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Trend towards institutional stability: regulation, training, and provision of doctors in Brazil during the Lula government

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Abstract *This article aims to analyse the characteristics of the regulation, training and supply policies of medical doctors in Brazil, during Lula government (2003-2010), as well as the process of dispute about a policy change proposed by senior officers of the Ministry of Health, who were members of the Health Reform movement. This is a case study that used process tracing as a methodological strategy and, as sources, documents and interviews. We used the theoretical resources offered by studies on political process and the theory of gradual institutional change. The main findings are the understanding of institutional arrangements in this policy, and the identification of individual and collective actors who acted to change the policy. Three political-institutional restrictions to change were found: the opposition of the Liberal Medicine advocates Community, which exerted a political influence on the area, the lack of support or resistance to change from the Ministry of Education and the government nucleus decision not to carry out proposals that, at the same time, had to be approved by the Legislative and had the opposition of the Liberal Medicine advocates Community. A balance tending to reproduce the status quo and the current institutional arrangement prevailed, despite the implementation of incremental policy changes.*

Key words *Human resources in health, Medical education, Public policy*

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Introduction

This paper undertakes an analysis of the regulation, training, and supply of medical doctors during Luis Inácio Lula da Silva's tenure as president (2003-2010), as well as the dispute involving a proposed change defended by the Health Reform Movement Community (HRM-PC) that didn't come to be. A change in the aforementioned policies that took the movement's proposal into consideration – like Mais Médicos (More Physicians) Program (PMM) – was consolidated only in 2013, during the following government. This paper develops the argument that although medical training and supply were clearly insufficient to fulfil the demand of the National Health System (SUS) and of municipalities for physicians, there were collective actors in advantageous political positions mobilized to hinder *status quo* changes.

The matter of insufficiencies in training and supply of medical doctors for health systems is explored both in national and international literature, not to speak of government discussions, since the end of the 1960s[1,2]. In the first decade of the century – that is to say, during Luis Inácio Lula da Silva's government – such insufficiencies were regarded as an objective matter regarded to the medical profession. The rate of physicians per 1.000 inhabitants in Brazil was a mere 1,7 in 2000. Public perception of an aggravation of such issues was intensified by and increasing economic participation of the health macro-sector, which resulted in an expansion of the job offer for physicians with no correspondent growth in university slots for Medicine students[3,4]. The number of graduated medical doctors during the whole decade was equivalent to only 69% of the newly available job posts. Medicine was also the only health area that saw an increase on its average salary and employability, as well as its candidate for job vacancies rate[3]. Both graduation and medical residency spots were concentrated in larger and wealthier cities, mostly on the Southeast and South regions of the country[3,5].

Given the scenario, privileged individual and collective actors in the institutional policy structure of medical regulation, training and supply were resistant to change – in special those who represented the interests of medical professionals[5-9]. Others, such as SUS managers and HRM-PC[10] agents, were favourable of changes, interpreting current institutional rules as prejudicial to the Unified Health System's proper functioning. The matter of medical training and supply, they defended, should be a focal point in federal government, being recognized as a present policy issue in the government agenda.

Ministry of Health directors during Lula da Silva's government understood that insufficiencies in training and supply of medical doctors limited access and quality of SUS services[9]. During said period, an alteration in professional regulation rules was proposed in order to increase quantity, better distribution and supply doctors in the areas that needed them the most. Directors also defended a reorientation of medical training around SUS' necessities, given that the current state of things was clearly unsatisfactory[5,9,11,12].

This paper offers an answer to this apparent paradox: directors in the Ministry of Health had the objective of inserting the issue of medical training and supply in the federal government agenda so as to formulate and implement policies to solve the issue – and none of it actually occurred. Literature has given space to the policies of training, regulation and supply of medical doctors in Brazil, but studies tend to focus on describing and analysing problems on the area[3,4], the solutions presented to public debate[12] or the set of actions took by the federal government during the period[11]. This article, instead, asks why this issue wasn't included on the government's agenda in order to make broader changes, leading disputes around alteration of maintenance of current policies. Despite all efforts made by individual and collective actors, what prevented changes on current policies? The following sections focus, respectively, on the study methods, its findings and the discussions of such findings on the light of the theoretical apport utilized.

