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What made the Mais Médicos (More Doctors) Program possible?

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Abstract *The article analyzes which were the actors who participated in the insertion in the governmental agenda of the issue of insufficiencies in the supply and training of medical doctors for the SUS and the adoption of the Mais Médicos Program (PMM) as a solution. Documental and bibliographic analysis and semi-structured interviews were carried out in the methodological perspective of process tracing. Theoretical resources from studies on political processes and from the theories of gradual institutional change and multiple streams were used. Outstanding results were the identification of factors related to the entry of the issue on the agenda, such as the aggravation of the issue, increase in its public perception and change of government. It was found that the action of the President and policy entrepreneurs was decisive for the process of formulating the PMM based on historical legacies of previous policies. We challenge studies that regard the PMM as a hastily formulated solution to an old problem to respond the street demonstrations known as "June Journeys". The inauguration of municipal governments, in 2013, and the electoral calendar were also important factors and taken into account in the strategic action of the actors who led the formulation of the PMM, with strong opposition from medical entities.*

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

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Introduction

This article aims to analyze which were the actors and how they acted during the process that inserted in the government agenda the policy issue of insufficiency in provision and training of medical doctors in the Unified Health System (SUS) and the adoption of the Mais Médicos (More Doctors) Program (PMM) as solution. The text presents an alternative comprehension to those found in literature, which tend to credit PMM's entrance on government agenda to 2013's political context[1-3], mainly to the great street protests denominated Jornadas de Junho (June Journeys) or as a result of a new Health Ministry (MS) management action which already prioritized the resolution of medical provision and training, seeing in 2013 an opportunity to face it[4-6]. To the authors, besides changes on the federal government direction and of 2013's conjunctural situation, a set of other factors were decisive to the matter's entrance on the government agenda and to PMM's formulation, despite strong opposition by medical entities. The worsening of lack of physicians and its consequences intensified the theme's media presence and the pressure for the problem's resolution by mayors and government representatives. Research shows the matter as one of the Brazilian population's greatest demands. Besides, previously implemented federal policies had insufficient results[7].

This conjunction of factors, as well as the overcoming of the Ministry of Education's (MEC) resistance to confer SUS the power over medical training, were amplified by the strategic actions of entrepreneurs proposing a greatest SUS participation in medical regulation, training and provision.

The matter of insufficiencies in the training and provision of physicians according to the healthcare system's needs and the policies formulated in order to face them are broadly studied and debated themes not only in Brazil but abroad, having been the object of thorough examinations by the World Health Organization (WHO) and of many Human Resources Observatory Network research in the period preceding PMM's proposition[4-12].

It is present in the national government agenda since the end of the 1960s, and it had been faced by limited, sometimes, temporary, policies, with no satisfactory results[4,5,7,11,12]. In Brazil, decisions involving such policies occur in an institutional arrangement of which National Congress, the Ministry of Health, the Ministry of Education and the Federal Council for Medicine (CFM). Professions are regulated by federal law and professional councils (such as CFM in Medicine) are created by law, directed by peer-elected members and responsible by non-statutory regulation and professional activity oversight. It is the Ministry of Education's responsibility to decide about matters of medical training in undergraduate, residency and post-graduate levels, such as the definition of curricular guidelines or the amount and location of training slots.

It is the Ministry of Health's responsibility to offer its feedback about changes on the healthcare profession legislation, to participate in government forums deciding about medical training and proposing measures in order to induce institutions to consolidate their training around SUS' needs, stimulating doctors to work in underserved areas. When compared to that observed in Other countries with broad public health systems, the Ministry of Health's influence on policy analysis is small[4,5,7-9,11-13].

Ministry of Health directors from 2003 to 2015, most of them members of Sanitary Movement Policy Community (PC-M Sanitary)[14] understood the matter limited possibilities of broadening access to health service and to improve their quality. They also considered it was SUS' responsibility to "ordinate human resources policies in healthcare"[7]. Policy communities (PC), concept used in actor analysis research, are somewhat cohesive groups of individual and collective actors with different institutional positions and related among themselves. They share goals and ideas, specialize over a question with its sectorial policies' designs and results in order to act coordinately and affect decision processes, making their positions predominant within the government[15].

