

# Medical organization doctors and policy communities' influence over Brazilian Health Workforce Policies

*A influência dos médicos nas políticas de recursos humanos em saúde: conclusões a partir da experiência brasileira*

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**ABSTRACT** This article aims to analyze the influence of medical doctors as social actors on developing a policy for the medical workforce in Brazil. The analysis focuses on the years following 2003, when a seeking to include this policy within the scope of the National Health System took office at the Ministry of Health and met with resistance from medical societies. The study adopted sources were process tracing methodology, documents, and interviews. It is based on a neo-institutionalist theoretical approach. Findings reveal long-standing stability (1960-2002) in the policy and its institutional arrangement under the policy community formed by Liberal Medicine advocates (LM-PC); a period (2003-2009) when a thwarted attempt at change by the Ministry of Health met with the opposition of the LM-PC; a period (2010-2016) when such stability was undermined, and the policy was changed despite the opposition of the LM-PC; and, finally, a period when stability was recovered favoring the policy mentioned above community again, reversing several previous changes. However, the LM-PC could not implement its propositions since it faced opposition from other actors influencing the policy. Stability tended towards reproducing the status quo.

**KEYWORDS** Health workforce. Health policy. Medicine.

**RESUMO** O artigo analisa a influência dos médicos, como ator social, na produção da Política para a Força de Trabalho em Saúde no Brasil, especialmente a partir de 2003, quando assume a direção do Ministério da Saúde (MS) um grupo interessado em fazer o Sistema Único de Saúde (SUS) ordenar essa política, mas sofre a resistência das organizações médicas. Trata-se de um estudo de caso que utilizou o process tracing como metodologia, documentos e entrevistas como fontes, e o Neoinstitucionalismo como recurso teórico. Os principais resultados são a identificação de um longo período de estabilidade na política (1960-2002), devido à atuação da Comunidade de Política Defesa da Medicina Liberal (CP-M Liberal). A análise de um período (2003-2009) no qual houve tentativa de mudança por parte da direção do MS, mas sem sucesso naquilo que sofria a oposição da CP-M Liberal; de um período no qual essa estabilidade foi rompida (2010-2016); e, por fim, de um período no qual foi restaurada a estabilidade em favor da CP-M Liberal, revertendo diversas mudanças feitas no período anterior. Porém, tampouco esta comunidade conseguiu implementar suas propostas que sofriam a oposição dos demais atores que influenciam a política. A estabilidade tendeu à reprodução do status quo.

**PALAVRAS-CHAVE** Recursos humanos em saúde. Política de saúde. Medicina.

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## Introduction

Health Workforce Policies (HWP) have been implemented in American countries since the introduction of 'mandatory civil services' in the 1930s. These policies guide the training of practitioners per the healthcare system's needs and plan the healthcare workforce by combining regulatory, economic, educational, and professional support actions to secure health service coverage for the population, particularly those residing in underserved areas<sup>1,2</sup>. There are records of meaningful discussions about the HWP since the 1960s when the Pan American Health Organization (PAHO) played a significant role in disseminating HWP experiments, supporting research, and organizing Human Resources (HR) departments within the governments of its member States<sup>1</sup>. In Brazil, the low availability of doctors' training was also the object of national policies during this period. The Military Dictatorship created the Rondon Project to encourage university students to work in underserved areas. In the wake of the Health Reform movement, the 1988 Constitution created the National Health System (SUS), establishing that it should manage the HWP. However, the analysis of the annals of National Health Conferences shows that, among HWP stakeholders, the prevailing perception is that the constitutional ruling needed to be carried out<sup>3</sup>.

Studies on health reforms in different countries and on the development of the HWP show the difficulties of promoting changes when doctors oppose them<sup>2,4,5</sup>. Carapinheiro<sup>6</sup> associates three main factors with the ability of medical associations to maintain their *status quo* and influence healthcare policies: the relationships they establish with dominant groups, the State's institutional arrangement, and the medical profession's level of organization and political action. Several studies address the relationships established by the medical sector and the role it plays in social production and reproduction, by performing economic, political, ideological, and biopolitical functions<sup>5-10</sup>.

