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Theorization about the limits to the inclusion of oral health teams in the Family Health Strategy

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Abstract *This study aimed to theorize, by means of social actors' conception, about the reasons for the non-inclusion of oral health in the Family Health Strategy (FHS) in the city of Juiz de Fora, Minas Gerais, Brazil. This is a qualitative, exploratory, descriptive, and analytical study based on the grounded theory methodology and the National Oral Health Policy. Eleven interviews were performed with public managers, delegates who participate in the municipal health council, and dental surgeons who belong to the public health service. The theorization of the study was created through the data analysis process, which resulted in "a consequence of the dominant disease-centered oral health care model" as the main category. Data were categorized according to a methodological framework. The health concept set forth by local social actors contributed to the non-inclusion of oral healthcare teams (OHTs) in the FHS. This theorization identified the origins of the studied phenomenon and can aid in future policy decision-making carried out by local social actors.*

Key words *Oral Health, Family Health Strategy, Grounded Theory, Health Policies*

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Introduction

The Brazilian Unified Health System (SUS, in Portuguese) resulted from the Brazilian Sanitary Reform Movement (BSR) by overcoming the biomedical hegemonic care model[1]. The struggle for the universal right to health, the social determination of health, the concept of health through its social determinants, the decentralization of management, and the social control formulated the array of demands called for by the movement and led to their inclusion in the Brazilian constitution[2,3]. The development of health policies highlighted the prominence of Primary Health Care (PHC) and the adherence of Family Health in the restructuring of health care[2] to tackle the population's health needs[1].

Despite the constitutional guarantee, SUS was not consolidated, its main challenge being political[4]. Since its creation, Brazilian public health has been conducted within a neoliberal perspective. Austerity measures have contributed to chronic under-funding, resulting in a non-universal SUS, which is restrictive and exclusionary. Constitutional Amendment 95[5] is a threat to the constitutional assumptions regarding SUS and implements a scenario of the de-funding of the system[6]. There are many obstacles and threats to SUS, stemming from an ideological, political, economic, cultural, and organizational nature[4]. Among these are: the reproduction of the hegemonic model of health care with a focus on disease and procedures, the difficulties in the construction of Healthcare Networks, the precariousness in the infrastructure of the services, "the devaluing of healthcare workers through outsourcing and work insecurity"[4] and the privileging of the private healthcare sector by the State through subsidies, exonerations, and a lack of regulations[2,4]. These setbacks affect the health of the Brazilian population and the guarantee of their fundamental rights[4,6].

In 2004, the National Oral Health Policy (PNSB, in Portuguese) rearranged the oral healthcare model, incorporating the expanded concept of health, the social component of the health-disease process, the strengthening of SUS, and the principles of the integrality and promotion of health care[7-9]. In the restructuring of the model, the oral health teams (OHTs) were included in the Family Health Strategy (FHS). Funding was allocated to oral health actions, incentives for health education, the use of epidemiological indicators, the establishment of a care network through the Dental Specialty Centers (DSCs), and the creation of Regional Laboratories for Dental Prostheses (RLDP)[7,9]. In the years following 2004, despite the financial incentives, the continuity and maintenance of the sustainability of the policy were affected by the lack of funding and by limits in the political and managerial coordination, as well as in governability at the local and state levels[10]. The traditional dental practice has continued to be predominantly marked by conflicts and contradictions[11,12]. Moreover, dental professionals have not taken on the PNSB as their own, relinquishing themselves from the responsibility of effectively implementing dental practices within health care[13].

Between 2015 and 2017, there was a restrictive political scenario concerning oral health actions, with a reduction in the inclusion of OHTs in the FHS, growth in the supply of private dental services, restriction in public funding, a decline in oral health indicators[14], and difficulties in the implementation of the PNSB within municipalities[8,12,15]. The process of the implementation of public policies in oral health has been the object of study for many authors[11,15-17]. However, studies on the comprehension of the subjects involved in the implementation of oral health policies in different political contexts are scarce.

The restructuring of the oral healthcare model and its inclusion within the FHS[7] has not occurred in many Brazilian municipalities[18], calling for further investigation on the underlying motives. The present study aimed to construct a theorization about the non-inclusion of oral health care in the FHS in a Brazilian municipality, through the understanding of social actors: health managers, dental surgeons (DS) inserted in the municipal SUS, and members of the Municipal Health Council (MHC). The uniqueness of this study lies in the theorization concerning the phenomenon of the non-inclusion of oral health in the FHS through the understanding of social actors, as its comprehension is essential for the development of health policies. Theorization can contribute to decision-making by public health managers regarding improvements in oral health care in consonance with the principles of the PNSB and for the strengthening of oral health within SUS.