Other collective actors with sectorial action are "theme nets" – groups in which members can participate, interact and have fluctuating access –, whose members dispose of unequal resources and are reunited to discuss, formulate and propose solutions related to a theme over which there is no consensus and the presence of conflict[16].

During Inácio Lula da Silva's government, Health Ministry directors proposed changes to the current institutional arrangements in order to increase ministry participation in policy decisions taken about the area. They also presented propositions as the mandatory civil service and foreign medical diploma recognition. However, they didn't succeed at the time due to two main

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factors: the action of medical professional organization and the Ministry of Education's opposition[7].

Mais Médicos (More Doctors) Program (PMM) was released in 2013. It had three main axes: provision, training and infrastructure. Provision gave the Ministry of Health the power to authorize the professional activity of physicians graduated above, in which it counted 18,240 medical doctors, both Brazilian and foreigners, practicing in 4,000 municipalities. The training axis created a regulation for the opening of new private Medicine schools – the main criteria for creation being the regional need for doctors and educational slots. It also ruled that curricular guidelines for Medicine undergraduate courses should be modified, broadening their integration with SUS and strengthening Community and Family Medicine (CFM) and established a new itinerary for the medical residency training: before choosing his or her specialty, the resident should pass for mandatory CFM training. Infrastructure destined resources for construction, ampliation and the renovation of health units[7]. The authors' analysis of PMM's insertion in government agenda and its adoption as a solution is developed in this article in three other sections: "Methods", in which the theoretical and methodological references are presented, "Results", in which the findings are discussed, and "Discussion", in which results are explored in the light of references.

Methods

Research employed process tracing as a methodological strategy, examining historical trajectories, documents, interview transcripts and other sources in order to verify possible explanations, considering chains and causal mechanisms of the case at hand – understood as theoretical constructs focusing dimensions of reality, pointed by theory as able to influence or determine events or phenomena and which, when applied to empiricism, have the goal of formulating middle-range theories that can explain said events or phenomena[17].

Distinctly from the previous period (2003-2010), when PC-M Sanitary directors were also in charge of the Ministry of Health but couldn't significantly alter current policies, from 2011 to 2013 it was possible to promote changes which culminated on PMM. Based on causal factors investigated in policy analysis, on the theoretical references utilized and on empiric material, this study's regard has been directed to the four explanative dimensions, which allowed the researchers to comprehend the changes on the researched process investigated in comparison to the previous period, which were 1) actors, their interests and ideas acting in the health and university subsystem, taking stands, raising problems and disputing in the current policy; 2) the evolution of the matter of insufficiencies in supply and training of medical doctors on the last decades and its effects on the attention of actors that became relevant in the analyzed policy; 3) changes on the subsystems' institutional framework and historical, ideational and institutional legacies, which influenced the production of PMM; 4) the political context and institutionalized relation patterns between governmental decision makers and society actors. In the analyzed process, these dimensions have become chained in decision moments and spaces forming PMM's production trajectory, due to what the study is focused in the actors' actions in circumstances full of institutional and contextual opportunities and embarrassments (Chart 1).

For documental analysis, the period between 2003 and 2013 was used – from the first year of government of the governing coalition that released PMM until the year of its release. Legal and administrative regulations (laws, decrees, ordinances and federal resolutions) from regulation, training and provision of medical doctors were examined, as were journalistic and institutional articles – mainly from entities representing mayors, municipal and state health secretariats and physicians. Bibliographical analysis aimed to answer research questions and to support the understanding of policy actions regarding regulation, training and provision of medical doctors from the second half of the 20th century, when Brazil saw an intense debate about training of human resources in health, PMM's insertion in the government agenda, its formulation and the medical organizations' position in front of those actions.

Semi-structured interviews were conducted with 19 key-informants (Chart 2) which, between the years of 2003 and 2018, were the main characters in formulating policies for regulation, training and provision of medical doctors. Many of the subjects were present in more than one of the three analyzed periods, holding positions either in the Ministry of Health, the Ministry of Education, the government core, the National Congress, the representing entities for munici-

Chart 1. Adopted evidence reunion strategy.

