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The socio-ecological and primary care approach to the creation of universal health systems in the work of Hernán San Martin

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Abstract *This article describes the contributions of Chilean physician San Martín Ferrari (1915-200), arguing that they constitute important cornerstones in collective health in Brazil, Latin America, and the Iberian Peninsula. His work is reviewed, establishing a dialog with the current theoretical research in this field and the context of contemporary health systems. Two main aspects are emphasized: the innovation of San Martín in insisting on the importance of analyses that incorporate the relationship between environment and health; and his role in the creation of the Chilean and the Spanish National Health Services. Although they arose in distinct moments and had different trajectories, these systems constitute examples for the creation of universal public health systems, such as the Brazilian health reform and the ongoing challenge to improve the Unified Health System. The analysis of his work and biography contribute elements for the comparative study of these reforms, as well as an eco-systemic approach to health.*

Key words *Environmental, Health systems, Primary care*

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Introduction

The builders of our field of collective health are many, but surely Hernán San Martín Ferrari laid the foundation for many of them, in Brazil as much as in Latin America and the Iberian Peninsula. For many years, his book *Health and Sickness*[1] has been the main treatise of reference on the subject. Published originally in Cuba (1962), it was released in Mexico in 1964 with successive reprintings in 1968, 1975, 1981, and 1995. In 1970, a second edition of this book was the subject of a review in the periodical *Milbank Quarterly*[2] which emphasized one of the central ideas of the work of San Martín: health and sickness are not opposite states but gradations in a constant process of adaptation of man to his environment. Medicine's integration with other sciences would be vital for its future, shifting from the individual to the social in such a way as to measure, interpret, and act on the factors that interfere in this process.

Comprised of forty-five topics organized in six sections, the book shows a rare equilibrium between classic technical content and a broad approach to the theme. The first section, "Man – goal of medicine and of the health sciences," considers the topics of ecology, social sciences, and human behavior. The section on preventive medicine includes mental health and sexology, while the section on the environment begins with a discussion of climate and health that has only recently received wider attention. In the final sections, "Health planning and administration" and "The role of medicine in society," we also find innovative themes for the era.

It is possible that part of the book's pioneering production can be explained by particularities of the economic, political, and social context of Latin America and Chile during this period. This context facilitated the creation of a Chilean national health service begun in 1952, the second after the National Health Service (NHS) of the United Kingdom, icon of a socialized healthcare organization. However, it is also necessary to know some aspects of San Martin's personal and professional trajectory to understand his expansive way of understanding the production of health and sickness in our societies.

Trained in medicine at the University of Chile in Santiago in 1943, he completes a master's in public health at a young age at Johns Hopkins University. In returning to Chile, he becomes director of the center for infectious diseases at the regional hospital of Concepción, and in 1947 becomes Local Health Director for this region. After the creation of the National Health Service in 1952, he will begin the organization of a local health system oriented by the principles of community health in collaboration with the University of Concepción. He works as a lecturer and, later, as director of the Department of Preventative and Social Medicine of this university (1960), completes a doctorate in social anthropology in England. This path led him to work as a consultant for international organizations and as a lecturer in Mexico (Universidad de Nuevo León, Monterrey) and in South Asia (the Medical Colleges of Rangoon, currently Myanmar, and of Surabaya in Indonesia). At the time of the military coup of 1973, he worked as the Chilean ambassador to Zambia, from where he departed for a long but productive exile in Paris. One of the trademarks of his personality was to cultivate permanent interactions with artistic expressions such as theater, folklore, literature, and poetry. In Concepción he participated in founding the university theater, acted as director of the Haulpén Museum (*Parque Museo Pedro del Rio Zanãrtu*), and in 1962 received the Municipal Award in Art and Literature for his book titled "Travels through the Universal Art," available even today on international sites[3].

