DOI: 10.1590/1413-81232015219.16042016

ARTICLE

Analysis of the *Mais Médicos* (More Doctors) Program in terms of its institutional arrangements: sector cooperation, federative relations, social participations and territoriality

Gabriela Spanghero Lotta [1]
Maria Cristina Costa Pinto Galvão [2]
Arilson da Silva Favareto [1]

Abstract *This article analyzes the* Mais Médicos *(More Doctors) program based on the concept of an institutional arrangement, understood as the set of rules, organizations and processes that define the specific design of a given public policy, defining how it will articulate across players and interests. This concept will allow us to understand the dynamics of the players in this arrangement, as well as their governance, decision-making and governability, and how these factors reflect on public policy performance. A deeper analysis is based on four categories considered essential to understand an organizational arrangement in Brazil: sector cooperation (sometimes referred to as intersecoriality), federative relationships, social involvement and territoriality*.

Key words *Institutional arrangements*, Mais Médicos *program*

[1] Universidade Federal do ABC. R. Catequese 242, Jardim. 09090-400 Santo André SP Brasil. gabriela.lotta@gmail.com
[2] Secretaria de Planejamento e Gestão do Estado de São Paulo. São Paulo SP Brasil.

Introduction

Public policies permeate the relationship between the State and society, concretely affecting their quality and governing standards, and reflecting the political and institutional transformations underway. A historical analysis shows, in the modern state, a policy production rationale marked by a clear division between politicians and bureaucrats. Based on the Weberian concept of State, the original idea was that those responsible for formulating and implementing policies would be defined ahead of time, with policy formulation being the domain of politicians and implementation of bureaucrats, within the dichotomous relationship between policy and management. In this, context public policies were managed with no flexibility, and bureaucrats were left with faithfully implementing and complying with standard procedures that were indifferent to changes in scenario[1].

This pure bureaucracy model persisted in many countries throughout much of the 20th Century, but started to weaken in the 1980s, as the political-institutional environment became more complex. As Brazil returned to democracy, and with the 1988 Federal Constitution, a set of transformations by the State and society changed these relationships, especially in terms of public policy. The advent of more active and participative institutions, which until then had not existed, favored the permeability of the State and a dynamic for developing public policies with more control and involvement of civil society. Also, the relationship between the different spheres of government (state, city and federal) became more complex, as all of them acquired the ability to independently define policies. This gave rise to new political players in the development of public policy, removing from the State and Federal executive powers their role as the sole main player, reducing their tutelage over certain society groups that had been at the margins of the political game, but are now full players[2,3].

Given this situation, government administrator understanding of the new social dynamic is essential for formulating and implementing policies, and requires a multi-institutional view and the incorporation of the forces at work regarding that policy. Should this not happen, there is a real risk of failure. In this regard, numerous authors have shown that one of the central elements of the current public policy agenda is the concept of coordination, which is key to enable the State to cascade down to Society, and the development of public policies jointly by state and non-state players. Verhoest and Bouckaert[4], and Verhoest et al.[5] mention that, among the issues on this agenda of transformation of public administration, are the design or recovery of coordination systems and the need to ensure policy effectiveness, The authors point out that, although coordination is one of the oldest problems governments grapple with, it has become even broader given the increased complexity of the state apparatus. Addressing these new challenges includes the development of new institutional arrangements focused on governance. The central idea is that complex problems addressed by public policies require complex solutions that cover the diversity of players and decision-making processes.

Bearing in mind this context and assumptions, this article analyzes a dimension of public policies in complex environments that is often overlooked, but that may be essential to their outcome: the creation of institutional arrangements focused on increasing or strengthening the required coordination among the different players. We will do this by looking at the *Mais Médicos* program, highlighting the arrangement used for its implementation, its organization and unique characteristics, as well as the outlook for results, or the relationship between policy design and performance.

This article is split into four sections, plus this introduction. In the first section we will introduce the literature on new institutional arrangements and the analytical model that will guide our analyses of the program. The second section discusses the program structure and operation. The third has analyses of the different variables affecting the institutional arrangement. The fourth is a set of final considerations.

