interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Articles

The insertion of oral health technicians: issues in dispute in the National Oral Health Policy

A inserção de técnicos em saúde bucal: questões em disputa na Política Nacional de Saúde Bucal (resumo: p. 16)

La inserción de técnicos en salud bucal: cuestiones en disputa en la Política Nacional de Salud Bucal (resumen: p. 16)

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The research analyzed the insertion of Oral Health Technicians (OHT) in the oral health team from 2003 and issues in dispute in the National Oral Health Policy. The study used a social-historical approach based on Pierre Bourdieu's sociology. Documentary and literature analysis and interviews were carried out with formulators and managers of oral health policy. The municipalities presented low adhesion to teams with OHT, as well as there was evidence of maintenance of the traditional relationships of division of dental work, underutilization and greater performance in prevention. The symbolic domination of the market axis prevails in the public service and in the wider dental space, even with achievements in professional regulation. This insertion has not yet been consolidated. The limitations of policy bets, in particular this issue of OHT, should subsidize new actions, considering this symbolic domination and possible ways to tackle it.

Keywords: Health policy. Oral health. Auxiliary professions. Oral health technician. Symbolic domination.

Lima AMFS, Chaves SCL. The insertion of oral health technicians: issues in dispute in the National Oral Health Policy. Interface (Botucatu). 2022; 26: e220159 https://doi.org/10.1590/interface.220159

Introduction

Since the insertion of oral health teams (eSB) in Primary Care in 2000, they can be composed of a Dental Surgeon (DS) and Oral Health Assistant (OHA) or Oral Health Technician (OHT), in the so-called modality I, or by DS, OHA, and OHT, in modality II. The acronyms OHA and OHT refer to the basic and medium level technical oral health workers, a group predominantly composed by women in Brazil[1]. The trajectory of this group began in Brazil in the 1950s, when the Ministry of Health (MoH), through the Public Health Services Foundation (FSESP), incorporated actions inspired by the North American model, the sanitary dentistry and incremental system, with emphasis on preventive and educational programs, later incorporated by school of dentistry[2]. The diffusion of these models occurs in parallel to the emergence of these workers in the country, and continues to influence their practices[2,3].

The first regulations for these professions were in 1975, by the Ministry and the Federal Council of Education, and in 1984, by the Federal Council of Dentistry (CFO)[4-6]. The first Regulatory Bill (PL) was created in 1989, but vetoed by President Itamar Franco[4,6,7]. In 2000, another attempt was rejected, and in 2003, the PL 1.140, of Representative Rubens Otoni (Workers' Party, Goias), resulted in Law 11.889, sanctioned in 2008[5,6]. The expansion of these professionals since the 1980s, in the context of the Health Reform, and the history of training and incorporation of new practices are well documented in the literature, as well as advances and difficulties, especially related to the incorporation of OHT[1-7].

The global literature advocates this incorporation by expanding coverage, access and quality of services, reducing costs and inequalities in oral health[6,8-11]. The division of dental labor is historically marked by regulatory disputes in many countries[9-13]. Therapists and hygienists, for example, exercise functions that in Brazil are exclusive to the SD[14].

Even in universal health care systems, such as Canada and the United Kingdom, dental care is greatly influenced by the free market, which since the expansion of capitalism at the end of the 19th century and the beginning of the professionalization of dentistry has produced and maintained a liberal-privatist ideology[2,15]. Market dentistry", where the assistance occurs through direct or indirect payment by the user, globally influences the organization of oral health practices in the private and public spheres[2]. In Brazil, since 1980, a space has emerged for the defense of oral health as a universal right, and of a model of care that aims to go beyond traditional public health and health and schools of dentistry, the Collective Oral Health (SBC)[16].This space will represent the "universalist pole", of the struggle for "oral health equal for all", and some of its agents occupied the bureaucratic managerial field of the National Oral Health Policy (PNSB) as of 2003. The demarcation of these two poles, universal and market dentistry, was based on Pierre Bourdieu's definition of social space[17]. It is a sociological resource to analyze the structure and dynamics of the relationships maintained by agents involved in disputes around a common interest, in this case, oral health[17,18]. These poles are not separate, and disputes are observed around this interest, whose correlation of forces also depends on the position of the agents in the specific social fields or spaces and in the wider social space.

