Analysis of the formulation process of the Mais Médicos Program

Análise do processo de formulação do Programa Mais Médicos

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Abstract

This study analyzes the formulation process of the More Doctors Program (*Programa Mais Médicos* - PMM), to answer the following questions: (1) Why was the PMM formulated with its specific format and (2) which actors, ideas, and institutions influenced its formulation process. To do so, we examine the solutions the public debate proposed to the medical supply and training insufficiencies from the 1960s until the creatin of the PMM. Based on process tracing, this study analyzed bibliographic, documentary, and interview data. Studies on political process and the theory of gradual institutional change formed its theoretical background. Results showed that the government significantly modified the program design from its proposal until its approval. The favorable scenario, characterized by the popular and political approval of the Program, together with its formulators' strategic actions, enabled the expansion of its scope, approaching the principles which the health movement policy community defended. Finally, previously implemented policies and its main formulators' ideas influenced its format.

Keywords: Human Resources for Health; Education, Medical; Public Policy.

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Resumo

O objetivo deste artigo é analisar o processo de formulação do Programa Mais Médicos (PMM). O estudo procurou responder: (1) Por que o PMM foi formulado com seu formato específico e (2) Quais atores, ideias e instituições influenciaram seu processo de formulação? Para isso, foram analisadas as soluções presentes no debate público para as insuficiências na oferta e formação de médicos, desde os anos 1960 até a criação do PMM. O método adotado foi de *process tracing,* com uso de análises bibliográfica, documental e de entrevistas. Foram utilizados, principalmente, os recursos teóricos oferecidos pelos estudos sobre processo político e a Teoria da Mudança Institucional Gradual. Dentre os principais resultados, destacam-se os seguintes: o desenho do programa foi modificado significativamente desde sua proposição pelo Poder Executivo até sua aprovação como lei; a conjuntura favorável, caracterizada pela aprovação popular e política do programa, junto à ação estratégica de seus formuladores, permitiu a ampliação de escopo, aproximando o PMM dos princípios defendidos pela Comunidade de Políticas Movimento Sanitário; o seu formato foi influenciado por políticas implementadas em períodos anteriores e por ideias defendidas anteriormente pelos seus principais formuladores.
Palavras-chave: Recursos Humanos em Saúde; Educação Médica; Política Pública.

Introduction

This study aims to analyze the formulation process of the More Doctors Program (*Programa Mais Médicos* - PMM) to understand why its implementation took its specific format and which actors, ideas, and institutions influenced its elaboration. The result of a doctoral thesis, this study refutes the view in the literature that the PMM suffered from a hasty formulation as an untimely response to the great 2013 June Journeys (*Jornadas de Junho*) demonstrations (Couto; Salty; Pereira, 2015; Pinto, 2021). On the contrary, we find evidence that its formulation took approximately a year and a half and based itself on historical legacies from decades of formulations and programs which sought to address weaknesses in medical supply and training. Moreover, we can only understand its format by analyzing the advocated ideas and its formulators' strategic action in a favorable political context, which enabled the resistance from medical entities to be overcome, reaching a format close to that proposed by sanitary community policies.

The policy issue regarding medical supply and training weaknesses is the subject of several studies and international recommendations from multilateral health organizations and has been in the Brazilian governmental discussion agenda since the late 1960s (Maciel, 2007). The Brazilian National Congress legislates on professions, and it is up to professional councils, such as the Federal Council of Medicine (CFM), to regulate and supervise professionals' performance. The Ministry of Education (MEC) decides on undergraduates and graduates' medical training (including residency). However, medical entities, such as the CFM and the Brazilian Medical Association, certify which physicians they recognize as specialists. Within this institutional arrangement, the Ministry of Health has little deciding power on policies for the medical workforce and its attributions; offering opinions on legislative changes dealing with the health professions in congress, participating in MEC discussion forums which deal with medical training, and proposing programs to stimulate physicians to act where the Brazilian National Health System (SUS) needs and to induce higher education institutions to implement changes to meet SUS needs (Pinto, 2021).