What should we prioritize in the legacy of a life with so many diverse experiences? We choose to emphasize two aspects of his contribution that are in dialogue with current preoccupations in the field of public health. The first refers to the innovation of San Martin in insisting on the importance of ecology or of analysis that incorporates the relationship of the environment to health, and the second deals with his role in the creation of a national health service and system in Chile and Spain. Although they came into being in distinct moments and had different trajectories[4,5], these systems were examples for universal systems with integral care that seek to reduce inequalities, as in the case of Brazilian healthcare reform and the ongoing challenge of improving the Unified Health System or SUS.

The broad understanding of the health-sickness process and the importance of integrating the economic, cultural, and ecological dimension in the analysis of social development

The concepts of public health, preventative medicine, and social medicine open the first section of *Health and Sickness,* addressing one of the

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principal debates that characterized the decade of the 1970s in our country. The well-known thesis, "The Preventivist Dilemma: A Contribution to the Understanding and Critique of Preventive Medicine," defended by Sérgio Arouca[6] in 1975, is a point of reference for this moment. This conjuncture is described well by Nunes[7] in situating the adoption of the term collective health in our country. While San Martín cites classic references on the origins of the expression "social medicine," he considers its emergence to be a response to the development model:

It could not be any other way, since the moment that the majority of problems in health and sickness have been a consequence of man's social organization. In practice, this has produced a conflict between our biology and social organization…[1]

The insistence on the importance of the fields of ecology and anthropology for the understanding of the phenomena of health and sickness was central to the trajectory of San Martin, demonstrating the pioneering innovation of this theoretical orientation and his proposals. In 1979, he published the book *Human Ecology and Health,* defending the idea that:

As an ecological unit, man should always be understood and studied in relation to his total environment. Ecology shows us the complex structure, the constant variation, and the dynamic of the unit (live being and environment), as well as the multicausality of all biological phenomenon[8].

The notion of the individual as an independent being on Earth would be a dangerous misconception for our future as a species. It would signify ignoring the cluster of existing ecosystems in nature and their extraordinary equilibrium which, while in constant variation, allows for all life. Yet, our singularity as *homo sapiens* means that the evolution of human beings would be much more the result of a historical-cultural process than a biological one. Although ongoing, the first happens in a rhythm much slower than the second. The benchmark of ecology would be indispensable "because everything indicates that we are close to reaching the limits of our adaptive capacity faced with an ecological environment modified and transformed to our detriment"[8].

Returning this theme to the framework laid out in *World Crisis in Health*[9]*,* he intensifies his dialog with Latin American social epidemiology. He analyzes the origins and context of this crisis beginning with the three main themes in the determination of health: the ecological relation between population and environment; the social system of production and consumption; and the socio-cultural system. He warns us of the fact that the use of analytical categories such as social class, mode of production, and economic dependence of populations should show the biological correlate of these determinants:

It is possible that this correspondence is produced via the life conditions of the population (living standard and way of living), understood as a materialization of them in an individual related in a historically determined and specific way to other individuals and to a given social structure, a materialization that is expressed in many and varied forms (attitudes, ideologies, behaviors, etc.)[9].

The notion of social determination broadening the notion of causality stimulated a broader debate, and there remain unresolved questions regarding the mediation between social process and those of a biological order. Yet it is interesting to note that there is an overlap of some of his ideas with the more recent literature on the social determination of health[10]. For San Martín, it was necessary to consider the enormous complexity of a combination of factors that include socio-economic considerations and living standards, but also aspects such as satisfaction with work, mental health, and cultural ties[11].

Another interesting dialogue in his work is with the field of health promotion. In order to address the discussion of the limits of the anti-ecological, productivist development model, he will deal with the theme in a different way from the well-known Lalonde report[12], published in Canada in 1974. According to this Report, the improvement of the health status of populations is to be related to four main factors: human biology, lifestyle, environment, and the organization of services.

Although it had been considered characteristic of health promotion policies to defend the limited role of services, this was the target of criticism within Canada. It was alleged that it justified an important reduction of federal resources for the provincial health systems, as well as deflecting responsibility for health maintenance to the sphere of individual behavior[13].

