Social protection models and the right to dental care for people with disabilities[1]

Modelos de proteção social e o direito à assistência odontológica às pessoas com deficiência

Joana Danielle Brandão Carneiro[a]
https://orcid.org/0000-0003-3629-8091
E-mail: joanadani9@gmail.com

Paulo Frazão[a]
https://orcid.org/0000-0002-3224-0020
E-mail: pafrazao@usp.br

[a]Universidade de São Paulo, Faculdade de Saúde Pública, Departamento de Política, Gestão e Saúde. São Paulo, SP, Brazil.

Abstract

Knowing and synthesizing expectations and recommendations on dental care as a right to oral health for people with disabilities (PwD) is essential to assist decision-makers. An integrative review was carried out, searching PubMed, Embase, LILACS, and VHL databases for articles published up to August 30, 2021. Term mining techniques were used via the Rayyan platform. Content analysis was based on welfare state theory. Sixteen articles were included. Expanding access was a need shared by all studies. The main expectations and recommendations were guaranteeing civil rights and reorienting the oral health care model (in the countries of liberal model); the need for professional qualification, systematic and free dental care, integration between services, multidisciplinary work and guaranteed financing (conservative model); qualification of infrastructure and workforce; and systemic articulation between care levels (social democratic model). We observed a complex and sometimes contradictory scenario of proposals, subject to indications with little potential for change, especially if we ignore contemporary challenges arising from economic crises and the welfare State that imply serious constraints to the models of social protection and the rights of PwD.
Keywords: Public Policies; Guidelines; Oral Health; People with Disabilities.

Correspondence
Joana Danielle Brandão Carneiro
Avenida Dr. Arnaldo, 715, Cerqueira César, São Paulo. CEP: 01246-904. Brazil.

1 This work was financed by the *Coordenação de Aperfeiçoamento de Pessoal de Nível Superior* (CAPES) - Brazil - Financing Code 001.

Resumo

Conhecer e sintetizar as expectativas e recomendações sobre a assistência odontológica como direito à saúde bucal para as pessoas com deficiência (PcD) é essencial para auxiliar tomadores de decisão. Realizou-se uma revisão integrativa, com busca nas bases PubMed, Embase, Lilacs e BVS, de artigos publicados até 30 de agosto de 2021. Técnicas de mineração de termos foram adotadas, via plataforma Rayyan. A análise de conteúdo teve por referência a teoria de *welfare state*. Dezesseis artigos foram incluídos. A ampliação do acesso foi uma necessidade compartilhada por todos os estudos. As principais expectativas e recomendações foram: garantia de direito civil e a reorientação do modelo de atenção em saúde bucal (nos países de modelo liberal); necessidade de qualificação profissional, atendimento odontológico sistemático e gratuito, integração entre os serviços, trabalho multiprofissional e garantia de financiamento (modelo conservador); qualificação da infraestrutura e da força de trabalho; e articulação sistêmica entre os níveis assistenciais (modelo social-democrata). Observou-se um cenário de proposições complexo e, por vezes, contraditório, sujeito a indicações com pouco potencial de mudança, especialmente se não forem considerados os desafios contemporâneos decorrentes das crises econômicas e do Estado de bem-estar social que implicam graves constrangimentos aos modelos de proteção social e aos direitos das PcD.

Palavras-chaves: Políticas Públicas; Diretrizes; Saúde Bucal; Pessoa com Deficiência.

Introduction

From the dissemination of studies on disability in the 1960s, the movement to demand rights and the struggle of people with disabilities (PwD) to be recognized as protagonists in their lives has grown (De Loureiro Maior, 2018; Diniz; Barbosa; Santos, 2009). An example of this was the approval of the Convention on the Rights of Persons with Disabilities, by the United Nations, in 2006, which mentioned the participation of this population as a parameter for the formulation of policies and actions aimed at them (Diniz; Barbosa; Santos, 2009).

In theory, the term "disability" has also taken on new meanings, moving from a disabling conception of the individual (the medical model of disability) to a social model of the definition, placing the individual in the position of an agent of society, who shares what they have to offer (Diniz; Barbosa; Santos, 2009; Merry; Edwards, 2002; Mota; Bousquat, 2021).

PwD occupy an important space in each territory and the uniqueness in outlook and assistance must be considered, as this reality impacts health and sustainable development indicators, which is reason enough for the social segment of this population to have their specific rights and needs included in the political agenda of all countries (De Loureiro Maior, 2018). In Great Britain, there were around 8.5 million PwD, of whom around 6.5 million were of working age (Merry; Edwards, 2002). In the United States, the 2000 census reported that there were 47.9 million PwD, representing about 19.3% of the population (Glassman; Subar, 2008). In Brazil, the 2019 National Survey of Health, released by the Brazilian Institute of Geography and Statistics (IBGE), showed that PwD represented 8.4% of the population, or 17.3 million people.

There is extensive literature showing that PwD are more likely to have dental diseases, missing teeth, and difficulty in obtaining dental care than other members of the general population (Glassman; Subar, 2008). In dental research, several studies on this type of assistance aimed at PwD have been published since the 1970s, of which we

highlight the following: research into oral care (Van Grunsven, 1976), the perception of parents and dentists about dental treatment (Davies; Holloway; Worthington, 1988), the use/attendance of dental services (Waldman, 1989; Van Grunsven; Cardoso, 1995), and the situation of dental care as a public policy in different countries (Haddad; Tagle; Passos, 2016).

The growing awareness about the need to implement effective and lasting public policies for the inclusion of PwD (Monteiro et al., 2018) has helped to put demands for the approval of normative provisions that ensure the rights of PwD at the center of the debate. Some examples are the Americans with Disabilities Act in the USA (Surabian, 2016), the Disability Discrimination Act in the United Kingdom (Qureshi; Scambler, 2008), as well as the National Health Policy for the Disabled Person and the Care Network for People with Disabilities (*Rede de Cuidados à Pessoa com Deficiência*), both in Brazil. These policies can be more or less comprehensive, depending on the social protection model adopted in each country. The financing proposals, service structure, and coverage of actions, among other aspects, vary according to the model. Thus, it is everyone's responsibility to grant PwD the same rights as those who are not in this condition (Monteiro et al., 2018).

