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The "Paulista way"; building collective health in the state of Sao Paulo, Brazil*

During the so-called Golden Age of the 50's through the 70's, new international relations and the technological strength that emerged from the 2nd World War, were the source of unprecedented wealth, spread (albeit unequally) worldwide[1] Within this background, new and strategic social demands surfaced in the medical arena, and specially in North America these demands were directed to the quest of technology for prevention[2-5]. The end of this Golden Age was also remarkable because of a gradual appearance of chronic and degenerative diseases in the landscape of population health, an exceptional challenge to the health system and its rising costs. Following this trend, the topic of prevention was gradually becoming apparent in the realms of research and medical education in partial and diverse expressions.

A meeting of representatives of the main North American medical schools in Colorado Springs, CO (1952) was a starting point for this movement[6] that later irradiated through similar meetings promoted by the Pan American Health Organization, gathering medical schools in different countries throughout the Americas[7].

This initial proposal was to promote a wide curriculum reform of medical courses, geared towards engendering a preventive attitude in future physicians[7,8]. It proposed a "Comprehensive Medicine", capable of integrating prevention and treatment in a coherent fashion, translated in the medical curriculum as Preventive Medicine[9].

Several international organizations jumped on this new doctrine, resulting in an internationalization of the Preventive Medicine, at this time already a clearly ideological movement. Throughout Europe, several Colorado Springs-type meeting were held in Nancy (France) in 1952 and Gothenburg (Sweden) in the following year, sponsored by the World Health Organization.

During the 60's the United States were shaken by diverse social and intellectual movements, concerned with the issue of human and social rights, that evolved into the debate of healthcare expansion and medically underserved populations. As a new emphasis of an aspect of the reforms of medical education and practice encompassed by the Colorado Springs Conference, it began to emerge the proposal of a so-called Community Medicine[2.]. It was based in the implementation of community health centers, funded by the government and managed by non-profit organizations delivering basic health care. The Community Medicine movement was thus able to put in practice several of the preventative principles, narrowing its actions on specific minority populations, thus leaving untouched the social hegemonic practice of the conventional medical care[10].

The preventative proposal was in short, an incentive to transform the professional practice of physicians, incorporating the social issues to their daily work, trying to identify a "health global status" and a comprehensive recovery of patients, using a new configuration of the medical activity. This medical activity was already considered at that time, a fragmented and unsatisfactory way of delivering healthcare. That holistic vision of individuals as a "bio-psycho-social whole", something innovative at the time, defined a conception of health and disease seen as dynamic states in continuous change, interacting with the environment. Thus, the idea of "cure" or alleviation of suffering was changed, and disease prevention was included into the list of medical activity goals[10].

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As the medical schools and the training of physicians mediated this new conception, there was a need of a reform of the existing educational standards, that was made explicit in the main pedagogic reorientation measures effective at that time. A deeper coordination, both horizontal and vertical of existent disciplines constituting the curriculum as an integration of separated fields of knowledge; and the introduction or highlighting of strategic disciplines such as Social Sciences, (basically as Behavioral Sciences), Epidemiology and Biostatistics. These new guidelines and discipline content were added to new pedagogic strategies such as teaching outside the hospital, contact with patients early in the course and in community settings, working with healthy individuals, among others. These guidelines were seen as educative practices that might help to form a holistic view of individuals, and also that those contents may be organized in departments of Preventive Medicine[6].

The American model was incorporated by the international health organizations, translating its doctrine core concepts to different contexts and needs where it may be potentially applied. From the WHO point of view, the so-called Community Medicine principles should stress the basic care dimension, specially in rural areas, with the aim of expanding health services coverage to previously excluded segments of population. In Latin America and specially Chile, Colombia and Brazil, North American foundations and PAHO sponsored this model, through programs that implemented community medicine as means of positive influence for the health systems in the continent..

The World Health Assembly in 1977 launched the Health for All in year 2000 motto (HFA-2000), through the adoption of a political proposal of expanding basic healthcare services coverage, using simplified care systems. In 1978, the International Health Conference on Primary Health Care, held in Alma Ata and organized by the WHO, reaffirmed that health is a human right and proposed Primary Care as a privileged strategy to achieve the HFA-2000 goals, incorporating tacitly elements of the community medicine discourse in the official WHO documents[11].