In the PNSB analysis[c], from 2003 to 2018, the incentive to the insertion of OHT in the eSB of the Brazilian National Health System (SUS) was one of the bets put forward by the federal administration. Thus, the transformations around this insertion and the main issues in dispute on the subject were analyzed, considering the position[d] of the policy makers.

[c] This research is part of the doctoral thesis entitled "National Oral Health Policy: a socio-historical analysis from 2003 to 2018," Federal University of Bahia, started in 2018 and is nearing completion.

[d] The positions taken are analyzed through the agents' strategies, their choices, positions, and publications[19,20].

Method

Study of social-historical approach, with documentary and bibliographical analysis, secondary data and in-depth interviews with agents involved in the formulation of the PNSB, from 2003 to 2010. It was based on Bourdieu's sociology, on the notions of social space, field, doxa, habitus, agents and symbolic domination. The PNSB was understood as a governmental response that interfered in the broader dental space, in which agents with different insertions interact, such as the scientific and bureaucratic fields, and specific spaces, such as Collective Oral Health and dental entities. The field is a relatively autonomous social microcosm, with its own laws, and it is also a field of games and disputes[17,19,20].

Bourdieu[17,19] points out that there is a space of points of view on a given issue resulting from the structure of the agents' positions and trajectories, guided by habitus, an acquired system of preferences, classifications, and perceptions, linked to the field. The agents fight to transform or preserve the structure of the space and dispute the legitimate discourse, the doxa, with forces and capitals that depend on their position in the field and in the social space[20]. An individual can act in several fields at the same time, and his practical sense is permeated by relations of symbolic domination[17,19].

The main disputes and positions taken in the dental space can be related to the tension between the market pole and the universalist pole. The latter is composed of interested agents, not dominant, and active in the space of struggle for the defense of health as a universal right. In Brazil, they are in the SBC space or are influenced by it[16]. The market pole is closer to the economic field, defends the liberal practice and aims at the resulting profit[2,16]. There is the subspace of the equipment and supplies industry, the distributors, the health insurance carriers, the clinics, the technical workers and dental surgeons, as well as dentists who own offices or clinics. Besides the PNSB itself and the regulation of training, the State appears in several other instances, including the Federal Council of Dentistry (CFO) and the National Agency of Supplementary Health (ANS). The class associations, such as the Brazilian Association of Dentistry (ABO), the unions, such as the Interstate Federation of Dentists (FIO) and the National Federation of Dentists (FNO), the network of Technical Schools of SUS (RET-SUS), the public and private dental schools, the Brazilian Association of Dental Teaching (ABENO), the Brazilian Association of Collective Health (ABRASCO), and the various graduate courses are present. The arrangement of these agents and institutions is not random in space, and there are dominant and dominated[17].

It is assumed that agents of the universalist pole occupied positions of power within the bureaucratic field that managed the PNSB between 2003-2015, with more cohesive performance as a group until 2010. This made it possible to confront the dominant doxas in the Brazilian dental space and to open new possibilities. However, Bourdieu

reinforces that innovations progress and adaptations are inventions under structural pressure, and at every moment the "universe of possibles" really possible is closed, and there is always interest in certain 'possibles' at the expense of others[19].

Thus, we sought to identify the main actions of the national management for the implementation of the eSB modality II, from 2003 to 2010, and the historical series of these teams, from 2003 to 2018, through official publications of the Ministry of Health (MOH) (Frame 1). These data were analyzed along with the construction of the viewpoint space on OHT insertion, from 16 social agents, selected for being most directly involved with the management of the PNSB in the period. Data collection and interviews took place between 2019 and 2021. The trajectories were analyzed from the interviews and official resumes. Frame 2 presents this group by region, gender, race/color/ethnicity, predominant fields and spaces of action, experience and ownership of a private dental office, experience in public service, and referred participation in movements, associations, and/or entities.

The time frame corresponds to the government of Luís Inácio Lula da Silva (Lula), for presenting two relevant milestones, the publication of the PNSB (2004) and Law 11.889 (2008).

Table 1. References from the documentary and secondary data analysis.