Method

Study design

This work consists of a qualitative study conducted by means of methodological referenc-

Ciência & Saúde Coletiva, 28(4):1139-1150, 2023

es from the Grounded Theory based on Data (GTD)[19]. GTD aims to generate a theoretical explanation for a process, an action, or an interaction through the understandings that the participants express about a studied phenomenon[20]. It can contain an exploratory character, when little is known about the object of study, as it has the capacity to generate a theory heavily based on the local reality[20] and focuses on the interpretive comprehension of the meanings and experiences of the participants[19]. The subsequent result is a high-level theorization[20]. This study, as it is derived from data, provides a better discernment and understanding of the phenomenon[19].

The theoretical reference was developed based on a critical and systematic analysis of the PNSB, forming a basic policy axis for the restructuring of the care model within micropolitics[7]. Stemming from the field of collective oral health[13,21], it seeks to break from the operational biomedical paradigm through the incorporation of epidemiology, of the promotion of health, in defense of citizenship, and of oral health as a right. The qualification of basic care is presented as an essential assumption for the restructuring of this model, with the incorporation of oral health in the FHS, as well as the establishment of the coordination of care and of the Oral Healthcare Network. The DSCs represent the secondary care and must be used as a reference by the OHTs. The PNSB established that the work of the OHTs should not merely be limited to the field of dental technicians, but should also be included in the expanded concept of health focused on care, as well as on the prevention and promotion of health. It should guide the construction of sanitary awareness among SUS professionals and users, understanding that oral health is a citizenship right. The management of oral health services should democratically define the policy, guaranteeing the participation of both the population, through Health Councils, and workers, given that this would serve to better identify the problems and produce a more effective design of actions strategies that would answer to the true health needs of the population[7,9,12,13,15].

Study location

This study was conducted in the municipality of Juiz de Fora (JF), Minas Gerais, a region in the Southeast of Brazil. JF has an estimated population of 573,285 inhabitants, and a Human Development Index of 0.778[22]. It is a regional pole for the rendering of services that are essential in the area of health, education, commerce, and industry[23]. The municipality is the headquarters of the state´s Southeast Macroregion of Health, with an extensive network of high-density technological, outpatient, and hospital services[24].

In December 2020, the municipality presented an estimated 11.35% oral health coverage of the population within basic care services, with no OHT included in the FHS. JF has five DSCs distributed throughout the health regions of the center, west, north, and south, with 183 dentists working in SUS. Regarding the population's oral health conditions, no representative epidemiological data were found.

Study participants

The participants are social actors who are members of the MHC, municipal and state health managers, and DS included in SUS. Our study chose informants capable of providing relevant information, based on their understandings and lived experiences[20,25] in the process of the non-inclusion of oral health care within the FHS. One key informant recommended participants who could contribute. As these participants were contacted, the interviews began to indicate new informants who worked with the theme. The inclusion of these participants was carried out in an intentional manner through decisions made by the research group. This technique was adequate, considering that the object of the study implies private sensitive and vague questions, requiring specific knowledge from the members of the group involved in the context of the pehnomenon[25,26].

The characterization of the participants was elaborated in such a way as to preserve the identity and guarantee the confidentiality of the participants. Thirteen invitations were made. Two subjects refused to participate: one due to disease in the family and the other because the subject felt his experience would not contribute to the research. In the end, 11 subjects were interviewed. There was no loss of data. Some of the participants worked as managers and service providers, other as workers in health and social control. The municipal management of oral health was represented by 7 participants – state-level managers, social control, and service providers – 2 each.

Data collection

Data was collected by means of intensive interviews[20], from November 2020 to May 2021, remotely, through the Google Meet platform,

meeting the demands of social distancing imposed because of the COVID-19 pandemic[27]. One main researcher conducted the interviews and another provided technical support. One of the participants requested that the interview be in person, outside of the normal working hours, on the grounds of the Municipal Health Secretariat (MHS). The request was granted, considering the relevance of the participant´s contribution. In this case, biosafety measures recommended due to COVID-19 were adopted. The interviews were scheduled at times that were comfortable for the participants. The interview lasted 40 minutes on average.

