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Collective oral health: ways from sanitary dentistry to buccality

ABSTRACT

This essay focuses on the pioneer activities of public health dentistry in Brazil and its evolution in the 20th century with emphasis on the emergency of a landmark, the *sanitary dentistry*. Social and preventive dentistry and market dentistry, with reference to the main theoretical works representative of these trends, are presented. The essential characteristics of *collective oral health* (Brazilian variant of public health dentistry) and *buccality* are presented. The relationship between collective oral health and collective health as well as the implications of the buccality concept for the development of public health dentistry actions and new guidance of clinical practice in public services of the Brazilian Health System (SUS) are discussed. The key elements of an agenda for collective oral health based on proposals presented at the 3rd National Conference on Oral Health are addressed.

KEYWORDS: Public health. Health promotion. Health education. Oral health. Dental health services. Collective health.

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INTRODUCTION

The publication of "Manual de odontologia sanitária" (The manual of sanitary dentistry)[5] in 1960 by Mário Chaves has deeply marked the theory and practice of public health interventions in dentistry in Brazil, influenced several generations and extended its outreach to the whole Latin America. The publication of a Spanish version of this work by the Pan American Health Organization[6] two years later was its definite recognition.

Vasconcellos[22] points out that Law 1,280 of 12/19/1911 established the first three positions of dentists in public services in the state of São Paulo, Southern Brazil. So public dental care services began to be provided to the State Police Force and to those people in custody of state authorities under the State Justice and Security Department. In 1929, dental providers were incorporated to the staff of the State Interior Department School Health Supervision, at that time in charge of education and health activities statewide. In 1932, after São Paulo State Education and Health Department was created, the Hygiene and Dental Care Inspector's Department was established in the health care service "to provide care to state public schoolchildren". Vasconcellos underlines that, when São Paulo State Health Department was created in 1947, the recommendation was that all health centers should have "oral-dental care services" available. Since then the organization of public dental care has been marked by successive institutional arrangements both at the state of São Paulo and national level.[21]

While education actions were developed[21,22] these providers' clinical practice basically replicated that of dentists in their private practices. Patients were approached on an individual basis and no population-based diagnoses were made, and nor even was applied any programming technology derived from planning processes that included oral health of the population as a whole.[14]

This scenario changed dramatically when, in 1952, there were implemented by the *Serviço Especial de Saúde Pública* (SESP - Special Public Health Service) the first sanitary dentistry programs, first in the city of Aimorés, state of Minas Gerais, then in several municipalities of the Northern, Northeastern, and Southern regions of Brazil.[14] These programs mainly targeted schoolchildren since they were regarded as epidemiologically more vulnerable and, at the same time, most sensitive to public health interventions. Methods and techniques of health planning and programming were incorporated to the daily practice of dozens of dental providers in many regions of Brazil.[13,14]

Narvai[14] emphasizes that, in the context of the Second World War, the "restricted" access to private dental practices to most Brazilians has resulted in a small but significant rupture of dental care services production due to the establishment of a state-run modality for these services. Market dentistry remained absolutely predominant but it was no longer the sole care modality in dental health.

The new *state-run modality of dental services production* was based on sanitary dentistry.

The present study focuses on the pioneer activities of public health dentistry in Brazil and their evolution in the 20th century with emphasis to the emergency of a landmark, sanitary dentistry.

SANITARY DENTISTRY

Chaves[5] describes sanitary dentistry as "a discipline of public health that addresses the diagnosis and treatment of oral health conditions (...) in the community," specifically "a city or part of it, a region, country or group of countries (...). At any level the weight is on the vision of the whole of the community, the more complex the greater its geographical area and population (...). The notion that sanitary dentistry is *prevention* or it is *care to the poor, pregnant women, schoolchildren or any other group* (italicized in the original) is not substantiated. Sanitary dentistry is an effort undertaken by the community, in the community and for the community to achieve the best average oral health conditions."

SESP experience in Aimorés and other municipalities was the subject of study and consideration of public health experts with good theoretical background and has originated several articles, especially Freire's[10] (1964), and Chaves' book[5].

The "Manual de odontologia sanitároa" was developed based on public dental health providers' practice in Brazil during the 1950s of the 20th century. Another important landmark, part of the process of thinking and streamlining such experiences, was the Public Health Specialization Program for Dentists, developed at the *Faculdade de Saúde Pública da Universidade de São Paulo* (FSP-USP).[8] Narvai[14] underlines the role of Mário Chaves and Alfredo Reis Viegas in developing this program and highlights that "to these pioneers of public health dentistry in Brazil can be credited the theoretical essentials guiding the training of hundreds of public health dentists in Brazil and other countries in Latin America."

