Dental care in social programs for socially vulnerable populations on the perspective of the Uruguay Trabaja program

Assistência odontológica em programas sociais para populações socialmente vulneráveis na perspectiva do programa Uruguay Trabaja

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Abstract

This paper discusses the characteristics of the oral health subprogram 'Uruguay Trabaja' (UT), in Montevideo, and identifies finished, unfinished, and abandoned dental treatments from 2008 to 2015. The implementation of the UT, its characteristics, and the subprogram aimed at oral health are described through documentary analysis. The Program is conceptually discussed according to two categorical levels. The first refers to the macro-social context, related to the expansion of dental care coverage integrated into social protection systems, while the second one is based on the systematic observation of the dental care included in social programs. The UT is a nine-month social program which occurs every year for people between 18 and 65 years old, in social and economic vulnerability situations and unemployed for a long term. It aims at improving employment chances and the participants' social integration. Comprehensive dental care is one of the benefits of the program, as it is not available at the National Integrated Health System. Of the 2.592 dental treatments initiated, 941 (36,3%) were completed. Focused programs such as the UT should be articulated to universal social policies, which must adequately meet the needs of the entire population. Comprehensive dental care should be included into the National Integrated Health System, to ensure the right to oral health.

Keywords: Oral Health; Dental Care; Public Policy; Vulnerable Populations.

DOI 10.1590/S0104-12902018180433

Resumo

Este trabalho discute características do subprograma da saúde bucal do programa Uruguai Trabaja (UT), em Montevidéu, e identifica os tratamentos odontológicos iniciados, completados e abandonados de 2008 a 2015. Por meio de análise documental, o UT é discutido a partir de dois níveis categóricos. O primeiro refere-se ao contexto macrossocial, relacionando-se à expansão da cobertura da assistência odontológica integrada nos sistemas de proteção social, enquanto o segundo se origina da observação sistemática da assistência odontológica inserida em programas de acompanhamento social. UT é um programa social anual de nove meses de duração dirigido a pessoas de 18 a 65 anos em situação de vulnerabilidade socioeconômica e desempregadas há muito tempo. Seu propósito é melhorar a empregabilidade e a integração social dos participantes. Assistência odontológica integral é um dos benefícios do programa, a qual não é disponibilizada pelo Sistema Nacional Integrado de Saúde. Dos 2.592 tratamentos odontológicos iniciados, 941 (36,3%) não chegaram ao final. Programas focalizados como o UT, enquanto dispositivos de proteção social, devem estar articulados funcionalmente a políticas sociais universais que devem responder adequadamente as necessidades da população. A saúde bucal, nesse contexto, deve ser incluída no Sistema Nacional Integrado de Saúde do Uruguai, garantindo o direito à saúde.

Palavras-chave: Saúde Bucal; Assistência Odontológica; Política Pública; Populações Vulneráveis.

Introduction

The political change that took place in Uruguay in 2005 brought the introduction of a new format in the design and implementation of social policies and programs. One of these institutional changes of great importance was the creation of the Ministry of Social Development (Mides - *Ministerio de Desarrollo Social*), responsible for coordinating intersectoral actions, plans, and programs implemented by the Executive branch to ensure the full exercise of the social rights to food, education, health, housing, healthy environment, work, social security, and nondiscrimination (Uruguay, 2005).

Mides created, between 2005 and 2007, the Plan of Nacional Care to Social Emergency (Panes - *Plan de Atención Nacional a la Emergencia Social*), and, from 2008 on, the Equity Plan (*Plan de Equidad*). Such policies aim to ensure the full exercise of citizenship rights to all Uruguayans and, especially, to those who are in a situation of social vulnerability (Midaglia; Antia, 2011). This process includes the Uruguay Works (UT - *Uruguay Trabaja*) program, directed to economically active adults, unemployed for more than two years and who live in households in situation of social vulnerability (of access to sanitation; housing conditions and overcrowding; availability of potable water, electric lighting, home appliances, and education) (Uruguay, 2011).

From 2014, UT starts to incorporate individuals of African descent (8%); with special needs (4%); transsexual (2%); and people facing problems of consumption of psychoactive substances, victims of domestic violence, deprived of liberty, and involved in other priority programs (6%) (Uruguay, 2015).

Since one of the assumptions of UT is to facilitate access to public health care services (Uruguay, 2009), the subprogram Oral Health Care (*Atención a la Salud Bucal*) was created to offer integral oral health care to its participants.

Despite the achievements in the health sector since 2007, with the creation of the National Integrated Health System (SNIS - *Sistema Nacional Integrado de Salud)* (Uruguay, 2010), the provision

of dental services followed practically the same guidelines that existed before the health reform and that was included in the previous regulations of the Ministry of Health (Ordinance 48/1983, extended in 1987) (Uruguay, 2008a).