The concepts of political community and thematic networks are central to analyze the most relevant actors in assessed issue. Policy communities are cohesive groups of individual and collective actors with different institutional positions (State, market, and civil) and relations who share ideas and values; specialize on certain issues, designs, and results of sectoral policies; and coordinate themselves so their proposals and positions prevail in government (Côrtes; Lima, 2012). We also find thematic networks – groups with varying participation and interaction whose members engage, discuss, and formulate several solutions for themes lacking a consensus (Côrtes, 2009).

Since the 1980s, the Health Reform Movement Community (HRM-PC) (Côrtes, 2009), consisting of intellectuals, researchers, workers, SUS users and managers, and their organizations, has advocated universal access to health, the primacy of primary care, and the SUS role of "organizing health human resources policies." On the other hand, the Liberal Medicine advocates Community (LM-PC), consisting of medical entities and subjects from the Ministries of Health and Education in the national congress and in leading positions in higher education institutions, residency programs, and important public and private hospitals. It had been able to block changes to the status quo of the medical profession and its regulation (Pinto, 2021; Pinto; Côrtes, 2022a). The Community in defense of Market Regulation of Healthcare and Higher Education (MR-PC) (Pinto, 2021), consisting of economic actors from the medical-industrial-financial complex, private market entities, higher institutions, and their media, academia, and executive, legislative, and judiciary supporters, also acted in the PMM formulation process.

Since the 1960s, the LM-PC has opposed medical provision proposals that fail to respect professionals' free choice and include "national medical careers," advocating the regulation of the medical act to ensure its monopoly over the professional performance, pitting itself against the expansion of the number of medical degrees; defending its control over the training of specialists; and fighting against measures to increase the number of physicians in the labor market, which included authorizing physicians trained abroad (whether Brazilian or foreign) to work in Brazil. LM-PC articulates *lobbies* in the executive, judiciary, and legislative (mainly with professional colleagues); occupies institutional spaces in the State, especially in areas responsible for "medical matters;" influences or coerces professionals via medical entities; and addresses society by occupying communication vehicles (Campos, 1988; Carapinheiro, 2005; Gomes, 2016; Machado, 1997; Pinto, 2021).

Until 2010, with the exception of the expansion of medical degree vacancies in the 2000s and the creation of the National Medical Diploma Revalidation Exam (*Exame Nacional de Revalidação de Diplomas Médicos* - Revalida) in 2010, Ministry of Health leaders failed to change any medical workforce policy which opposed LM-PC objectives and ideas (Pinto; Côrtes, 2022a). New actors' support of the federal government in 2011, the increasing scarcity of physicians and its consequences, and its greater importance resulted in the government decision to exceed the limits established by the LM-PC and implement the primary care professional valorization program (*Programa de Valorização do Profissional da Atenção Básica* - Provab) in 2011 (which created a bonus in the medical residency competition to attract physicians to a provision program for underserved areas) and the National Medical Education Plan (*Plano Nacional de Educação Médica*) in 2012, which generated 1,063 health undergraduate vacancies (Pinto; Court, 2022b).

Due to the unsatisfactory results of the implemented actions, "policy entrepreneurs" sought and obtained President Dilma's support and, using the lessons of previous policies, began to formulate the PMM in February 2012. We understand policy entrepreneurs as key agents to create or seize "windows of opportunity" (fleeting opportunities in which new issues and solutions may gain policy makers' attention and enter the government agenda), give them visibility, and normalize their approach to issues (Kingdon, 2011). The 2013 conjuncture, which saw the inauguration of new mayors, the "June Journeys," and the approach of the 2014 elections, favored the launch of the PMM via a provisional measure, in July 2013 (Pinto, 2021; Pinto; Côrtes, 2022b).

In the National Congress, the process of converting MP-621/2013 resulted in law no. 12.871/2013,

which instituted the PMM on October 22. The program consisted of three axes: "Provision", which recruited national and foreign physicians to work in more than 4,000 underserved municipalities; "Infrastructure", which passed on resources to municipalities to build, expand, and reform their basic health units; and "Training", which expanded undergraduate and medical residency vacancies and created new curricular guidelines for medical graduation, integrating more training to SUS (Pinto, 2021).