Four dimensions and the analysed process	Analysed elements	Sources
(1) Individual and collective actors	Positions, goals, ideas, propositions and actions	Literature, diverse documents (media articles, civil society or state organizations resolutions), interviews with directors
(2) Evolution of the matter and its effects in later relevant actors	Change in indicators and characterization of policy problems/ positions of relevant actors	Literatura, documentos diversos (como relatórios, estudos especializados, matérias em meios de comunicação, resoluções de órgãos da sociedade civil ou do Estado) e entrevistas com dirigentes
(3) Institutional framework and ideational and historical legacies	Change and creation of programs and rules, associated ideas na resource mobilization	Legislation, other official documents, literature, interviews with directors
(4) Policy context, institutionalized govenrment-society relation patterns	Changes on the correlation of forces and on "traditional" relations between decision-makers and societal actors	Literature, media articles, interviews with directors
(5) trajectory process	Changes on legislation, regulations and programs	Literature, legislation, official documents, interviews with directors

Source: Authors.

Chart 2. Interviews.

Position	2003-2010	2011-2013	2013-2018
First-tier, federal Executive	5	4	2
Second-tier and intermediate positions, bureaucrats, federal Executive	4	6	4
State and municipality secretariat representation entities' directors	3	3	2
Senate and House respresentatives	-	2	3
PAHO	1	-	1
Total by period	13*	15*	12*

*Note: 19 people were interviewed, but some occupied different positions in more than one period – a few of them having occupied different positions during all three periods.

Source: Authors, adapted from Pinto[3].

pal and state health secretariats and in the Pan American Health Organization (PAHO). Among them, 15 held decision-making positions from 2011 to 2013, the period studied in this article.

Content Analysis[18] techniques were employed to treat interviews, making use of analytical categories such as actors, ideas, institutions, matters, problems and solutions. Also employed was the Political Discourse Analysis[19], making use of discourse premises such as: goals, values, preoccupations, circumstances, courses of action and consequences. Resources from the Multiple-Streams Theory (MST)[20], from public policy process studies[21-23] and from the Theory of Gradual Institutional Change (TGIC)[24] were also used.

MST offered analytical instruments to define what it denominates as the three policy streams related to the entrance of new solutions in the government agenda: the streams of "problems", of "solutions" and of "policy process and context". The theory also allows the identification of "opportunity windows": fleeting opportunities in which the three streams are coupled, allowing the chance for new matters and solutions to be brought to the attention of policy decision-makers, entering the government agenda.

In the policy process, there's a dispute over which are the matters, priorities and explana-

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tions for problems and which solutions should be implemented. To MST, "policy entrepreneurs" are key agents to create or enjoy opportunity windows, to bring awareness and to accord the approach of matters[20,25]. Studies about policy process[21-23] offered analytical instrumental to examine the settings and the development of relations between organizations and actors – individual and collective, society and state – and to define their interests, ideas and actions considering the context and its rules.

TGIC[24] supplied theoretical resources for the comprehension of institutions as distributive instruments charged with power implications and tensions. Due to having unequal effects in resource allocation, institutional rules give way so certain actors in dominating positions – be it in the institutional or the societal setting – can project institutions corresponding to their preferences in order to achieve their goals and maintain their privileged condition. However, to secure an institutional arrangement's stability, it is necessary to continuously mobilize political support. In TGIC, change becomes possible when current balances are ruptured due factors that are internal and/or external to the institutional arrangement, analyzed in conjunction with the specific actor strategic action in the policy process.

The study is focused on the analysis of two public policy subsystems – health and university. Subsystems are stratified power structures that distribute unequal resources and confrontation arenas for actors defending different solutions for policy matters[25]. They are also sectorial units in a meso social level for public policy production, with certain autonomy in relation to the policy macro system, and to institutional arrangements with its own rules and dynamics[26].