The initial impressions and insights were recorded immediately after the end of the interviews through intuitive memoranda in order to allow for successive comparisons and not forgo any notable facts[20,26]. The interviews were recorded on the computer, using the application *Open Broadcaster Software* and transcribed in Word (Microsoft Office®).

The research group produced a guiding script based on information from the public domain about the studied phenomenon and on the knowledge of prior concepts on the theme[19,20]. The interview was divided into three moments: initial open questions focused on the professional career of the participants; intermediary, seeking to understand the functioning, features, and organization of public health and oral health care within the municipality and the participants' conception concerning the non-inclusion of oral health care within the FHS; and final questions, related to the expectations of the inclusion of oral health within the FHS, in addition to a moment in which the subjects were open to explore their own perceptions about the interview and if they had anything to add. During the interviews and their subsequent analysis, new questions arising from the data and that were considered necessary for the understanding of the phenomenon were included[19,20]. The study guiding script is available in a supplementary file (https://doi.org/10.48331/scielodata.5DRGF9).

Data analysis

Data analysis and collection were performed concomitantly, as was the drafting of the successive memoranda[19]. The analysis took place in a free and creative manner, using systematized analytical tools and procedures from the method, enabling the merging of categories, codes, and concepts[19,20]. The literature review was conducted throughout the study, and the researchers kept an "open mind" as regards the data and their meanings[19].

After the transcription, the process of dynamic and fluid analysis was begun by coding. The comparative method of intuitive analysis was used, marked by the comparison among the data, codes, and categories[19]. The coding was carried out in three stages: open coding, axial coding, and selective coding. These stages aim to find the concept and categorization of the data that represent the phenomenon[19]. Examples of data analysis during the open coding stage and of a memo for axial coding are available in a supplementary file (https://doi.org/10.48331/scielodata.5DRGF9).

The main study category was developed and discussed by the researchers in such a way as to refine the theorization[19,20]. The formulation of the theorization about the non-inclusion of the oral health care in the FHS was ordered and integrated through theoretical connections among the categories. The main category explains how the problem of this study is treated.

Recommendations from Decree No. 466, of 2012, from the National Health Council were respected. The project was approved by the Research Ethics Committee of Universidade Federal de Minas Gerais (UFMG) (logged under protocol number 35791320.2.0000.5149), and all participants signed a Free and Informed Consent Form.

Results

The GTD resulted in the main category: *Consequence of a hegemonic disease-centered concept of health for oral healthcare model*. The following categories are related to this concept: 1) biomedical hegemonic care model; 2) care model defended by the management focused on dental clinics; 3) different concepts of the oral healthcare model; 4) loss of a window of opportunity provided by the PNSB (Chart 1)

The *Biomedical Hegemonic Care Model* refers to the organization of the rendering of healthcare services, the availability of healthcare units and equipment, the concept of health, and care actions focused on the production of procedures. The following subcategories were also associated: a) care model historically focused on high and medium complexity; b) municipal funding for health compromised by high and medium complexity; and c) most Basic Health Units (BHUs) have an inadequate infrastructure.

According to the participants of this study, historically, the municipality played the role of the technological health pole, providing, even to-

Ciência & Saúde Coletiva, 28(4):1139-1150, 2023

Chart 1. Main category and remaining categories and sub-categories of the theorization.