The main theoretical tool of sanitary dentistry used for

diagnosing and treating the community's oral health conditions was the so-called *incremental system*. Pinto[20] conceives it as a "method of work aiming at providing comprehensive dental care for a given population eliminating their cumulative needs and subsequent monitoring according to priority criteria based on age and conditions," and underlines the planning of "an horizontal action through preventive programs to monitor the incidence of conditions, and a vertical action through treatment programs to solve prevalent conditions. In parallel, those actions are supported by an education program". He points out that, although usually applied in schoolchildren for operational reasons, "its general methodology, after some adjustments, can be easily applied to other groups".

Assessing the application of this technology in Brazil, Diniz[8] ponders "it was practically a cure-all to public health authorities and dental services managers at the central level of both health agencies and human resources training organizations," pointing out that one of SESP's technical regulations "recommended to focus more on (...) schoolchildren as this would allow, due to their concentration in schools, a systematic effort and dynamic action (...) providing treatment at the very education setting."

Given these characteristics and recommendations, the tool was mixed up with sanitary dentistry itself and the idea – highly praised by Chaves – of "an effort developed by the community, in the community and for the community" was lost. Sanitary dentistry has then become limited to dental programs to schoolchildren. Narvai[14] thinks the incremental system lost its effectiveness as "it became a prescription, a model to be replicated acritically," and in contexts of "managerial inadequacy, paucity of resources and lack of epidemiological approach to the programs".

Sanitary dentistry had the historical task to build on a dental practice that would break with market dentistry but it failed.

MARKET DENTISTRY

Market dentistry[14] has always prevailed in the Brazilian health system. In general, its practice conceived to be focus on dental care to ailing people, and provided exclusively by an individual provider in a restricted clinical-surgical setting not only prevails in the private sector, but continues to have a powerful impact on public services. *Market dentistry* lies on biological and individual core elements from which its clinical practice are built up, and on its organicity to the capitalist mode of production, making health care into goods, mining health as a common asset with no exchange value, and imposing widely known mercantile and ethics deformations.[15]

In this beginning of the 21st century, most public dental services replicate mechanically and acritically core elements of the private's sector dental practice model.

SOCIAL AND PREVENTIVE DENTISTRY

In Brazil, the theoretical concepts of sanitary dentistry have been associated to an authoritarian period; they reached their apogee in the Brazilian military dictatorship darkest years (1968-1978)[14] but subsequently declined in the 1980.

The second half of the last century witnessed the rise of several *forms of dentistry* in Brazil. In university settings, the term *social and preventive dentistry* was widely recognized as locus of this profusion of propositions. In "Odontologia e saúde bucal coletiva" (Dentistry and collective oral health), Narvai[14] describes the following different forms of dentistry: sanitary, preventive, social, simplified, comprehensive, community and also collective oral health. He examines them vis-à-vis in the contexts they arose from and explores their connections with more general proposals to the health sector and different society designs.

In 1989, Pinto[20] published his book, "Saúde bucal: odontologia social e preventiva" (Oral health: social and preventive dentistry), which became a reference work in the field. This author organized, systematized and updated the theoretical foundations on which should lie the planning and programming of public health dentistry actions. Together with the second edition of Mário Chaves' book,[7] an expanded and revised publication released in 1977 with the new title "Odontologia social" (Social dentistry), Pinto's book constituted a significant contribution to both service planning and human resources training.

By the end of the last century, the *Associação Brasileira de Odontologia Preventiva* (ABOPREV - Brazilian Association of Preventive Dentistry) published "Promoção de saúde bucal" (Oral health promotion), a collection of works from dozens of Brazilian and foreign authors coordinated by Kriger,[11] that further described the technical and scientific foundations on which planning and management of dental services could be built on. More recently, further significant efforts have been undertaken with the publication of "Odontologia em saúde coletiva" (Dentistry in collective health), by Pereira[18] (2003), and "Saúde bucal coletiva: metodologia de trabalho e práticas" (Collective oral health: work methodology and practices), by Angelim[1] (2006).