In this scenario, not exempt of criticism and counterproposals[12,13], the idea of a so-called Collective Health area was built in the Brazilian academic setting, both in research and in state-run health delivery organizations. It had, as Nunes (1994) points out, two key moments in 1977: the First National Meeting of Collective Health Graduate Programs, in Salvador, and the PAHO Sub-regional meeting on Public Health, organized jointly with the Latin American Association of Schools of Public Health (ALAESP), held in Ribeirao Preto. In Nunes[12] words:

> Both meetings had as purpose to redefine the health personnel training, and it was perceived the need of a new institution that may be able to gather together, through an association, the interests of the training institutions, at a time of exhaustion of an specific orientation, the one related to classic public health and social medicine. This particular context was crystallized in 1979 with the foundation of ABRASCO. (p. 15)

Is it possible that the Collective Health movement may have specific traits in different Brazilian regions, in spite of being from its beginning and until the second part of the 90's a national trend?

This was our primary question, in the origin of the research that focused in particular contexts in the state of Sao Paulo. Two different questions, characterized

as specific of Collective Health since its inception, point in this direction. First is the fact that even if it may be presented nowadays as an academic matter, Collective Health was historically rooted in the relation with health services, with the issue of expanding coverage vs. growing healthcare costs and with the need to have a rationale regarding the institutional duplicity of the public sector healthcare delivery system, as it had simultaneous responsibility by the Ministry of Health network (public health activities) and the welfare medical system, the individual medical care of workers, located in the Ministry of Welfare and Social Services during the 60's and 70's. The second issue is the fact that the preventative mindset of the 50's, as a transformative impulse calling for innovation in the approach to diseases and healthcare, was incorporated into Public Health and Medicine, forcing them to reform the professional training and the whole of care services. In this way, and not only because of types and volume of healthcare services, but also because of the number and quality of the health professional training institutions, the Brazilian regional realities were in themselves already very different.

Throughout this process, the Paulista institutions had a key and particular role in the national background. A recent approach to the issues relative to Public Health and Medicine in Sao Paulo show the particularities of settings and contributions of the Sao Paulo state, based in the critical analysis of the idea of a "Paulista way" ("Paulistanidade")[4], a concept that uses Sao Paulo as the symbolic trend of the country. As any other cultural reference, this is anchored in socio-economic specific traits of Sao Paulo and the materiality of the social practices that they produce, both for the region as well as for the country.

This approach is geared towards the comprehension of issues of the health area beyond their internal techno-scientific dimension, being it in a medical healthcare context or a public health context, as well as to understand the genuine "Paulista" contributions to the larger Brazilian society in this field. In this dimension it contradicts the vision of health as "a separate world", an isolated region inside society, neutral in relation to economic, political or ethical questions. On the opposite, this approach is in line with the critical thinking that, within Collective Health, points to the consubstantial nature of the technical matters with those of social nature, showing how in each specific way of being a medical or public health practice, there is a reproduction of the hegemonic way of life of society[2]. For this critical thinking, physicians as the first agents and original formulators of modern health practices in modernity, in their quality of "men of the state"[15] were historically (and still are) part of the collective responsible for the project of a modern country that Brazil in building as a nation.

In spite of the fact that Sao Paulo concentrates a large share of the Brazilian academic production, research has still scarcely examined its particularities in relation the beginnings of Collective Health. Most of historiography production was directed to the public health activities in the so-called Old Republic, 1899-1920, dealing with the homeland regeneration through the extinction of malaria and lifting the countryside population from their lethargy, as well as the "public health armies" in the urban settings, invading homes and streets, imposing improvements and diagnosing diseases[14,15-18]. Further than that, the historic studies analyzed the political shake-ups in public health structures and in Sao Paulo municipal and state health agencies during the 30's and 40's[19] as well as the new order that institutional and scientific philanthropy brought about, well exemplified by Rockefeller Foundation and the centralizing stance imposed in the Getulio Vargas ("Getulista") period[20].

There is a special consideration the "Years of Lead", between 1964 and 1985, and the "years of re-democratization", between 1985-2013, still scarcely explored through historical research, passing by what may be called the Paulista traces on Collective Health and its areas of action. In a succinct way, we intend to consider three orders of questions that influenced the emergence and development of Collective Health in Sao Paulo.

First, we note the fact that the 50's and 60's were the years of Paulista development, aiming to foster the development of the state countryside. This intention was associated with the preventative movement and its remarkable technologic innovation, creating a synergy for developmentalism. Reform in medical schools with novelties in training, popped out not only in the capital city, and were supported by agencies such as PAHO and WHO along with the opportunity brought by the creation of new medical schools. In spite of what was previously believed, this movement did not produce a homogeneous incorporation of prevention in medical training.

The previous existence of a relatively solid and well developed Public Health training, purporting a different vision of that of the medical actions in public health, as compared with those that were supposed to perform prevention through their individual medical care, was going to give birth to different thinking schools regarding to health prevention in Sao Paulo. Additionally, it is noteworthy that the Brazilian approach regarding preventative action –pioneered by Paulistas as Arouca[5] and Donnangelo[2] was highly critical to the individual focus in this approach, something that further amplified the range of thinking schools regarding prevention practices. In this way and even having implemented departments of preventive medicine in previous existent and new schools of medicine, and even though these departments were oriented by the same content and curriculum guidelines, those departments were differently permeated by the original preventative proposal. This original proposal was at times conceived in a more critical way or even through the specific way that the public health movement embodied prevention.