Results

The analysis of documents, literature and interviews showed two collective actors had a striking action in the process that had as a result PMM's formulation as a solution for the problem of insufficiencies in the training and provision of physicians for SUS: Political Community Defense for Liberal Medicine (PC-L Medicine), which was against the problem, and PC-M Sanitary, which was in its favor. The first of them was led by directors of medical entities; its members acted in consulting and decisive Ministry of Education and Ministry of Health forums. It had as its members congressmen, public and private hospital directors and deans of medicine. The community defended the *status quo*, which was at the time the medical profession self-regulation, conceived as a liberal profession, the profession's monopoly over the health practice of larger symbolic and economic value; medical doctors' freewill as their area of expertise, and a strong opposition to measures that could increase the quantity of doctors in the job market, be it an increase of foreign doctors practicing in the country or offered graduation slots or the loss of professional control over specialist training[7]. PC-M Sanitary [14] was composed by scholars, health workers and managers (mainly inside SUS), union leaders and other professionals in civil society organizations related to healthcare. It defended SUS and Sanitary Reform principles and that policies for regulation, training and provision of medical doctors should be decided mainly within the health subsystem, taking SUS' necessities in account.

With the inauguration of President Dilma Rousseff in 2011, there was a change of directors inside the government core and on the Ministry of Health; directors on the Ministry of Education were maintained. A relatively cohesive group in which concerned its ideas about SUS and its professional trajectories took over the Ministry of Health first-tier chairs. They were part of a recent generation of PC-M Sanitary and had acted together from 1990 to 2004 as Medicine student leaders and in the theme net Medical Education Net (Rede Educação Médica)[7], composed mainly by Medicine students and professors, which discussed changes in medical training and involved both members of PC-L Medicine and PC-M Sanitary. These directors, along with others with leading positions in MEC and a congressman, acted as PMM's entrepreneurs. Informants interviewed (Interviews 1-6 ,8-14, 17, 19) indicated 16 peoples besides of President Dilma as main characters in the formulation and defense of PMM, with three of them receiving more emphasis: Alexandre Padilha, minister of Health, Congressman Rogério Carvalho and Mozart Sales, Ministry of Health's chief of staff (2011) and director of the Ministry of Health's Secretariat of Labor and Education Management for Health (SGTES) from 2012 to 2014. Sales was a direct responsible for implementing PMM. All three of them were doctors, members of the Workers' Party and, in the 1990s, they occupied in sequence the highest office in the National Executive Direction of Brazilian Medical Students (Denem).

Padilha, who announced at the beginning of his tenure a priority in facing the matter of insuf-

ficiencies in the training and provision of medical doctors, stated in an interview that a former ministerial director said to him and his team that "along Padilha is the group which […] discusses medical education" (Padilha Interview), and added:

He (the director in question) *was sure that medical education would be a debate we would provoke. […] A group of people that had this debate on their history, be it by being a part of Medical student movements or by taking part in Abem (Brazilian Association for Medical Education). […] We wouldn't miss the chance to […] seek concrete measures so the Ministry could take its constitutional responsibilities: […] make SUS and its authorities the main regulators of the process for training and supplying medical doctors* (Padilha Interview).

The evolution on the matter of insufficiencies regarding the provision and training of medical doctors during the years 2000, as well as the demands of population and SUS managers for a solution to the problem catapulted the matter to the macro policy system (Interviews 1,2,4,9,11-13,15,19). This occurred in great part due to the coverage expansion of health services combined to low growth in physician supply: those graduated in the years 2000 filled only 69% of the job market's demand[10].

There was a concentration of medical doctors, Medicine courses and residency programs in big cities of the South and Southwest regions. A third of the family medicine teams had no physicians at all[10,27]. Hardships and increasing costs in order to broaden access to healthcare services, along with the population's abhorrence over the lack of physicians increased the problem's political importance.

Before her inauguration, President Dilma was alerted that her campaign promise to expand access to healthcare services was threatened by the problem of lack of physicians in SUS, that obtained relative importance with the media[28]. Attentive to the question, the president said in her inauguration speech that this would be one of her government's priorities. PMM entrepreneurs – PC-M Sanitary members – established negotiations with PC-L Medicine, supporting their arguments with ideational and institutional legacies to structure their proposition of facing and publicly defending the matter.