Method

This case study used process tracing as a methodological research strategy, examining historical trajectories, documents, interview transcripts and other sources to verify whether possible explanations derived of theories are valid or should be modified/refined considering intervenient variables on a case – with the ultimate object of identifying chains and causal mechanisms[13]. It is considered that "chains and causal mechanisms" are theoretical constructs elaborated by researchers that focus on dimensions of reality that, according to theory, can influence or determine events or phenomena applied to empiricism with the goal of formulating medium spectrum theories that might explain said events or phenomena.

There were no significant alterations regarding the policy of regulation, training and supply of medical doctors during Lula da Silva's government, although directors in deciding positions inside the Ministry of Health considered the current policy to be insufficient to SUS' necessities. Searching for an explanation for the aforementioned fact, we direct our approach to three explanative dimensions and to the characterization of the process in analysis. (1) The first dimension is formed by individual and collective actors and their interests and ideas which acted in both subsystems, taking stands in the dispute and discussing the problematics of current policy to determine its permanency or transformation. (2) The second dimension is composed by the current institutional framework in the health and university education subsystems, formed by a set of administrative and legal rules. (2) The third dimension refers to institutionalized patterns, relation "traditions" between government agents and society actor. When analysing the political process which this article is about, all those factors are chained in determined times and spaces of decision, composing the policy trajectory in both subsystems at the time and identifying attempted alterations with successful results or not, as seen in Chart 1.

Documentary analysis comprehends Lula da Silva's tenure (2003-2010). This paper prioritizes the official standardization of policy actions for regulation, training and supply of medical doctors (laws, decrees, ordinances, resolutions and other state documents), civil society organization documents – both from medical and health reform entities –, as well as discourses published by the media, by private PR or by government representatives. Bibliographical analysis supports the study in its questions and research hypothesis as week as in the comprehension of analyzed processes – focusing on a longer period, from the second half of the 20th century, when the discussion of human resources in the healthcare sector started to be more discussed in Brazil[1,9], until 2010. Research about the main actions and programs in the period, about human resources in the healthcare sector and the position of medical councils were also analyzed.

Interviews were made with 19 key informants that had a role in the governmental formulation of the policies for regulation, training and supply of medical doctors, whose characteristics are presented in Chart 2. Twelve of them occupied deciding positions in the period studied in this article (2003-2010). Content Analysis[14] and Critical Analysis of Political Discourses[15] were used to treat interviews, combining both analytic categories (actors, ideals, institutions, questions, problems and solutions) and discursive premises[15] (objectives, values, preoccupations, circumstances, courses of action and consequences). Research for this paper was originally made in order to present a doctorate thesis for the Public Policy Post-Grad Program, which was approved by CEP-UFRB (number 05760818.9.1001.0056).

The undertaken analysis makes use mainly of theoretical resources offered by public policy process studies[16-18] and by the Theory of Gradual Institutional Change (TGIC)[19]. The first set of studies provides analytic instruments so that the social relations between organizations and actions, individual and collective, social and governmental could be emphasized, characterizing their interests, ideas and actions. Individual and

Chart 1. Gathering strategy for the study's evidences.

Analyzed dimension and process	Analyzed elements	Sources
(1) Institutional arrangement	Legal and administrative regulations	Legislation, other official documents, literature, interviews with directors
(2) Individual and collective actors	Positions, goals, ideas, propositions, actions	Literature, diverse documents (media articles, civil societies or state resolutions)
(3) Institutionalized relation patterns between government and society	"Traditional" relations between decision makers and society actors	Literature, media articles, interviews with directors
(4) Process trajectory	Changes in legislation, regulations and programs	Literature, legislation, official documents and interviews with directors

Source: Authors

Chart 2. Interview.