Main category: Consequences of a hegemonic, disease-centered conception of health, for the oral healthcare model		
Categories	**Sub-categories**	**Examples of crude data**
Biomedical hegemonic care model	a. Care model, historically focused on high and medium complexity	With a health care system that is both complex and incomplete, Juiz de Fora historically concentrated a lot of high and medium complexity health services. Therefore, it has a very good technological structure, it has access to high and medium complexity services, almost in their totality. - P01
		[...]we have quite a satisfactory offer of services in Juiz de Fora, we have a tertiary care system, (...) the quality of hospital care in Juiz de Fora is very good. - P03
	b. Health financing in the municipality is compromised by medium and high complexity	In Juiz de Fora, high and medium complexity take more than 85%, almost 90% of the health resources [...] This draining of resources from primary care to medium and high complexity hampers any expansion of the service, especially of services that will be expensive for the town, which will require construction, remodeling, equipment, will demand the hiring of personnel, demand inputs, all with precarious financing. - P01
		So, how can we expect and hope that PHC can resolve 85% of the health problems of the population if it has just a little more than 12% of the resources invested? So, we have to consider that there is a contradiction and a problem in this reality. But we are aware that the resources that are available for health care today are minimal. - P11
	c. Most of the PHC units have inadequate structures	There must be a structure in the first place. It is not easy to organize a structure for dental services like this, in a municipality the size of this, because not all the PHC units have a dentist's office. - P07
		We will have challenges ahead, challenges to our structures. At least part of them were not planned for FHS, nor for oral health. Even for structural interventions, the resources are meager. - P11
Care model proposed by management focused on the dental clinic	a. Oral healthcare model in PHC, organized by regional centers	Dentistry is one of the weakest areas of PHC in my understanding é [...] We do not have a dentist in every UBS, more than half do not have a dentist. - P01
		In management, our concept was regionalization. [...] So, we decided to also regionalize UPS for Dentistry, [...] planning large Regional Dental Units where we had a DSC connected to the unit. [...] Today, in the city we have 4 ROUs that work very well and manage to provide access to the population [...] where we have state of the art infrastructure, [...] where we can put this principle of integrality into operation. - P05
		Healthcare at the DSC is global, because the users have everything there. You can do everything, get an x-ray, root canal treatment. The only thing you cannot do there are prosthetics. Unfortunately. - P10
	b. Oral health management is verticalized and inarticulate	So, I think that this fragmentation is something from the oral health department dividing PHC from oral healthcare being in one sector, while the DSCs and the hospital technology are in another sector, it ends up making it difficult to manage. - P07
		There is no desire to adopt those policies from that department [OHD]. There is a very clear discourse that we [OHD] are different [...] the National Oral Health Policy is not up to you [...]. I cannot see any desire for a collective construction of the policies. - P11
	c. The proposal of insertion of the OHT in the FHS that management defends does not seek the restructuring of the care model	[In 2020] the Oral Health Department of Juiz de Fora began this movement of getting dentists [into the FHS] [...]. That situation lasted many years, it only ended with the approval of this Bill [...] in 2016 by the Municipal Council. - P05
		Obviously, there should be a study to make the areas of greater social vulnerability viable [...] putting more FHS in distant neighborhoods, and here in downtown, you can work with RDUs, which already exist even with primary care. - P05
		[In 2018] We put together a financial impact study, to hire this dentist and assistants [...]. - P05
		We always proposed the implementation of the OHT. We used to make the projects to present to the administrative managers [...] 10 teams, in the end we got down to 5 [...]. - P06
		We have it in our Municipal Health Plan, established [...] 2021 two more, totaling 6 OHTs until the end of 2021. - P05

it continues

Chart 1. Main category and remaining categories and sub-categories of the theorization.

