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EDITORIAL

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Health marginal themes and areas

The first class I taught to nursing students had nursing care for migrants as its central theme. We were at the end of the eighties of the twentieth century and Portugal was not facing any migration crisis worthy of the name. Despite this, the topic was part of the curricular plan of the nursing course and, of course, of the curricular unit that I was teaching at the time. Basically, it was about what would be later known as culturally competent care in a clear influence of the Theory of the Diversity and Universality of Leininger 's Transcultural Care and/or Nursing.

Then, future times seemed to be predicted, marked by the arrival in Portugal, during the nineties of the 20th century, of an important number of citizens from the African continent (mainly from the PALOP - Portuguese-spoken countries) and which culminated in a large wave of migrants from Eastern Europe, and with the arrival of the second wave of people from Brazil, during the first years of the 21st century. Since then, migratory movements have not stopped and today Portugal (although it is not one of the countries with more migrants or that more migrants currently receive, contrary to what some political forces claim) is faced with migratory flows essentially from Asian countries, with culture, customs, and beliefs unknown to many health professionals.

By mere coincidence, the last class I will teach has precisely the same theme and is part of a Health and Society curricular unit where the so-called marginal themes punctuate (healthification, overdiagnosis and medicalization, the macdonaldization of care, gender issues, violence interpersonal or care for migrant populations, among others), which since the beginning of the nineties of the twentieth century have gradually been integrated into the nursing course curriculum, and to which I have always been directly or indirectly linked as a teacher and/or researcher, in largely due to my specialization in public health nursing and my additional training in sociology. But essentially due to my concern with the society in which I live and the way in which, at each moment, the dynamics of healthcare are maintained, altered or reconstituted.

They are considered marginal themes because they do not control the agendas, nor capture the interest or the passion that intensive care and lifesaving technology captivate, whether among teachers, students, or professionals. These are also themes that neither appear as frequently as they deserve and require in scientific nursing and health publications, nor are frequently the target of research in master's or doctoral theses. It is argued and maintained that the biomedical model has been outdated, but in practice, the profound transformations that occurred in the populations health and in technology were not accompanied by the necessary and appropriate in political, organizational and training responses.

Of course there have been changes in these areas, because in three and a half decades it would be impossible for changes have not occurred. However, these changes focused mainly on the hospital context and the reinforcement of the so-called intensive care, largely supported by growing technology and different lifesaving configurations. Changes occurred, new dynamics were installed, but hospital-centrism and a persistent lack of care integration always remained.

Primary Health Care (PHC) has inevitably undergone several reforms over these thirty-five years, and today its organization and operation have changed profoundly, but its place as peripheral care has remained unchanged, in practice and in the imaginary of population and the professionals themselves (namely hospital workers). There are dichotomies that have proved and continue to prove extraordinarily difficult to overcome, if they ever will be overcome.

Long-term care emerged, in an organized way, in Portugal in 2006 through the creation of the National Network of Integrated Continuous Care (RNCCI), with different responses for a population where mostly counted (but not exclusively, there were also some responses within the scope of pediatrics, mental health and palliative care) elderly people and/or those with chronic illness with multimorbidity and severe dependence. The initial success of this care, despite the scarcity of supply, never was able to compete with the before mentioned hospital-centrism. Once again, this care and the units in which is provided, prevail in the professional and social imagination at the same level as PHC – a level that is too fragile to the importance they have in responding to the health needs of the populations.

The current reform of the organization of care, with the generalization of the model of Local Health Units (ULS) throughout the country, can bring contributions to blur these dichotomies, but its questioning by current political leaders and beyond, suggests once more, difficulties in operationalizing new organizational dynamics that, once and for all, go beyond permanent settings.

I do not intend to make in this editorial a history of the evolution of healthcare or the National Health Service (SNS) itself, just to highlight the importance of what I called marginal themes and the centrality they have in the current social and health context and warn that it is not enough to change the names of models or stop naming them so that they cease to exist. The biomedical and hospital-centric model, in view of technological development (namely Artificial Intelligence) and the current conditions of organization and operating of both, the public and private health sector, remains strong and healthy. They reveal themselves as if they were indestructible and eternal, unlike people/users, who continue to be fragile and mortal, despite the widespread improvement in their living and health conditi-

ons. If it is true that, in each era, are the sociocultural constructions that determine the health centralities at each moment, impossible alignments seem to persist to overtake.

But there are marginal themes that impose themselves socially when they became inevitable in Western countries and when scientific evidence highlighted them. This is the case of aging (social, cultural, political and health) and the new needs and challenges it requires in the organization of healthcare, in addition to the new markets it feeds. For years, aging has assumed a marginal status in society and in the professional and academic context. Currently, however, both society, but essentially the markets (from health to academia), have discovered and recognized the potential of the "golden generation" and "silver economy" and when this happens, the marginality of the topic fades, or the centrality of the topic imposes itself, as you prefer, and starts to dominate all agendas.

Other themes and/or marginal areas that I have always been linked to were those that make up Public Health. The importance of this area is historically recognized by the work carried out over time, namely in improving various health indicators, of which those in the area of maternal and child health are a classic example. The historic success of Public Health, along with the improvement of living and health conditions, seems to have worked as the path to its erasure. In such a way that its action of continuous risk monitoring through continuous epidemiological, environmental and entomological surveillance, appears to remain unknown or irrelevant.

The recent SARSCoV-2 pandemic allowed, once again, Public Health to gain an unavoidable and indispensable role. Once the pandemic situation has been overcome, everything seems to have eclipsed and its condition of marginality or peripheral area is returning (possibly until the next pandemic). The contributions of Public Health, marked in most cases by simplicity, are essential to the provision of quality healthcare. Everyone should know the history of Public Health and the legacy of those like Semmelweis, who in the 60s of the 19th century attributed the high mortality of women associated with puerperal fever to the lack of hand hygiene on the part of the professionals who performed the birth. Once the hand hygiene rule was introduced before birth procedures, by all the professionals involved, the number of infections dropped immediately. An important, simple, efficient and effective measure.

All professionals know, from school benches, the hand hygiene measures, which were central and reinforced during the recent pandemic. The link is not direct because there are different variables to consider (fragility and vulnerability of hospitalized people, antibiotic resistance, invasive procedures), but hand hygiene is decisive in containing hospital infections. The question then arises why Portugal goes on being one of the three countries with

the highest prevalence of hospital infections in Europe, according to 2022-2023 data from the European Center for Disease Prevention and Control (ECDC).

I also cannot ignore the marginal role of health policies in the training of professionals (from which they are aseptically kept away). But it is the knowledge of health policies and through them of the SNS and its importance for most of the Portuguese population, which must inevitably lead us to defend it against of media voices (to which common sense is rarely indifferent) that gradually become consensual in their discrediting. This consensual media coverage corrodes and destroys not only the SNS, but also the population's trust in it. We need to analyze, understand and question these messages, the strategies that support them and the objectives they serve. Nevertheless, we also must analyze and understand the difficulties the SNS is going through and make contributions to overcome them. If the SNS is completely dismantled (and this is not merely an ideological issue) most of the Portuguese population will be left without access to healthcare, because they do not have the financial capacity to access private healthcare and because health insurance plans are far from covering the costs of the healthcare they are actually intended to provide.

In conclusion I highlight that the health marginal themes and areas, from knowledge of the evolution of society and health care to social constructions that express changes at each moment, are fundamental and increasingly central in the work of health professionals. It is necessary to understand, analyze and question as a whole the world of health and never ignore how new dynamics emerge, shape and assert themselves in each socio-historical era.

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