The group reunited evidence, promoted research and used as reference international and national experiments, as well as propositions already discussed in Brazil. The first proposed solution was the Program to Value Primary Healthcare Professionals (Provab), a strategy for medical training and provision to underserved areas that gave bonus point in residency exams in the intention of attracting recently graduated physicians. With the support of the Ministry of Education and of the government core, and besides of the strong opposition of PC-L Medicine (whose members were mostly against Provab), the Ministry of Health officially created the problem in September 2011. With Provab, there was an increase in physician recruitment for basic attention; however, in 20013, it responded to only 26% of municipalities' demands for doctors in their family health teams[7].

Other initiatives formulated during Lula's government and implemented in the first year of Dilma Rousseff's government had insufficient results, such as the National Examination for the Revalidation of Medical Diplomas Issued by a Foreign Higher Education Institution (Revalida) and the alteration in the federal student loan program (Fies) in order to diminish the debt of physicians that opted to practice with family health groups in underserved areas or that chose their residency in priority specialties according to the Ministry of Health[7,29].

In February 2012, the government core was convinced by the entrepreneurs that the lack of physicians limited the health policies' success rate, representing a big obstacle in the government evaluation improvement concerning the healthcare area. It would be necessary to implement a broader problem that included the international recruitment of physicians to respond to SUS' demands, to the expectations of lawmakers and municipal and state managers and to the greatest population complaint: the lack of physicians. It was then when a work group was created including seven ministries: its goal was the formulation of PMM, as states a former Ministry of Education director:

(It was attempted to) *improve via Provab. […] There was a very insufficient response, […] there's a frustration […], it's taken to the Presidency: 'look, we'll have to try something bolder, because the instruments […] we have […] are insufficient'. […] We have identified it would be practically impossible to attack the matter uniquely with traditionally trained Brazilian physicians* (Interview 16).

From the provision point of view, PMM reproduced Provab, aggregating international recruitment which, to be implemented, needed change in legislation. The basic law draft was

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finalized by the beginning of 2012, and PMM entrepreneurs conducted the definition in secret to minimize reactions from opposition, mainly from PC-L Medicine. Parallel to that, they tried to alleviate resistance to the federal government, mainly from the Ministry of Education and from members of PC-L Medicine, markedly directors from medical entities and people occupying positions in the government and in collegiate organs. With the support of the government core, Ministry of Education directors committed to the construction of PMM were nominated and the program's formulation happened in the ministry's institutional spaces in which there was a smaller PC-L Medicine influence, such as the Secretariat for University Regulation and Supervision (Seres) and a direction created to implement PMM (Interviews 3, 16, 17). That way, the Ministry of Education ceased to oppose the policy change, as was the case from 2003 to 2010[7,29], and started supporting it.

The formulation of PMM was influenced and made possible, according to the informants interviewed, by ideas, teachings, instruments and resources related to measures previously implemented to face the matter of insufficiency in medical provision and training.

PMM had three axes. Infrastructure was an increment of a program originally named Requalifica-UBS, established in 2011 in order to build, expand and renovate basic health units. Training reclaimed and amplified the expansion goals for Medicine courses proposed in 2012 by the National Plan of Medical Education and incorporated the Pro-Residency program, created in 2009 as means to expand medical residency problems in regions and specialties needed by SUS. Provision can be seen as part of a trajectory of provision programs perfecting that, during the 21th century, abridged the creation of the Interiorization of Work in Health Program (Pits), in 2001, and Provab, in 2011. Besides, respondents claimed SUS Open University's (est. 2010) structure was essential to secure the service training of the thousands of physicians recruited by PMM and that the cooperation between Brazil, PAHO and Cuba was also decisive to build physician "savings" to secure PMM's success in case national and international physician recruitment couldn't respond to the municipalities' demands (Interviews 2,3,8,13,15,17).

By the end of 2012, the formulation and feasibility of the program's implementation were practically ready. However, PMM's release was postponed due to the proximity of municipal elections, given that the program design predicted the involvement of city health managers in its execution, and the change of mayors could make the program implementation difficult (Interview 13). It was postponed one more time: during the first semester of 2013, PC-L Medicine acted on the government core (Interviews 2, 8, 13, 15, 16).

