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NOVAS ESCOLAS MÉDICAS E REGIONALIZAÇÃO
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NOVAS ESCOLAS MÉDICAS E A REGIONALIZAÇÃO
NEW MEDICAL SCHOOLS AND REGIONALIZATION

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The concept of regionalization has in recent years become a central issue in the debate on organizing care in the SUS. One initial question is that this focus remains largely concentrated among the higher bureaucratic echelons and academia, meaning that the mentality of managers – and clinicians – continues to be pervaded by the perspective of decentralization and municipalization. This corresponds to asserting that technological incorporation is still considered by the Departments of Health very much in terms of 'municipal (or state) equipment', at the expense of a vision of interdependent and integrated regionalized networks. There is a further serious problem for this regional, strategic task, evidently charged to the academia: the reality is that the concept of regionalization has yet to be frankly engaged in dialogue with the 21st century.

The notion of regionalization per se is not a new one. Defended since the first half of the 20th century, it gained greater exposure from the late 1960s onwards, years of thriving discussions regarding health planning.\(^\text{10}\) It is noteworthy that since it was first put forward the idea has remained tightly bound to the medical education system, including community outreach and graduate programs.\(^\text{4,14}\)

In Brazil the historical incorporation of regionalization into the public health argument has followed a path common to the field, whereby the concept is molded into an administrative framework of the bureaucratic thinking in health, and is basically restricted to a plan that could be treated as intra-sectorial. It is, therefore, progressively removed from a farther-reaching ideal of interactions, not only of medical training, but also of other regional proposals and designs in the areas of education, agriculture, work, citizenship, etc. (this rationale is mediated by the concept of 'integration', which, similarly, when restricted to the field obscures the idea of integrating the health sector with other productive sectors of society – seen back in the 1970s by Reinaldo Ramos as 'intersectorial' integration \(^\text{13,p.5}\) – and also contributes to the limited strategic vision of science, technology and innovation in sanitary thinking of subsequent decades).

As is known, despite being incorporated into the SUS principles, the regional approach was eclipsed in the 1980s-90s by the historical window which opened the door to the municipalization of the system, in synergy with the old municipalist ambition.\(^\text{10,16}\) Its political rehabilitation can be followed specifically through the
ministerial directives and their mish-mash of acronyms that brought us the NOAS, PDR, PDI, PPI, Pact, CIB, CGR, CIRS, COAP, etc. However, this dynamic - spanning a period of more than a decade as from the introduction of the NOAS (Operational Standards for Health Care) – was not accompanied to the same degree in the intellectual sphere; with the development of the SUS being repressed by the difficulty in identifying audacious currents.

The essential analysis of the conditioning and determinant factors for regional cooperation and coordination in health demonstrates a whole multidimensional range of challenges in view of the Brazilian interfederative framework. But, roughly speaking, this analytical body gives little importance to the academic role in this process, especially of education (might the saying 'out of sight, out of mind' be appropriate?). On the contrary, here the academic role and responsibility is understood as key to the regionalization process, from its educative basis to its ongoing development of the concept, unveiling new theoretical strands, processes and technologies.

The MoreDoctors for Brazil Program - with its dozens of new courses to instil a vibrant institutional culture - should be viewed in terms of its huge potential to induce Science, Technology and Innovation in Health (STIH). It is set to offer 11,500 places on medicine courses over the next two years and a similar amount in specialist training courses by 2020. In this regard, it is worth looking at the options of the Federal University of ABC.

In view of this rare historical window that has opened – not at any time, but during an extremely rare global epistemological rupture – the health sector should be intensively taught and learned (and apprehended) as a powerful regional and productive health complex. However, even that would not be enough, for it is fundamental to ask the question: what is the scale and magnitude of the epistemic gamble in this new process?

This text does not intend to cover such a vast field, but can at least raise the seemingly most urgent questions that stir debate. For starters, there should be no doubt that the scale of transformation must be systemic and global. The theoretical model proposed by Hartz and Contrandiopoulos helps illustrate this intention, as it clarifies the size of
the problem. The normative, functional integration of the clinical and care team represents the most diverse social, professional and political dimensions, and relates governance, technical capacities and representations of values. Yet, in a reorganization it would be challenging to supplant the idea of a closed, mechanical and binary model and without any clear regional dimension of interdependence.

On the other hand, how can we propose a new episteme if we only learn to think bureaucratically in terms of protocols, decrees, departments and governmental agencies? Not that this is expendable, it is of great value, but clearly insufficient for the current diagnosis, and already anachronous at a very brief glance.

Let us now list therefore some ideas for debating the required academic role:

**Teaching hospitals**

Teaching hospitals play a central role in the regional model of health care services. Strictly speaking, one could say that without a teaching hospital, or the equivalent, no regionalization is possible (a matter which should not be confused with individual care, which prioritizes primary health care and opposed to the hospital-centric care model). In time, every hospital linked to new courses should have the regional outline and understanding formally shaping their institutional culture (mission, values, charters, etc.).