The need to guarantee rights for PwD is the subject of study in scientific literature, especially from a perspective of universalizing rights, inclusion of those who are different, and promotion of health (De Paula; Maior, 2008; Carvalho; Almeida, 2012). However, no study has summarized researchers' expectations/recommendations regarding dental care for PwD as part of the right to oral health. A review of these expectations/recommendations could help decision makers understand the possibilities/limits arising from the respective social protection models, which determine the design of the health systems adopted in each country and the proposals for implementing strategies aimed at expanding access. and increasing the quality of oral health care for PwD. Furthermore, it could help to recognize the importance of social participation in the fight to guarantee the rights of this population.

This study aims to produce a synthesis of the scientific literature on expectations/recommendations regarding dental care as a right to oral health for people with disabilities.

Methods

An integrative literature review was carried out, which is an appropriate type of study when the aim is to produce a synthesis of a given research problem (Whittemore; Knafl, 2005). The following steps were adopted: (1) identification of the research question; (2) selection of keywords and search in bibliographic databases of scientific literature; (3) export of files to the Rayyan platform; (4) removal of duplicates; (5) term mining to determine the inclusion and exclusion of records; (6) selection of records for full reading; (7) assessment of relevance and methodological quality; (8) final selection of articles to be included in the study; (9) data extraction; (10) interpretation and discussion of results; and (11) synthesis of information and production of knowledge.

The guiding question of the research was "What is the state of science on expectations/recommendations regarding dental care as a right to oral health for people with disabilities?" The search was carried out in the following databases: National Library of Medicine (PubMed), Virtual Health Library (VHL), Embase, and Ovid Tools & Resources Portal (Ovid). The search keys were defined based on the Health Sciences Descriptors (DeCS) and the Medical Subject Headings (MesSH). Articles in Portuguese, English, and Spanish were included, published from January 1975 to August 2021. The year 1975 was used as a result of the approval of the UN Declaration of the Rights of Persons with Disabilities (UN, 1975). Chart 1 shows the general search expression used according to each platform. Two independent evaluators carried out the searches to identify the studies.

Chart 1. List of descriptors used in the search for works according to the selected database, 2021.

Data base	Descriptors	Total
Pubmed	(((((“health policy” [Mesh] OR “health policies” OR “policy, health” OR “healthcare policy” OR “healthcare policy” OR “healthcare policies” OR “policy, healthcare” OR “national health policy” OR “health policy, national” OR “national health policies” OR “policy, national health”) OR (“public policy” [Mesh] OR “policies, public” OR “policy, public” OR “public policies” OR “social protection” OR “protection, social” OR “population policy” OR “policies, population” OR “policy, population” OR “population policies” OR “social policy” OR “policies, social” OR “policy, social” OR “social policies”))) AND (“oral health” [Mesh] OR “mouth rehabilitation”)) OR (“dental care” OR “dental service, hospital” OR “dental health service”)) AND (“disabled persons” [Mesh] OR “disabled person” OR “disabilities, people with” OR “people with disability” OR “persons with disabilities” OR “disabilities, persons with” OR “disability, persons with” OR “persons with disability” OR “physically handicapped” OR “handicapped, physically” OR “physically disabled” OR “disabled, physically” OR “physically challenged”)	888
VHL	(mh:(“política de saúde”)) AND (mh:(“assistência odontológica”)) AND (“pessoa com deficiência”)	438
Embase	‘health care policy’ AND ‘dental procedure’ AND disability	19
Ovid	(“health policy” and “oral health care” and “handicapped”)	12

Source: elaborate by the authors.

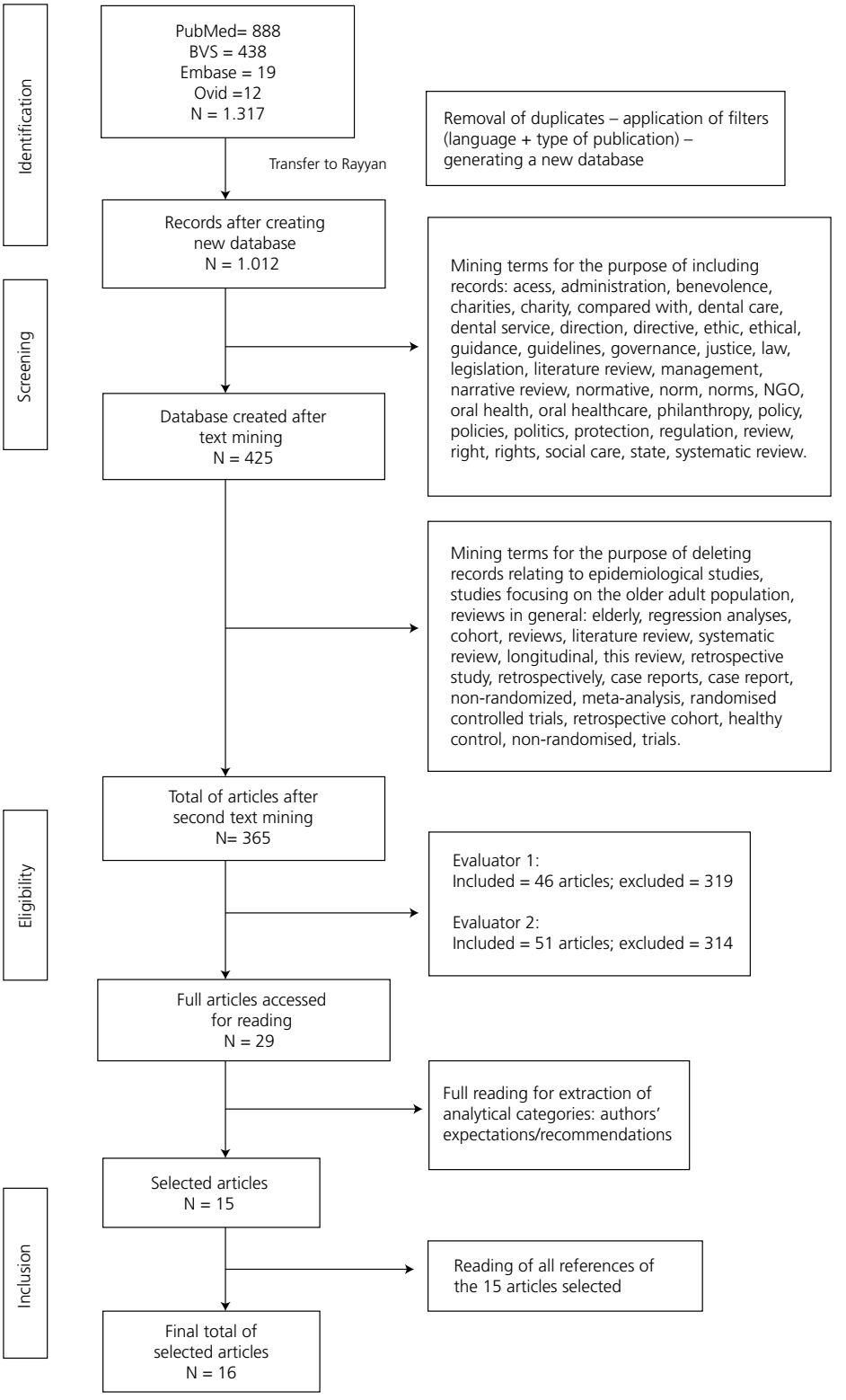
The records identified in each database were transferred to the Rayyan tool, which allows term mining to assist the reviewer in screening abstracts for literature reviews. Other interesting features of Rayyan are the independent and simultaneous screening by two or more users, removal of duplicates and labeling references, and highlighting of the keywords (Olofsson et al., 2017).