Several studies have described the PMM, but few have analyzed its formulation process. We highlight, among them, one which focused on the role of scientific evidence (Oliveira *et al.*, 2018); another, on medical entities (Silva, 2018); and another, on the parliamentary process of turning the provisional measure into law (Couto; Salty; Pereira, 2015). Our original contribution is examining the PMM formulation process to assess the reasons the program has its instituted format and which actors, ideas, institutions, and events influenced its formulation. The following sections deal, respectively, with our methods, results, and discussion in light of the used theoretical framework.

Methods

This research was designed as a case study which used process tracing (Bennett; Checkel, 2015). This strategy examines historical trajectories, documents, interview transcriptions, and other sources to analyze whether the possible explanations which were derived from theories are valid or if they should be modified or refined, considering the various intervening variables in a case to identify chains and causation mechanisms. As shown in Chart 1, three hypothetical explanatory dimensions (which could explain the process) were analyzed: (1) actors (and their interests and ideas) in health and higher education subsystems who positioned themselves, problematized, and disputed the current policy; (2) changes in the institutional framework of these subsystems and the historical legacies which influenced the PMM formulation; (3) the political context, institutionalized relation patterns between government decision-makers and societal actors and actors' strategies in this political-institutional context. In the analyzed process, these factors alternated between themselves or were combined, affecting decision moments and decision-makers forming the PMM formulation trajectory.

Chart 1 – Evidence collection strategy

		Analyzed elements	Sources
Analytical dimensions	(1) individual and collective actors	Positions, objectives, ideas, proposals, and actions	Literature, several documents (press, civil or state agency resolutions), and interviews with leaders
	(2) institutional framework and historical legacies	Change and creation of programs and rules, associated ideas, and resource mobilization	Legislation, other official documents, literature, and interviews with leaders
	(3) Political context, institutionalized patterns of relations between government and society, and action strategies	Changes in the correlation of forces, relationships between decision-makers and societal actors, and strategies	Literature, media publications, and interviews with leaders
PMM trajectory		Changes in legislation, standards, and programs	Literature, legislation, official documents, and interviews with leaders

Our documentary analysis comprised Lula and Dilma's governments, from 2003 to 2016. Official documents – which standardized the health workforce policy (HWP) (laws, decrees, ordinances, resolutions, and other state files) –, those from civil society organizations (from medical entities on the "sanitary reform"), and actors' discourses (published in the media and by their own means) were examined. The literature on the HWP in the PMM formulation process, on the moment the Brazilian debate on the formation of health human resources was broadened (during the second half of the 20th century), and on how medical organizations positioned themselves on the issue was also analyzed.

Semi-structured interviews were conducted with 19 key informants who played a role in the governmental formulation of the HWP between 2003 and 2018. Their institutional positions are shown in Chart 2. Several subjects were found in many analyzed periods and 15 occupied decision-making positions between 2011 and 2013.

Chart 2 – Interviewees

Position	2003-2010	2011-2013	2013-2018
First echelon of the federal executive branch	5	4	2
Intermediate echelon and bureaucratic members of the federal executive branch	4	6	4
Leaders of representative entities of state and municipal health departments	3	3	2
House and Senate parliamentarians	-	2	3
PAHO	1	-	1
Total per period	13[1]	15[1]	12[1]

[1] In total, 19 people were interviewed but some occupied different positions in more than one period, whereas others had different positions in all periods.
Source: adapted from Pinto (2021)

