PRESENTATION

This issue of **Interface** presents us with texts analyzing the possibility of the Family Health Program (*PSF – Programa de Saúde da Família*) contributing to the development of a new paradigm for the Single Healthcare System (*SUS – Sistema Único de Saúde*) and the training of healthcare workers. In addition to the dossier on the Family Healthcare Program and the Debates on Permanent Healthcare Education, the magazine offers an analysis of scientific production about drug use prevention programs, as well as articles focusing on those who are the subjects of healthcare practices, regardless of whether they are overlooked by the hegemonic medical model, such as mothers or senior citizens, or whether they are subject to the arenas of learning and interchange between professors and students.

The Dossier texts cast a glance over the healthcare services system in Brazil from the standpoint of care models, highlighting challenges to the realization of the principle of integrality in the production of care. They recognize the Family Healthcare Program as one of the strategies for reorienting the care model, although it has showed itself incapable, thus far, of enabling a rupture from the hegemonic model. In the words of Scherer et al, (2005): *either the Single Healthcare System (SUS) becomes consolidated and its principles and guidelines are respected, through the effective implementation of its operating strategies, such as the Family Health Program, or the dominant clinical / biological / Flexnerian model will be maintained.* As for the article of Iêda da Silva and Leny Trad, in problematizing the technical articulation of and the interaction between the agents-subjects in teamwork, it casts a light upon aspects of the issue that transcend the Family Health Program, pointing to the problematics of this way of working in the healthcare field in contemporary capitalist societies.

I recognize that the Family Health Program is one of the most successful public policies implemented in Brazil, not only because of the quantitative dimensions it has reached, but above all because of the new relations is has established in the construction of the Single Healthcare System. Despite its expansion and advances, however, it remains subject to hegemonic healthcare policies. Even in towns regarded as exemplary and among teams recognized as the most developed ones, one can see there is a gap between reality and the proposals put forth by the Ministry of Health, with severe effects on day-to-day work. The program's insufficient coverage in the face of a haphazard occupation of urban space and of the expansion of poverty penalizes the teams that are committed to its ideas and to the quality of care, tending to enhance a narrow focus, to the detriment of policies that radicalize the project of Brazilian Sanitary Reform.

Working with almost two thousand registered families and carrying out 14 consultations in four-hour shifts means slipping back to the "prehistoric" problems of care models and reproducing the "inattentive model" that is currently in force, thereby discrediting the Family Health Program in the eyes of the population. As the patient goes round and round emergency rooms and the family health unit that was unable to solve his problem, the entire line of discourse underlying the program becomes demoralized and the ethical and political project of the proponents and heads of the Single Healthcare System (SUS) become disqualified. If the criteria, agents and conducts employed in the sorting process do not undergo a critical examination by and a discussion with the community, how can one imagine that people who are both sick and in a frail position will be happy to accept that they will not be seen to, especially when children, pregnant women or urgencies are involved? What are the technical difficulties that still stand in the way of making appointments for a set time? How can one accept that the same number of consultations be established for a Family Health Program professional and for a conventional basic unit? In sum, unless infrastructure issues are overcome, how can one face new issues regarding the promotion of health, the prevention of damage and risks and the fostering of overall care, including psychosocial aspects?

Organized offerings and vigilance of health issues do not constitute a proposal for changing care models in order to rationalize or reduce care costs, but for changing the rationality or, at the very least, enabling a more rational use of resources, with a view to attaining greater effectiveness. Draconic routines that establish that 50% of the dental slots must be allocated to the zero to 14 years of age group, that only ensure one return for the other age groups and that establish a monthly quota of consultations and procedures for each team where specialized care is concerned can only generate stress among committed workers, conflict among the team members and loss of the legitimacy of the Family Health Program among citizens.