National studies show a still precarious oral health situation for Uruguayan adults and older people. Dental assistance appears closely linked to the socioeconomic status of individuals, and authors have observed that access to dentistry increases with income and education (Álvarez et al., 2015; INE, 2007; Laguzzi et al., 2016). The provision of dental services is limited to consultation, preventive procedures (health education; sealants; fluorine, remineralizing agents, and cariostatic agents application), basic periodontal therapy, amalgam and resin restorations, extractions, surgery, and medical imaging (Uruguay, 2010). The scope of the dental care offered to participants of UT is wider, providing a major opportunity in oral health care (Uruguay, 2008a).

This study aimed to: (1) describe and discuss features of the oral health subprogram of the UT program; (2) identify the dental treatments started and completed or not, from 2008 to 2015.

Methods

This is a descriptive study on the implementation of the Uruguay Trabaja program, its characteristics, and, in particular, its subprogram focused on oral health. The following documents were analyzed: *Programa Uruguay Trabaja. Edición 2009. Resultados Evaluación. Informe Final* (Uruguay, 2011); *Informe final de Seguimiento. Documento de Trabajo* nº 18 (Uruguay, 2013), *Ley 18.240 /2007 Creación UT* (Uruguay, 2009).

Information on the participants who received dental care from 2008 to 2015 were also examined. Demographic variables, such as sex and age, were obtained from the participants' medical records. Data on the abandonment of dental treatments and oral health clinical conditions were found in the reports prepared by the dentists who performed the dental care of participants. The properly filled medical records of participants of the UT program who adhered to the subprogram aimed at oral health from 2008 to 2015 were considered as inclusion criteria. Partially or inconsistently filled medical records were excluded. These same criteria (period from 2008 to 2015 and proper filling) were applied to the reports included in the research.

The data were analyzed by descriptive statistics (frequency and percentage) with the aid of the R Program for Windows, a free software for statistical computing and graph creation, and conceptually discussed from two categorical levels. The first refers to the **macrosocial** level, relating to the expansion of the coverage of dental care integrated to social protection systems. The second originated from the **observation of dental care** in social support programs, such as the UT program. These two levels led to the creation of two categories of analysis, which are presented in the results: context of the UT program, related to the first category; and oral health in the UT program, related to the second category.

The research project was submitted to and approved by the Research Ethics Committee of the School of Dentistry of Universidad de La República (Udelar), Uruguay (091900/000270/10), and in Brazil by the Research Committee of the School of Dentistry of Universidade Federal do Rio Grande do Sul (UFRGS).

Results

Context of the Uruguay Trabaja program

The Equity Plan in Uruguay included the whole population, reshaping the Social Protection System and including reforms such as: (1) tax reform; (2) health reform; (3) review of employment policies; (4) new housing policy; (5) educational reform; (6) national plan for equality of opportunities and rights (Uruguay, 2008b). It also included specific components, constituting a Network of Social Assistance and Integration structured in a set of measures and action strategies aimed at individuals in a socioeconomic vulnerable situation, including policies associated with protected work.

As part of the policies associated with protected work, the UT program was implemented, with two

main objectives. The first is to contribute to the development of processes of social integration by socioeducational strategies. The second is to improve the level of employability of individuals in condition of socioeconomic vulnerability and long-term unemployment (for more than two years). The action developed by UT involves a social support regime to reintegrate individuals between 18 and 65 years old to the labor market. As basic requirements, these individuals must be long-term unemployed, with incomplete high school, and belonging to families in situation of socioeconomic vulnerability.

During their stay in the program, participants engage in temporary activities, which consist in carrying out works with social value (in schools, gymnasiums, polyclinics), with a load of 24 hours per week of operational tasks and six of training for a period of up to nine months. These participants receive a compensation of about US$ 112 (in 2016) and the benefits of social security (Uruguay, 2009).

The process of social, personal, and collective support developed with UT participants is under the responsibility of Organizations of Civil Society (OSC – *Organizaciones de Sociedad Civil*) (Uruguay, 2009). These are non-governmental organizations that provide organizational and technical assistance to empower groups and communities, providing the necessary tools so that they can solve the problems and challenges they face by themselves. OSC are selected and hired each year by Mides, considering their institutional capacity, the integration of technical teams, and pedagogical coordination. Social support includes the completeness of personal and collective intervention for tasks of community value previously agreed with relevant government agencies. It also included social inclusion strategies in networks, access to basic social rights and public services, participation in collective activities (assembly, plenary session, and other meetings) that enable them to face the social aspects of work, of bond, and solution of conflicts resulting from the proposed tasks (Uruguay, 2009).