Members of PC-L Medicine alerted that the political wear caused by the measure would overcome its benefits. Govern hesitation also had to do with the attempt to identify which would be the best moment to propose the law to the National Congress, an arena in which, core members of the government thought, PC-L Medicine had a lot of influence. Besides of 24 physicians in Congress chairs (5% of the total), most of them identified with PC-L Medicine, opposition parties and the repercussion of critics to the program made on the media could provoke an expressive damage to the government's image.

At the same time, changes on the policy context were treated as an opportunity by PMM's entrepreneurs: they would counterbalance PC-L Medicine's pressure and try to build the conditions for the program's release. With the inauguration of new mayors in 2013, entrepreneurs (Interviews 8, 13, 15) stimulated the National Mayors Front to release the "Where's the doctor" campaign in January 2013, demanding international physician recruitment from the federal government. The campaign expanded and was joined by over 2,000 mayors until May 2013, when the Front obtained from the president the commitment that PMM would be released (interviews 8, 13, 15). In this context, the government scheduled the release for the second semester of 2013, after the FIFA Confederation Cup, held in June 2013 (Interviews 2, 8, 13). The June journeys and the vertiginous drop in government approval rates in less than a month from the beginning of the campaign for the 2014 general elections hastened PMM's release, made via national chain of television by the president in June 21st, 2013. As its formulation was already very advanced, it could be easily implemented as a response, at least partial, to the demands of health assistance improvement (Interviews 2,5,8,13,15).

Discussion

Research found evidence for the comprehension of the process that led to the government agenda entrance of the matter of insufficiency in the training and provision of doctors to SUS and to

the creation of PMM that were either absent or undervalued in both the predominant explanation strands and the identified in literature revision. The first, exemplified by the works of Couto and collaborators[1], Ribeiro and collaborators[2] and Macedo and collaborators[3], draws attention to the coupling of streams of problems, solutions and political context in an opportunity windows – the June Journeys – to explain PMM's construction, having as main characters the federal government and/or the National Congress. The second explanation strand, exemplified by the works of Rocha[4], Silva[5] and Paula[6], emphasizes the importance of the change of government and the position of subjects that already prioritized the matter of the insufficiency in medical training and provision and that knew how to enjoy or to react to the June Journeys to propose a solution according to their ideas and objectives.

The analysis of interviews and documents showed that the entrance of the matter of insufficiencies in the training and provision of medical doctors in the government agenda happened due to mainly two factors: the aggravation of the problem, expressed in the increase importance mayors gave to it, in opinion polls and in the press; and the inauguration of the Dilma Rousseff government in 2011, which on its first discourse committed to prioritize the matter. It's worth to highlight that the aggravation of the problem and the increased awareness of the public and of policy actors about its seriousness have not received enough emphasis in literature. Usually, the matter is treated as an old problem; little attention is given to its increased importance in the eyes of the public and the policy world during the period that preceded the political context change in 2013[1-3].

The change in government is considered an explanation factor for alterations in the governmental agenda by many public policy analysis theories[20,24]. The inauguration of Dilma Rousseff's government, in 2011, is considered as the most important explanation factor for the entrance of the matter in the government agenda both by the informants interviewed and the literature.

However, in this theory the vision of government as an unitary bloc is predominant, something very diverse to how contemporary societies' governments work – with sectorial subsystems specialized in their own dynamics, rulings and hierarchies[16,20-26], even in policy systems (such as the Brazilian) in which the presidency has a lot of power[31]. It has been observed that, during President Dilma's first tenure, there were members of PC-M Sanitary in the direction of the Ministry of Health – and the importance of their actions was highlighted by the interviewed informants (Interviews 1-5,8-13,15,17,19). Some studies mention the acts of such subjects in the formulation and defense of PMM, but don't treat them as policy entrepreneurs[4,6,31], which they were since they acted in articulate and strategic ways in defense of the program. They searched for support in the government core, in the direction of the Ministry of Education and among congressmen, not only to promote the matter's introduction in the government agenda but also to defend a solution to the problem: PMM.