This role would result from their monopoly of the most valued (both symbolically and economically) health practices and the State's delegation of powers to regulate and oversee professional activities and set guidelines for medical training and professional practice<sup>5-7,10</sup>. In the Brazilian case, besides monopoly and scientific/professional autonomy, the institutional arrangement in which the HWP is developed delegates great power to medical doctors.

Besides such factors, we observed that the influence exerted by policy communities on the formulation and implementation of public policies in general, and particularly on health policies, is a decisive factor in comprehending the HWP in contemporary liberal democracies, in which the development of sectorial policies occurs within highly specialized environments that cross the State-society borders. A 'policy community' is a somewhat cohesive group of individual and collective stakeholders who specialize in an issue, the design, and outcomes of a sectorial policy, and share ideas and act coordinately to affect governmental decisions to their favor<sup>11</sup>. Three policy communities have been acting to influence the HWP, namely the Health Reform Movement (HRM-PC)<sup>12</sup>, the Liberal Medicine advocacy (LM-PC), and the Market Regulation advocacy (MR-PC)<sup>3</sup>.

The collective stakeholder HRM-PC has recently been conceptualized as an epistemic community<sup>13,14</sup>. The concept refers to "a network of professionals with recognized expertise in a particular field and an authoritative claim to knowledge of rulemaking in this field"<sup>15(3)</sup> that promotes policy changes, "spreading innovation, converting ideas, perceptions and beliefs, and creating opportunities for the realization of change"<sup>16(12)</sup>. The role of HRM-PC in advancing the reform of the Brazilian health system since the 1980s makes the concept suitable for this collective stakeholder rather than for the other two groups that supported the reform, often hindering changes. Therefore, we have used the concept of policy community, applicable to the three groups that consider shared beliefs among members, without referring to

the reformist drive usually associated with epistemic communities.

Components of these policy communities and their beliefs can be seen in *box 1*.

Box 1. Policy Communities

Policy Communities	Composition	Defended arguments
Health Reform Movement Community (HRM-PC)	Scholars, researchers, representatives of healthcare workers, social movements and social organizations, the National Health System (SUS) management staff, and legislators from the three government spheres.	Health Reform principles, SUS, and its principles: universality, gratuity, integrality, and equity.  Training, regulation, and workforce supply should be a State responsibility, fulfilled through the health subsystem and aimed at serving the needs of the SUS and the population.
Liberal Medicine advocates Community (LM-PC)	Led by medical entities, it is also composed of individuals who operate in institutional spaces within federal education and health administration areas, in Congress, in management of healthcare services, and in universities, both in the direction of Medicine courses and as lecturers or researchers, and in the direction of medical residency programs.	Historically hegemonic principles and policy propositions regarding the medical profession aim to uphold privileges by opposing changes in the status quo of medical training, supply, and regulation. The State should control the private education market, limiting the number of schools. Conversely, it should refrain from intervening in professional practice, the scope of practices within each profession, doctors' distribution, or medical training. Doctors should enjoy autonomy regarding medical training and professional practice and regarding the guidance, through their professional organizations, of directions for medical training and regulation of medical practices. They should also be free to preserve their job market.
Community in defense of Healthcare and Higher Education Market Regulation (MR-PC)	Economic actors from the private universities and medical-industrial complex, from financial capital in health services and their supporters in media, universities, and the Executive, Legislative, and Judicial branches.	The market and its mechanisms should regulate healthcare professionals' distribution, earnings, practice scope, training, number, and profile. Private initiative in education is a constitutional guarantee, and its regulation should be left to the market. State interference should be minimal, without the imposition of extra-market professional conditions to keep market stability or control prices of medical services.

Source: Adapted from Pinto<sup>3</sup> by the authors.