Position	2003-2010	2011-2013	2013-2018
High-ranking officials, federal government	5	4	2
Middle-ranking officials and bureaucrats, federal government	4	6	4
High-ranking representatives of state and municipal health departments	3	3	2
Members of the Senate and Chamber of Deputies	-	2	3
Panamerican health organization (PAHO)	1	-	1
Total by period	13*	15*	12*

* The total number of interviewees was 19, but some of them occupied different positions in more than one period – among which a few occupied different positions in all three periods.

Source: Authors, adapted from Pinto (2021).

collective actors frequently present public policy analysis as rhetorical tools in order to typify problems that may be an object of policies in case they make it to the government agenda[16-18]. That's why the characterization of public policies is both a normative judgement and the establishment of the objective existence of a matter or fact. In that sense, contemporary studies of governmental policy process compose an analytic scheme that allows us to highlight the role of state and society actors, individual and collective, with their ideas for the formation of a government agenda in a context in which rules, conceived as institutions, beacon possibilities for delineating public policy problems and their respective solutions.

TGIC[19] defines institutions overall as distributive charged with power implications – and, rightly so, surrounded by tension. Institutional rules have unequal effects to resource allocation, causing actors in dominant positions in the social or institutional environment to be able to project institutions matching their preferences, maintaining or even increasing their privileges and achieving their goals. However, in order to guarantee an institutional arrangement's stability, it is essential to continuously mobilize political support, making those responsible for applying rules to comply and actively solve, to their favor, any institutional ambiguity. That is why compliance – understood as effectively abiding and subordinating to rules – is a crucial variable in analyzing stability and institutional chance. In TGIC, change becomes possible when current balance is broken, a process that can be triggered by different devices and can also take place due to internal and/or external factors to the institutional arrangement, depending on the analyzed process characteristics. Concerning actor, political context and institutional arrangement traits influence which change strategies have more or less chances of success. In contexts with a strong veto power and low discretion, the best strategy would be a "change in layers" – when conflict is avoided with well positioned actors in the current institutional arrangement, instead creating new rules without altering the previous set significantly. If the power to veto intended changes is weaker, "dislocation" as a strategy (when mobilization happens for new rules, against current rule) has more chance of success.

This study examines two public policy subsystems: health and university education. Both subsystems are considered stratified power structures which distribute unequal political resources and materials, although they are also a fighting arena between individuals and groups defending different solutions for public policy issues[20]. At the same time, mesosocial level sectorial unities producing public policies present certain autonomy when compared to the political macrosystem, with its own dynamics, rules and institutional arrangements[21]. TGIC allows to analyze rules and institutional arrangements of both subsystems to verify if and in how actors in privileged positions used such rules to hinder the policies for training and supply of medical doctors in Brazil during Lula da Silva's administration, despite the pressure for their approval.

Policy process studies help on the understanding of individual and collective actors with their interests, beliefs and their actions on public policy subsystems. Policy entrepreneurs are key individual actors that create or seize opportunities and means to put their problems and defended solutions under the spotlight. They also search for a favorable policy process so their problem of choice can enter the institutional agenda and find its solution[22]. They lead and produce coor-

dination in policy communities – understood as somewhat cohesive groups with different institutional positions (State, market, civil society organizations) and relations among themselves – that share goals and ideas on what should the results be for sectorial policies, acting coordinately to interfere in decision making and making their stands preponderant in government[23]. In this paper, the goals, ideas and actions of those policy entrepreneurs and policy communities that promoted change have been mainly analyzed.

Results

Literature, documents and interviews analyzed led to the identification of policy entrepreneurs leading three policy communities which pursued influence on the are of regulation, training and supply of medical doctors with the goal of sustaining or altering current policies. One of them was HRM-PC[10], formed by health scholars, leaders and professionals, mainly inside SUS, as well as union leaders and other civil society organization professionals on the healthcare sector. HRM-PC defended health reform, SUS and the decision of policies for training, regulation and supply of medical doctors under the healthcare subsystems, considering the needs of SUS. During Lula da Silva's administration, iconic figures of this policy community had privileged space in the Ministry of Health, such as Sérgio Arouca, Gastão Wagner, Maria Jaeger, Saraiva Felipe, Francisco Campos and others. They led an expressive group of higher-up Ministry of Health members that demonstrated a large sense of belonging, defending community values.