San Martin joins the debate by delving into the genesis and modeling of human behavior, showing how the influences of the socio-cultural system impact individual and collective health:

…there are notable differences in the behavior of animals depending on their degree of differentiation. But their basis is always the same: genetic, ecological, and acquired by learning. Where man differs from the other animals is that we are dealing with behavior of a type that is greatly varied,

creative, and not always related to the interests of his species[11].

A long evolutionary process allowed us to develop language, memory, intelligence, consciousness, and abstraction until we arrived at the development of culture. Old behaviors with genetic and ecological roots were substituted by others learned in relation to an environment increasingly less natural and which became socio-cultural. Human conduct, however, is a dynamic process that changes and adapts to a social structure that is also dynamic. For this reason, San Martín argued:

… the chain of causality that begins with the economic, social, and cultural structure continues in the possibilities and risks that exist in the life environment as products of economic activity, continue in the social-professional and cultural condition of every individual and group, and finally in the relation produced via the behavioral response of each group and individual. In this sequence we clearly observe the secondary role and its influential, non-productive factor that human behavior has on health[11].

In one of his final books, published at the end of the 1980s, he goes on to insist on the importance of the environment in the analysis that he called "socioecological system of the health-sickness process in human societies"[14].

Some decades have passed, and the questions regarding the environment have become the subject of important international meetings, are part of academia, and occupy the attention of mainstream media. However, as Minayo[15] argues, the necessary relationship between environment and health is still tenuous.

Documents on the creation of public systems oriented toward primary care

In addition to his varied theoretical and teaching activity, San Martín had a direct involvement in the construction of new practices of service organization that became benchmarks for national health reform, including in Brazil. These are: the experience of community health developed in Concepción, Chile, between 1952 and 1973, participation in the implementation of the National Health Service interrupted by the military coup in 1973, and the creation of the Spanish National Health System beginning with the redemocratization of this country in 1982.

The content and elements of the Concepción experience correspond to proposals that circulated throughout various countries in the decades of 1960-1970. They introduced ideas of the rationalization of practices (community as the foundation of health needs, coordination and integration of care) associated with a greater democratization of services (work teams, community agents, expansion of access and participation)[1,9,11]. They coincide with the ideas with which SUS engaged in making the consideration of the family health strategy and primary health care (APS) as a policy for changing the care model into a reality.

They incorporated old traditions of the field of collective health such as medical police, local integrated service provision for the poor, and the organization of coordinated, regional care contemplated in the Dawson Report (United Kingdom, 1920)[16]. They were revitalized by community-driven activities of North American Departments of Preventative Medicine, informing a variety of actions, from counter-hegemonic community health projects in Latin America to health reforms in countries like Canada (Quebec Province) and Mozambique[17].

The work developed in Concepción sought to implement new practices to support the political project of the creation of a National Health Service (SNS). The SNS began in 1952 with a reform effort that unified medical support services with those of public health. However, it did not manage to modify the funding standards nor universalize social security. The project - spearheaded by physician, senator and ex-Minister of Health and Social Welfare, Salvador Allende – faced strong opposition from conservative sectors and corporate doctors. After Allende is elected president of the country, he tries to negotiate the founding of a unified health system. But the situation grew increasingly hostile, culminating in the military coup of 1973, and the beginning of a reform based on privatization. This reform deepened social stratification and stimulated the market which created a dual system, a characteristic that would end up prevailing in the reforms carried out across Latin America, although with distinct causes and trajectories[4,5].

It was participation in the Murialdo community health project of the Rio Grande do Sul Secretary of Health, one of the many initiatives of this type carried out in Brazil at that time, which allowed me to work with and learn from Professor San Martín. I sought him out because he was part of the teaching faculty of the Institute of Economic and Social Development (IEDES) at the *Université de Paris I, Sorbonne,* where I began a doctorate in 1978. He surprised me with his simplicity that contrasted with the French aca-

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demic formalism of the time, and his enthusiasm when I explained where I had worked and what I wished to study. I had found an interlocutor in a France that had kept itself apart from the proposals of primary care for many decades.