A second order of issues relates to the history of the construction of the health services network, and specifically in Primary Care, through the public sector in Sao Paulo. It had two different moments, before the inception and implementation of the Brazilian National Health Service (SUS) beginning in 1988. This situation is crucial to the characteristics of the network, and specifically to the technological and care services model that was implemented in the following expansion of coverage that Sao Paulo state developed between the 60's and the 90's. In that long period of time, the so-called Leser reform happened during two office tenures (1967-1971; 1975-1979) of Walter Sidney Pereira Leser, a Preventive Medicine professor in the Paulista School of Medicine (presently UNIFESP) that was the State Secretary for Health in those years. Additionally, the implementation of the Integrated Health Actions (AIS in Portuguese) in 1984 is simultaneous with the joining of the state and municipal health facilities with the Federal individual medical services. This process gathered together the services of the State Secretary of Health, the municipal services and the welfare medical services of the National Institute for Medical and Welfare Care (INAMPS in Portuguese) that was created in 1974, putting together a large network that was born in 1930-40 and largely developed from 1945 onwards.

Both situations show a quest to articulate in a single arrangement of service organization, or in a single technological and healthcare model, what we may

call as different institutional "callings", using implementation devices that were sometimes convergent, and some times opposing. Throughout the Leser Reform, that formulated a Health Programming Policy and had as foundations the technological model that integrated medical and public health approaches[21], this combination needed to be done between two types of care practice and technological arrangements: the pre-natal and child care, preventative in nature and performed by public health doctors and other practitioners in a team, with the medical care performed by infectologists, nurses and sanitary agents in household visits, acting upon the sick individuals recovery, at the same that intervening upon the healthy contacts in infectious diseases as TB, Leprosy and Trachoma.

Even though there are historical records of resistance and complaints over such integration, specially on the part of the doctors affected by the changes, both parties were in the Public Health field, one more on the disease treatment, the other more emphatic on prevention. In the AIS implementation, the abovementioned different "callings" were also present: on the one hand by the actions originated in the Health Programming looking for medical-public health integration that may constitute a future national health system; on the other hand, the individual medical care services, the curative type of the welfare outpatients' clinics that have no intention of leaving the purely medical field and its individual clinical actions.

In the capital city, where the services network was larger and more heterogeneous, with a strong presence of the elements of the welfare medicine, the trend was to push the services towards a pinpointed and mainly curative medicine through the so-called walk-in clinics. In this model there was a faster response to demands, not always acute, as could be suggested from the term "walk-in", and with very little expectation of follow-up, resulting in an episodic and highly simplified model of care. In the countryside there was a larger local political interest in establishing Health Centers and the trend moved in the direction of a prevalence of the traditional public health model combined with the Health Programming or a quite remarkably preventative care within Maternal and Child programs.

Being on one side or the other, the intentions of integrating medicine and public health were lost exactly when in 1990 the comprehensiveness became part of SUS principles. This SUS, that would suffer all kinds of resistance in Sao Paulo, is the third order of issues that give foundation to our approach to Sao Paulo specific aspects related to the emergence and development of Collective Health. Even if Collective Health is not restricted to SUS, its implementation features are a large part of its political and technical bets, and here again the "Paulista way" has a challenging expression: even though in other regions of the country, SUS was the first experience in expanding the public network, the SUS implementation in Sao Paulo faced the challenge of the pre-existent networks, already structured but presenting rationales and institutional cultures widely diverse.

Due to reality of traditionally well-established and consolidated care networks, the challenge of comprehensiveness was focused in the choice of technologic and healthcare models to be implemented and not so much in the articulation among the different institutions already in place in the health field as well as in its policies and programs. A specific example of this situation in Sao Paulo was the enhanced implementation of the Family Health Program/Strategy (FHS) in the lager urban core areas, through the Ministry of Health program "Expansion and Consolidation

of Family Health (PROESF). Under this program Sao Paulo will reveal itself as a mosaic of basic health units, among them some implementing the FHS model, others with incomplete teams, closer to the so-called PACS (Community Workers Program) and the remainder with different mixes of previously existent models, called "conventional" or sometimes "traditional" units

For better or worse, Sao Paulo presents its regional specificity, at times ahead of its time, in other circumstances resisting national proposals and projects, and forcing to have a careful look to the "Paulista way" phenomenon to be able to interpret the development of Collective Health in this land.

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