In this article, we analyze the influence of medical doctors as social stakeholders in developing the policy for regulation, training, and supply of doctors in Brazil. This analysis focuses on the years following 2003, when a group identified with the HRM-PC and interested in putting the HWP within the Unified Health System (SUS) scope took office at the Ministry of Health (MH). The group, however, met with resistance from the LM-PC. We argue that, due to their activities and privileged position in both the social structure and the current

institutional arrangement, doctors hindered changes in this arrangement and prevented the development of an HWP, even if wished by stakeholders who are well-positioned in the SUS hierarchy.

## Material and methods

This study uses the methodological approach of process tracing<sup>17</sup> to analyze documents, interview transcripts, and other

sources and to test a theory-derived hypothesis, to understand the actions of the Liberal Medicine policy community throughout the HWP. Considering the institutional arrangement that frames the HWP, the analysis was focused on the activities and goals of the LM-PC in keeping, changing, and recovering this policy in the 1960-2021 period. The documents examined comprise regulations of the HWP in the period (laws, decrees, ordinances, and resolutions) and materials published in the press and media outlets belonging to medical organizations.

Semi-structured interviews were conducted with 19 key informants (*table 1*) who held decision-making posts regarding the HWP in multilateral and governmental bodies during the 2003-2018 period, respectively, the starting year of the administration of the government coalition that produced significant changes in that policy – whose Ministry of Health administration was composed by members of the HRM-PC –, and the final year of the administration of another government coalition, which significantly reversed previous changes.

Table 1. Interviews

Position	2003-2010	2011-2013	2013-2018
High-ranking officials, the federal government	5	4	2
Middle-ranking officials and bureaucrats, the federal government	4	6	4
High-ranking representatives of state and municipal health secretariats	3	3	2
Members of the Senate and the House of Representatives	-	2	3
PAHO	1	-	1
<b>Total by period</b>	<b>13<sup>(1)</sup></b>	<b>15<sup>(1)</sup></b>	<b>12<sup>(1)</sup></b>

Source: Adapted by the authors from Pinto<sup>3</sup>.

<sup>(1)</sup> The total number of respondents was 19, but some held different posts in more than one period – among which a few held different posts in all three periods.

The theoretical framework that guided the analysis of the empirical material comes from the historical neo-institutionalism approach, which emphasizes historical legacies, assuming that previous events establish parameters and affect decisions, subsequent events, and the dynamics of the agent-structure relationship. It values the analysis of social stakeholders and their goals – which comprise interests and ideas – and the analysis of such stakeholders' stance on in a given institutional arrangement that allows them to manage rules and resources in order to achieve their goals<sup>18-20</sup>. The Theory of Gradual Institutional Change (TGIC)<sup>21</sup> was employed within that strand.

According to Roit and Bihan<sup>22</sup>, there is a distinction between (a) radical transformations brought about by exogenous shocks, (b)

institutional stability associated with endogenous and slow adaptations<sup>23</sup>, and (c) change processes that can be either incremental or radical and produce continuity or discontinuity<sup>24-26</sup>. The latter, comprising TGIC, comprehend change as a rupture of current balances due to exogenous or endogenous factors and emphasize how the political context, the institutional arrangements, and the veto power of the best-positioned actors inside such arrangements can influence not only changes but also the strategy of other actors. We used TGIC due to the characteristics of our research object: the long-term participation of medical doctors in developing a policy for regulation, training, and supply of doctors in Brazil, in which there were persistent policies but also changes due to incremental and exogenous factors.

Policy analysis has shown that medical associations strongly influence health policy decisions to the extent that they can veto any proposal they oppose<sup>27-29</sup>. The literature on veto power often emphasizes the role of veto players who hold key institutional posts<sup>30</sup>. However, others, such as Immergut<sup>28</sup>, refer to the importance of veto points within institutional structure<sup>31,32</sup> because it allows a focus on how collective stakeholders, such as medical associations, can exploit such points through lobbying, litigation, and other means.