Main category: Consequences of a hegemonic, disease-centered conception of health, for the oral healthcare model		
Categories	**Sub-categories**	**Examples of crude data**
Different conceptions of the oral healthcare model	a. The Municipal Health Council's conception of a care model is counter-hegemonic	Family health care is not done with just doctors. It is done with doctors, nurses, social workers, dentists, primary care, so you can have prevention. - P08
		We never agreed to this process of regionalization [RDUs]. [...] It goes against what the system establishes [...]. I had serious arguments concerning this issue of the regionalization process, I didn´t agree, I even created a certain animosity towards people. - P08
		Look, we've noticed that since my first term as manager in the Council in 2001. [...] Ready to implement, we tried to adapt the legislation so that the dentists could do 40-hour shifts. Only now, in 2016, the legislation is ready. - P02
	b. The expectation by the Municipal Health Council for the insertion of oral health care in the FHS does not find the support of the population or the dentists	But there is no pressure by the users, the people. [...] They do not mobilize for Dentistry. - P01
		There is still no evidence of a demand for oral health care. Did you search for oral health events at the ombudsman? You do not have to, because there is none. A large part of the population does not search for oral health, it seems as if there is no need for oral health expressed by the population. - P11
		So, it is not a common demand in the local and regional councils, in the municipal council it appears in these conditions by means of a representative of social control who has a high level of education and knowledge of the cause. - P11
		I do not notice a desire on the part of many dentists to implement oral health care into family health care, the dentists do not want this change. - P11
		There is also a lack of social cohesion. [...] That shows fragility. [...] of how much the discussion around oral health is still incipient in terms of its importance for the population. - P09
	c. Model for oral health care meets the professional profile and the expectations of the dentists	The training of the dentist is pretty much aimed at specialization. [...] they want to become specialists, and few have the availability for public service. - P03
		There is the professional valuation [...] there is studying, there are careers, and there is [...] a certain accommodation, it is easier to leave things as they are [...]. So, maybe because of all that we do not have a strong mobilization to achieve the implementation of oral health in the FHS. - P03
		The view that I have today is that the fellow municipal dentists approve of the model that is being proposed and offered. - P11
Missing the window of opportunity provided by the PNSB	a. Choices by the management in terms of applying the resources from the PNSB	[In 2004] financing was not sufficient, we [...] demonstrated that the expenses were valid…but with the passing of time, with the reduction of financing by the Federal government, nowadays the financing do not meet the expenses with the professionals. So Dental equipment was something very expensive, [...] with the 2004 health policy, the price went down a lot. We managed to buy a lot of equipment... - P03
		We still have a long way to go, [...] because it was with the management of oral health care [in 2006] [...] when the government created the Smiley Brazil Program, and that brought an opportunity for funding for Dentistry that we did not have before [...] so we had a lot of difficulties with materials, a lot of difficulty with infrastructure, and after Smiley Brazil things began to change, and we received funding for the implementation of the DSCs. - P05
	b. Constitutional Amendment 95: from chronic under-funding to the de-funding of health care	This town suffers, as do all the others, with a severe problem of under-funding of SUS. - P01
		The federal resources to fund OHTs in the FHS is a small amount [...] not enough to implement all that is needed. - P07
		The most important barrier, perhaps, has to do with the decline in funding in recent years. - P03
		So, I do not see much hope, that this possibility, that it happens now. Even more so with Constitutional Amendment 95, which froze public expansion for the next 19 years. - P01

Source: Authors.

Ciência & Saúde Coletiva, 28(4):1139-1150, 2023

day, many high and medium complexity services. The "inheritance of municipalization" is presented by the participants as one of the conditions responsible for the maintenance of the biomedical model, focused on high and medium complexity. Municipal funding for health responds to these priorities, leaving insufficient resources for Primary Health Care (PHC). For this reason, basic care witnessed a minimal growth over time and presented an inadequate infrastructure in the majority of UBSs, making it difficult to organize oral health care within the FHS. In PHC, oral health care is precarious and is described as costly and difficult to maintain.

The second category, *Care model defended by the management focused on dental clinics*, is referent to the management process and to decision-making regarding oral health services. The subcategories that explain this category are: a) oral healthcare model in PHC organized according to regional poles; b) verticalized and unconnected oral health management; and c) the proposal of the inclusion of OHT within the FHS, defended by the health management not seeking to restructure the care model.

In the oral healthcare model, the offer of dental services within basic health was organized in regional poles with Regional Dental Units (RDUs), located in the physical spaces of the DSCs. The justification for this decision was to take advantage of the spaces with good infrastructure, with the allotment of additional resources. These service production units, from the point of view of some management actors, guarantee the integral and continued care, together with the expansion of population access for areas of the municipality that are not covered by basic health care. The organization of regional poles positioned itself in opposition to the expectations of some health and MHC managers regarding the inclusion of oral health within the FHS.

The proposal to include oral health care within the FHS is given as a possibility, given the management initiatives, such as studies conducted on financial impacts and in the bureaucracy. However, it does not seek to surpass the model, since it is in need of a universal perspective and maintains the centrality of care within dental clinics.

With the theorization, it was possible to justify that the oral health management within the MHS is verticalized and disconnected. Secondary and tertiary care are the responsibility of the Oral Health Department (OHD), while primary care was submitted to the Primary Healthcare Management of the Under-Secretary of Health Care. Communication problems were detected between sectors and levels of management as regards the proposal and follow-up of programs and actions.

The category *Different understandings of the oral healthcare model*, shows the willingness present in the MHC to include oral health within the FHS and their critical position in relation to the implementation of regional poles. The category presents three subcategories: a) the concept of the MHC care model is counter-hegemonic; b) the expectation of the MHC to include the OHTs in the FHS is not supported by the general population and among the DS of the FHS; and c) the oral healthcare model meets the professional profile and the expectations of the DS of the FHS.