Other two policy communities had its actions identified regarding the coordinated action of its members and the fact they shared values and visions about desirable results of the policies studied in this paper as well as the national health policy: Community in defense of Market Regulation of Healthcare and Higher Education (MR-PC) and Liberal Medicine advocates Community (LM-PC)[9]. The first was composed of medical-industrial-financial complex organization representatives and of private university institutions (IES), as well as its supporters, such as lawmakers, public servants and directors attached to Legislative and Executive. It defended that the market should regulate the distributions, the remuneration, the specialty scope, offer and content of the healthcare professional training. LM-PC was led by medical entity directors. Members of this community represented the medical category in consultive and decision-making ministerial forums, mainly about education and health. The community also had lawmakers, health service and university leaders as members. LM-PC defended the *status quo* – at the time, professional self-regulation for physicians, with medicine highly regarded as a liberal profession. It advocated also for the profession's monopoly over larger symbolic and economic value practices, medical freedom to choose their area of action as well as the imposition by medical entities of extra market conditions aiming to control the workforce and medical services' prices[9].

The institutional arrangement responsible for decisions about regulation, training and supply of medical doctors involved the National Congress (CN), the Ministry of Education (MEC), the Federal Medical Council (CFM) and the Ministry of Health (MS). Professional activities in Brazil have a strong state presence, in a work relations model of corporate origins[24]. Professionals, medical doctors among them, have their activities regulated by federal laws approved by the Congress. MEC is responsible by decisions related to undergraduate and graduate degrees, as well as medical residency, defining, among other things, the competences professionals should have at the end of their courses. Another indicative of state presence is the necessity that each regulated profession should have its professional council, created by law – CFM's case –, which should be directed by elected fellow professionals. Such councils are responsible by infralegal regulations and professional activity control. An important part of the definition both of specialists' competences and titles is not MEC regulated, instead being controlled by medical specialty societies recognized by CFM. MS weighs in legislation changes about health professions discussed by the Congress and partakes in MEC discussion forums about medical training. Its influence on policies in analysis is relatively small if compared to that observed in other countries with wide public healthcare systems such as the United Kingdom, Canada and Spain[5-8,11,25].

During the Lula da Silva's administration, most important MS members belonged to HRM-PC. Their intention was to implement policies according to their principles and to the propositions they defended. One of the areas that should be submitted to changes was the one referring to the policy for regulation, training and supply of medical doctors. Proposed changes intended mainly to increase MS' power, stablishing that

SUS necessities should be the main decision criteria concerning adopted policies. The action production and coordination center defending such propositions was in the Healthcare Work and Education Management Secretariat (SGTES), from MS, created in 2003 (decree nº4.726). SGTES was ran, since its beginning until 2005, by Maria Luísa Jaeger, which was responsible for its structuration, along with the group which occupied the secretariat's superior positions at the time. SGTES and its directors were HRM-PC members and could be considered entrepreneurs with their proposed changes to the area's policies. With the rise of a new Health Minister in July 2005 – with Humberto Costa, from the Workers' Party (PT), being substituted by Saraiva Felipe, from the Brazilian Democratic Movement (MDB), Francisco Campos took charge of SGTES, changing part of its directors. The new secretary and his team were also members of HRM-PC but were less identified with social movements and workers' union, unlike their predecessors (interviews 3, 9, 12, 13, 17).

Three institutional fronts were seen by the proposed changes entrepreneurs as fundamental in order to alter the policies for regulation, training and supply of medical doctors: the National Congress, the government core (markedly the president), his entourage and Civil House, as well as MEC (interviews 3, 9, 13). Alteration possibilities concerning the legal framework weren't promising. At the National Congress, many of the lawmakers were medical doctors and identified with the ideas defended by LM-PC. During the 2003-2007 legislature, of the 626 members and alternate members of the House of Representatives to sit on its chairs, 71 were medical doctors – a percentage of 11,3%. On the Senate, medical doctors were 8 among 199 – 6,7% of the total[26]. Even though some of these doctors were members of HRM-PC (the cases of Jandira Feghali, Dr. Rosinha and Saraiva Felipe), most of them were sensible to LM-PC's demands. Its members, should they be lawmakers of medical entity representatives, had veto power in proposed changes of the current policy for regulation, training and supply of medical doctors being discussed by the National Congress. Besides, there was already a conservative precedent in Congress decisions about changes in regulated professions (interviews 3, 9, 12, 13, 15, 18).