The decision to formulate what came to be PMM was taken in February 2012 and not somewhere in 2013 as frequently pointed in literature[1-3]. Until then, Ministry of Health directions had implemented limited reach programs due to the positions and the veto power of PC-L Medicine, that could not hinder the aggravation of the matter. Insufficient results in the increase of SUS doctors with programs implemented in 2011 such as FIES, Revalida and Provab encouraged the government core to decide for the formation of a more effective policy, even with the opposition of PC-L Medicine. The strategic actions of entrepreneurs, the president's actions and the changes in the Ministry of Education's direction and structure in order to make their participation possible in building PMM were central so that the program's formulation could happen during 2013 with no interference (as was the case from 2003 to 2010, when neutral or contrary positions inside the government core and the Ministry of Education hindered from going forward propositions for more significant changes in the policies of regulation, training and provision of medical doctors. In Brazil, the president holds a lot of power when forming the agenda of the Legislative and, more so, of the Executive power[30]. In PMM's case, Dilma's involvement with the theme and her determination in solving the problem in favorable circumstance, along with the fact that the two most crucial ministries to implement the program were directed by the president's party can be added to the equation. That way, the government core coordinated the action of the ministries involved in the program's formulation, giving conditions for the entrepreneurs' action and securing mobilization of the necessary resources to it's formulation, a process not enough emphasized by literature[1-3].

In the formulation actions of PMM, policy entrepreneurs enjoyed institutional legacies

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and teachings from the previously implemented programs to face the matter of the lack of physicians. They related it to a bigger scope of problems associated to insufficiencies in the provision and formation of medical doctors, justifying the proposition of an array of solutions that also involved medical regulation, training and provision. Choices made by entrepreneurs, expressed in the design with which the program was release, could be related to their ideas and their acting trajectory, mainly in Medical Education Net.

The government core's decision to implement PMM (taken in 2013 but with no certain release date) was also motivated by a set of combined factors: the inauguration of new mayors in 2012, their actions articulated to those of entrepreneurs, the progression of deals with PAHO and Cuba and the proximity of the 2014 general elections.

The release in July 2013 was decided due to changes in the political context, provoked by the June Journeys, that came to change the strategic calculations of the government core. Before that, with stable governability and high popularity, negative political consequences of facing PC-L Medicine in the arenas of Congress and media surpassed the sectorial benefits that could come from PMM. After that, with negative government evaluations, needing to react and to present answers to the demands and the damage in its reputation, the Program became a solution for policy and sectorial problems. The Journeys can provide help in understanding the moment of decision, but they weren't the factor that generated the agenda setting, formulation and decision of how to solve the problems in the training and provision of medical doctors with the program, as points an important part of the literature[1-3]. The context change acted as an exogenous factor that aided in altering the previous balance of the area along with the position of individual and collective actors that acted to change previous existing rules in an environment of intense dispute in the definition of institutional ambiguities that – once explored with the edition of new legal and administrative rules – altered the power distribution in the context of the two analyzed subsystems.

The conduction of interviews, apart from the documental and bibliographical analysis, was essential to the study because PMM's construction was secret, making documents telling its history scarce. It was also important to consider the production trajectory of previous policies.

It was noted that studies based on MST[1,2] presented the bias of excessively focusing in the moment of stream coupling – the Journeys, in this case –failing to identify the influence of relevant factors in the production of PMM, mainly the role of institutional elements and processes that presented a longer trajectory, influencing, moreover, the way in which the problems were processed, and the solutions selected.

In this research, the use of MST was combined to the examination of the policy process that conducted to the released of PMM and to TGIC, which allowed us to analyze the trajectory of incremental changes in this process during the last decades, focusing on the social actors and on the health and university subsystems institutional arrangements, their historical legacies, as well as the action strategies of actors and the way they influence decision processes. Besides aiming to offer a middle-range theory for the comprehension of how the matter of the lack of physicians got into the government agenda and how was PMM's formulation process, the study can also contribute to an effort of combined use of MST, policy process analysis and TGIC.

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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