Year	Reference
2003	Ordinance nº 396/GM (04/04/03). Readjusts the financing of the PSF, ACS and Oral Health Actions.
	National Health Council Resolution no. 335 (11/27/03). Approves the Education and Development Policy for SUS and the Permanent Education Hubs.
2004	Ordinance no 198/GM/MS (02/13/2004). Establishes the National Policy of Continuing Education in Health.
	Ordinance nº 74/GM (22/01/2004). Readjusts the financial incentives for the OSH in the PSF and inserts prosthetic procedures in Primary Care.
	Guidelines of the National Oral Health Policy.
	Profile of Competencies of the Dental Hygiene Technician and the Dental Office Assistant.
2005	Report from the 3rd National Oral Health Conference
2006	Ordinance No. 648/GM (March 28, 2006). Approves the National Primary Care Policy.
	Basic Health Notebooks (n.17) -Mouth Health
	Ordinance nº 650/GM (03/29/2006). Defines fixed and variable PAB values for PSF and PACS
2007	Ordinance GM/MS no. 1.996 (08/20/2007). Provides guidelines for the implementation of the National Policy of Continuing Education in Health.
2008	Ordinance No. 3066/GM (12/23/2008). Defines values of Variable PAB for ESF and Oral Health.
	Federal Law no. 11.889 (12/24/2008). Regulates the exercise of the professions of oral health technician - OHT and oral health assistant - OHA.
	Management Report. Secretariat of Work Management and Health Education.
2009	Ordinance No. 2372/GM (07/10/2009). Creates the dental equipment supply plan for the ESF.
	Port. Nº 3189/GM (12/18/2009). Provides for the implementation of the Middle Level Professionals for Health Training Program (PROFAPS).
2010	Letter from the XX National Meeting of Dental Public Service Administrators and Technicians - ENATESPO. Vitória-ES.
	Management Report. Secretariat of Work Management and Health Education.
2011	Ordinance No. 1599/GM (July 9, 2011). Defines values of Variable PAB for ESF, eSB and ACS.
2015	OHT and OHA Manual Volume 1. Regional Council of Dentistry of São Paulo.
2021	e-Gestor Primary Care Public Reports. History of Coverage and of the number of teams and services funded. Accessed on 04/23/2021.
	Statistics. Federal Council of Dentistry. Accessed on 06/30/2021.

Source: Authors.

Frame 2. Interviewees participating in the formulation and implementation of the PNSB, 2003-2010, Brazil.

Agent	Gender and race/ color/ethnicity self-declared*	Region of activity	Predominant field(s)/space(s)	Office experience	Had a consulting office	Experience in the dental public service	Referred participation in student/ professional movements/ associations/entities*
1	M/W	Southeast	Scientific	No	No	Yes	ME, Cebes, MBRO, Enatespo, Abrasco, Abrasbuco
2	M/Ni	Midwest	Bureaucratic/ Space of the dental entities	Yes	Yes	Yes	ME, Enatespo, FIO
3	F/Ni	Midwest	Bureaucratic/ Space of the dental entities	Yes	Yes	Yes	ME, Enatespo, FIO, Trade Unions, Political Party Health Sector
4	M/B	North	Bureaucratic/ Space of the dental entities	Yes	Yes	Yes	ME, Enatespo, Unions, CRO
5	M/W	South	Bureaucratic/ Scientific	No	No	Yes	ME, Enatespo
6	F/W	South	Bureaucratic/ Scientific	Yes	Yes	Yes	Enatespo
7	M/W	South	Scientific	Yes	Yes	Yes	ME, MBRO, Cebes, Enatespo
8	M/W	Southeast	Bureaucratic/ Space of the dental entities	Yes	Yes	Yes	ME, MBRO, Enatespo, Cebes, CRO
9	M/W	Southeast	Scientific	Yes	Yes	Yes	MBRO, Enatespo, Abrasco
10	M/W	Northeast	Bureaucratic/ Political	No	No	Yes	ME, CRO, Political Party Health Sector
11	M/W	Northeast	Scientific	Yes	No	Yes	ME, MBRO, Enatespo, Political Party Health Sector
12	M/W	South	Bureaucratic/ Scientific	Yes	Yes	Yes	ME, Political Party Health Sector
13	M/W	Northeast	Bureaucratic/ Scientific	No	No	Yes	ME, Enatespo
14	M/W	Midwest	Bureaucratic	Yes	Yes	No	No participation
15	M/W	Southeast	Bureaucratic	Yes	No	Yes	ME, CRO
16	M/W	Southeast	Bureaucratic	Yes	No	No	No participation