After transcribing 1357 records into the Rayyan tool, 41 duplicates were removed, resulting in 1316 publications. Then, 304 records were excluded for not meeting the inclusion criteria regarding eligible languages and types of publication, resulting in 1012 works. To identify records compatible with the guiding question, text mining was carried out, as shown in the Flowchart in Figure 1.

Based on the focus of the study, there was agreement on the inclusion of 29 titles/abstracts and the exclusion of 297 records, obtaining a moderate degree of agreement (Kappa=0.537). After discussing disagreements, 19 more records were included for full reading, totaling 48 articles. The papers were examined according to their relevance to the topic, clarity of presentation, rigor of content, and presence of theoretical references. Of these, 15 were included in the study. Based on the references of the research included, one more document was chosen, totaling 16 articles to extract an analytical category linked to the authors’ expectations and/or recommendations about dental care, such as the right to oral health for people with disabilities.

The content analysis was based on the theory of welfare state regimes, where three models of social protection stand out (Esping-Andersen, 1991). The liberal model, in which health care is regulated by the market and depends on the user’s ability to pay. In this way, the role of the State is limited to the support of philanthropic organizations that provide assistance to the verified poor. The conservative model, corresponding to social insurance, in which health care depends on formal connection to the labor market (regulated citizenship), being financed by contributions from employees and employers, with or without state participation. Finally, the social democratic model, relating to social security, in which health care does not usually depend on the user’s ability to pay and is assumed as a citizen’s right, being financed by resources from the public budget, coming from taxes and other contributions (Esping-Andersen, 1991).

Figure 1. Publication selection flowchart, 2022.



Results

Figure 2 presents the publication selection flowchart. Sixteen works were selected for data extraction. The authors' expectations/recommendations were based on nine countries: USA, Sweden, Denmark, Norway, Finland, Iceland, France, England, and Brazil. They were presented according to the three types of social protection model mentioned and the characteristics of access to health care resulting from them (Chart 2).

Chart 2. Objectives of the included articles and expectations/recommendations of the author(s) according to the social protection model of the study country.

Social protection model in the study country	
Author/Year Objective (territory)	Authors' expectations/recommendations
LIBERAL MODEL; represented by the USA, a country in which healthcare depends on the user's ability to pay; it is regulated by the health insurance market, with part of the population eligible to receive subsidies from specific government programs (Medicaid, Medicare, and the Children's Health Insurance Program).	
Dart, 1988 To share a proposed agenda to guarantee the rights of people with disabilities (USA).	The need to establish protection of civil rights by law; to take vigorous measures to ensure the enforcement of such laws; to ensure the availability of legal services for the defense of PwD, communication, transportation, and other support services; to promote education and empowerment initiatives, so as not to depend on paternalistic systems or be led astray by misinformation; to implement an effective and comprehensive oral health care service system, with a high degree of administration and professionalism involving partnerships between public (federal, state and local) and private entities, consumers, families, lawyers, and service providers; to ensure that the service system is accessible to all people through a single point of entry for information, referral, and counseling, based on a national computerized information network integrating services at the local, state, and federal level, in order to reduce costs and delays, eliminate gaps, provide reliable and up-to-date statistical information, and increase the power and productivity of professional service providers, as well as the quality and use of these services; for federal agencies to support research; to eliminate the regulatory and bureaucratic barriers that hinder access; and to develop international relationships with PwD advocacy organizations in other countries.
Waldman & Perlman, 1997 To reflect on the lack of assistance that occurs with children with disabilities covered by Medicaid who lose coverage in adulthood but continue to have disabilities and needs (USA).	Since Medicaid is a government-funded program that guarantees health care to certain groups, such as children, as long as they are below the poverty line, the authors recommended increasing dental services for adults with disabilities. This includes increasing the Medicaid budget and reimbursement amounts for paying for dental care.

continues...

Chart 2 – Continuation.