In terms of methodology, this study used analytical methodology based on secondary documents produced by experts in the *Mais Médicos* program, and legal texts and studies on the institutional arrangements used by recent governments to implement public policy.

Since 2011, technicians and researchers at UFABC, USP, FGV, IPEA and FUNDAP have analyzed how the Federal Government has structured itself to implement complex public policies.

Based on these reflections, we were able to extract categories and concepts to quantify the programs implemented, stressing their social permeability, the inclusion of institutional players, the degree of articulation between the sectors involved in the policies, and the fit between territorial specificities and program design.

Ciência & Saúde Coletiva, 21(9):2761-2772, 2016

The papers by these authors (see references), especially the text by Lotta and Favareto[3], summarizing this methodology, has been used as an important tool to analyze public policy institutional arrangements, such as the case of the *Mais Médicos* program, which here we also look at from the point of view of sector cooperation, involvement, inter-governability and territory.

New institutional arrangements - definition and analytical models

Studies on public policy design are scarce in the literature, as for a long time this variable has been considered of lesser importance by public policy formulators, and "resolved" by the existing structures within public administration. With the change in vision, we have incorporated the concept of institutional arrangements, broadly understood as the rules, organization and processes that define the specific design of a given public policy, and the articulation between the various players and interests.

Based on specific rules created for economic, political and social relationships and how they are coordinated, "stipulating who is qualified to participate in a given process, its object and goals, and the relationships between players"[2], it is possible to proceed with an analysis of the institutional arrangements, monitoring the variables most important to understand the role and interests of the players of this arrangement, and the articulation of governance, decision-making and player governability, and how these factors are reflected in the performance of public policies.

These same authors believe these arrangements incorporate advances in the technical/administrative and political capability of the state, specifically public policy design and enforcement, and the articulation, negotiation and coordination of the different players and interests. These capabilities are essential to understand the consistency of State development and legitimation of its technical role and its role to rally different interests around a common cause.

Broader and stronger coordination of public policy design are key for handling the complex environment in which these policies are formulated and implemented, and the specialization and differentiation developed by the States in the 20th Century, to the extent that increasing specialization and differentiation brings with it more need for coordination[6].

Lotta and Favareto[3] consider there are four categories essential to understand an organizational arrangement in Brazil: sector cooperation, federative relationships, social involvement and territoriality. The authors believe these dimensions determine the relationship and articulation of the different players involved in public policies.

The first dimension, *sector cooperation or horizontal articulation*, includes the coordination of the different government sectors in building solutions to overcome real problems[7]. It articulates the knowledge required to formulate, implement, monitor or assess public policies to provide multi-disciplinary responses to a problem found across government organizations: excessive specialization.

This rationale assumes the articulation of sector competences, programs or themes in public policy, focusing on the specific territory, target public or complex problem to be addressed[8].

Sector cooperation is therefore related to adjustments between players to produce interactions capable of delivering more favorable results to participants, in an attempt to minimize disturbances, resulting in increased consistency and limiting excesses, gaps and contradictions between and within policies[6].

The second category, *vertical or federative coordination*, has to do with the interaction between public policies and federative relationships, involving the federal, state and city governments.

The main question is the type of relationship and responsibilities of federative bodies within the process of formulating and implementing public policies, especially in terms of understanding the coordination of players of the three federative agents in promoting public policies. The Brazilian Constitution of 1988 decentralized the enforcement of a number of public policies, shifting responsibility to the states and cities, meanwhile defining rules and expanding the legislative authority of the Federal Government. According to Arretche[9], this created a situation of relative autonomy regarding public policy, with institutional mechanisms that limit the ability of local governments to make decisions regarding their activities, despite their political autonomy, as the Federal Government exerts a "powerful influence on the agenda and policies of sub-national governments";[9]

The third variable is the *territorial dimension*, which looks at the extent to which policies incorporate territorial considerations in their design and implementation. The theme of policy territoriality emerged in the literature at the end of the last century, the consequence of political assessments showing widespread differences in outcomes[10].

In addition to the broader relationship between public policies and territory, some authors stress the need to mobilize along the four dimensions of territory: inter-municipality, especially when planning investments in small cities and towns/regions, an inter-sectoral outlook coordinating interests and capabilities compatible with the specificities of local social structures, permeability, meaning the consideration of [local] interests, and the involvement of local social forces in planning and management mechanisms[10,11].