After the publication of "Epidemiologia e bioestatística na pesquisa odontológica" (Epidemiology and biostatistics in dentistry research), by Luiz et al[12] (2005), and "Epidemiologia da saúde bucal" (Epidemiology of oral health), by Antunes & Peres[2] (2006), the field, cleared by sanitary dentistry, continued to stress its calling for contemporaneousness and for highly knowledgeable and expert exchange of ideas with the best international scientific production on account of the quality and high theoretical content of these works.

In 2000 the fourth edition of Pinto's[19] book was published under a new title, "Saúde bucal coletiva" (Collective oral health).

With regard to that, Narvai[15] (2001) points out to the increased use of the term *collective oral health* in technical and scientific publications, arguing that *collective* was added to the term *oral health* in 1980 in Brazil. According to him, *collective oral health* has become widely known, especially in the state of São Paulo by clear influence of the collective health movement, and that besides showing in many articles and books, a national association (*Associação Brasileira de Saúde Bucal Coletiva* – Abrasbuco – Brazilian Association of Collective Oral Health) was created in 1998 having the term collective oral health as part of its official denomination.

COLLECTIVE ORAL HEALTH

According to Narvai & Frazão,[17] "collective oral health is a field of knowledge and practices that are part of a broader whole known as *collective health* and, that at the same time, also comprises the *dentistry* field, incorporating it and redefining it and thus necessarily transcending it". For them, collective oral health (COH) advocates that people's oral health "is a result not only of dental practice but also of social constructions consciously created by people in any concrete situation, including health providers and also (or even) dentists. As a social process, each situation is unique, singular, historical, and does not allow to being mechanically replicated or reproduced in any other concrete situation since the elements and dimensions of each process are contradictory, conflicting and characterized by individual negotiations and agreements". This concept implies (and, in a sense, imposes) an epistemological rupture of COH with (market) *dentistry* since its theoretical framework is set on biological and individual foundations (on which its practice is based) and its practice disregards the effect of complex social processes.

Frazão[9] argues that COH intends to "replace all types of *technicism* and de *biologism* existing in specific formulations in social and preventive dentistry, (....) by carrying out a theoretical reconstruction of collective health thinking and action in an articulate and organic manner and reinforcing the historical compromise of collective health with society's quality of life and people's rights protection against both the predatory action of capital and the authoritarian action of the State."

This replacement of "all types of technicism and biologism" has gained significant theoretical contribution from the proposal of *buccality*" formulated by Botazzo[3] (2000) in "Da arte dentária" (*Of dental art)*, Botazzo states that buccality consists of a theoretical-methodological approach where "oral mechanisms," identified as mastication, language and eroticism, are key, and are defined as "world's consumption" to naturally survive (mastication), "word production and consumption" (language), and love relationship and production of "sexual oral acts" (erotica), respectively.[3,4]

Botazzo[4] emphasizes that health does not exhaust itself in the clinical form and that dentistry theory does not manage to recover human beings as a whole, opening up infinite possibilities to produce knowledge and practices from the reference of buccality.

In this sense, Narvai[16] points out that the epistemological rupture with (market) dentistry COH intends to carry out entails developing a *praxis* that should dialectically break with the prevailing dental practice. Such rupture requires the development of dentistry efforts based on (*all*) people's needs and that, in opposition to the market logic, be able to break with the *status quo* basically characterized by the merchantability of services and maintenance of the monopoly of access to (*all*) dental resources by elites. This author believes COH has inherently a double intent: on one hand, it intends *to render* oral health *less dental*; on the other hand, it intends to assure to all access to all required resources effectively establishing dental care as a human right.

AN AGENDA FOR COLLECTIVE ORAL HEALTH

In order to promote changes, COH needs to develop an agenda taking into consideration the relevant events in the beginning of the 21st century. *Sistema Único de Saúde* (SUS – Brazilian Health System) implementation is at a stage indicating the possibility of carrying out actions that would allow to meet the needs of all people (principle of universality), making it possible their access to all dental and general health resources they need (principle of compre-

hensiveness), and offering more to those in most need (principle of equity).

SUS is recognizably an important social achievement of Brazilian people that proved to be able to survive the neoliberal avalanche that, in the last decades, has destroyed most public health systems in Latin America. Recognizing that does not mean to overlook the serious difficulties the health sector has had to face due to either poor life conditions of most population (which have great impact on health) or budget and management problems characteristic of public administration.