Social protection model in the study country	
Author/Year Objective (territory)	Authors' expectations/recommendations
Glassman, 2005 To present the conclusions of the conference on oral health for PwD, analyze the implications for the dental profession and society, and recommend systems and strategies that can lead to better oral health for these populations (USA).	Organized by the University of the Pacific School of Dentistry, with support from the California Dental Association Foundation, in California (USA), a new model of oral health care delivery for PwD was recommended: focus on prevention; greater financial incentive for promotion/prevention actions; integration between oral health and other community health and social services; case management approach for solution-based referral; oral health matrix support for other health and social service professionals; care system with increasing levels of complexity; caregivers closer to individuals with planned incentives; evaluation and monitoring of oral health services; increase the training of all dental professionals in the care of people with special needs; coordinating data systems across state programs; cataloging and disseminating successful models/experiences; financing research into models of oral health provision and prevention for PwD.
Keels, 2007 To identify policies and guidelines proposed by organizations other than the American Academy of Pediatric Dentistry (AAPD) that influence oral health care for PwD (USA).	Educational and professional accreditation entities play an important role in the qualification of service providers for PwD. Legislative agendas at the national and state level have impacted dental care for PwD. Efforts have been made through different governmental and non-governmental entities to defend PwD, who must be seen, first and foremost, as people. AAPD should be aware of these activities and develop activities in conjunction with these and other organizations whenever possible.
Nowak, 2007 To analyze the extent to which AAPD policies and guidelines include mention of PwD (USA).	Include recommendations on clinical dental signs (oral manifestations) of child abuse and neglect; frequency of dental follow-up; list of preventive dental services (menu of care offer; early guidance on oral health and guarantee of dental treatment; pediatric restorative dentistry; management of acute dental trauma; fair and adequate compensation for the treatment of complex patients and other special needs.
Edelstein, 2007 To identify the strengths and weaknesses of the US healthcare system in relation to oral care for PwD, to provide a framework for understanding the system's capacity, to describe the context in which dental care is provided (USA).	Institute a holistic approach to benefit the capacity of the dental care system to provide services to children with special needs, considering oral health as a health need and not just an individualized need with dental services that respond only to this demand. Defend an accessible, safe, competent, individualized, compassionate (humanized), integrated, high-quality, and educational health system. Focus on Primary Health Care (PHC): effectiveness, efficiency, punctuality, safety, user-centeredness, equity. This model may hold strong promise for incremental improvements in dental care for special needs children. The suggestions were: 1. to improve the supply and skills of dentists; 2. to establish sufficient funding streams (especially through Medicaid); 3. to integrate the medical and dental care team via: a. collaboration: b. co-training; and/or c. mobile installations. In order to facilitate implementation, this may require matching funds from states, foundations, health plans, hospitals, professional associations, or other interested parties.

continues...

Chart 2 – Continuation.

Social protection model in the study country	
Author/Year Objective (territory)	Authors' expectations/recommendations
Glassman & Subar, 2008 Given the expansion of the population with disabilities, to describe the challenges of providing oral health care services to this population and discuss the implications of these challenges within the dental profession and the organization of the oral health system (USA).	Growing workforce shortages, inadequate training and a reimbursement system that does not reward the types of services needed contribute to the failure of the current system. Training and education of professionals compatible with the needs that PwD require when seeking dental care; to understand the appropriate use of language and know how to work in a multi-professional and interdisciplinary team, taking into account the different needs of PwD (social, health, cultural); territory-centered care practice (understanding the community arrangements, equipment and services available); to establish communication for compatible care with the user being assisted; broadening the scope of dental hygienists' duties; and a multi-level care model in which increasingly complex care is carried out by those with the most extensive training, and less complex care is provided by those with less extensive training.
Edelstein, 2013 To describe federal legislation for public oral health coverage for children with disabilities in contrast to the absence of such coverage for dependent adults (USA).	In order to be successful in changing policy (or including oral health in other policies), oral health advocates need to: (1) articulate their issue with clarity, urgency, and articulate the significant consequences; (2) link their issue to some political agenda that is "in motion"; (3) achieve significant levels of consensus within the oral health and general health communities and related communities of interest to avoid dissension and competing voices; and (4) commit to doing the "heavy lifting" of daily involvement in the policy-making process. As Congress recasts itself every 2 years, advocates must adjust to the political philosophies and economic realities of the time by modifying their "request," reframing their issues, and renegotiating the political process.
Tegtmeier et al., 2016 To reflect on the future of Special Needs Dentistry, Hospital Dentistry, and Dental Education, and formulate recommendations to ensure that PwD have access to adequate oral health care in the years to come (USA).	Despite the growing recognition that good oral health has an impact on general health, hospital dentistry programs and centers of excellence for patients with special needs are in financial difficulties and threatened with closure. It is necessary to ensure adequate payments for hospital dental services, special needs services and a well-trained and skilled workforce; to control costs with prevention; to advocate for a public policy, which means attracting the interest of policymakers; to advocate for oral health, which means reducing injustice and social inequalities; to advocate for a collaborative model of oral health (user, service, provider, company).
Cruz et al., 2016 To identify the types of oral health services offered by community-based organizations to children under 6 with special health needs and the barriers and facilitators to their provision in a community without access to fluoridated water (USA)	A closer look at the resources available for children under 6 with special needs is necessary, especially since they are less likely to receive preventative dental care than those of school age. Other recommendations include use of fluoride; partnership between community organizations and dentists from the ABCD (Access to Baby and Child Dentistry) program to provide services to children with special needs; including oral health education in the agenda of organizations' professionals (physiotherapists, occupational therapists, speech therapists) as part of the care of special children, including the education of those responsible for them.

continues...

Chart 2 – Continuation.