## Results

The analysis of LM-PC actions led by medical associations showed that their primary goals related to the HWP during the studied period have been: 1) to implement a law regulating medical acts, preserving or even expanding the monopoly of professional practices; 2) to hinder measures that could increase the number of doctors in the workforce (which includes those who graduated abroad, whether Brazilian or foreigners); 3) to establish a moratorium regarding expanding university slots in Medical Schools; 4) to increase their control over specialist training; 5) to reject plans for doctor supply incompatible with doctors' freedom of choice; and 6) to create a national 'medical career' for primary health care.

In Brazil, medical associations hold a privileged place in the HWP's institutional arrangement when compared with the Ministry of Health, particularly regarding doctors' regulation, training, and supply. The National Congress legislates over professions, delegating their non-statutory regulation and oversight of professional councils, which are state bodies directed by peer-elected representatives.

The Ministry of Education (MEC) rules on undergraduate and post-graduate training levels, although with considerable participation of LM-PC representatives in forums aimed at technical analysis and decisions.

In institutional spaces such as the former Department of University Hospitals and the Expert Committee, both linked to the MEC Higher Education Secretariat, members of the LM-PC could veto proposals, and this position was often upheld by the Secretary or Minister of Education (Interviews 3;5;9;12;14;17;19).

The Ministry of Health is left with the decision to assess proposed changes to legislation in Congress regarding health professions and participate in the Ministry of Education's discussion forums, within which decisions about training are taken. The influence of the Ministry of Health on the HWP is relatively negligible compared to what is observed in most countries with broad health systems, such as Canada and Cuba in the American continent<sup>5,10,33,34</sup>.

The Liberal Medicine policy community has shown an action pattern since the 1960s<sup>35,36</sup>: it organizes lobbies in the Executive, Judicial and Legislative branches, mainly with peers holding posts in the Executive or Legislative seats; it keeps an essential proportion of medical doctor representatives in legislatures (in the 2003-2007 legislature, 71 of the 626 incumbent and substitute legislators in the Federal House of Representatives were medical doctors – 11.3%)<sup>37</sup>; it builds its presence in major media, forming opinions and is often recognized as more legitimate than government officials and other professionals when giving statements about health policies; it directs medical associations to defend what it sees as the profession's interests, and to persuade their associate members to do the same; its members hold seats in technical commissions and positions in the Government high and middle ranks with power to make decisions on 'medical subjects' that are conducted by the Health and Education ministries. The following excerpts illustrate how managers from the three levels of the Executive branch recognized LM-PC influence over the HWP from 2003 to 2018.

*The medical corporation posed significant corporate barriers inside the policy establishment. There was a perception of great strength and political power in the hands of the medical category, which we never dared to confront for fear of the consequences. (Interview 6, 08-02-2019).*

*Medical corporations were powerful; they controlled the training apparatus, held much weight in the National Council of Education, and made the training rules regarding medical residency. (Interview 9, 08-07-2019).*

*We evaluated [...] which initiatives [...] had better chances vis-à-vis the medical entities. [...] We would consider the possibilities that would not drastically confront them. (Interview 17, 06-01-2019).*

The interviews and the analysis of the composition of specific institutional spaces showed that the so-called 'medical corporation' exercised significant 'veto power', restricting the universe of possible policies. The former Department of University Hospitals and the Commission of Experts in the Secretariat of Higher Education, the National Commission for Medical Residency, and the National Council of Education are standing out among these spaces, all linked to the Ministry of Education. The Social Security and Family Commission of the House of Representatives also exists. Moreover, the interviews report significant political action by LM-PC members along with the Ministry of Education, the Ministry of Health, the Executive Office of the President, and the National Congress leaders to discourage measures they would oppose. Decision-makers say it was a common practice to give up measures that could meet LM-PC opposition (Interviews 3;5;8;9;12;13;15;17;19).