The Murialdo project was a unifying center for similar projects carried out in other Brazilian municipalities and for the creation of the Brazilian Society of General Community Medicine (currently the Brazilian Society of Family and Community Medicine). The description of this project and the actions which made it viable were incorporated into the book *The World Health Crisis*, in the section *Strategies and Response Techniques to Problems in Health,* considered as an innovative project that "for its continuity is permitting the development of its own operational model of the concrete reality of labor, whose components can be useful to other experiences of community health in other countries"[1]. In fact this is just what occurred, as the works of San Martín came to contribute to a relevant orientation in the movement for the creation of a Spanish National Health System (SNS).

The 1978 Constitution and the General Health Law (LGS) promulgated in 1986 were legal supports for the organization of this system. However, it is interesting to note that primary care reform preceded this process, granting an important hallmark to Spanish health reform. In 1984, the Decree of Basic Health Infrastructure led to the establishment of Health Centers on a model influenced by national and international experiences from previous decades[5]. In this context, San Martín's activity intensified, publishing works that could support this process, as was the case with the book titled "Community Health: Theory and Practice"[18].

The concluding section of the first and second edition of his work on the world crisis of health furnishes an important historical registry of the creation of the SNS. It includes testimonies by three Spanish professors[19-21] that analyze the health situation and discuss strategies for change. This material confirms the involvement of important political and social actors in this reform movement. Thus, Yuste Grijalba[19]affirms

We have worked in this way for a long time, with the collaboration of Hernán San Martín in the platforms offered by the General Workers Union and some health working groups of the Spanish Socialist Workers Party; and the theses that were generated in these works were presented to the Congress of the General Union, the Health Federation, and the XXIX Congress of the PSOE.

When the PSOE comes to power in 1982, in addition to the creation of an integrated and universal health service, its governing platform contains specific operational details such as: concerted health care with criteria of complementarity, reform of the public hospitals with more autonomy and quality control, and work teams in health centers with full-time professionals[20]. In this sense, another interesting aspect to emphasize in the Spanish reform was the intensity of the training process of family and community doctors who, to the rhythm of 500 openings per year, benefited the changes in services, which added to the professionals in public health[5]. The implementation of the SNS was evidently not exempt from problems, but today the system constitutes an example of the viability of public systems oriented by primary health care.

Final considerations

Even in the adversity of exile, San Martín maintained hope in the construction of more just and healthy societies. A tireless worker, he brought his ideas to fruition without losing sight of the consistency between theory and practice, since his contribution to the Spanish National Health System gave continuity to what he could not achieve in his country.

The analysis of his work constitutes interesting material for comparative studies of health reform. Some elements in the Spanish case are emphasized, among them the participation of important social actors (political parties, large central unions, health workers) and the prioritization of effective changes in the assistance model. These elements should be recalled in guiding new processes of this type, or in formulating the maintenance of strategies for the improvement of access and quality in the Brazilian Unified Health System.

Health and Sickness certainly represented an important reference for many of the pioneers of Brazilian collective health as one of the main books in the field in the decades of 1960-1970. However, San Martín did not have any direct intervention in our country, perhaps because he was distant from Latin America during his exile or because he prioritized his focus on the reform that occurred in Spain.

There is a doubt that emerges in the review carried out here: what motives can explain the restricted diffusion in Brazil of the innumerable books he published in the decade of the 1980s?

More specifically, the socio-ecological framework that he knew how to defend in such an innovative way? Aside from those already mentioned, other hypotheses can be considered such as, for example, the significant publishing of books by European presses with distribution geared toward Spanish-language countries in the pre-internet era. Also, the relatively late discussion of this approach in a country where the health care movement, from 1980 to the middle of the 1990s, concentrated its efforts on advancing political-institutional aspects of health care reform. The rediscovery of his writings can enrich the work of those interested in the theme of health and the environment. To keep alive what should not be forgotten is an important contribution of this new section.