Social protection model in the study country	
Author/Year Objective (territory)	Authors' expectations/recommendations
CONSERVATIVE MODEL: represented by countries where health care is based on mandatory social insurance and universal coverage regulated by the State, financed by work-related social contributions and taxes. Competences and resources can be transferred to health regions as arranged in each country.	
Haavio, 1995 To describe the current situation and plans for the future of oral healthcare for PwD in the Nordic countries (Sweden, Denmark, Norway, Finland, and Iceland).	In these countries, the right to dental care is guaranteed by local public services, generally until the end of adolescence, with the age range varying depending on the country. Since 1984, the Oral Health Law in Norway prioritizes mental PwD, older adults, chronically ill people and PwD in institutions or home care. In addition, it guarantees these groups free dental care. The social and economic situation had worsened and could deteriorate the structure of the welfare state. Increasingly, PwD are experiencing reduced health and services. The Nordic Society for Dentistry for the Disabled has recommended education for oral health professionals providing services to PwD. Both theoretical knowledge and practical training should be included in the training of dentists, dental DHA and DHT; all intellectual PwD must be guaranteed free, systematic dental care, including health promotion and preventive dentistry; as well as referral systems, multi-professional cooperation. It is expected that mental PwD will be guaranteed free systematic dental care, also including health promotion and preventive dentistry. In addition, active search systems, multi-professional cooperation, and the special expertise of the dental team were considered necessary.
Gondlach et al., 2019 To describe the results of the internal evaluation of the Réseau Santé Bucco-Dentaire et Handicap de la région Rhône-Alpes and discuss the health networks model as a response to improving access to dental care for people with disabilities (France).	In France, competencies and resources have been transferred to health regions. A national expansion of the organization of oral health services is advocated from the perspective of health care networks, with accompanying financing and professional training programs. This advocacy involves developing primary care services that are local, inclusive, user/territory-centered, comprehensive, sufficient in quantity, quality, and accessibility.
SOCIAL DEMOCRATIC MODEL: represented by countries where health care is financed by the State and does not depend on the user's ability to pay, having a universal character	
Merry & Edwards, 2002 To describe the Disability Discrimination Act (DDA) and how it affects dental practice, taking as a starting point the results of a survey into access to dental services by PwD in Merseyside (England).	In the UK, the law was passed in 1995. Service providers are expected to make reasonable adjustments where it is impossible or unreasonably difficult for a PwD to use the service in three areas: (1) policy, procedure, and practice changes; (2) offering an ancillary service that enables or facilitates PwD access to the service's logistical resources; (3) providing a reasonable alternative method of service provision when this is prevented or unreasonably hampered by a physical feature. These measures aim, above all, to overcome barriers to access to care for PwD. And dentists need to be aware of their responsibilities under the Disability Discrimination Act, whether as employers or service providers.

continues...

Chart 2 – Continuation.

Social protection model in the study country	
Author/Year Objective (territory)	Authors' expectations/recommendations
Dougall & Fiske, 2008 To define Dentistry aimed at PwD and offer practical tips to encourage access and dental care, transfer to the chair, and access to the oral cavity by the professional (United Kingdom).	The need for an appropriate approach for a shared care, via a well-developed oral health network for PwD in the primary and specialist care sectors, which allows patients to move seamlessly between services and be seen by the right person, in the right place, at the right time. Adopting a patient-centered approach is essential to ensure that service users with disabilities have the same level of access, consented choice, and service user care as anyone else. Ensure the quality and quantity of the workforce in services for PwD in the United Kingdom.
Qureshi & Scambler, 2008 To present the results of a study exploring access to dental care following the Disability Discrimination Act among general dentists based in the city center of Aylesbury (England).	Law in the United Kingdom recommends 'reasonable adjustments' to the physical structure of dental care services to increase accessibility and achieve an inclusive approach: internal and external ramps (temporary or permanent), handrails, parking, bathrooms with railings, elevators, decoration, doors, escalators, lighting, paving, ventilation, easy visual identification of the location at a certain distance (differentiated colors), carpets flush with the floor, Braille or tactile communication for general instructions, level surfaces whenever possible, non-slip surfaces, noise reduction as much as possible, repetition of key messages for care/consultation/ treatment, availability of a variety of seats to meet different needs, and creating a lowered space at the reception desk.
Rocha et al., 2015 To evaluate the accessibility of dental services in Fortaleza (CE) for PwD (physical, hearing, and visual) considering the presence/ absence of geographic, architectural, organizational, cultural, economic, and communication barriers (Brazil).	Health services that provide dental care in primary health care in Fortaleza, an influential capital located in the Northeast region of Brazil, were evaluated. It was recommended that practices be institutionalized, in a more articulated way, both in care routines (trained professionals, reception for scheduling, user participation) and in referring patients to more complex services; reduction of social, economic, communication, architectural and geographical barriers to enable the inclusion and comprehensive care for PwD.

Source: Prepared by the authors based on Esping-Andersen (1991).

Most of the articles included (10/16) were written by researchers from the USA, a country characterized by the liberal model of social protection, their publication dates varied between 1988 and 2016. Among the main recommendations/expectations raised were: the defense of the guarantee of protection of civil rights that would be ensured by a safe, accessible health system guided by Primary Health Care (PHC); the approval of legal mechanisms to enforce these rights; support for agencies that promote research on PwD; and the expansion of financing for public health care programs (including oral health), to expand the supply of services and access to the population. Proposals for reorienting the oral health care model, from a collaborative perspective to enable clinical case management, matrix support between the oral health team and other professionals, and greater resolution were mentioned. With the support of educational bodies and the control of the professional category, it was suggested that oral health service providers for PwD should be qualified in order to respond to the specific needs of this target group. In addition, there was a need both to defend public policies aimed at PwD, in order to attract the attention of policymakers to the priorities appropriate to each specific context, and to formulate clinical guidelines with a view to reducing social injustices and inequalities.

Of the remaining six records, two were recommendations/expectations formulated by researchers from countries characterized by the conservative model of social protection. Published in 1995 and 2019, the studies highlighted the need for professional education for oral health

professionals (dentists, oral health assistants and technicians), both in theoretical and practical terms; the provision of systematic and free dental care; mechanisms for improving the work process and qualifying care (organization of services in Health Care Networks (RAS), integration between services, multi-professional work, provision of funding for actions).

The other records were recommendations/expectations proposed by researchers from countries characterized by the social democratic model of social protection. Published between 2002 and 2015, the main aspects raised mentions the expansion of access and accessibility to dental care services for PwD; an infrastructure and workforce that would ensure the quality of care provided to this population; systemic articulation between primary and specialized care services, with an approach centered on users with disabilities; and ethical-professional responsibility in complying with laws related to PwD's right to health.