When a measure required a legislative act, LM-PC's influence and ability to block the measure's approval seemed even stronger since interviewed decision-makers considered that they would imply high political costs resulting from a public confrontation with the medical corporation (Interviews 3;5;6;9;12;13;15;16;17).

Such corporate power was strengthened due to the access and influence of LM-PC members on decision-makers by acting as their doctors or doctors of people around them (Interviews 2;3;6;9;12;13;16;17).

The main HWP programs implemented by the Ministry of Health from 1960 to 2002 were Project Rondon, Program of Inland Expansion of Health and Sanitation Actions (PIASS), SUS Inland Expansion Program (PISUS), and Healthcare Inland Expansion Program (PITS). These programs aimed to attract students, health technicians, and, for the latter two, doctors, nurses, and odontologists to serve primary health care in underserved areas. No action planned in their scope was contested by the LM-PC – none of them compelled doctors to work in underserved areas, altered the institutional arrangement that delegates the authorization for professional exercise to medical organizations, or even provided for the increase in the number of medical doctors in the workforce.

During the second presidential term of Fernando Henrique Cardoso (1998-2002), two initiatives defied these constraints of the LM-PC: the implementation of mandatory civil service and the permission for Cuban medical doctors to practice in Brazil – within cooperation agreements between Cuba and some Brazilian states (Acre, Pernambuco, Roraima, and Tocantins). In the first case, the federal government formulated the policy and opened it to debate, though it backed off when met with LM-PC opposition (Interviews 3;12). The second initiative allowed approximately 140 Cuban doctors to practice in 50 Brazilian cities for up to four years. However, the strong reaction of the LM-PC led the National Congress to revoke the 1974 Convention for the Recognition of Studies, Degrees, and Diplomas in Higher Education in Latin America and the Caribbean, thus interrupting and making the practice of Cuban doctors illegal<sup>3,36,38</sup>.

Between 2003 and 2010, when Lula da Silva became President through a government coalition led by the Workers' Party (PT), Ministry

of Health directors – most of them members of the HRM-PC – did not have enough strength to implement measures opposed by the LM-PC. Both mandatory civil service and international cooperation agreements on mutual diploma recognition between American countries returned to the government's agenda but were abandoned. The same occurred with attempts to increase the power of the MS in training the health workforce. On the other hand, voluntary enrollment for HWP programs was implemented, free of measures opposed by the LM-PC and awarding incentives to encourage doctors to work in underserved areas, such as discounts on their student loans. Incentives were also given to medical schools and residency programs that performed curricular reforms to adjust their training to SUS needs, as were the cases of the National Program for Professional Health Training Reorientation (Pró-Saúde) and National Supporting Program for Medical Specialists Training in Strategic Areas (Pró-Residência) (Interviews 3;8;9;12;13;17).

Only two initiatives that challenged LM-PC opposition were implemented in that period: The National Exam for Revalidating Medical Diplomas Issued by Foreign Higher Education Institutions (REVALIDA), and expanding slots in medical schools at universities to a higher level than tolerated by the LM-PC. The first initiative was implemented during the last year of President Lula's second tenure. The validation of foreign medical diplomas was on the President's agenda since the beginning of his first tenure, and he demanded a solution before the end of his second term (Interviews 3;9;12;13;17). Although slot expansion in undergraduate medical courses was not a specific goal, it was an outcome of substantial slot expansion in higher education, promoted by the government and strongly supported, both politically and economically, by the policy community that advocates for market regulation (MR-PC) (Interviews 12;17;19).

Differently, though, from 2011 to 2016, when Dilma Rousseff was President of the

government coalition led by the Workers' Party, some factors made the government increasingly propose and implement measures that met with intense opposition from the LM-PC. Such factors included the aggravated shortage of medical doctors in the National Unified Health System (SUS), the increased perception of this problem by the population and political agents, the failure of previous initiatives, the managing group's conviction that the problem should be addressed despite LM-PC opposition, and a favorable political context<sup>3</sup>.