Content analysis (Bardin, 2014) and political discourse (Fairclough; Fairclough, 2013) techniques were used in the interviews, building categories for cross-sectional analysis and discursive premises to understand actors' positions and actions. Our analysis was based on theoretical references of the political process (Birkland, 2016) and on the theory of gradual institutional change (Mahoney; Thelen, 2010). Studies on the political process were used to characterize the trajectories of social relations established between organizations and actors, individuals and collectives, and society and state, considering interests, ideas, and actions which were expressed under certain rules and contexts to influence the direction of public policies (Birkland, 2016). Based on the theory of gradual institutional change, institutions were analyzed as distributive instruments loaded with power implications and thus fraught with tensions. In theory, institutional rules enable certain dominant actors to design institutions which correspond to their preferences so they can achieve their objectives and maintain their privileged condition. However, maintaining the stability of this institutional arrangement requires the permanent mobilization of political support. Opportunities for change occur when a given balance is broken due to external or internal factors to the institutional arrangement. Thus, we must analyze both the institutional arrangement and actors' strategic actions in the political process to imbalance and seize political and institutional opportunities (Mahoney; Thelen, 2010).

Via this reference, we analyzed the trajectories to cope with medical supply and training weaknesses and the formulation of the HWP from the 1960s to 2013 in health and higher education subsystems. Subsystems are understood as stratified power structures that distribute unequal political and material resources; clash arenas between actors who advocate different solutions to public policy problems and mesosocial sectors which produce policies with relative autonomy regarding their political macrosystem and institutional arrangements, rules, and dynamics (Adam; Kriesi, 2007; True; Jones, Jones, Baumgartner, 2007). Our analysis (which took place from January 2011 to October 2013) was focused on the PMM formulation process and the

actors who formulated, positioned, and disputed the offered solutions, especially those belonging to the HRM- and LM-PCs, within a conflicting context which altered the balance of the involved forces and created political and institutional opportunities for change.

Results

Analyzing actors and their interests and ideas that acted in both subsystems is central to assess the forms the PMM took in MP-621/2013 and in its conversion into law no. 12.871/2013. In Dilma's government, some HRM-PC individuals, who had a history of joint action in student movements and in the medical education thematic network to promote medical education and profession reforms, assumed the direction of the Ministry of Health and strategic positions on MEC and the national congress (Pinto, 2021). These individuals, who strategically acted as entrepreneurs, led Provab in 2011 and coordinated the development and implementation of PMM, in line with proposals and ideas they had advocated since the 1990s. Among them, we highlight the then Minister Alexandre Padilha, Ministry Secretary Mozart Sales, and Mr. Rogério Carvalho, law rapporteur in the national congress (Interviews 1;2; 5;7; 10-12; 15-19).

Dominant among healthcare providers and controlling the regulation of its professional practice, the LM-PC saw Provab (especially the PMM) as threats. It was the main opponent of the program, developing a strong public clash, defending the status quo of the profession, and aiming to limit the scope of the PMM (Gomes, 2016; Silva, 2018; Pinto, 2021; Interviews 1-3; 5-8; 10-19).

MR-PC argued that it was up to the market and its mechanisms to regulate the distribution and remuneration of healthcare providers, the scope of their practices, their numbers, and training profile. MR-PC opposed both State intervention (which the HRM-PC advocated) and the constraints (which the LM-PC defended) which aimed to reserve the market and control prices for the workforce and medical services. MR-PC focused its action on the PMM training axis, ensuring that its measures to regulate medical undergraduate vacancies failed to challenge private higher education goals and ideas (Pinto, 2021; Interviews 1;12;15;16).

The HWP historical legacy is also essential to evaluate the PMM format. The literature on health human resources and multilateral organizations, such as the Pan American Health Organization (PAHO) and the World Health Organization (WHO), formed an ideational set which drew attention to the scarcity of physicians in several countries (hindering health care) and to programs which several regions in the world developed to address this issue, some in the 1930s (WHO, 2010). On the one hand, how HRM-PC entrepreneurs and members (many of whom belonged to the Human Resources Observatory Network - *Rede Observatório de Recursos Humanos*) supported the government with research – which they justified as promoting changes and proposing solutions (Interviews 1;2;5;10;18) – evinces the influence of their ideas on the PMM design. On the other, it shows the similarities between the proposals from the 2011 Provisioning Seminar (*Seminário de Provimento*) and the Provab and PMM structures. The Seminar, organized by the Ministry of Health, discussed national and foreign policies to address the issue, such as recruiting national and foreign physicians, granting scholarships for teaching-service integration, and incentivizing physicians to provision and training programs.