References

1. San Martín H. *Salud y Enfermedad.* 4ª ed. México: La Prensa Médica Mexicana; 1981.
2. Teruel J. Review: Salud y Enfermedad by Hernan San Martin. *Milbank Quarterly* 1970; 48(3):373-378.
3. San Martín H. *Viajes a traves del arte universal*. Concepción: Universidad de Concepción; 1962.
4. Labra ME. Política e saúde no Chile e no Brasil. Contribuições para uma comparação. *Cien Saude Colet* 2001; 6(2):361-376.
5. Conill EM. Sistemas Comparados de Saúde. In: Campos GWS, Bonfim JRA, Minayo MCS, Akerman M, Júnior MD, Carvalho YM, organizadores. *Tratado de Saúde Coletiva*. 2ª ed. São Paulo: Hucitec; 2012. p. 623-631.
6. Arouca ASS. *O dilema preventivista. Contribuição para a compreensão e crítica da medicina preventiva* [tese]. Campinas: Universidade Estadual de Campinas; 1975.
7. Nunes ED. Saúde Coletiva: uma história recente de um passado remoto. In: Campos GWS, Bonfim JRA, Minayo MCS, Akerman M, Júnior MD, Carvalho YM, organizadores. *Tratado de Saúde Coletiva*. 2ª ed. São Paulo: Hucitec; 2012. p. 17-37.
8. San Martín H. *Ecologia humana y salud.* México: La Prensa Médica Mexicana; 1979.
9. San Martín H. *La crisis mundial de la salud. problemas actuales de epidemiologia social*. Madrid: Editorial Karpos S.A.; 1982.
10. Carvalho AI, Buss PM. Determinantes sociais na saúde, na doença e na intervenção In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI. *Políticas e sistemas de saúde no Brasil*. 2ª ed. Rio de Janeiro: Ed. Fiocruz; 2012. p. 121-142.
11. San Martín H. *La crisis mundial de la salud. Problemas actuales de epidemiologia social.* 2ª ed. Madrid: Editorial Ciencia 3; 1985.
12. Lalonde M. *A new perspective on the health of Canadians. A working document.* Ottawa: Minister of Supply and Services of Canada; 1974. [documento na Internet]. 2008 [acessado 2015 set 10]. Disponível em: http://www.phac-aspc.gc.ca/ph-sp/pdf/perspect-eng.pdf
13. Conill EM. *Les Implications de la Santé Communautaire en tant que Nouvelle Politique de Santé: Analyse du Cas du Québec* [thèse]. Paris: Institut D'Étude du Développement Economique et Social, Université de Paris I-Sorbonne; 1982.
14. San Martín H. *Manual de Salud Pública y Medicina Preventiva.* 2ª ed. Paris: Masson S.A.; 1989.
15. Minayo MC. Saúde e ambiente. Uma relação necessária. In: Campos GWS, Bonfim JRA, Minayo MCS, Akerman M, Júnior MD, Carvalho YM, organizadores. *Tratado de Saúde Coletiva*. 2ª ed. São Paulo: Hucitec; 2012. p. 79-108.
16. Gran Bretaña. Ministerio de la Salud. *Informe Dawson sobre el futuro de los servicios médicos y afines,*1920. Washington: OPS/OMS; 1964. Publicación científica 93.
17. Conill EM. Sobre a necessidade de legitimar as práticas de atenção primária. *Saúde em debate* 2012; 36(94):355-357.
18. San Martin H, Pastor V. *Salud comunitaria. Teoria y Practica.* Madrid: Ediciones Diaz de Santos S.A; 1984.
19. Yuste Grijalba FJ. La crisis de la salud en el mundo: España dos años después. In: San Martín H. *La crisis mundial de la salud. Problemas actuales de epidemiologia social.* 2ª ed. Madrid: Editorial Ciencia 3; 1985. p. 753-759.
20. Pastor y Aldeguer V. La crisis mundial de la salud en España. In: San Martín H. *La crisis mundial de la salud. Problemas actuales de epidemiologia social.* 2ª ed. Madrid: Editorial Ciencia 3; 1985. p. 761-770.
21. Miguel JM. La crisis actual de la salud en España. In: San Martín H, organizador. *La crisis mundial de la salud. Problemas actuales de epidemiologia social.* 2ª ed. Madrid: Editorial Ciencia 3; 1985. p. 771-784.

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