Although the principles of social protection are different, some recommendations and expectations were common regardless of the model adopted. These are: the concern to guarantee access to everyone in need of dental care, through an integrated network of services with a structure of equipment, supplies, and a multi-professional workforce adequately prepared and supported by fundings and payment systems for health organizations and services, which ensure an optimum level of quality.

Discussion

This integrative review produced a synthesis of the scientific literature on expectations/recommendations regarding dental care as a right to oral health for people with disabilities internationally. To this end, term mining techniques were adopted to identify studies that explicitly mentioned words such as rights, policies and politics, management/administration, legislation/standards, among other similar words. As a result, the expectations/recommendations originated from studies that shared the defense of dental care for PwD as a human right and a principle of social justice. Since science can help both in perpetuating injustices and promoting paths to social emancipation, it is important to highlight the effort/commitment of researchers from different countries toward the causes of PwD. Nevertheless, from the point of view of the rights of people with disabilities, a complex and sometimes contradictory scenario of proposals was observed, subject to indications with little chance of changing the quality of the response, especially if the contemporary challenges resulting from economic crises and the welfare state, which imply severe constraints on social protection models, are not addressed.

The results showed that the researchers' expectations/recommendations regarding the extension of the right to health and the menu of care offered for PwD varied according to the social protection model adopted in the country of origin of the respective studies. Common characteristics were also identified, regardless of the model adopted, such as the defense of expanding access to dental care for PwD and the qualification of the actions and services offered.

In the study in which the country's social protection model was guided by a liberal perspective, the recommendations and expectations highlighted the need to guarantee civil rights by means of legislative mechanisms and reorienting the oral health care model, with public policies aimed at the PwD, as a way of reducing inequalities and injustices. PwD and low-income individuals were eligible for health insurance administered in a decentralized way by state governments, in which care entities received a monthly payment to provide care based on the number of people registered. However, this funding mechanism has aroused great concern among PwD, due to situations where there is no guarantee of coverage. Researchers have warned that this mechanism could put successful programs (hospital dentistry) at risk, as there would be a restricted portfolio of services authorized for payment, and more specific procedures for certain situations would not be covered. In practice, there would be a decrease in the reimbursement of actions, generating a decrease in the supply of services and professionals and an increase in unmet needs (Tegtmeier; Miller; Shub, 2016).

The defense of this financing mechanism tends to impact especially those segments of the population that depend on access to continuous dental care, such as the most vulnerable, among them the PwD, which is why researchers from one of the included studies argue that it is necessary to invest in equity as a guiding principle of health policy, in professional partnerships and community interest groups, and to attract policymakers to frame the model in the context of social justice (Tegtmeier; Miller; Shub, 2016).

However, this framing is not a trivial matter and requires tackling the inefficiencies generated by the lack of an integrated system that can promote an appropriate combination of personal medical and dental care and public health measures, as well as implementing financing and payment mechanisms adjusted to health risks and the costs of procedures (Chernichovsky; Leibowitz, 2010). In unregulated health systems, where the logic of the free market prevails, people with disabilities tend to be particularly disadvantaged. Studying the effects of neoliberal reforms on the trajectory of health systems in Greece and Chile, analysts have commented that PwD can be seen as "expensive bodies" that consume more resources and should therefore be held responsible for their own health, completely ignoring the social determinants of health and the principles of social justice (Sakellariou; Rotarou, 2017).

The recommendations and expectations of studies in countries whose social protection was guided by a conservative model highlighted the need for professional qualifications for oral health workers, systematic and free dental care, integration between services, multi-professional work, and provision of funding for actions. The context referred to the Nordic countries (Sweden, Denmark, Norway, Finland, and Iceland) and France, which shared a common basis regarding the organization of health care through compulsory social insurance. Universal coverage was regulated by the state, financed by work-related social contributions and taxes, and health care was provided by public and private providers. Among the differences, there were variations in the participation of voluntary health insurance in the financing of health care and the extent and scope of public health strategies (Winkelmann; Gómez Rossi; Van Ginneken, 2022).

Integrated services that coordinate care tend to increase accessibility, especially if guided by a health network perspective, as they improve access to treatment and ensure coordination, continuity, and multidisciplinarity of user management in their health territory (Gondlach et al., 2019). Integration and coordination of care are fundamental to reducing barriers to accessing services at different levels and within the same level of the health system (Almeida et al., 2018). However, the problem of integrating services is a common challenge in many health systems, especially those where public and private providers compete with each other. Generally, dental and medical care in these systems operate in separate domains (silos), with parallel education and health policies under different professional cultures and funding models (Winkelmann; Gómez Rossi; Van Ginneken, 2022). Without a broader approach that considers the establishment of regulatory mechanisms aimed at integrating services, and the implementation of qualification strategies aimed at strengthening multi-professional work and the coordination of care, it is unlikely that these challenges will be addressed in countries whose social protection is guided by a conservative model.

The provision of funding for actions appeared as an expectation and recommendation raised by the authors, however, it is necessary to consider that, since 1970, neoliberal reforms have been implemented to contain welfare state spending, especially in the social area, in order to produce economic growth (Sakellariou; Rotarou, 2017; Steudler, 1986). In France and Belgium, among other European Union (EU) countries, direct payments for dental services have accounted for the majority of finance sources, due to low coverage by public or private dental health insurance (Winkelmann; Gómez Rossi; Van Ginneken, 2022). On the other hand, in the Nordic countries, provision outside private practices generally includes oral health care for statutory employees, preventive services and emergency care. Public provision is most pronounced in Sweden and Finland, where most dentists work in public dental clinics or municipal health centers, which focus on children and adolescents. In Norway, compulsory dental care is provided by salaried dentists in health clinics run by the local