The fourth and last dimension is the *involvement of social players* in decision-making processes, and seeks to understand the insertion of different social players in the process of formulating, implementing and assessing public policies.

Stimulating involvement via the mechanisms (Management Boards, Conferences, Public Hearings, Ombudsmen and the like, such as negotiating desks, management committees, stakeholder meetings, etc.) defined in the 1988 Federal Constitutions has become a central element for democratizing policies and increasing their effectiveness. Furthermore, the very configuration of the arrangements leads to *ample negotiation and debate among the various players involved, further contributing to policy internal consistency* [...]. *Involvement may be understood as part of the process and of the actual content of a revised notion of development*[2].

However, despite the many participative institutions created in recent years in this country, assessments of involvement show it has not been incorporated in public policies, and even where it has, it has not always been effective in terms of making involvement democratic or promoting development[12].

The *Mais Médicos* Program: Structure, operation and institutional arrangements

The *Mais Médicos* program emerged in response to social demands at a time of crisis, culminating in the street protests of June and July 2013. The poor quality of public services was a common agenda across these public demonstrations at the time, with better healthcare one of the main claims. 2013 was also the first year of the mandate of numerous mayors and city councilmen, who also protested against the lack of doctors in regions that were less attractive to this type of professional. The main goals of the program are to expand basic healthcare for Brazil's citizens, create the conditions required to ensure qualified care by SUS, and humanize healthcare[13].

The program emerged from a diagnostic of the low ratio of doctors to inhabitants in Brazil and, above all, the huge inequality of doctor distribution by region, impacting primarily the North and Northeast, as shown in Figure 1.

Over time, the low doctor/inhabitant ratio and geographic inequality led to a number of government initiatives to address this situation, trying to take public policies to the interior. In 2013 however, it became clear that while more structured responses were needed over the medium and long terms, a short-term or immediate solution was also needed. This gave rise to *Mais Médicos* as a priority policy to address these problems, attempting to reach 2.7 medical professionals per 1,000 inhabitants by 2026. The program was created by articulating actions in the planning or execution phase that, combined, could provide short, medium and long-term answers to the problems affecting the healthcare area. Thus, although the combination constitutes a new program, the solutions it comprises had already been formulated individually, only waiting for the right time for implementation (a window of opportunity), based on a new arrangement. The issue is that given the urgency to launch the program, there was little time for a broader

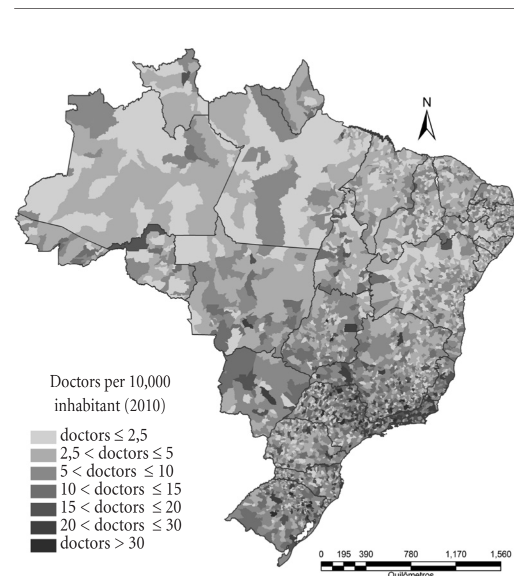

Figure 1. Doctors per inhabitant in Brazilian cities and towns (2010).

Source: Based on Datasus[10] data.

Ciência & Saúde Coletiva, 21(9):2761-2772, 2016

discussion with government sectors and society, which had a negative effect on planning and disclosing the program.

When it was launched in 2013, the *Mais Médicos* program was broadly criticized by the media, corporations and academia, but in a very limited manner. The discussion was limited to contracting foreign doctors, mostly from Cuba. However, this is just one dimension of the program, aimed at providing a short-term solution to the shortage of doctors. The program is structured along three dimensions[13]:

Dimension 1 - Emergency Provision – *Mais Médicos* Project

This is a short-term solution developed to increase the number of doctors in the Basic Healthcare Units, offering *18,240 positions* in *4,058 cities and towns* across the country, or 73% of the cities and 34 special Indigenous Health Districts (DSEIs). The call was for doctors trained in Brazil and other countries, who would be assigned to positions not filled by Brazilian doctors.