Given its hardships in the National Congress, change entrepreneurs, mainly SGTES directors, directed their efforts towards reducing MEC's interferences in the area, increasing the Ministry of Health's influence on medical training with consideration of SUS necessities. MEC, besides from deciding about training, used to regulate medical residency by the National Commission of Medical Residency (CNRM), whose members were mostly medical entity representatives (decree nº 91.346/1985). Amongst the nine CNRM members, four represented the federal government and five represented medical entities – CFM, Brazilian Medical Association, National Medical Federation, National Association of Resident Doctors and Brazilian Association of Medical Education. Besides, MEC constituted specialist commissions, both consultive and *ad hoc*, which examined and discussed matters related to professional training. Regarding medical training, MEC consulted said commissions and departments in the Ministry of Health, such as the old University Hospitals Department. Obstacles to change weren't only the actions of LM-PC members along with CNRM, National Education Counsel and MEC directors – there was an institutionalized, historical relation between MEC and medical doctors as a category, besides of respect of the medical knowledge's symbolic power about its own practices, something that also made changes harder (interviews 3, 5, 9, 12). There was a prevalent vision that, since Medicine involved professional training, medical entities should, with IES as partners, guide said training[9].

Sgtes directors aimed their actions mainly to alter the roles of MEC and MS in the training of healthcare professionals. The minister of education, Cristovam Buarque and the whole government core in 2003 were inclined to transfer the power of decision over medical training from MEC to MS. CNRM and specific MEC departments would be transferred to MS. A change in ministries in 2004, with Tarso Genro taking over MEC, stopped the process. According to a former SGTES director: *there was a regulation that was going to be signed […] transferring it all to us. […] It came with everything, CNRM, all of the directions (MEC health training areas). He said yes. […] But then Lula fired him* (Interview 13).

Warned of the possibility of such a transference for the MS, where it would lose its privileged deciding position, LM-PC reacted. Its strong reactions, allied to a new MEC direction that repeated the hegemonic comprehension in the education subsystem that regulations should be controlled by MEC, not by SUS or the MS, made MS representatives back from their intent to exert more power over the area[9]. On the side, LM-PC continued, so forth, to veto "statist visions"

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that aimed to change professional self-regulation or their privileged positions in the current institutional structure. This excerpt of an interview with a MS director echoes the situation:

Medical corporations were very strong, they controlled the training device, they had such a big weight in the National Counsel of Education, they commanded training as far as medical residency was concerned. And they were against it (proposed changes). At the same time, (MEC) ministers […] understood that our search for allying medical training to the necessities of SUS was an interference to MEC's autonomy […] we couldn't go on due to corporate forces and MEC's positions (Interview 9).

Between 2003 and 2010, policy change entrepreneurs in the direction of the MS presented several propositions to change the ways the regulation, training and supply of medical doctors was organized in the country[9]. Besides of the frustrated attempt of transferring to the MS the attribution of guiding health training, we highlight four proposed changes, considering the government's core and, in most cases, the National Congress' involvement in the decision making that led to their implementation or failure: (1) Mandatory Civil Service, (2) International agreements on medical degrees, (3) Revalida and (4) Alterations to the Financing Fund for University Students Law (FIES). The proposition of a mandatory civil service consisted of making mandatory to newly graduated doctors a certain time of offering their paid services to the Unified Health System in underserved regions. Its implementation depended on a federal law being approved. Celebration of international deals had as a goal the mutual recognition of medical diplomas between countries – it also depended on Senate approval. The changes in Fies predicted moratorium and debt relief of FIES loans to medical doctors who chose to act in Family Health Strategy in underserved areas or that made their residency in priority specialties according to MS. Alteration also depended on Congress approval. The creation of Revalida, usual name of the National Exam of Revalidation for Medical Diplomas Given by Foreign University Institutions, was uniquely a MEC decision[9].