authorities. The private sector generally takes care of adults, who may receive reimbursement from the state, depending on the service (Winkelmann; Gómez Rossi; Van Ginneken, 2022). In the social democratic model, the main recommendations and expectations raised mentioned the need to expand access to dental care, with adequately sized infrastructure and workforce, and greater systemic articulation between care levels. In Brazil, one of the countries reported, the need to expand inclusive policies that ensure greater accessibility to health services for PwD was mentioned by other researchers as an important factor that has not been guaranteed, compromising the principle of equity (Castro et al., 2011; Condessa et al., 2020). As the continued expansion of the private sub-sector is subsidized by the Brazilian state, the public sub-sector becomes underfunded (Paim et al. 2011), potentially compromising its ability to invest in quality care and expanding access to services for PwD and the population in general. In the United Kingdom, another country analyzed, the authors also mentioned recommendations for services in order to make them more inclusive and accessible, either through adjustments to their physical structure or changes to the policy that guides care practices (Merry; Edwards, 2002; Qureshi; Scambler, 2008). These changes are not simple. Factors such as high cost, prolonged disruption, and lack of financial incentives can discourage service providers. A disability rights commission established by the British parliament has been working since 1999 to monitor, eliminate discrimination, and promote equal opportunities (Hurstfield et al., 2004). In 2007, the committee was disbanded and its functions taken over by an equality and human rights committee.

The need to increase access in order to reduce inequality appeared as a recommendation and expectation common to all social protection models. It requires greater availability of resources (adequate funding) and management strategies (investment in PHC as the preferred gateway and integration of services) to organize the care network (Menicucci, 2019). In France, the law acknowledges the State as responsible for compensatory measures to ensure equal access to healthcare for people with disabilities. However, there is no system within French dentistry to guarantee this right. The local response to the problem has been to organize services into care networks, with PHC as the coordinator of care (Gondlach et al., 2019). In Brazil, PHC is the form of organization of the care model, of a comprehensive and universal nature (Menicucci, 2019). Some expectations and recommendations raised by authors who study dental access for PwD in the liberal model highlight the need to centralize care in PHC, in an effective, efficient, safe, and user-focused way (Edelstein, 2007).

A permanent threat to the rights of PwD concerns neoliberal reforms. They have profoundly changed health systems around the world, starting in the 1970s and, more recently, in 2008, with the global financial crisis, when several countries implemented structural adjustment programs impacting on various sectors, including health (Sakellariou; Rotarou, 2017). A direct effect of these health reforms was to increase inequality in access to services and widen socioeconomic inequalities. In this way, PwD can be particularly disadvantaged due to their growing health needs, which can reinforce their stigmatization (Gondlach et al., 2019; Sakellariou; Rotarou, 2017).

Final considerations

This review sought to produce a synthesis of the literature on researchers' expectations/recommendations regarding dental care as a right to oral health for PwD. Distinct and common aspects were highlighted, showing that these recommendations have scopes and limits linked to the social protection model adopted in the countries where the studies were published. However, this analysis did not address the effect of health policies, especially oral health policies, on dental care for PwD, as, for example, a mechanism for reducing inequalities in access to health care in countries with the same or different social protection models. Possible areas of shading that exist between different mixed models, characterized by the diversity of arrangements between private entities under varying degrees of regulation by the public entity (social organizations, public-private partnerships), were not considered either, suggesting

the need for studies along these lines. Although science has the role of subsidizing structural changes, it is not always considered, given that the decision is subject to multiple determinations of the political-social context and the different conjunctures of each moment. Another limitation concerns the non-inclusion of gray literature, such as laws and normative acts that guide dental care for PwD in countries with different social protection models.

Based on this review, we conclude that expanding access is a need shared by all the studies included, regardless of the social protection model adopted. In the liberal model, the main expectations and recommendations were to ensure civil rights and reorganize the oral health care model. The conservative model highlighted the need for professional qualifications for oral health workers, systematic and free dental care, integration between services, multi-professional work, and provision of funding for actions. The social democratic model called for the qualification of infrastructure and the workforce, as well as systemic coordination between care levels. A complex and sometimes contradictory scenario of proposals was observed, subject to indications with little potential to change the quality of the response, especially if the contemporary challenges arising from the economic crises and the welfare state are not taken into account, which imply serious constraints on social protection models and the rights of PwD.

References

ALMEIDA, P. F. et al. Coordenação do cuidado e Atenção Primária à Saúde no Sistema Único de Saúde. *Saúde em Debate*, Rio de Janeiro, v. 42, n. spe. 1, 2018. DOI: 10.1590/0103-11042018S116

CARVALHO, L.; ALMEIDA, P. Direitos humanos e pessoas com deficiência: da exclusão à inclusão, da proteção à promoção – Inclusive – Inclusão e Cidadania. *Revista Internacional de Direito e Cidadania*, João Pessoa, v. 12, 2012.

CASTRO, S. S. et al. Acessibilidade aos serviços de saúde por pessoas com deficiência. *Revista de Saúde Pública*, São Paulo, v. 45, n. 1, 2011. DOI: 10.1590/S0034-89102010005000048

CHERNICHOVSKY, D.; LEIBOWITZ, A. A. Integrating public health and personal care in a reformed US health care system. *American Journal of Public Health*, Washington, DC, v. 100, n. 2, 2010. DOI: 10.2105/AJPH.2008.156588

CONDESSA, A. M. et al. Atenção odontológica especializada para pessoas com deficiência no Brasil: perfil dos centros de especialidades odontológicas, 2014. *Epidemiologia e Serviços de Saúde*, Brasília, DF, v. 29, n. 5, 2020. DOI: 10.1590/S1679-49742020000500001

DAVIES, K. W.; HOLLOWAY, P. J.; WORTHINGTON, H. V. Dental treatment for mentally handicapped adults in general practice: parents' and dentists' views. *Community Dental Health*, London, v. 5, n. 4. p. 381-387, 1988.

DE LOUREIRO MAIOR, I. M. M. Movimento político das pessoas com deficiência: reflexões sobre a conquista de direitos. *Pesquisa Brasileira em Ciência da Informação e Biblioteconomia*, Brasília, DF, v. 13, n. 2, 2018.