*M=Male; F=Female; W=White; B= browns and blacks; Ni= no info
**ME=Student Movement; Cebes=Brazilian Center for Health Studies; MBRO=Brazilian Movement of Dental Renewal; Enatespo=National Meeting of Technicians of the Public Dental Service; Abrasco=Brazilian Association of Collective Health; Abrasbuco=Brazilian Association of Collective Oral Health; CRO=Regional Council of Dentistry; FIO=Interstate Federation of Dentists.
Sources: Interviews and official resumes.

The literature was consulted in SciELO, PubMed, Scopus, Lilacs, and Medline, by the indexed descriptors: oral health, oral health technician, health personnel, dental assistants. Articles in Portuguese and English, theses, dissertations, and chapters on the theme from 2003-2020 were included.

N-Vivo 11 software was used for document and interview analysis, and Excel for secondary data. The study was approved by the Research Ethics Committee from the Institute of Collective Health at the Federal University of Bahia (ordinance nº1.466.724). The presentation and discussion of the results was divided into two sections. The first focused on the implementation of the eSB modality II, and the second on the main issues in dispute that emerged from the space of the formulators' points of view, considering their legal, financial, administrative, political and ideological nature.

Results and discussion

The implementation of eSB mode II

In the period analyzed, we identified actions of the MH for training, regulation and insertion of OHA and OHT in the eSB (Frame 1). There were adjustments in the financial incentive, donation of equipment, and initiatives in training through the Secretariat of Work and Health Education Management (SGTES). Gradually, this workforce has been incorporated, however, especially in the private network, part is still trained by the dentist himself[8,21].

It is worth noting that the institutionalized training of these professionals has been taking place in Brazil since the 1980s, through training centers and technical schools, as components of the RET-SUS[3]. Starting in 2004, SGTES also financed projects and the expansion of seats in this network, which already had 30 schools in 1997, rising to 36 in 2014, and 41 in 2018[3,22]. In 2008, there were 14 courses in 9 states, with 2,928 vacancies for OHT. In 2009, the Middle Level Professionals for Health Training Program (PROFAPS) was launched, training 1,690 OHT in 2010.

In 2003, the CFO had only 4,799 registered TSB, and using the parameter of 1 TSB/750 inhabitants, the best relation was in the Federal District (1/6,000 pop.), with alarming lack in the states of Tocantins (1/1,230,000 pop.) and Maranhão (1/325,000 pop.), and a national average of In 2003, the CFO had only 4,799 registered TSB, and using the parameter of 1 TSB/750 popitants, the best relation was in the Federal District (1/6,000 pop.), with alarming lack in the states of Tocantins (1/1,230,000 pop.) and Maranhão (1/325,000 pop.), and national average of 1 OHT/36 DS[23]. In 2010, there were 231,610 dentists, 10,680 OHT, and 79,603 OHA. In 2014, there were 18,847 TSB, however, the incorporation of this professional in SUS was only 10%[24].

The analysis reveals the shortcomings of the implementation of the teams with OHT. Adherence to modality II was low throughout the country. In 2003 there were 5,631 eSB modality I and 539 eSB modality II, rising to 18,731 and 1,693, respectively, in 2010. In 2014, modality II rose to 2,257, and in 2018 there were 2,145, representing only 8.03% of teams. There was greater deployment of mode II in the Southeast and South (Table 1).