The results indicate that the MHC has an understanding of the care model focused on the principle of the integrality of care and the defense of the strengthening of oral health in PHC. This concept is counter-hegemonic and opposes the organization of regional poles, which has led to clashes with city hall. Nevertheless, there are doubts about the true position of the MHS on the issue. The position would not be of the MHC, but rather of some representatives who work for the Council, in conjunction with the Brazilian Dental Association.

The proposal to include oral health within the FHS, presented by the MHC in 2001, has remained in effect for 20 years under the national Budgetary Guidelines Law, under the Annual Budget Law, and within the Annual Health Planning. In 2016, the city council approved the inclusion of oral health care within the FHS and the extension of DS working hours to 40 hours/week. In 2019, a study was conducted regarding the budget impact on the implementation of some OHTs within the FHS, which did not result in an effective movement of the health management sector in favor of changing the model. The non-existence of records in relation to oral health in the municipal ombudsman would indicate the absence of a demand for improvements and changes in oral health services.

There is no mobilization among DSs for the inclusion of oral health within the FHS, which shows a certain accommodation among the professionals who choose not to engage in changes in oral health care. This understanding is reinforced by the fact that these professionals have achieved a reduction in weekly working hours from 20 hours to 12 hours and 30 minutes, without a loss in salary.

The category *Loss of the window of opportunity provided by the PNSB*, presents internal factors of the municipality that resulted in the loss of opportunities to strengthen oral health in PHC

and funding to implement health policies. It also presents external factors related to the macropolitical and economic scenario of the country, such as factors that hinder the process of the inclusion of oral health within the FHS. The situation of recent de-funding was the most heavily impacting because of the lack of investment at previous moments. The following subcategories were associated with this category: a) choice of management concerning the application of resources coming from the PNSB and b) Constitutional Amendment 95: from the chronic under-funding to the de-funding of health.

The PNSB allowed the municipality to buy dental equipment and inputs, as well as implement new DSCs. Despite the greater allocation of financial resources from the federal government, the proposal to include oral health in the FHS did not progress due to municipal costs with inputs and the professional work force. Brazilian Constitutional Amendment 95 imposed a reduction in health funding, even further hindering the project to include oral health within the FHS, which is under debate in the municipal administration.

It becomes clear that, during the studied period (2001-2020), changes occurred in the MHS organization, and the sectors related to oral health and PHC changed in nomenclature and in position within the administrative framework. The flow chart (Figure 1), constructed according to the data, present oral health care within the organizational structure of the MHS.

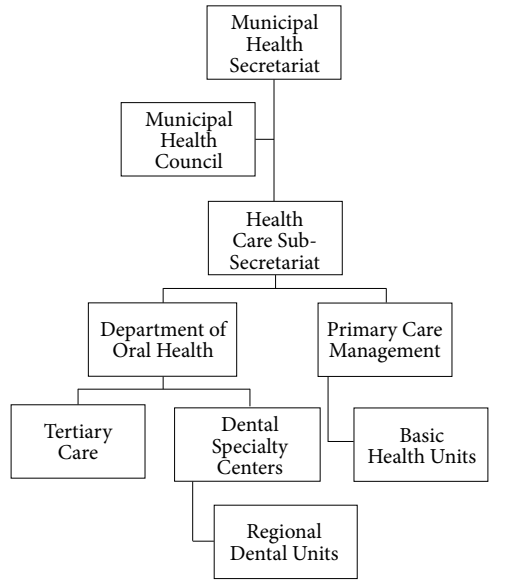

Figure 1. Flow chart constructed from the data, which represents Oral Health Care in the organizational structure of the Municipal Department of Health.

Source: Authors.

Discussion

The emerging theorization allowed for the understanding of the phenomenon of the non-inclusion of oral health care within the FHS in the municipality studied here. The elements that enabled this theorization were identified through the concept of social agents who spearheaded conflicting relations in the processes of the organization of oral health care within the municipality over the past 21 years. The non-inclusion of the oral health service within the FHS runs in opposition to that established by the PNSB[7], bearing in mind that Family Health is a strategy for the qualification and reorganization of basic care. The difficulty in this adherence is also shared by other Brazilian municipalities[8,13,17,18].