**Teaching-Learning**

The new courses already offer the benefit of a pedagogical standard based on active methodologies. However, the tool ought not to be confused with the design. It is quite possible to reinforce archaic structures with new tools. There is also no universal tool; not only does a construction need a complete tool kit but, for those vanguardists, it also needs to develop many other tools of its own.

With the suitable tools, an ambitious curricular matrix should guide the pedagogical project toward current and future needs. One of the severe challenges is the excess of class time Brazilian students are required to fulfill when contrasted with the international model - in indirect correlation to study hours. Such passivity resonates in the designs of national training in CTI (a common theme in lectures related to
Outside the classroom, in addition to an adequate study load, why not develop problem situations which would require in loco visits or interviews; as could be the case for the CIRs (Regional Intermanagerial Commissions)? Schedule participation in planning. Furthermore, considering the whole multiprofessional and intersectorial contribution, let us think of curricula that are genuinely centrifugal as opposed to the centralizing learning of the current model. To do this it may be necessary to consider the course from back to front, that is, starting at the endpoint - the professional inserted into a regionalized system - and from there designing the curricular path incrementally. Such stages to be completed in the various regional instruments – in a health system-based vision of the curriculum – allow the student to gain a first-hand, practical understanding of the necessary regional integration. Indirectly, two unprecedented benefits may also be achieved. Firstly, instilling in the rawest possible manner the pressing need for policies and criteria to incorporate technologies into the health system. And, in another regard, the regional combination of undergraduate, graduate and community outreach training is propitious to the prevalence of an ‘us' culture in place of the current 'I and them' relationship.

**Epistemology**

Herein lies the great challenge, since any sectorial outlook is found within a global epistemological transition. And a few lines about the issue will always result in serious reductionism.

From a specific and sectorial viewpoint, it is important to supplant the old compartmentalization in the primary, secondary and tertiary system. Currently the smallest part of the system, that is, the smallest autonomous subsystem unit, corresponds to each of the people involved at that moment. Without doubt the vision of protocol-regulated mechanical systems must be refined by the influence of adaptive complex systems. All this is aimed at collective needs, but now also centered on user expectations (consumer-driven health systems). The need for basic technological enhancement of care in relation to technologies available on an everyday basis in

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*For example, the lecture by Marcio de Castro Silva Filho, CAPES director of Programs and Grants in Brazil (DPB), at the Universidade Católica de Santos, Santos-SP, on 26 November 2014.*
other industries sees the distances grow with each passing day. As one of the best-known North American assessments of this matter concludes, it's as if we need to break the sound barrier and only have a Model T Ford available. The possibilities of 'disruptive technologies' are unlimited. Without needing to go into more depth here, some preliminary considerations about the opportunity for STIH and primary health care, an elementary basis for health training, can be found in the text cited above.

From another angle, the technological perspective should be compared to the humanistic approach. There is no way of going against innovation, on it the country's technological independence relies (and on that the social policies depend). But innovation presupposes market relations, which incite the financial dimension, which in turn unveils accumulative actions. On this side, there is the known strong market appeal so that consumption in the health sector becomes as natural as in any other. This resonates with the wise words of Frei Betto, who foresees the new global epistemology as driven toward the total commercialization of man, nature and their relations; and with an antithesis of medical humanization that comes about precisely through the commercialization of medicine. Therefore, although potentially inbuilt to regionalization is the whole discussion of curricula, complexity and STIH, regionalization by itself cannot face its own obstacles. And the new episteme urges of medicine major systematization and arrangement of the field of bioethics and social equality. To defend the patient from the excesses of the system, from medicalization, from disease mongering and overdiagnosis; and the system itself from purely commercial trap.

Final considerations

This essay resulted from the authors' teaching experience and dialogue in relation to the proposals and role of new, or planned, medical courses, made in field visits connected to the "Region and Networks Project" and others, such as new course assessment visits by the MEC (Brazilian Ministry of Education). As mentioned above, the text intends to encourage the field of medical education – and other health fields,

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Lecture at the More Doctors Program Conference. UNIFESP, 11/02/2015.
connected by the departments of preventive medicine/collective health – to go beyond the polarization of tools (for example, active methodologies, simulation), processes (for example, integration, coordination) and knowledge (primary versus specialized care); all of which are important but insufficient for the 21st century. Within this objective, three major concepts are identified as pervading the new curricula: 'Regionalization', as the smallest unit of complexity of the comprehensive system; 'Bioethics', as a field for the protection of humanistic principles; and 'Equity', as a foundation for the construction of the social role of medicine.
References