In 2011, the Government implemented the Primary Healthcare Professionals Recognition Program (PROVAB), which offered doctors incentives to work in underserved areas. In the corporation's view, the LM-PC rejected it because one of the incentives interfered with the rules for doctor selection for specialist training, limiting its ability to control selection. The National Plan for Medical Education (PNEM) was proposed in 2012. It aimed to expand medical schools' public and private offers substantially. This could affect the medical job market by increasing supply and, as a result, reducing the professional's income.

In 2013, the government created the More Doctors Program (PMM), promoting an even more significant expansion in medical courses and specialist training (medical residency) slots. The program also changed rules for undergraduate courses and residency to better adapt them to SUS needs, promoted international recruitment of medical doctors, authorized doctors with non-validated diplomas to practice in the country, and allowed the celebration of cooperation agreements and international doctor exchange without requiring approval by Congress. PMM was the policy that faced the strongest reaction from the LM-PC in the whole period studied.

From 2016 to 2021, the LM-PC regained its influence over the government, following the overthrow of President Dilma Rousseff, with the change in the government coalition since President Michel Temer's inauguration, and

finally, with the new coalition change since the election of Jair Bolsonaro as President. In Bolsonaro's tenure, LM-PC leaders got to hold posts in government ministries, such as Henrique Mandetta (Minister of Health) and Mayra Pinheiro (Ministry of Health Secretary, responsible for the HWP). In this period, programs implemented since 2010 underwent significant changes that either interrupted them – as in the case of REVALIDA, PROVAB, and PNEM – or neutralized the activities opposed by the LM-PC, as with the PMM, which was reduced to national recruitment of Brazilian doctors. Bolsonaro's government announced the replacement of the PMM for the Doctors for Brazil Program (PMPB), launched with the support of the LM-PC. However, although the law that established the program was approved in 2019, its implementation only started in the last year of the Government, already close to the elections.

It is worth noting that the LM-PC failed to implement its priority propositions, which faced opposition from the government, the HRM-PC, or the MR-PC. Such propositions included the expansion of the monopoly on professional practices and the establishment of a unique national 'medical career'. Furthermore, the aforementioned policy community could not prevent undergraduate medical school slots in private universities from experiencing their most significant expansion in history from 2016 to 2021<sup>39</sup>.

## Discussion

This study's results confirm national and international literature findings regarding medical doctors' influence and significance as collective social stakeholders in formulating and implementing the HWP<sup>1,2,4-10,35,36</sup>. The study shows this power relates to elements widely described in literature<sup>5-10</sup>, such as the relationships the medical profession establishes within the social structure, the power delegated by the State to medical organizations, and their

political action. It also confirms the significance of other elements when explaining that influence, such as the presence and intervention of medical organizations in state spheres, mainly in the Executive and in the Legislative branches, in which they have veto power in the analysis of alternatives and policy formulation.

Three additional reasons for this influence, less explored in the literature, were observed. The study identified and analyzed the existence and operation of a policy community, the LM-PC, which has had a regular and influential action on the HWP during the last six decades. It also showed that considering the composition, operating modes, and goals advocated by this policy community helps us understand the Brazilian HWP trajectory better and anticipate measures that will – and indeed they will – face resistance from medical organizations. Secondly, the analysis of specificities of the Brazilian institutional arrangement related to the HWP helped revealed how medical associations operate to try to veto measures they oppose. Finally, it showed that formal and informal relationships established by LM-PC leaders with policy decision-makers are crucial to their influence.