Previous programs which combined physician training and provision also influenced the PMM design. They began a trajectory of institutional learning with the Rondon Project (Projeto Rondon) in 1967, followed by the Health and Sanitation Interiorization Program (*Programa de Interiorização das Ações de Saúde e Saneamento*) in 1979, and the SUS Interiorization Program (*Programa de Interiorização do SUS*) in 1990. It then authorized Cuban physicians to work in the states of Tocantins, Acre, Roraima, and Pernambuco at the end of the 1990s and created, in 2001, the Health Work Interiorization Program (*Programa de Interiorização do Trabalho em Saúde*). Their insufficient results motivated the formulation and implementation of Provab, offering physicians all the benefits from the Health Work Interiorization Program - scholarships, specialization courses, remote tutoring, and housing assistance - plus an additional 10% score for admission to residence programs.

Provab mechanisms formed the basis of the PMM provision axis, together with the international recruitment of physicians (despite work permits) and the Ministry authorization for international cooperation, such as with PAHO and Cuba. This cooperation was a decisively strategic resource in the formulation of the program since, without the possibility of a large contingent of actionable physicians in case the recruitment of Brazilians and foreigners failed to meet municipal demands, it would hardly have jumped from Provab to PMM (Interviews 1;5;7;10;16;18). The threefold increase and incorporation of the Requalify-UBS Program (*Programa Requalifica-UBS*) budget built the infrastructure axis in 2011. It passed on resources to reform, expand, and build basic health units. This axis expanded Requalify-UBS, answering the LM-PC explanation for the low number of physicians in the most vulnerable areas of the country, i.e., the "precarious structure" of health services. The provisional measure training axis sought to overcome the limits in the expanded undergraduate vacancies since the Medical Education National Plan (*Plano Nacional de Educação Médica*), created in 2012, reached less than half of its goals in 2013. The PMM created a new regulation for private higher education institutes, guiding the private expansion of undergraduate vacancies to areas with social needs and establishing bold goals to publically expand undergraduate and residency vacancies.

The decision to recruit foreigners in the first quarter of 2012, due to the unsatisfactory results from Provab (Pinto; Côrtes, 2022b) required the legislation to be amended. However, moving the formulation from the executive to the legislative branch meant expanding the number and diversity of actors in the process. LM-PC strongly influenced the national congress, a usually conservative political arena, on issues regarding the maintenance of rules and professional privileges (Pinto, 2021). In June 2013, the government decided to launch the PMM, choosing to change the legislation via a provisional measure which (unlike a bill) has immediate effect but requires conversion into law within 180 days. The 2013 political context, marked by the "June Journeys" and the decreasing government approval caused the urgent need to implement the PMM. Interviewees claimed that the arrival of physicians to underserved areas would increase support for the program (Interviews 1;5;7;10;16;18), as the head of the Ministry of Health stated at the time: "an important calculation had been made [...] because we knew that what was going to turn the public opinion was the arrival of doctors to those places" (Interview 18).

Decisions to expand as much as possible the number of participating municipalities, physicians, and the infrastructure works in each of them also aimed to expand political support to face the public debate and favor the approval of the law in Congress (Pinto, 2021). The rapid and comprehensive implementation of the PMM affected public opinion and increased its social and political support, influencing parliamentarians' position on the program (Interviews 1;5-7;10;15;16;18). Along with other factors – such as entrepreneurs' strategies (1) to build a law based on consolidated legislation and regulatory standards and (2) to organize a defense of the program with legal institutions and control agencies (Interviews 5; 7; 10; 12) – the rapid implementation of the PMM also hindered its legal answer. Although actions against the program have been filed in various units of the federation, they avoided any legal setback in the year of its implementation (Pinto, 2021).