The WHO recommends that foreign doctors only be recruited from countries with a larger doctor/inhabitant ratio than Brazil (1.8). Doctors with degrees from well-known medical schools in their countries, with curricula similar to the curriculum of Brazilian medical schools and widely accepted worldwide, were chosen. In Brazil, these doctors were put through a basic care onboarding and assessment period lasting three weeks.

All cities and towns are eligible, so long as the program is not used to replace doctors already working in the location, and that the Ministry of Health analyze the availability of basic care and confirm the need. According to the program, criteria for filling these positions are:

- Cities with 20% or more of the population living in extreme poverty, low to very low HDI and located in the priority regions;
- Highly vulnerable areas of state capitals, metropolitan regions and cities with large populations but a low tax-base.
- Special Indigenous Health Districts.

Dimension 2 - Education

This dimension is related to the plan to expand medical education and residence, and the changes in doctor training. The goal of the Federal Government is to create 11.5 thousand new places in medical school, and 12.4 thousand new resident positions by 2017, within the broader proposal of geographic de-concentration.

The premise is that 80% of the population's healthcare problems can be resolved with prevention and patient follow-up. Thus, the actual practice of medicine by students in Basic Healthcare Units would become part of their education and training.

By 2017, some 12,372 new medical residence position should be available, funded by the Federal Government to make access of medical school graduates universal, initially prioritizing SUS specialties.

Dimension 3 – Infrastructure

In this dimension, the program calls for refurbishing, expanding and building UBS, Urgent Care Units (UPA) and hospitals. Over R$ 5 billion are being invested to fund 26 thousand jobs in almost 5 thousand cities. 10.5 thousand of these are ready and 10 thousand are under construction.

Coordination and Management

To enable implementing all three dimensions, the Program was formulated following incremental actions and re-articulation involving the Federal, State and City governments with a new proposal for coordination, which also involves a number of ministries, each with specific responsibilities:

- Ministry of Health: overall coordination of the Program and for Residence programs in General Family and Community Health Medicine within the health-school network.
- Ministry of Education: authorize medical schools and regulate curricular changes in medical residence programs.
- Ministry of Health and Ministry of Education: coordinate the activities required to sign the Organizational Agreements for Teaching-Health Public Actions and the *Mais Médicos* program.
- Ministry of Defense: transportation and support in national border areas.
- Ministry of Foreign Relations: articulation with other countries for professional visits and temporary visas for the legal dependents of foreign exchange physicians.
- Ministry of Labor and Ministry of Social Security: labor and social security matters.

The Ministries of Education and Health are primarily responsible for coordinating the program, and may issue additional rulings to comply with the laws that created it.

Physicians selected for the program have specialized in basic care in medical school, and have been supported by tutors linked to teaching institutions and supervisors lined to public universities, teaching hospitals, medical schools or medical residence programs.

Regarding the cities, states and federal district, they will participate in the program, but the Federal Government will be responsible for national coordination and for payment of the training grants and aid for moving from the physicians country of origin to Brazil, as well as the oversight and specialization of the physicians involved. State governments help the Federal government oversee and monitor compliance with Program rules and UBS working conditions, and follow up claims made against the cities and physicians. City and federal district governments are responsible for transportation and registration of physicians in the new Basic Care teams, and for ensuring housing and food.

In terms of organization, the overall coordination of the program is in the hands of DEPREPS (Department of Planning and Regulation of the Provision of Healthcare Professionals), part of the Ministry of Health Department for Health Management and Education.

Given its characteristics and complexity - a federative inter-sector program that takes place in low-income locations that are hard to reach, it requires a lot of coordination to answer question such as: interlocution between the Federal, state and city governments; relationships with other players; cultural differences; city fulfillment of their counterparty (food and housing for contracted physicians); implementation of a new curriculum grid by universities; the precarious conditions of a number of cities, in particular regarding their management capability, and bureaucratic issues involving foreign professionals. The institutional arrangement to promote coordination of the various players is therefore a key and determining element for the program's success, further discussed later in this document.