The tensions observed in the day-to-day life of the teams and the participation of the subjects in planning the work, especially local work and municipal work, pose new questions regarding the removal of obstructions to the transformation of team agents into historical subjects–agents. Instead of contraposing communicative action to strategic action, the daily activities of the services can be thought of as a political arena for the establishment of

social relations focused on the emancipation of the subjects. To this end, hindrances in the construction of a common care project must be faced. A supervision of a political, pedagogical and technical nature must be considered by those responsible for the Family Health Program. An awareness of the power of the work may suggest certain paths that transcend educational and cultural aspects in the organization of public healthcare and replace political action in the institutional quotidian and "cost-benefit" calculations worked out by the subjects as part of their choices. Thus, democratic control over the work process cannot be snatched. The issue is not the top-down internal control of the nurse over the nursing aides and community healthcare agents, the process whereby the dentist's and the physician's work is carried out being ignored, but team supervision alternatives capable of problematizing the authoritarianism of professionals and even of community healthcare agents vis à vis the users and of fostering the values of subject autonomy and emancipation.

Regarding this particular issue, the reflections put forth by Silvia Matumoto et al (2005) concerning team supervision in the Family Health Program lend new dimensions to the dominant conception of supervision and provide clues for the development of alternative approaches: *external supervision with the purpose of making it easier to face difficulties and the resistance produced, by means of successive processes of coming and going, of auto-analysis and auto-suggestion that may encourage one to risk new ways of producing healthcare actions.* This is a type of supervision centered on political and pedagogical practices, rather than only on managerial practices.

Hence the fact that it is indispensable to have a critical view of pedagogical training in the health care area, this being one of the possible paths for reproduction of the hegemonic medical model in the healthcare field. Healthcare workers that have been educated, conformed and reformed as "subjects devoid of will" both within and without universities have a great deal of difficulty establishing dialogical, educative relations with citizens. An illustration of this is the fact that healthcare professionals from the Family Health Program, even in towns that have adopted the program as a reorientation strategy for their healthcare services system, point to difficulties in the development of educational practices. However, arguing in favor of the relevance of changes in the higher education of these professionals and in the implementation of permanent educational programs in the services is not enough. It is necessary to think and to take action concerning the work processes, by activating possibilities for altering technical and social relations (political, ideological and symbolic) in the organizations. In this sense, an investment and a bet on the communicative and dialogical capacity of the subjects as well as recognition of the value of promoting joint reflection arenas for the agents do not merely represent political propositions for the counter-hegemonic struggle, but express a concretely established need for the very way of producing care in the healthcare field. To the extent that healthcare professionals have not been prepared for becoming autonomous subjects, as a result of the banking education that they are given and the supremacy of biomedical culture, it is no wonder that there occurs a reproduction of these relations and values vis à vis patients, families and communities. Vânia Alves, in her article, reviews the state of the art where healthcare educational practices are concerned and discusses a dialogical proposition seen as coherent with the Family Health Program.

The identification of counter-hegemonic trends, even if they are minority ones, in certain healthcare organizations in the thought of formulating intellectuals and in the practice of certain professionals suggests that the dialogical model is possible and indicates a need for alliances for changing the current correlation of forces. The reflections produced by Ricardo Ceccim, Mario Rovere e Emerson Merhy on permanent education in the healthcare field represent an illustration of the possibilities that these alliances offer. From this standpoint, a scrupulous analysis of reality imposes itself, as well as a contextualization of the concepts and categories of analysis so that the ideas, suppositions or hypothesis may stand out from the consequent political proposals in each concrete situation. The transformation from "human resources" into the situation of social players does not depend only on an act of will, as Rovere points out: "*This transformation is complex and profoundly social, given that being included in the struggle for the right to healthcare requires conditions and a certain period of maturation."*

The construction of educative healthcare practices, both culturally sensitive and dialogical, within or without the Family Health Program, will not result merely from a cultural or pedagogical transformation, but from a new distribution of power in the healthcare field as one of the strategic components of the daily construction of social change. This is policy, in addition to pedagogy and culture.

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