About 3,000 quotas were defined for the program throughout the country. Over time, the sociodemographic profile of participants has remained constant at the national level. Most participants are women, aged between 18 and 49 years, with elementary school and living in families of female leadership (Uruguay, 2011, 2013).

Oral health in the Uruguay Trabaja program

The Ministry of Health of Uruguay set in 2007 a national oral health program aiming to improve the oral situation of the population, incorporating this component in the comprehensive health approach (Uruguay, 2007b). Only a restricted set of procedures, however, are included in the Integral Plan of Health Care (PIAS – *Plan Integral de Atención en Salud*). The procedures laid down in PIAS are required compliance by public and private providers of SNIS. According to article 19 of Law 18,211/2007 (Uruguay, 2007a), users pay an additional value per procedure to the amount established by the government in partnership with private providers. PIAS also set policies that facilitate access to oral health care for groups that are prioritized by the Ministry of Health, and provides mandatory control consultations as, for example, the dental examination for the worker's health booklet.

Dental care in UT ensures access to all dental procedures required by its participants, including prosthetic rehabilitations. It includes diagnosis, health education, calculus scraping, composite resin restorations, endodontics from premolar to premolar, dental extractions, and partial and total prosthesis. Since that previously submitted to the coordination of the program, one can also perform more complex treatments.

A part of the UT program participants is selected by Mides in Montevideo to receive dental care in the services of the town hall of the municipality. The care is financed by Mides via payment of a fee per participant.

The distribution of individuals in health services occurs according to the proximity of their house or work, during their permanence in UT. Consultation are performed weekly, outside the working hours of the participants. During the term of the program, there is a permanent communication between

dentist and representatives of social organizations (social worker, psychologist, social educator), to give continuity to the patient care process. Since the start of the program, it is observed that a significant number of people do not use the services or abandons the dental treatment without being discharged.

To know the epidemiological profile of the participants, an epidemiological survey was carried out in 2007 to analyze the oral health situation and treatment needs in a sample of 308 patients from the *Trabajo por Uruguay* program (predecessor that met a population similar to that of UT). This survey had as result an average DMFT (decayed, missing, and filled teeth) of 18.32, in which the components missing and filled represented 95% of the index. The most frequent reason for dentist appointments was tooth extraction, and only 20% of individuals did not need any type of dental prosthesis (Blanco et al., 2010).

According to the evaluation report of the *Trabajo por Uruguay* program, the access to health services (mainly oral and ophthalmologic ones) promotes gains in participants' self-perception: self-esteem, self-presentation, and socialization, which improves the subjective (and objective) chances of inclusion in the labor market. From the results of dental care, the fourth goal of the *Trabajo por Uruguay* program defined that 65% of the participants should have dental treatments started (58% of 65%) (Uruguay, 2011). In 2011-2012, the set goal was 75%, which was achieved in 2012 (Uruguay, 2013).

Throughout the country, of the 6,213 individuals participating in UT who could receive dental care, 3,145 started treatment (Uruguay, 2013). Between 2008 and 2015, 2,592 people received dental care in UT in the municipal health services of Montevideo and 941 (36.3%) abandoned the treatment (Table 1). A treatment is considered complete if the patient is willing to receive it during the program, even it it may be different from that initially proposed by the professional. The discharge results from the dialogue between professional and patient, respecting the autonomy of the latter. For example, a patient can decide to perform restorative and dental extraction treatment, but not the prosthetic one.

The patient is considered to have abandoned treatment when they no longer search for the service, according to registration made six months after the end of the program. The abandonment percentage per year ranged from the minimum value corresponding to 2011 (23%) and the maximum in 2014 (59%).

Table 1 – Dental treatments completed (discharge) and abandoned by participants of the Uruguay Trabaja program, 2008-2015

Year	Discharges n (%)	Abandoned n (%)	Total n (%)
2008	321 (70.1)	137 (29.9)	458 (100.0)
2009	271 (56.0)	213 (44.0)	484 (100.0)
2010	251 (60.3)	165 (39.7)	416 (100.0)
2011	241 (77.0)	72 (23.0)	313 (100.0)
2012	201 (66.1)	103 (33.9)	304 (100.0)
2013	163 (68.8)	74 (31.2)	237 (100.0)
2014	69 (41.0)	101 (59.0)	170 (100.0)
2015	134 (63.8)	76 (36.2)	210 (100.0)
TOTAL	1,651 (63.7)	941 (36.3)	2,592 (100.0)

It should be noted that, in general, the number of treatments completed and abandoned decreased in the period studied because the number of people belonging to the city of Montevideo taking part in the program also decreased (increasing the number of members met in the interior of the country).