Table 1. Historical series of implementation of eSBs. Brazil and macro-regions, 2003 2018

	Brazil			North			Northeast			Midwest			Southeast			South		
Year*	eSB Mod I	eSB Mod II	Total	eSB Mod I	eSB Mod II	Total	eSB Mod I	eSB Mod II	Total	eSB Mod I	eSB Mod II	Total	eSB Mod I	eSB Mod II	Total	eSB Mod I	eSB Mod II	Total
2003	5.631	539	6.170	339	10	349	2.968	86	3.054	565	84	649	986	153	1.139	773	206	979
2004	8.234	717	8.951	448	17	465	4.417	122	4.539	708	131	839	1.576	213	1.789	1.085	234	1.319
2005	11.717	886	12.603	695	24	719	6.416	136	6.552	981	145	1.126	2.191	276	2.467	1.434	305	1.739
2006	14.019	1.067	15.086	922	27	949	7.573	154	7.727	1.090	148	1.238	2.759	381	3.140	1.675	357	2.032
2007	14.563	1.131	15.694	1.036	35	1.071	7.710	158	7.868	1.098	182	1.280	3.010	392	3.402	1.709	364	2.073
2008	16.423	1.384	17.807	1.181	51	1.232	8.487	211	8.698	1.267	186	1.453	3.549	521	4.070	1.939	415	2.354
2009	17.465	1.517	18.982	1.331	67	1.398	8.937	215	9.152	1.315	189	1.504	3.786	624	4.410	2.096	422	2.518
2010	18.731	1.693	20.424	1.447	84	1.531	9.433	257	9.690	1.450	201	1.651	4.197	720	4.917	2.204	431	2.635
2011	19.492	1.933	21.425	1.496	86	1.582	9.687	309	9.996	1.513	196	1.709	4.503	906	5.409	2.293	436	2.729
2012	20.155	2.048	22.203	1.543	93	1.636	9.772	306	10.078	1.635	189	1.824	4.773	995	5.768	2.432	465	2.897
2013	21.016	2.134	23.150	1.638	92	1.730	10.191	314	10.505	1.678	184	1.862	4.969	1.089	6.058	2.540	455	2.995
2014	22.066	2.257	24.323	1.748	101	1.849	10.615	322	10.937	1.800	173	1.973	5.200	1.182	6.382	2.703	479	3.182
2015	22.227	2.240	24.467	1.769	106	1.875	10.708	318	11.026	1.813	165	1.978	5.234	1.176	6.410	2.703	475	3.178
2016	22.194	2.190	24.384	1.727	94	1.821	10.599	323	10.922	1.798	156	1.954	5.358	1.157	6.515	2.712	460	3.172
2017	23.721	2.184	25.905	1.859	100	1.959	11.345	320	11.665	1.995	152	2.147	5.719	1.172	6.891	2.803	440	3.243
2018	24.567	2.145	26.712	2.018	113	2.131	11.684	321	12.005	2.163	144	2.307	5.903	1.158	7.061	2.799	409	3.208

*values referring to December. eSB Mod I-modal oral health team I; eSB Mod II-modal oral health team II.
Source: Public Reports e-Gestor AB, Ministry of Health, accessed on 04/23/2021.

In 2018, if at least half of the eSB were modality II, the SUS would have absorbed 40% of this workforce (n=13,356). In July 2021, the CFO registered 335,929 dentists, 33,084 OHT and 146,567 OHA. The Southeast region has 33.4% of the total number of TSB, and most of the training centers and eSB modality II[24]. In 2010, Minas Gerais (MG) had the highest number of mode II teams (n=520), followed by Paraná (n=386), Goiás (n=115), São Paulo (n=113) and Ceará (n=123). MG continues to have more active OHT registrations (n=4,814) and more mode II eSB (n=769). The better implementation in the Southeast and South, in addition to the better HDI, reflect differences in investments, reinforcing the importance of federal induction in reducing regional disparities[25].

In Belo Horizonte, in 2007, the teams were improved and a protocol was created, including the practice of atraumatic restoration[26]. In that year, the city had 189 eSB, with 27.17% of population coverage and 53 modality II eSB (28%). Noteworthy is the study of Sanglard-Oliveira *et al*.[12] because of the comprehensiveness of the sample of OHT (n=231), and for revealing that more than half performed direct intraoral actions. More recent studies on MG have reinforced the positive association between modality II and improvement in indicators and work process[25,27]. However, considering the whole country, there was little absorption of OHT in the services, and they often exercise OHA functions[21,24,28,29]. In the SUS, there is greater participation in promotion and prevention activities, an aspect that reveals, to some extent, the persistence of the SESP Foundation model[3,24,28,30-32].