The existence and daring of the program has led to a number of problems, in particular the reaction of the Brazilian medical establishment to hiring foreign-trained professionals, misinformation regarding the program on the part of the population and the media, and the fact that the program hired only Cuban physicians. The Program is not limited to providing physicians, its training aspect is essential for effectiveness.

Regarding program assessment, a report prepared by the TCU (Federal Audit Court or *Tribunal de Contas da União*) after physicians were hired for 1,837 cities, found a 33% increase in monthly basic care visits, and 32% increase in home visits. Data from the *Mais Médicos* Program Observation Network, made up of 14 universities and research institutions, also found a 33% increase in the number of visits between January 2013 and 2015, in all of the cities that registered for the program.

As described above, the *Mais Médicos* Program has a complex rationale of coordination across different players within and between states. In order to operate therefore, it requires the ability for broad coordination and joint action by the various players and interests. Thus coordination process takes place through the program's institutional arrangements, which we will analyze using the methodology described above.

Analysis of the *Mais Médicos* Program Institutional Arrangements

Below we analyze each of the four dimensions listed in the first section, and related to the program's institutional arrangement. These analyses are consolidated in Table 1, in the attachments.

Sector cooperation

Sector cooperation is analyzed by checking the level of integration of the different sectors (ministries and organizations) involved in the program. We will analyze the existence of horizontal integration across the various policy phases: formulation, implementation and assessment.

In terms of sector cooperation in formulation, it is fair to say that the program fosters progress, as it emerges from joint and articulated actions taken by different ministries: Health and Education. Therefore, there is sector integration in formulating program rules.

Mais Médicos has also made progress in terms of implementation sector cooperation, considering the complex implementation structure involving a range of sectors and responsibilities. In addition to developing different players, the program advances to the extent that it builds or uses shared decision-making systems involving several players - such as the National Medical Residence

Ciência & Saúde Coletiva, 21(9):2761-2772, 2016

Committee, of which the Ministry of Health and of Education are members. Articulated activities between different ministries to find solutions to specific problems for a policy recognized as priority have also enabled inter-sector advances. We could mention, for instance, the involvement of different ministries to enable foreign physicians to work in this country.

Inter-sector progress however, is still limited when we look at the involvement of the various ministries in the entire public policy cycle. Although the ministries are involved in specific steps, the initial formulation and monitoring of the process are still sector-based, with the Ministry of Health and its logical and traditional structures playing the protagonist roles.

Federative relationships – vertical articulation

An analysis of vertical articulation looks at how the different federative agents are involved in the program, and the assignment of responsibility for policy regulation, funding and execution.

Looking at vertical articulation, we should first remember that the *Mais Médicos* Program was created by Law 12,871 of 22 October 2013, which in turn started out as a Provisional Measure giving the Ministries of Health and Education freedom to issue additional regulations to comply with the law. In other words, this is a program of the Federal Government. Meantime, physician availability in the various cities and towns is based on rules of other SUS programs and actions, which in turn are regulated in a cooperative and articulated manner with the cities and states in the CIBs and CITs (bi-partite and tri-partite inter-management committees). Thus, although the broader rules of the *Mais Médicos* program came from the Federal Government, its operation is also defined by shared regulations.

Financial responsibility for the program is largely the Federal Government's, which pays for the training grants, and for moving expenses. The cities must only ensure food and housing for the physicians. Funding is therefore largely federal.

Regarding program implementation, there is a clear division of responsibility between the three federative entities, which cooperate in execution. Their responsibilities break down as follows:

- Federal Government - The Ministries of Education and Health are primarily responsible for coordinating Program implementation, and supervising and training the physicians involved.
- State governments help the Federal government oversee and monitor compliance with Program rules and UBS working conditions, and for following up claims made against the cities and physicians.
- City and federal district governments are responsible for transportation and registration of physicians in the new Basic Care teams, and for ensuring housing and food.

It is fair to conclude that the Program has made significant progress in terms of coordinating the activities of the various federative players. The fact that it uses the SUS decision-making structure already gives it a broad advantage in this sense.