Entrepreneurs were able to maintain their leading role in the legislative due to two main factors: the organization of a strategic intelligence center which coordinated their actions in the executive and legislative and the fact that one entrepreneur, Deputy Rogério Carvalho, was its rapporteur (Interviews 7;10;15;16;18). Consistent with their medical education thematic network trajectories, entrepreneurs found a "window of opportunity" to broaden the PMM scope and include more measures on medical regulation and training in the law (Interviews 1;5;10;15;16;18), considering that opinion polls showed a progressive increase in popular support for the PMM (Pinto, 2021). This change relates to four elements: the effects of the PMM implementation; its media repercussion; the popular perception that Brazilian physicians refused to service the most vulnerable areas; and that corporate interests motivated medical "representatives'" criticisms (Pinto, 2021).

The decision to prioritize vacancy occupation – first by physicians registered in Brazil, followed by Brazilian physicians training abroad, foreign physicians, and, finally, physicians from the PAHO-Cuba cooperation – was important to build this perception about Brazilian physicians as they occupied only 6% of the vacancies opened in the first 2013 provision cycle. This helped convince the population that the "importing physicians" was a necessity, as a leader in the Ministry of Health shows:

> *That formula which prioritized Brazilian physicians was very intelligent* [...] *from a tactical point of view because everything demonstrated* [...] *that Brazilian physicians would not occupy [those vacancies]* [...] *But you have to make sure that Brazilian physicians were the first to be called and this, even politically, would demonstrate that it was not a Program to bring Cuban physicians [to Brazil].* (Interview 7)

The strategy the LM-PC adopted weakened its own position. The media highlighted it negatively, greatly impacting public opinion since hundreds of physicians were unable to act in the PMM since medical councils refused to issue them professional records (as provided for in the provisional measure) and scenes of physicians and representatives of state medical entities verbally assaulting Cuban workers. The literature shows that most major media outlets were abandoning the LM-PC arguments and helping to consolidate the image that its interest in criticizing the PMM was strictly corporate (Gomes, 2016; Menezes, 2018; Silva, 2018).

The federal government partially recovered popular approval in September 2013, characterizing the negotiation in Congress of changes to the provisional measure into law, increasing support for the PMM among mayors and public opinion, and strengthening the bloc favorable to the PMM approval, consisting of the HRM-PC, mayors, municipal health secretaries, and parliamentary supporters of the program (Pinto, 2021). As a majority formed in Congress in favor of the program, its opponents – LM-PC, including part of the medical bench and parties opposed to the government, especially *Democratas* and the *Partido da Social Democracia Brasileira* – began to negotiate changes in the bill and had to accept measures which they would reject in other circumstances.

During negotiations in Congress, entrepreneurs developed action strategies which are key to evaluate the format the PMM took in the approved law no. 12,871. It defined an essential core for the program operation and the government acted to prevent its change (Pinto, 2021). Thus, it rejected all amendments which tried to derail the provisional axis, such as requiring diploma revalidation from foreign physicians or attempts to prevent the Ministry of Health from signing international cooperation agreements (Oliveira *et al.*, 2017). Entrepreneurs took advantage of public opinion in favor of PMM and included provisions in the law to resolve conflicts with medicine boards in its initial implementation. They increased the power of the Ministry to regulate the medical labor market by including the competence of the Ministry to issue registrations authorizing the work of foreign physicians in Brazil in the law. Entrepreneurs perceived the negative reaction to the proposal of the "second cycle" (which extended medical courses by two years) and decided to use it as a diversion to replace it with measures to expand the scope of the PMM and regulate medical training and work. Other measures served as distractions, i.e., in parliamentary jargon, referring to something placed in a negotiation which draws agents' attention and becomes its main problem and thus the object of exchange. Examples include creating the National Forum to Order Health Human Resources (*Fórum Nacional de Ordenação de Recursos Humanos na Saúde*), which the law rapporteur proposed to regulate the practices of all healthcare providers. Other professional councils suspected of this measure and the LM-PC rejected it, as it would enable the Ministry of Health to transfer or divide activities currently practiced by physicians with other healthcare providers (Jornal Medicina, 2013). The negotiation to withdrawal these measures enabled the insertion of other expedients related to changes in graduation and residency and the creation of the Specialists' National Register (*Cadastro Nacional de Especialistas*), which made the axis training in the law reasonably different from that in the provisional measure.