In regulation, the main highlight was the creation of Law 11.889 (2008). As an act of the State and a regulatory framework, it represented an achievement, including greater support for disputes in the legal field and in the labor market. Frazão e Narvai[7] compared the Law with previous regulations and concluded that despite the quantitative reduction, there were gains in the scope of direct actions and viability of other actions. As for Zanetti *et al*.[13] they consider that there have been revisions and updates of previous competencies, with ambiguities. Oliveira[5] points out losses in the wording during the course of the PL, and the substitutes maintained technical and corporate limits. In this debate, the entities were divided. A public hearing was held in 2005 in the House of Representatives, and new changes were made after an agreement among FIO, CFO, ABO, and the Brazilian Association of Dental Surgeons. In the perception of OHT and OHA leaders, despite some losses in the text, the Law was a historical achievement[5].

The legal and symbolic domination of the DS around the competences of the OHT is maintained in Brazil[9]. The ambiguities and limitations of the Law contribute to maintaining the dominated status quo of this professional[5-7,13,24,28]. This issue was pointed out in Uberlândia, MG, as one of the main reasons for not exercising the profession, together with low salaries and lack of appreciation by the DS[29]. In Vitória in the state de Espirito Santo, besides these aspects, the absence of a second piece of dental equipment and of protocols, the lack of time and work conditions for planning construction were underlined[33]. And finally, a competitive labor market, with DS and OHT receiving similar salaries[33].

The space of the formulating agents' points of view: main issues in dispute

The group of formulators of the PNSB showed a predominance of trajectory linked to the bureaucratic field (n=12), followed by the scientific field (n=8) and the space of the dental entities (n=4). There was regional diversity, but with less representation from the North region (n=1). Majority of men (n=14) and self-declared white race/color/ethnicity (n=13) (Table 2). White homology and male domination was verified in this section, as the dominant fraction in the field of power of the state bureaucracy[34].

For this group, the performance of direct intraoral actions by the OHT is the main issue in dispute.

> They still understand that those people are taking the place of dentists, they are doing things that were supposed to be exclusively dentists [...] (E10)

> The initial proposal was a greater expansion of attributions, to be able to do restorations, to do periodontal procedures that were larger than those that are in the legislation, to exercise the role that the hygienists, in a certain way, develop in other countries. (E8)

Zanetti *et al*.[13] argue that, in Brazil, disputes over jurisdictional boundaries of competence are marked by three main ideological currents, professionalism, scientific administration, and administrative-politics. This proposal converges with the classification of Vieira-da-Silva[18] of the market, traditional and universal public health. Bourdieu[18,20] states that despite being independent, there is a homology between the agents' position space and the space of position-taking. We verified this homology in the interviewees. Even with 75% (n=12) having some experience in private practice, the participation in movements and organizations defending the Health Reform, and experience in public service, were differentials for entry and adjustments to the universalist pole.

In the case of leaders of dental entities closer to the market pole, such as the CFO, the rejection has been justified by market reserve, judicial risk for the DS, and the perception of lower quality in the work of an OHT[6]. In the universalist pole, the OHT was progressively incorporated, although more in the prevention[14]. Agents from this pole defend teamwork, expansion of the work capacity, and access to the SUS[6,7].

> We failed in the expansion of oral health teams, when I speak of team, I mean the team itself, dentist surgeon, oral health technicians and assistants [...], we should only speak of oral health team when we actually have the team, university-level professional, mid-level and auxiliary professional [...]. (E1)

The ENATESPO of 2010 ruled that modality I be transitory, and that managers assume a deadline for implementation of modality II as the standard[5,6]. The fact of OHT being optional was a matter[13]. This analysis becomes more complex in view of the need for greater federal transfers and counterpart contributions from the other entities to guarantee the minimum number of OHTs, the different epidemiological, social, and economic realities of the municipalities, as well as the autonomy of the management levels, elements that are often disregarded or little addressed in the studies.