Regarding the variables sex and age (Table 2), the data were grouped into four age groups, allowing the data to be available for 905 individuals who abandoned the dental treatment. Of them, most were women (64.5%). The group from 25 to 34 years old had the highest percentage of abandonment (36.5%), contrasting with the group of 45 years or more, which had the lowest percentage (14.5%).

The analysis of clinical oral health conditions related to dental caries showed that the average DMFT was 15.8 for the total of individuals who abandoned the dental treatment. The average DMFT was 15.5 for men and 16.02 for women.

Table 2 – Distribution by age groups and sex of individuals who abandoned the dental treatment of the Uruguay Trabaja program, 2008-2015

Age (years) / Sex	<25 n (%)	25 to 34 n (%)	35 to 44 n (%)	45 or + n (%)	TOTAL n (%)
Women	196 (21.7)	204 (22.5)	98 (10.8)	86 (9.5)	584 (64.5)
Men	86 (9.5)	127 (14.0)	62 (6.9)	46 (5.1)	321 (35;5)
TOTAL	282 (31.2)	331 (36.5)	160 (17.7)	132 (14.6)	905 (100.0)

Discussion

The expansion of the coverage of dental care in the adult population in Uruguay has been accomplished by programs similar to UT. Before this reality, the question of dental care can be addressed in two dimensions. The first is the expansion of dental coverage from social programs and the second relates to how the insertion of dental care occurs in programs focused on and limited in time.

At the macro level, social programs are part of the concrete interventions of the social protection systems that provide coverage against risks that can affect the lives of individuals, such as illness, accidents, old age, poverty (Castel, 2004).

One of the components of social protection is health care. In the case of Uruguay, the health reform process started in 2007 recognizes health as a right, setting a universal system run by public or private services. The advances observed in medical care, however, had no parallel in dental care regarding access, funding, type of procedure, or care model (Conill, 2004), definitely compromising the character of integrality of health care (Muntaner et al., 2011).

The relationship between health and the social welfare state configuration of countries has been studied by different authors (Bambra, 2007; Navarro et al., 2006). Uruguay maintains a mixed-type social provision format, in which public and private services coexist, generating a relatively hybrid matrix of welfare and social protection (Midaglia; Antia, 2007). In the health system, in particular, it is possible to recognize the influence of the organizational models of social security, linked to the development of wage labor funded around contributions, and of the national health services, given the existence of a universality-oriented centralized social security. This social security is inspired by the welfare model of both conservative and social-democratic European countries (Setaro, 2013).

According to Guarnizo-Herrero et al. (2013), little is known about the relationship between welfare states and oral health. An analysis involving oral health in adults and welfare states in European countries concluded that those with highest levels of oral health are precisely the welfare states with the highest number of universal policies based on redistribution, such as the Scandinavian model. A study comparing data from national surveys in the United Kingdom, Finland, Australia, and Germany, in adults over 30 years (Sanders et al., 2009), showed that the extent of coverage of the welfare state reduces the levels of inequalities of oral health-related quality of life. The lower the universal nature of policies and the greater the focus on the poorer, the greater the inequalities in oral health-related quality of life. In Brazil, public policies have benefited more the oral health of adolescents in good socioeconomic condition, not contributing to the reduction of inequality resulting from a regressive public spending (Celeste; Nadanovsky, 2010).

The ways of inclusion of dentistry in policies and health care models are very diverse, presenting different answers to general health policies and to the welfare state of different countries (Currie; Tickle; Maupomé, 2012; Holden, 2013; Locker; Maggirias; Quiñonez, 2011; Saekel, 2010; Sanabria-Castellanos; Suárez-Robles;

Estrada-Montoya, 2015). The full incorporation of dentistry in health systems does not occur frequently, even in social-democratic scenarios, in which governments clearly offer more benefits in terms of health care. In this environment, dentistry has been inserted as something "exceptional" regarding coverage, financing, and management, including universal coverage health systems (Listl; Moeller; Manski, 2014).