The proposition of Mandatory Civil Service and of celebration of international mutual recognition of medical diplomas were discussed with the government's core during the years of 2003 and 2004. As was the case of the health training attributions being transferred from MEC to MS, both were denied. The three negatives had in common a strong opposition from LM-PC and the lack of support or simple refusal from MEC. Mandatory Civil Service and international agreements depended on additional Congress approval, making their defense more expensive to the government – more so with the clear opposition of LM-PC. The government's core wasn't willing to make such a confrontation, since – so it was thought – that taking matters to the Legislative would wear the government down instead of earning it a win (interviews 12, 13, 17). On the following interview excerpt, a MS director during Lula da Silva's government reveals the presence of a restrictive effect imposed by LM-PC over government decisions, as well as the preference for policy alteration proposition that wouldn't create such opposition:

We evaluated all the things made by the MS that involved training and supply, […] which initiatives we though would be more negotiable with medical entities. […] We evaluated possibilities that didn't have such a drastic confrontation (Interview 17).

This scenario led MS, from 2005 on, to settle for such limitations on the political and institutional context, going through with propositions that would have MEC and LM-PC support. Or, as a first-tier director would argue when interview, making use of a metaphor: *It's like that story in which you trace a circle with chalk and the turkey feels stuck. […] You don't step out of the circle. […] All of our actions are still inside of the circle* (Interview 3).

Entrepreneurs tied to HRM-PC that ran MS argued that there was an acute unsuitability in the training of medical doctors and an insufficient offer of professionals given SUS necessities. The issue would limit, on the mid-term, the success of some government goals, such as better medical attention and healthcare service expansion. During this period, the government worked around the problem with measures such as the offer of diverse courses to SUS professionals (paid by SGTES) and an increase in federal resource allocation, as was the case with the Basic Healthcare Package, which increased municipalities' capacity of hiring medical doctors in the workforce (interviews 1, 9, 17).

Even though LM-PC was able to veto changes to the institutional arrangement that gave it privileges, both HRM-PC, mainly with its members inside MS direction, and MR-PC could hinder propositions defended by LM-PC. In 2009, government paralyzed on the Congress the Medical Act law project, which increased the number of

activities exclusive to medical doctors – considered a harm to SUS by the standards of HRM-PC. Another example was the opposition by MR-PC that avoided a moratorium on new Medicine courses desired by medical entities. Such a measure would not only limit the expansion of the private university market: it would restrict physician offer – an obvious interest to the private health sector as it upheld medical labor costs[9].

By the end of Lula da Silva's second tenure as president, in 2010, the government core got the approval of Revalida – the only proposal in analysis that counted with strong opposition of LM-PC. President Lula was sensible to the matter of recognizing diplomas from medical doctors trained outside of the country since his first year in charge. However, he couldn't make bilateral agreements go through. By the last year of his tenure, he demanded a solution from MEC and MS, which was proposed and approved working around a vote by the Congress: by recognizing only the diplomas of medical doctors that passed by a thorough examination, they spoke to the "meritocracy" argument defended by LM-PC. In the end, the alteration was only incremental: universities still got to validate diplomas and could opt out of the national exam if it was their wish (interviews 3, 9, 12, 13).

Discussion

Neo-institutionalist approaches to the policy process help us understand how political and institutional instructions offer opportunities or restriction to the action of individual and collective actors which, even already at the top of the social hierarchy, take action and contribute with results that differ from their goals and ideas[23]. Among them, we highlight TGIC[19], which made possible the analysis of structures and the actions and strategies of well positioned actors that were able to hinge changes to the policies for regulation, training and supply of medical doctors in the analyzed period other than incremental alterations. Three politic and institutional restrictions were identified as the most important for a relative stability of policies: 1) strong opposition by of the three most influential communities in the process; 2) MEC's lack of support or mere refusal of proposed changes and 3) the government core decision of not going through with propositions that would have to be approved by the National Congress and at the same time had opposition from any of the communities. Transferring the discussion to the Congress, thought the government, could wear out its structure more than it would bring success with the measures' approval.