However, although it failed to prevent the law passing, the LM-PC succeeded in suppressing some points included in the provisional measure, such as the "second cycle," blocking the entry of other agents (such as the Forum), and including measures which required concessions from Entrepreneurs, such as the delimitation of the foreign physicians' maximum numbers and working time. The interviewed leaders and parliamentarians said that the law could only be passed after an agreement with the LM-PC (represented mainly by the CFM), which signaled its support for the rapporteur's final version to parliamentarians (Interviews 5-7;10;15;18).

Discussion and final considerations

Our results challenge the view that PMM was hastily formulated to respond to the 2013 "June Journeys". Our analysis, which inserted the creation of the program in a past institutional trajectory and avoided focusing solely on the context of its launch, enabled us to consider historical legacies and political community actions (which have affected the HWP for decades, and strongly influenced its design) and the PMM formulation process, begun in February 2012.

According to Oliveira *et al.* (2018), ideas on health human resources, which several countries and multilateral agencies have discussed, influenced the PMM formulation. As certain evidence and proposals agree more with some actors' preferences and interests (Birkland, 2015), we had to analyze the relation of ideas with the goals, proposals, and actions political communities defended and developed over time.

Our bibliographical research showed that most studies analyzing PMM use the dyad "government-medical entities" and consider periods of up to four years (Pinto, 2021). Analyzing the actions of political communities over the last decades showed that their positions and actions were consistent and coherent and that their members shared ideas and proposals, defending them as they occupied institutional positions. We can claim that HRM-PC goals and ideas influenced the PMM design the most, which, in the case of its training axis, joined those of the medical education thematic network. Furthermore, we had to analyze the role of entrepreneurs who led the PMM formulation process to assess its decisive moments and fundamental characteristics. Studies, such as Gomes (2016) and Paula (2017), found these individuals as protagonists in the PMM implementation but ignored the analysis of their role in its formulation. Strategically positioned in the Ministry of Health, MEC, and the National Congress, since the beginning of Dilma's Government, they acted strategically to create and seize "windows of opportunity," aiming to change an institutional arrangement which had been stable until then (Pinto; Côrtes, 2021a). The entrepreneurs who were members of HRM-PC aimed to expand the scope of the PMM beyond the issue of physician scarcity, which originally motivated their entry into the government agenda. Universalizing residences, establishing new guidelines, and reformulating the evaluation of medical training in Law 12,871 exemplify propositions associated with the ideas and proposals entrepreneurs developed in experiences at the medical education thematic network in the 1990s.

Nevertheless, both LM- and MR-PCs had veto power due to the privileged positions they occupied in the institutional arrangement. Although it failed to prevent the approval of the law, we can only understand the PMM design by analyzing what the LM-PC managed to suppress, block, and include in it. The role of the MR-PC in the program design was more limited to the training axis, vetoing measures which would harm the private higher education interests.

Ideational and institutional legacies of previous studies, debates, formulations, and implementations on the HWP, influenced and gave political-institutional viability to the creation, first, of Provab, then of the PMM. Previouspolicies have promoted learning, created conditions for its implementation, and generated instruments which made the program feasible.

Despite of the expectation that, as the formulation arena moved to the National Congress, LM-PC ideas and proposals would alter the PMM design due to its influence in the legislative, which never occurred. The law received even more influence from the HRM-PC, creating instruments which expanded the state capacity to "order health training." The choice of MP format, the strategies for rapid and comprehensive implementation of the PMM

and negotiation in Congress, the LM-PC actions that created a negative image of its performance and positions with public opinion, and the growing popular support for it, were decisive both to approve the Law and to offer a second window of opportunity which expanded its scope with measures aimed at training and planning the health workforce.

Thus, our research showed that, to understand how it was possible to build the PMM with its specific design, we had to place, at the center of the analysis, the political context and the correlation of forces at certain moments of the PMM formulation process and the strategic actions of the actors at decisive moments of its construction. Therefore, this article aims to contribute to policy production focusing on the individuals and groups' role of the agency without ignoring the importance of macropolitical structures and processes.

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Authors' contribution

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