The confrontations in the political field are highlighted:

> [...] the interests linked to market dentistry prevailed [...] there was a lot of pressure, many representatives put pressure not to approve the project, it was much modified in relation to what it was initially [...] the current law was ambiguous in some articles, this ambiguity stems from defects in legislative techniques, these defects are not because people didn't know how to write the article, they stem from the need to reconcile interests and compositions that are incompatible and that ultimately expressed concessions to market dentistry [...]. (E1)

In the financial and administrative dimension, the agents of the bureaucratic field highlight the budget limitations and the Fiscal Responsibility Law as restrictions to the expansion of the payroll. In the last adjustment of Lula's government, in 2008, the MH transferred a monthly value of 2.6 thousand Reais to eSB modality II, only 600 Reais difference to modality I. The minimum wage that year was R$415.00. The municipal counterpart, therefore, remained high, especially for municipalities that did not receive the dental equipment. The precarious conditions of the services for insertion of extra equipment, besides the need for adjustments in the work process were highlighted.

> [...] the physical structure of the units that are still precarious, a new structure of services has to be made to attend a type II team [...]. (E15)

> [...] the Ministry transferred the money for implementation and costs, now the municipalities and states were responsible for the human resources, that was one of the obstacles, because many municipalities were financially exhausted [...]. (E2)

In the political and ideological aspects, the strength of corporate thinking, the opposing lobby of dentists and entities, and the lack of understanding and/or opposition of managers, also influenced by these categories of thought, were evidenced. Historically, the dental corporation shows distance from the experience of these professionals[33]. These dominant views are present in many countries with different social realities and availability of DSs[8,11].

> [...]. The manager's own understanding, the understanding of 4-handed work, well, not everyone has it. The logic of the biomedical model is still very strong in the managers' heads, so for them what solves it is the dentist [...]. (E4)

> [...] inclusive, it was an entity with banners that were against and held banners in the Federal Chamber against the approval of the technicians' bill, because they said they were going to take space from dentists, it was a very serious issue [...]. (E2)

Zanetti *et al*.[35] understand the OHT as a bureaucratic body subjugated to two others and, therefore, vulnerable to the interaction of two rationalities, one more administrative, of the managers, and the other more corporate, of the clinical dentists. In management, the authors highlight the rational motivations for the presence of an OHT on the team[35]. However, this rationality is also influenced by the dominant habits in the medical field and in the dental space, tied to the interests of the market pole, and maintains the correlation of forces unfavorable to the integration and more autonomy of OHTs[16,17].

The reduction in the capacity for mobilization and political confrontation of the entities representing these professionals appears as an issue, and deserves further study.

> [...] the debate was held with the national entities, there was also the participation of entities representing oral health technicians and assistants, which today is very disorganized, but at that time there was a national organization, with an important role in defining the Law [...]. (E8)

> [...] the technicians' defense bodies, they have not been strong enough, they are not yet so strengthened [...]. (E6)

Among the entities that position themselves in defense of these professions, the FIO, a union entity, stands out, and its relationship with the National Association of Assistants and Technicians in Dentistry (ANATO)[4,7]. Leaders of the FIO worked with the National Coordination of Oral Health and in the National Health Council in the period. We identified the relation between the founding agents of the FIO with ANATO, an entity that had its first organizational initiatives in the 1980s, after the formation of the National Commission of Dental Assistants and Technicians (CONATO)[36]. One of the reasons for its emergence was the interest of the category in participating in the CFO Commissions, which required professional organization. CONATO has been working for regulation since the first Bill (1989), and was the forerunner of ANATO, which continued working for the approval of the Law in 2008[4,36].

There was also recognition of the insufficiencies of the policy for training of OHTs and the lack of regulation of the opening of new dental schools, which contributes to an excessive number of DSs. The literature also points out the uncontrolled expansion of DSs as a factor in the worsening of legal disputes over competencies[13].

> [...] colleges generate a mass of people with quality that ranges from very debatable to excellence, you will have an oral health assistant or oral health technician to do what? If these underemployed professionals do exactly what these professionals should do [...]. (E7)

The analysis of this space of viewpoints of agents who occupied the field of power in the bureaucratic field of the PNSB evidenced the continuity of disputes around the division of dental work in Brazil. The hypotheses about its mechanisms of reproduction and different local realities require further study. This formulating group continues to dispute the PNSB in the power spaces in the bureaucratic, scientific and political fields, and in the dental entities, and the present analysis can contribute to updating the responses and inducing federal policies in future scenarios, especially in those in which the correlation of forces in the field of state power is again favorable to the universalist pole.