Mid and large-scale municipalities, which composed regionalized poles of the care system from the National Social Security Institute for Medical Care (INAMPS, in Portuguese), with an apparatus of medium and high-complexity services[28] and contracting with private initiatives[29], passed through the process of municipalization with no change in the health services model[28]. The municipality studied here is an INAMPS pole, remains as a reference in the rendering of public and private health services of middle and high complexity, and shares with other Brazilian municipalities the hegemonic experience of reproducing of biomedical model practices. Not overcoming this paradigm has consequences for the organization of the services and the practice of health professionals[12,13,15].

The reproduction of the biomedical care model takes place due to the interaction among the economic, political, and social conditions that favor their maintenance[15]. To break with this hegemony it is necessary to strengthen the role of the State and the political project that restructures the organization of the system in favor of the population's health needs[30]. The starting point for change is to adopt the expanded concept and the promotion of health within the restructuring of the model of adherence to the FHS[7,12,13,15,31].

In the municipality, the biomedical care model is reproduced in oral health care, in misalignment with what was originally proposed in the

PNSB guidelines. According to the PNSB[7], the concept of care and the expanded conception of health should be the foundation of health care, with protection and promotion actions geared toward the quality of life.

Oral health care in the municipality is organized primarily in regional poles of clinical care in RDUs located in the spaces occupied by the DSCs, and the OHTs are present in less than half of the BHUs. Oral health care should assume a commitment with the qualification of basic health and guarantee the principle of integrality, interlinking individual care with collective care. It should also defend the promotion, prevention, treatment, and recovery of health within Brazil[7]. The organization, according to regional poles, concentrates dental clinical care in equipment that is distant from the communities. Thus, the qualification of PHC is not promoted due to the lack of bonds and presence in the territory, the lack of a multidisciplinary team, and the lack of intersectoral actions. In the regional poles, oral health care is reduced to dental care focused on clinics. Oral health care should not only be limited to clinical care, but it should also consider the health needs, community work, and preventive and educational actions within health care[32]. The heavy focus on the dental clinic indicates that the hegemonic biomedical model and the concept of health focused on disease and procedures have not been overcome[13,15].

In the municipality, the implementation of DSCs was a priority for the municipal administration; however, there was not a corresponding effort to include oral health within the FHS. Chaves *et al.*[33], in the state of Bahia, verified that in municipalities that have an FHS, there is a greater possibility of guaranteeing the integrality of care. In this sense, it is clear that there is a need for primary care in oral health to precede the implementation of DSCs.

The municipalities, proportionally, have greater expenses within the three spheres of government[34]. The chronic under-funding of SUS impacts the maintenance of the providing of health care where dental professionals' salaries are included[4], with a significant reduction in the perspectives of the expansion of oral health services throughout the country[6,33,35]. The scenario of the insecurity of the BHU infrastructure is present throughout Brazil[36] and hinders the expansion of oral health care in PHC.

With the PNSB[7], the municipality's oral health management had the opportunity to obtain financial incentives to implement and expand their oral health services[8,9,34]. While many Brazilian municipalities included oral health within the FHS with qualifications in basic care[9,10,16,34], the municipality under study here allocated resources for the strengthening and implementation of DSCs and the consolidation of RDUs, even though there was a proposal from the OHD, backed by the MHC, for the inclusion of oral health within the FHS.

In the municipality, there is no clear mobilization of the DSs linked to the service for the inclusion of oral health within the FHS. The professionals seem to be in consensus regarding the care model established by the municipal administration. This posture may well be associated with the professional education marked by specialization, where curative and technocare practices prevail[5,8,12,37]. In this sense, the DS can represent a low adherence to the public service, as this occupation would not respond to the expectations of professional achievements[38]. It is important to provide an education that is based on the foundational principles of the FHS and on the production of medical care, in which the core focus in the clinic is on the user[12,39]. Chaves and Silva[38] point out that the hegemony of the private sector seems to influence the practice of DSs in the public sector. The reduction in the weekly work hours conceded in 2016 to the DSs in the municipality may well indicate a predilection for a professional career in the private clinics, which is in accordance with the *modus operandi* of dental practices in Brazil[12,14,37] and worldwide[13], where the providing of market services and the heavy influence of the liberal model in Dentistry is still predominant[13,15].