Among South American countries, Brazil, with a Unified Health System (SUS) since the 1990s, only established the National Oral Health Policy from 2004 on. In this model, oral health is proposed as a right, although inequalities in access to oral health care still remain (Pucca Junior; Lucena; Cawahisa, 2010; Pucca Junior et al., 2009). In recent years, there have been two concomitant movements in dentistry. The first consists in strengthening public policies, bringing oral health as an important issue on the health priority agenda. The second points to the sharp growth of dental segment of complementary health that reproduces the curative and individual practice of the private sector (Listl; Moeller; Manski, 2014). In the case of Argentina, the health system is mixed and segmented, being formed by the public services subsystem in which the entire population has coverage, by the social security subsystem comprised by the "Obras Sociales," and, finally, by the private subsystem, with the practice of prepayment medicine. The public subsystem develops collective actions in oral health that include education and prevention campaigns. State and municipal governments offer different care services depending on the locations considered. Dental care is included in the social security subsystem and in the private subsystem with various procedures, not including prostheses (Giovanella, 2013).

In Uruguay, the oral health care of adults is the combination of access to basic services of the system with programs focused on integral care included into the social programs aimed at the most vulnerable sectors of society. Despite its limitations, this option can be considered a breakthrough in relation to overcoming the maternal and child welfare models that historically guided health care.

Expanding the dental care by the programs of the social protection systems, and not in the structure of the health system, weakens the inclusion of dentistry in the public health system. This produces the fragmentation of access of public sector users from a positive and focused discrimination.

The option to expand the provision via social programs such as UT, aimed to meeting poverty situations, ends up reinforcing the idea that dental care is a benefit to program participants, who receive it not by their condition of citizens but for their exclusion situation.

Focused programs seek to resolve the tension between equal access and positive discrimination. Thus, they generate a greater flexibility in the protection system by reducing the "protective collective" that qualifies subjects as public sector users, and gathers them in smaller and unstable collectives, tending to the individualization of this protection (Ortega; Vecinday, 2009).

Castel (2004) notes that the individualization of social protection has a high cost, because the positive discrimination of groups can generate negative stigmatization, linking them to the condition of beneficiaries in a contract that is regressive before the universal social protections. In addition, when one enables the access to social protection motivated by a condition of disadvantage of individuals, there is a risk to legitimize a practice not oriented to social citizenship and continuity of rights.

Including oral health care in UT is a way to value oral health as part of the process that seeks the social inclusion of participants of the program in the short term, as well as their social integration in the long term. However, providing access to dental care to individuals who have been historically excluded from it is not a process that can be quickly reversed.

The data of the oral health condition related to dental caries (DMFT) of the UT participants who abandoned the dental treatment showed high levels of pathology, despite the free access to integral care. This result reinforces the understanding that oral health, while necessity, is a social production. Thus, it is related to the individuals' social conditions of life, their historical traditions

and representations about the body and the health-disease phenomenon. Individuals consider as their need what they problematize as such, leading to the set of necessities that identify them to be marked by habits and standards and also by the social morality of their time. The design of the effective follow-up of subjects suffering from difficulties, aiming to help them get out of their situation of socioeconomic vulnerability, is a challenging proposition. Often, one seeks to modify the conduct of individuals, encouraging them to change their representations and strengthen their motivations, as if they were primarily responsible for the situation in which they are. There will be individuals who may include oral health care in their life project, but exceptions will be noticed. These are people exposed to a similar social context that sometimes can conclude the oral health care process successfully and sometimes abandon it.

This analysis has shown that, in certain periods, the results regarding completed and abandoned treatments were numerically similar, as in 2009 and 2014, which shows the need for studies that seek to understand the phenomenon observed from the perspective of its participants. Aspects related to the time of involvement of participants in the activities of UT and tasks related to the care of their families (since most are women), and even to the link established between participants and professionals who work in the public dental services can be associated to the abandonment. It should be noted that the abandonment of oral health care entails to participants the loss of their acquired rights. UT opens a window of care opportunity that closes quickly for many participants. As a result, the remaining option is the regime of access to oral health care available to the general population, not including the integrality of care to their needs. In addition to this, the response space to the needs in oral health starts to be market dentistry, private and liberal, to which most individuals have no ability to pay.

Final considerations

This study analyzed a social program for vulnerable populations in Uruguay, from its oral health subprogram, identifying completed and abandoned dental treatments. Its contribution is in the possibility to bring to debate the fragility of the inclusion of dental care in social protection policies based on strategies focused on vulnerable populations. The continuity of these strategies can result in an escalation of care proposals from increasingly restricted protective collectives, which may not solve or even reproduce the abandonment and lack of protection.

Incorporating integral dental care in the health system is the only possibility for Uruguay to transform oral health in effective right. Focused programs, while social protection devices, must be functionally articulated to universal social policies that must, such as that of health, adequately meet the needs of the entire population. Research that can deepen the analysis of the UT program, including the perspective of its participants, are recommended.

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Authors' contribution

Blanco and Abegg were responsible for the study design. All the authors analyzed the data and contributed to the writing and review of the article.

Received: 08/24/2018
Approved: 09/14/2018