Involvement of non-state players

Analysis of the involvement of non-state players seeks to observe the extent to which the program arrangements make room for shared and participative decisions. This dimension is analyzed by looking at non-state player involvement in program formulation, implementation and assessment.

Regarding involvement in formulation, it is fair to say that given the emergency nature of the program launch, there really was no time for a broader discussion with government sectors and society, which had a negative effect on program planning and execution. In fact, non-involvement in program formulation is the source of several of the criticism the program suffered when it first started, as it was presented to the public in a segmented, limited and unclear way. We also see certain restrictions to getting involved in implementation, as it is limited to government agencies.

For monitoring and assessment, we not only have government agencies, but also the *Mais Médicos* Program Observation Network, which includes universities and research institutions. This is a "scientific network of researchers from teaching and research institutions across the country, in the format of integrated multi-center studies". Participating institutions: Universidade Federal (UF) do Rio Grande do Sul, UF da Paraíba, UF do Mato Grosso do Sul, UF da Fronteira Sul, UF do Pará, Fiocruz Manaus, Escola do Grupo Hospitalar Conceição, UF de Ciências de Saúde de Porto Alegre, UF de Minas Gerais, UF de São Carlos, UF de São Paulo, UF de Campina Grande e UF de Santa Maria, Instituto Federal do Rio Grande do Sul[14].

While direct involvement in management of the *Mais Médicos* program seems relatively

Chart 1. Analysis of the Institutional Arrangement Dimensions in PMM.

Horizontal integration (sector cooperation)	Vertical integration (federative subsidiarity)	Involvement dimension	Territorial dimension
Is policy formulation inter-sectoral? - It is an incremental policy born from rearticulating actions of the Ministries of Education and Health. Sector cooperation of formulation was limited due to incrementality.	Who is responsible for regulation? - The Ministries of Education and Health, formulation is the responsibility of the federal government (Provisional Measure).	Are players involved in policy formulation? - Because of the emergency nature of the program launch, there really was no time for a broader discussion with government sectors and society, which had a negative effect on program planning and execution.	How does the policy address the territorial dimension? - Priority criteria for allocating program physicians are based on a territorialized diagnostic.
Is policy implementation inter-sectoral? - Yes, especially coordination between Program activities and the responsibilities assigned to the different Ministries.	Who funds the policy? What is the funding instrument? - Funding is the responsibility of the Federal Government. Cities are responsible for providing food and lodging for the physicians.	Which players are involved in policy implementation? - Policy implementation is limited to government bodies.	Does the program include spaces for territorial involvement? (forums, boards, committees, collegiates) - Considering that this is a program within the Unified Healthcare System, territorial involvement is based on the areas already involved in policy formulation - Boards and Conferences
Is policy monitoring and assessment inter-sectoral? - To a limited extent, as it is included in the more traditional healthcare monitoring system using SUS tools.	Who implements the policy? - the federal, state and city governments as follows: The federal government coordinates program players and physician specialization and oversight. The state governments oversee compliance with the program rules and working conditions. The city governments are responsible for actions at the UBS level.	Which players are involved in policy assessment? - Monitoring and assessment are handled by the city (data gathering) and federal governments, who actually performs the assessments. A *Mais Médicos* Program Observation Network was created, made up of 14 universities and research institutions, to promote participative assessments.	Are there existing mechanisms of articulation/dialog/integration with other participating areas in the territories? - Articulation takes place with the SUS-related participating institutions that already exist in the territories.

Source: the authors.

Ciência & Saúde Coletiva, 21(9):2761-2772, 2016

limited, because it is part of SUS, the program benefits indirectly of the participation structure already built into the system, or in other words, the federal, state and city conferences and boards of health. Thus one could argue there is limited structure involvement in the program, but ample involvement via SUS institutional programs.

Territoriality

The last dimension analyzed is program territoriality, or the extent to which the program design includes the territorial dimension in its formulation, implementation and assessment. In order to analyze this last dimension, we must know how the initiative differentiates incentives and investments based on the geographic inequality of physician and healthcare services, so as to mobilize local social structure on behalf of the program strategy, which is involvement of players representative of local interests in designing and implementing initiatives.

