. However, the original article had a more restricted scope: describing which policy was formulated, the normative changes in the way the State orders the formulation of human resources in health, and the new public policy tools resulting from it.

Correia also observes that "disequilibria in the supply of a health workforce is found in most countries, even in those that strengthened the state regulation on education seats." He acknowledges that state regulation is important to the availability of working professionals. The market's self-regulation is not adequate to ensuring a comprehensive and universal care, and is permeated with corporate and partial interests. However, experience has shown that this state regulation is not, but itself, sufficient to retain professionals.

We agree with his observations. Analyzing the supply axis[2], it is possible to discuss how PMM tried to implement the World Health Organization's retention recommendations[6]. However, this analysis was not under the scope of the main article. Other studies highlighting this essential topic, correctly indicated by Correia, are required. The topics suggested by Ferla and De Sordi related to other elements

that constitute this debate should also be addressed: medical corporation, medical institutions, and the behavior of doctors in SUS and in the job market.

Correia highlights what doctors understand a problem is or is not, comparatively to what PMM considers the object of intervention, which consequently is an important topic in the analysis of the position and practice of doctors regarding the policy.

De Sordi argues that part of the medical corporation "strongly resisted to the advances of policies that induce changes in health education that would benefit exactly those who mostly need SUS or who depend exclusively on it for healthcare." She also argues that this non-aloof behavior helped create a hiatus between the effectiveness and institutionalization of public health and education policies in the last period.

Ferla mentions Collective Health reference studies to alert that, when studying PMM, understanding the medical corporation as a simple agent in the policy cycle is not enough. It is imperative to analyze the "liberal logic in medical professions," the "tensions produced by transformations in the occupational world," and "the changes in education over the last two decades, particularly the profile diversification of higher education newcomers." These considerations are essential in any analysis focused on the dynamics of emergence, formulation, and implementation of PMM.

Lastly, all three debaters discuss the sustainability possibilities and conditions of PMM when faced with an action of dissolution, which they identify based on the evidence presented in our article.

Correia questions to which extent the action of dissolution of PMM's initiatives, decisions, and norms is also related to the way and degree of implementation of the program. He questions if the government's purpose after the 2016 coup "was to 'nip the policy in the bud' before it was effectively adopted by the agents" or if the ways it is being changed reveals a poor policy adoption. He also inquires which would be "the necessary conditions for PMM to try to achieve its objective."

According to De Sordi, the current government's intention is to give "room to privatization without much embarrassment." She argues that, although the "challenges in maintaining SUS" require reorienting the education axis, discourses opposed to the new curricular guidelines regain strength. These discourses deny PMM's advances and disqualify SUS and policies that induce changes in the medical education's logic. However, she says there are "political agents in different spaces [...] who will certainly resist and fight for historical causes."

Ferla, on the other hand, indicates that education and research institutions do not seem strong enough to produce the necessary resistance and that the ongoing action of dissolution makes us reflect not only about "professional health education" but also about "democracy and the institutions that comprise the State and the society."

We understand PMM's supply axis stopped advancing as of 2016. However, it only faced significant changes after the end of the Cuban doctors' participation, in late 2018, after Bolsonaro's election and because of it. However, the education axis has a rather different situation.

We could suggest several elements and hypotheses for further studies on this matter. The supply axis had the most media exposure and debate. Except for the medical corporation, its measures are accepted by practically all relevant health agents. Its effects are more immediate and have a significant support of relevant social agents in cities and some states that try to preserve these effects.

The education axis requires more implementation time in order to start noticing its effects, from its centralized actions to different changes required in education institutions. It faces greater resistance and a sense of conservation from government apparatus and education institutions, where medical teachers are predominant, many of which are against PMM and the suggested changes. It also had less media exposure and was less discussed. Therefore, it was less appropriated by social agents who work in sustaining the supply axis.

Just like the debaters, we identified that the group of PMM's measures is backed up by international literature, and that the change intended by the education axis is necessary to SUS' sustainability. Due to these and other issues, such as the program's effects perceived by the population or evidenced by researches, we believe PMM's original project (or a new formulation based on it) can be resumed in another more favorable context as a public policy solution. In any case, the challenge will be to implement it with the greatest involvement of agents possible in order to expand the policy's sustainability. This element involves and depends on several aspects, many of which were not yet covered in our studies.

Authors' contributions

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

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