The first strategy tested by change entrepreneurs – directors of the MS that were also members of HRM-PC – was "dislocating"[19]. They tried to change the institutional arrangement in order to increase the MS importance in the policy decision process. Their failure and the subsequent maintenance of the *status quo* (with the strong resistance of LM-PC and the "conformity" of MEC directors to rules and traditions that gave medical entities and universities discretionary power over policies) gave impulse to a change of strategy by the Ministry of Health, composed mainly by HRM-PC members.

Noticeably after 2005, considering limitations of the political and institutional context, MS directors opted by developing a "layered change" strategy[19], in which they would only go through with proposals that had MEC support, had its boundaries respected by LM-PC and didn't profoundly change the *status quo*. At the same time, opposition from MS or MR-PC prevented measures defended by LM-PC from being accepted by the government core, as was the case with the Medical Act law project and the moratorium in new Medicine schools. Chart 3 presents the main changes proposed in the policies of regulation, training and supply of medical doctors that entered the policy process between 2003 and 2010 and the positions of MEC directors and of the three policy communities, indicating whether legal changes were necessary, if they were implemented and when they were in fact implemented or were excluded of the government debate agenda.

The only solution that wasn't opposed by none of the policy communities or MEC directors was the change in FIES Law, which got to the Congress with the support of the government. The only solution in fact implemented, despite of LM-PC's resistance, was Revalida – however, its implementation depended uniquely on MEC. Besides, President Lula defended it, which was decisive for MEC's approval despite LM-PC's negative to the measure. The power of the president's agenda is recognized as an important factor of change in sectorial subsystems, specially in Brazil[27]. Apart from Revalida, all prosper measures were "tolerated" by all three communities and MEC's direction.

That is to say that, from 2003 to 2010, the analyzed institutional arrangement didn't go through changes, neither did the medical work

Chart 3. Main proposed (legal or administrative) policy changes: policy communities' and Ministry of Education positions – 2003/2010.

Proposed changes	Positions				Necessity for Congress approval	Implemented	Year of implementation/ decision of not implementing
	HRM-PC	LM-PC	MR-PC	MEC			
Mandatory civil service	In favor	Against	Neutral	Neutral	Yes	No	2004
International agreement for mutual recognition of medical diplomas	In favor	Against	Neutral	Neutral	Yes	No	2004
SUS with the attribution of controlling the training of human resources in healthcare	In favor	Against	Neutral	Against	No	No	2004
Moratorium in the foundation of new medical schools	Neutral	In favor	Against	Against	No	No	2005
Medical act law	Against	In favor	Neutral	Neutral	Yes	No	2009
Fies	In favor	Neutral	In favor	In favor	Yes	Yes	2010
Revalida	In favor	Against	Neutral	In favor	No	Yes	2010

Source: Authors.

regulations or the professional supply policy – the FIES law acts only as a stimulation for physicians to work in underserved areas and Revalida, although it could increase the number of professionals in the workforce (which didn't occur[9]), wasn't articulated with supply instruments to underserved areas identified by MS. Incremental measures of smaller impact were implemented in an attempt to change the traits of medical training, but they didn't change the institutional balance of the area nor did they use existing policy instruments to regulate the federal university system.

Even so, a legacy of ideas and institutions was constructed, and it was decisive to the formulation, articulation and implementation of Programa Mais Médicos three years later. Although in a different context, the program indeed changed the policy for regulation, training and supply of medical doctors, even in face of the strong opposition upheld by the liberal MR-PC. It is impossible to explain how PMM was possible without analyzing during the worsening of the already existing insufficiency of medical professionals, a lack of policies that fought this problem, the paths of this policy with its advances and vetoes and what was learnt from all of these experiences, as well as the resources they offered to the decision, formulation and implementation of PMM[9].

Collaborations

The authors participated in all stages of the construction of the work, namely: conception, design, data analysis, article writing and approval of the version to be published.

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