To start with, we can say that the *Mais Médicos* has a territorial focus given that, as explained above, the geographic inequality of health and human development indicators is adopted as a criterion for focusing the program. Satisfying the shortage of professionals in certain areas of the country, traditionally short of physicians, is one of the key goals of the initiative, and a major contribution in the search for greater fundamental freedoms that today are limited. More recent developmental trends highlight that, among the fundamental capabilities for the exercise of freedom of choice, is avoiding early morbidity, which in turn requires access to medical knowledge and basic healthcare infrastructure. The Human Development index shows that in Brazil, where one is born and grows up limits access to these services from the onset, and the effects are cumulative in terms of developing cognitive and other skills that equally important for making individual choices. Addressing unequal distribution of healthcare services and equipment is one of the most virtuous manners of addressing territorial inequality.

Looking at the integration of the expected investments and incentives and local social structures reveals a certain ambiguity. On the one hand, the territory is seen as a passive entity, receiving program investments. There are no mechanisms to encourage integration with local structures such as universities or vocational training, both of which expanded greatly over the course of the past decade. On the other hand, especially as regards education, local structures such as the UPAs are part of existing programs to reinforce local infrastructure and capabilities. For this reason, it would be unfair to say that there is no territorial articulation. However, one would be correct in stating that there the existing vision focuses on short-term strategy - providing physicians -, and that because these territories traditionally lack this type of service and equipment, it is difficult to develop synergies with local structures. In any event, and this is closely related to other aspects analyzed in this paper, such as sector cooperation, some of the structures and spaces created in recent years could be better utilized and articulated on behalf of the milestones of this initiative. Finally, this same ambiguity reveals itself regarding the mechanisms of articulation with local players. One assumes the program will be monitored by the City Boards of Health and the conferences stipulated in the governance and social involvement in healthcare policy models. This could be considered something good, as one would not want to create new structures and forms of local player involvement to verbalize and forward their interests. In this case, one must know how the management of this program would be addressed within these spaces that already exist, and even if the program themes and problems would be handled by such forums and processes. In any event, considering that the program was designed centrally, the role assigned to these participative spaces is today limited at most to program execution, limited territorial adherence to one of the phases of the policy cycle.

Final Considerations

As shown from the start, given the importance and priority of the *Mais Médicos* Program, and its complex design, a central dimension to understand its operation is an analysis of the institutional arrangements that determine the players and processes to articulate and coordinate the Program. This analysis enabled a number of conclusions regarding how the program operates, a summary of which is presented below.

In the first place, it is important to point out that the Program has been successful to the extent that, overall, it is simple and efficient, and delivers quick wins. Although it delivers short-term emergency solutions (such as a larger number of physicians), it is structured to create medium and long-term solutions based on how physicians are trained in Brazil. The relative simplicity and ef-

fectiveness of these solutions resides in using the existing decentralized coordination structure of the SUS. Based on the already consolidated participating institutions (Boards of Health), on the federative logic in place (CIB, CIT, SUS funding), and on equipment already existing in the territories (UBS), the program is able to advance towards an effective solution without the need for significant new efforts. Therefore, it advances in terms of vertical and territorial articulation as it is incorporated into the SUS management logic.

Additional efforts required include building new arrangements for long-term policies and to attract and train physicians. These efforts are largely based on inter-sector and inter-organizational articulations with players that are key to the program's success. In other words, the program is successful at the federative and territorial level because it is based on the existing and consolidated structure of the SUS. It has had a significant measure of success in the inter-sectoral dimensions, creating a priority agenda that depends on ample articulation between sector players for which it has legitimacy.

It is fair to conclude, therefore, that to a considerable extent, the ability to articulate around the program and its solutions is due to the important place it occupies in the government's agenda, which fosters its ability to articulate and involve players. On the other hand, if we look at non-government player involvement, success is quite a bit more limited. The program did not advance in building new participative institutions, using those already existing in SUS. On the other hand, this might be a good strategy as it enables involvement with limited new effort. However, there was no room for involvement in program design, and even implementation and assessment are shadowed by other themes in which participative healthcare institutions are involved. The creation of the *Mais Médicos* Program Observation Network is further progress in this direction, but still relative as involvement is limited.