The municipal administration's proposal for the inclusion of oral health care within the FHS restricts the OHTs in BHUs of neighborhoods of greater social and peripheral vulnerability, with the maintenance of dental care in the regional poles, is dissonant with the principle of the universality of healthcare[7], and the manner in which it is proposed reinforces the oral healthcare model focused on the dental clinic. Its understanding harkens back to the discussion about the selective PHC presented by Mendes[40] as a specific program focused on and geared toward poor populations and regions, offering a group of simple and low-cost technologies. The concept of PHC must surpass this restrictive concept to become the chief space for a healthcare network[40]. This project, developed in 2001, is still being debated with the MHC, demonstrating the sluggishness in the decision-making process. In part, this can be explained by the disconnection between the oral health management sectors of the municipality. The fact that oral health care is managed by

two sectors within the municipal administration hinder the planning, surveillance, and assessment processes. The qualification of the PHC, as part of the PNSB, requires strong engagement and decision-making on the part of the managers and the professionals of the team[8,15].

The verticalized management, in addition to jeopardizing the participative and democratic proposal of public policies[7], can also cause demotivation, a lack of commitment among professionals, and flaws in the rendering of services[41]. In the municipality, in addition to the management being conducted in a centralized and disconnected manner, there is also the distancing in relation to social control. This condition hinders the population's participation in the management of SUS, effective answers to health problems, and the definition of care and management models according to social demands and health needs[8].

The participative culture and the councils, as innovation in health governance in Brazil[2,4], present challenges in relation to their representativeness and to the communication between actors and institutions[42,43]. In the municipality, the crystallization of the positions of city councilmen impedes the disclosure of the interests of the population. This fragile link between representatives and the represented weakens the defense of common interests and hinders a collective construction of a social and political project[42].

The institutional positioning of the MHC is contrary to the oral healthcare model focused on the dental clinic and defended by the municipal administration. This positioning could fortify the positions favorable to the inclusion of oral health within the FHS[7]. Nonetheless, the consensus of this position in the MHC is rather uncertain and fragile. The inclusion of oral health within the FHS is defended by one of the members of social control and is shared by professionals linked to the Brazilian Dental Association. Magalhães and Xavier[44] found, as a critical point in the work of the MHC of JF, the discursive asymmetry between actors of social control and the need for greater societal engagement in their true interests.

In the municipality, there is no record of popular initiatives to call for changes in oral health services, which points to the need to expand the debate surrounding the appreciation of oral health as a right to be demanded together with the public service's structures of governance[45]. Further studies are needed, which indicate strategies to sustain the reproduction of the existing oral healthcare model, to engage in municipal governance with advice from the PNSB, and to exercise participative management. In this same sense, the strengthening of social control geared toward the recognition of oral health as a right represents a major challenge.

This study highlighted the need to establish the Oral Healthcare Network[40], since the implementation of the OHTs within the FHS should not be bureaucratic, but rather result from a group of initiative in the fulfillment of the PNSB. Although the scenario of federal de-funding for health[2,6,4] harms the maintenance and expansion of oral health services[35], the municipality must set priorities to guarantee high-quality health care. Mobilizing social actors and strengthening social control geared toward a sanitary awareness is essential in order to exercise citizenship, to combat iniquities and inequalities, and to maintain health as a right.

Conclusion

Theorization enabled the identification of the origin of the conditions of the studied phenomenon and can contribute to social actors' decision-making in future policy actions. The disease-centered hegemonic concept of social actors of the municipality contributed to the non-inclusion of oral health care within the FHS. The consequences of this concept are observed in the advice from the oral healthcare model, which is in historical misalignment with that established by the national health policies before the approval of Constitutional Amendment 95.

This study points out the *modus operandi* reproduction of the technicist practice that hegemonically mirrors the clinic and the liberal model of observed dentistry, even in countries that have universal systems and treat health as a right. In this light, it is clearly necessary for the PNSB to become a policy of the State in order to consolidate the healthcare model included in the defense of life and of social determinants, and oral health should be understood as a social right for the entire population, within a high-quality universal public system. What is needed is a policy that opposes the de-funding of health and the dismantling of SUS. Collective oral health care must be a guiding principle in the processes of professional education, with teamwork, integral care, the guidance established in the expansion of health, and the promotion of health being absolutely indispensable.

Collaborations

EL Pinheiro participated in the conception, methodology, data collection, data analysis, and writing. JHL Amaral worked on the conception, methodology, data analysis, writing, and text review. M Vasconcelos on the data analysis, methodology, and text review. VE Gomes on the conception, methodology, data analysis, and review. FF Mattos on the data analysis. CPS Andrade on the data collection, data analysis, and methodology. All authors approved the version to be published.

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