The study traced some institutional spaces in which LM-PC most acted to try to veto measures contrary to its objectives. The fact, on the one hand, that acting in these spaces managed to block some policies for most of the period studied and, on the other, that overcoming this blockage involved modifying these spaces or withdrawing them from a place of decision reinforces the importance of these spaces as veto points<sup>21,27-32</sup>. The work of LM-PC in the former Department of University Hospitals, in the Expert Commission, and the National Commission of Medical Residency, all linked to the Secretariat of Higher Education of the MEC, managed to prevent changes in rules that favored a more significant opening of slots for graduation and residence by government initiative. The study showed that it was central to the significant expansion of undergraduate and residency vacancies at the PMM to change

the composition of the National Medical Residency Commission, increasing government representatives, and shifting decision-making power over undergraduate slots to the Secretariat for Regulation and Supervision of Higher Education of the MEC, which LM-PC and more by MR-PC less influenced.

Another example was the creation by the PMM Law of a new and parallel process for authorizing the practice of Medicine, concentrating decision-making power on the MS. Because in all other ways – for instance, diploma validation via a public university, evaluation and approval by REVALIDA, and authorization by the Medical Councils – the privileged position of LM-PC had allowed reducing to a minimum the work of doctors trained abroad in Brazil. Containing the increase in undergraduate slots and the number of doctors trained abroad and able to work in Brazil performed by the LM-PC since the 1980s, to make the aforementioned market reserve, contributed to the situation that justified the creation of the PMM in 2013, when Brazil had a ratio of 1.8 doctors/1,000 inhabitants, an average much lower than that observed in the OECD<sup>3,39</sup>.

The successful endeavors of LM-PC from 1960 to 2009 to block measures in the HWP contrary to their goals and positions is remarkable. They acted within the State, constraining the process of formulating and choosing alternatives and putting pressure on Executive and Legislative leaders to inhibit the proposition of unwanted changes. However, it is also relevant to point out that there are measures proposed by the LM-PC, which opposed proposals of the other two policy communities acting in the area – the HRM-PC and the MR-PC – that were not implemented. That is, the performance of these policy communities in the analyzed institutional arrangement showed a balance of forces that tended to institutional stability in most of the HWP trajectory.

This balance was modified from 2010 to 2016. The HRM-PC took over the MS in circumstances that allowed its action to overcome the influence of LM-PC and implement

policies opposed by the latter<sup>3</sup>. The PMM was the best example in this regard. Even so, the influence of LM-PC, and its strength in the institutional arrangement described, can once again be observed in the capacity of this community to interrupt policies and neutralize measures created between 2010 and 2016 as soon as the balance was reestablished after the deposition of President Dilma, with the consequent departure of the HRM-PC from the Ministry of Health managing board.

The analysis of this historical trajectory of the HWP, in the light of the Theory of Gradual Institutional Change, shows that there is indeed lasting institutional stability, in which actors who hold privileged posts in the current institutional arrangement act in veto points and exercise considerable power to block significant changes. It also shows that the only period of change – comprising only seven among the 60 years considered – resulted from a rupture in the institutional balance due to endogenous and exogenous factors. The HWP returned to its previous *status quo* once the balance favoring the LM-PC was reestablished.

## Conclusions

This article analyzed the influence of the medical corporation organized as a policy community on the development of the HWP in Brazil, particularly from 2003 to 2018. It found that the advantageous position in both the social structure and the current institutional arrangement of a policy community that advocates for Medicine's *status quo* as a liberal profession, the way it operates in the State – acting in some decisive veto points – and in civil society by putting pressure on leaders of the Executive and Legislative branches, explains its relative success in hindering changes in the HWP they do not concur.

The trajectory of the HWP in Brazil over the last 60 years shows remarkable institutional stability in which neither this community

allowed significant changes to take place, nor it managed to impose changes in its favor that were rejected by two other policy communities that acted in the HWP – one that defends the Brazilian health reform and another that defends that it is the market that should regulate the health and education sectors. The government could implement measures that had been proposed and blocked for decades only in seven years (2010-2016) through favorable circumstances that combined endogenous and exogenous factors to the PFTS. However, part of these measures was reversed again with

the change in the federal government and the privileged repositioning of that community in the institutional arrangement.

The analysis and results developed in this research can also support the understanding and analysis of other long-term policies in Brazil.

## Collaborators

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