DE PAULA, A. R.; MAIOR, I. M. M. L. Um mundo de todos e para todos: universalização de direitos e direito à diferença. *Revista de Direitos Humanos*, Brasília, DF, v. 1, p. 34-39, 2008.

DINIZ, D.; BARBOSA, L.; SANTOS, W. R. Deficiência, direitos humanos e justiça. *Sur. Revista Internacional de Direitos Humanos*, São Paulo, v. 6, n. 11, 2009. DOI: 10.1590/S1806-64452009000200004

EDELSTEIN, B. L. Conceptual frameworks for understanding system capacity in the care of people with special health care needs. *Pediatric Dentistry*, Chicago, v. 7, n. 2, p. 108-116, 2007.

ESPING-ANDERSEN, G. As três economias políticas do welfare state. *Lua Nova: Revista de Cultura e Política*, São Paulo, n. 24, 1991. DOI: 10.1590/S0102-64451991000200006

GLASSMAN, P.; SUBAR, P. Improving and maintaining oral health for people with special needs. *Dental Clinics of North America*, Amsterdam, v. 52, n. 2, p. 447-461, 2008. DOI: 10.1016/j.cden.2007.11.002

GONDLACH, C. et al. Evaluation of a care coordination initiative in improving access to dental care for persons with disability. *International Journal of Environmental Research and Public Health*, Basel, v. 16, n. 15, 2019. DOI: 10.3390/ijerph16152753

HADDAD, A. S.; TAGLE, E. L.; PASSOS, V. A. B. Momento atual da Odontologia para pessoas com deficiência na América Latina: situação do Chile e Brasil. *Revista da Associação Paulista de Cirurgiões Dentistas*, São Paulo, v. 70, n. 2, p. 132-140, 2016.

HURSTFIELD, J. et al. *Monitoring the Disability Discrimination Act (DDA) 1995* – Phase 3. Stratford upon Avon: Disability Rights Commission, 2004.

MENICUCCI, T. Política de saúde do Brasil: continuidades e inovações. In: ARRETCHE, M.; MARQUES, E.; FARIA, C. A. P. (Org.). *As políticas da política*: desigualdades e inclusão nos governos do PSDB e do PT. São Paulo: Unesp, 2019. p. 191-216

MERRY, A. J.; EDWARDS, D. M. Disability part 1: The Disability Discrimination Act (1995) - Implications for dentists. *British Dental Journal*, London, v. 193, n. 4, 2002. DOI: 10.1038/sj.bdj.4801522

MONTEIRO, L. P. A. et al. O conhecimento de deficientes visuais em relação à saúde bucal. *Revista Ciência Plural*, Natal, v. 4, n. 1, 2018. DOI: 10.21680/2446-7286.2018v4n1ID14476

MOTA, P. H. S.; BOUSQUAT, A. Deficiência: palavras, modelos e exclusão. *Saúde em Debate*, Rio de Janeiro, v. 45, n. 130, 2021.

OLOFSSON, H. et al. Can abstract screening workload be reduced using text mining? User experiences of the tool Rayyan. *Research Synthesis Methods*, Hoboken, v. 8, n. 3, p. 275-280, 2017. DOI: 10.1002/jrsm.1237

ONU – ORGANIZAÇÃO DAS NAÇÕES UNIDAS. *Convenção sobre os direitos das pessoas deficientes e protocolo facultativo à convenção sobre os direitos das pessoas com deficiência.* Brasília, DF: Unicef, 1975. Available from: <https://www.unicef.org/brazil/convencao-sobre-os-direitos-das-pessoas-com-deficiencia>. Access on: Nov.13, 2022.

PAIM, J. et al. The Brazilian health system: history, adcances and challenges. *The Lancet*, London, v. 377, n. 9779, p. 1778-1797, 2011. DOI: 10.1016/S0140-6736(11)60054-8

QURESHI, B.; SCAMBLER, S. The Disability Discrimination Act and Access: practical suggestions. *Dental update*, London, v 35, n. 9, p. 6, 2008. DOI: 10.12968/denu.2008.35.9.627

SAKELLARIOU, D.; ROTAROU, E. S. The effects of neoliberal policies on access to healthcare for people with disabilities. *International Journal for Equity in Health*, v. 16, n. 1, 2017. DOI: 10.1186/s12939-017-0699-3

STEUDLER, F. The state and health in France. *Social Science and Medicine*, Amsterdam, v. 22, n. 2, 1986. DOI: 10.1016/0277-9536(86)90070-5

SURABIAN, S. R. Americans with disabilities act. its importance in special care dentistry. *Dental Clinics of North America*, Amsterdam, v. 60, n. 3, p. 627-647, 2016. DOI: 10.1016/j.cden.2016.02.008

TEGTMEIER, C. H.; MILLER, D. J.; SHUB, J. L. The Impending Oral Health Crisis. *The New York State Dental Journal*, Albany, v. 82, n. 3, 2016.

VAN GRUNSVVEN, M. F. Dental care for the mentally retarded. *Ned Tydschr Tandheelkd*, v. 14, n. 83, 1976.

VAN GRUNSVVEN, M. F.; CARDOSO, E. B. T. Atendimento Odontológico em Crianças Especiais. *Revista da APCD*, São Paulo, 1995.

WALDMAN, H. B. Special pediatric population groups and their use of dental services. *ASDC Journal of Dentistry for Children*, Chicago, v. 56, n. 3, p. 211-215, 1989.

WHITTEMORE, R.; KNAFL, K. The integrative review: updated methodology. *Journal of Advanced Nursing*, Hoboken, v. 52, n. 5, p. 546-553, 2005.

WINKELMANN, J.; GÓMEZ ROSSI, J.; VAN GINNEKEN, E. Oral health care in Europe: Financing, access and provision. *Health Systems in Transition*, Copenhagen, v. 4, n. 2, p. 1-176, 2022.

Contribution of the Authors

Carneiro and Frazão contributed to the conception of the work, data analysis and interpretation , preparation and critical review for intellectual content and approval of the final version to be published.

Received: 12/06/2023
Approved: 12/08/2023