SUS framework, an enduring social fabric involving hundreds of agencies, institutions, trade union organizations, patient advocacy groups among others, has being able to prevail over the fragmented and centralized public health structure that predominated in Brazil in the last century.

An accomplishment of this process is the establishment of periodical health meetings held in the three levels of government, among which are oral health meetings. These meetings should be the main reference for the *collective oral health* agenda.

The Final Report of the Third National Meeting on Oral health (CNSB) (Brasília, 2004)* illustrates how this agenda should be drawn up. This document describes a process that directly involved around 90,000 people nationwide and stresses that "oral health and teeth conditions are definitely one of the most significant signs of social exclusion. Fully addressing these problems requires more than aid actions developed by experts. It requires intersectorial policies, integrating preventive and treatment actions with rehabilitation, health promotion, universal access, public responsibility at all society's levels and, more importantly, government compromise and institutional involvement at all three levels of government".

The Third CNSB Final Report includes 298 proposals adopted by 883 representatives elected in 27 state meetings which, in turn, involved representatives nominated in 2,542 regional or local meetings on oral health. This document is based on four focal points, namely: 1) education and empowerment; 2) social leadership, participatory management and oral health; 3) oral health training and work; and, 4) financing and organization of oral health care.

In regard to *education and empowerment*, it was highlighted the importance of promoting equity in health care, reducing regional inequalities, scaling up health actions available to assure universal access to most vulnerable populations as a result of social, gender, race, ethnicity and generation inequalities, and to migratory populations. It is thus expected that the right to health and oral health will no longer be only part of a declaration but becomes part of Brazilian people's daily lives giving them universal access to medium and high complexity dental services.

To put *social leadership and participatory management* into effect, there is a need of creating mechanisms to increase involvement of managers, providers and users in every SUS unit, to create sympathetic environments and new possibilities of associations in these units as well as establishing a voting process for public health services managers to be elected by health providers and users, monitored by local health councils, thus implementing collegiate management in these bodies and setting up protection mechanisms against interference of partisan policies into technical health issues.

As for *oral health training and work*, it is thought that higher education has been ineffective in educating providers who are compromised with SUS and social leadership. Health providers training has not been guided by critical understanding of social needs in oral health. Also, training has been provided without any discussions by managing bodies and SUS social involvement. As a consequence, the Ministry of Education, public and private universities, training institutions for middle level health providers and groups of decision making experts have been autonomously ruling on issues such as the number of health providers to be trained and technical and political contents to be provided to them. Hence "there are real obstacles for SUS to apply the constitutional principle to direct human resources to the health system and providers are still not properly qualified for SUS effective implementation and development, hindering comprehensive care and resulting in low quality services". It is stressed that "in the last 10 years poor working relations have been established, circumventing the social value of public employees as a democratic state agent for people's social protection and the rights conferred on providers by the 1988 Brazilian Constitution". It is also recommended, among other, "to implement a humanization policy for working conditions and users' care involving oral health providers, users and managers, and promoting empowerment and respecting regional particularities, cultural diversity, and working relations". In addition, "to create a role performance evaluation system that would be included in position descriptions, and career and wage plans with clear mechanisms of career advancement by value, dedication, and competence supervised by local health coun-

*Relatório final da 3ª Conferência Nacional de Saúde Bucal; 2004; Brasília, BR. Brasília (DF): Ministério da Saúde; 2005.

cils and employees' representative commission annually elected".

On *financing and organization of oral health care*, reference is made to the embarrassments caused by the way Brazil's inclusion in the new world economy came about, in particular the country's indebtedness and massive subordination to foreign money. The representatives agreed that "access to basic care should be scaled up and qualified," ensuring dental care services in all basic health units, including those located in hardly accessible rural areas and borders, and providing care during opening hours that would allow access of adults and working population to this care, including the implementation of dental prosthesis laboratories in public care settings at regional and local levels. It is also underlined the importance of "implementing oral health actions to indigenous and slave descendant populations after extensive discussions with their organizations to ensure non-mutilating, universal, comprehensive and equitable care programs that would take into account cultural experiences and values concerning hygiene and diet practices in each one of these people".

These indications constitute a key reference to both production of knowledge and planning and organization of public oral health interventions.

There is a need for all those involved with production of knowledge and health managers not only be familiar with this set of proposals but also take it into consideration while developing a *collective oral health* agenda consistent with the needs of those who wishes were democratically expressed in the Third National Meeting on Oral Health.

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