Conclusion

The insertion of OHT as advocated by the universalist pole may become a voided "possible", i.e., historically unrealized, according to the analysis supported by the referential of Pierre Bourdieu. Despite the efforts in the legal, bureaucratic, political fields, and the space of the entities, modality II had low implementation, with a downward trend since 2014. Law 11.889 was an achievement; however, the final text maintained the monopoly of dentists in professional practice, with no gain in autonomy for OHT. The participation of these primary and secondary level workers in the formulation of the PNSB was not evidenced. The national monthly costing incentive remained unattractive to managers. In the places where insertion occurred, traditional relations of division of dental work and underutilization of OHT predominate. Legal, practical, and symbolic domination of the market pole prevail in the SUS and in the broader dental space. The opening of possibilities provided by the PNSB has not yet been enough to bring about changes in the dominant doxa and habitus around this issue. Transformations in the work processes are still under dispute in the micropolitics of management and services. OHTs, dentists, entities, and researchers from the universalist pole remain as interested agents. Studies that update information and analyze the actions and positions of technicians as protagonists, as well as those of the market pole on the subject are necessary.

The sociological perspective of political analysis undertaken emphasizes the role of symbolic domination to legitimize the status quo and give an appearance of "natural" to the relations of domination. It is necessary to know and recognize the immanent rules and laws of the field and objects in dispute in order to continue to "play the game" and transform it. The analysis of the Brazilian case revealed potentialities and limitations of the bets that have not yet been consolidated in the space of the possible, still open, and, subsidize future actions, considering the persistence of this domination and possible ways to confront it.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Funding

This study was supported by the Coordination for the Improvement of Higher Education Personnel (Capes) through the Edital 010/2019 - Capes PrInt UFBA - Sandwich Doctorate Scholarship.

Conflict of interest

The authors have no conflict of interest to declare.

Editor
Antonio Pithon Cyrino
Associated editor
Franklin Delano Soares Forte

Translator
Félix Héctor Rigoli

Submitted on
11/27/21
Approved on
03/16/22

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Analisou-se a inserção de técnicos em saúde bucal (TSB) na equipe de saúde bucal a partir de 2003 e questões em disputa na Política Nacional de Saúde Bucal. Estudo de abordagem sócio-histórica apoiado na sociologia de Pierre Bourdieu. Realizou-se análise documental, da literatura e entrevistas em profundidade com agentes formuladores e gestores da Política Nacional de Saúde Bucal. Houve baixa adesão à equipe com TSB pelos municípios brasileiros e evidências de manutenção das relações tradicionais de divisão do trabalho odontológico, subutilização do TSB e maior atuação em prevenção. A dominação simbólica do polo do mercado prevalece no serviço público e no espaço odontológico mais amplo, mesmo com conquistas na regulamentação profissional. Essa inserção ainda não se consolidou. As limitações das apostas da política, particularmente a questão do TSB, devem subsidiar novas ações, considerando a dominação simbólica e possíveis formas de enfrentá-la.

Palavras-chave: Política de saúde. Saúde bucal. Profissões auxiliares. Técnico em saúde bucal. Dominação simbólica.

Se analizó la inserción de técnicos en salud bucal (TSB) en el equipo de salud bucal a partir de 2003 y cuestiones en disputa en la Política Nacional de Salud Bucal. Estudio de abordaje sociohistórico apoyado en la sociología de Pierre Bourdieu. Se realizó un análisis documental de la literatura y entrevistas en profundidad con agentes formuladores y gestores de la Política Nacional de Salud Bucal. Hubo baja adhesión al equipo con TSB por parte de los municipios brasileños y evidencias de mantenimiento de las relaciones tradicionales de división del trabajo odontológico, subutilización y mayor actuación en prevención. La dominación simbólica del polo del mercado prevalece en el servicio público y en el espacio odontológico más amplio, incluso con conquistas en la reglamentación profesional. Esa inserción aún no se ha consolidado. Las limitaciones de las apuestas de la política, particularmente la cuestión del TSB, deben subsidiar nuevas acciones, considerando la dominación simbólica y posibles formas de enfrentarla.

Palabras clave: Política de salud. Salud bucal. Profesiones auxiliares. Técnico en salud bucal. Dominación simbólica.