At the same time, it is worth mentioning that beyond the institutional arrangement, the program has also created a successful strategy to legitimize the nature of the solution proposed: a high-visibility, short-term solution and the perception, among a significant share of the country's population that access to physicians, formerly difficult and limited, is now direct and observable. In this way the program gains credibility and legitimacy with users as a quick and effective solution to part of the problem.

Ciência & Saúde Coletiva, 21(9):2761-2772, 2016

In closing, we would say that the *Mais Médicos* program offers important progress in the direction of access to basic healthcare in Brazil, while at the same time investing in long-term solutions to ensure quality of access. Part of this success lies in the way the institutional arrangement was structured, incorporating in a positive way (albeit with room for improvement); the dimensions of sector cooperation, federative relationships, territoriality and the involvement of non-state players. Thus we have demonstrated that the effectiveness of a program lies not only in the solution it proposes for an existing program, but in how it builds the institutional arrangements that will define which players will participate in the decision processes, and how they will participate.

Collaborations

GS Lotta, MCCP Galvão and AD Favareto participated equally in all steps of this paper.

References

1. Weber M. The essentials on Bureaucratic Organization: An Ideal-Type Construction. In: Robert K, Gray A, Hockey B, editors. *Reader in Bureaucracy*. New York: Columbia University, The Free Press; 1952. p. 18-28.
2. Gomide A, Pires R, organizadores. *Capacidades Estatais e Democracia. Arranjos Institucionais de políticas públicas*. Brasília: IPEA; 2014.
3. Lotta G, Favareto A. Desafios da integração nos novos arranjos institucionais de políticas públicas no Brasil. *Revista de Sociologia e Política* 2016; 24(57):49-65.
4. Verhoest K, Bouckaert G. Machinery of government and policy capacity: The effects of specialisation and coordination. In: Painter M, Pierre J, editors. *Challenges to state policy capacity: Global trends and comparative perspectives*. Basingstoke: Palgrave MacMillan; 2005. p. 92-111.
5. Verhoest K, Bouckaert G, Peters G. Janus-faced reorganization: specialization and coordination in four OECD countries in the period 1980-2005. *International Review of Administrative Sciences* 2007; 73(3):325-348.
6. Bouckaert G, Peters G, Verhoest K. The coordination of public sector organizations: shifting patterns of public management. Basingstoke: Palgrave McMillan; 2010.
7. Cunill Grau N. *La Intersectorialidad en el Gobierno y Gestión de la Política Social*. X Congreso Internacional del CLAD. Chile: CLAD; 2005.
8. Inojosa R. Intersetorialidade e um novo paradigma organizacional. *Revista de Administração Pública* 1998; 32(2):35-48.
9. Arretche M. *Democracia, federalismo e centralização no Brasil*. Rio de Janeiro: Fundação Getulio Vargas, Fiocruz; 2012.
10. Favareto A, Galvanese C, Barufi AM, Seifer P. *A dimensão territorial do desenvolvimento brasileiro recente (2000-2010)*. Santo André: UFABC, Cebrap, Rimisp; 2012. Relatório de Pesquisa. Projeto Coesão Territorial para o Desenvolvimento.
11. Abramovay R. Para uma teoria de los estúdios territoriales. In: Ortega AC, Almeida Filho N, organizadores. *Desenvolvimento territorial, segurança alimentar e economia solidária*. Campinas: Alínea; 2007. p. 19-38.
12. Coelho V, Favareto A. Dilemas da participação e desenvolvimento territorial. In: Dagnino E, Tatagiba L, organizadores. *Sociedade civil e participação*. Chapecó: Argos; 2007. p. 97-126
13. Brasil. Ministério da Saúde (MS). *Programa Mais Médicos*. [acessado 2016 mar 1]. http://maismedicos.gov.br
14. Brasil. Ministério da Saúde (MS). *Programa Mais Médicos – 2 anos*. [acessado 2016 mar 1]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/programa_mais_medicos_dois_anos.pdf

Article submitted 11/03/2016
Approved 14/06/2016
Final version submitted 16/06/2016