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Perception on Oral Health and Recommendations for Improvement of Public Service Dental

Percepção Sobre Saúde Bucal e Recomendações para Melhoria do Serviço Público Odontológico

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Abstract

Social participation is an important tool for the improvement of the Brazilian Unified Health System, strengthens the institution of performance evaluation processes and contributes to the expansion of access and quality of services provided. This study evaluated user's perceptions on oral health and recommendations for improvement of public dental services. This is a cross-sectional study, type inquiry, with 390 users of the Brazilian Unified Health System. The analyzed variables were self-assessment of oral health, evaluation of the team and the dental service provided. A qualitative analysis of the discursive questions was performed and Chi-square or G-test statistical association test, at a significance level of 5%. The self-assessment of oral health was categorized as very good/good, regular, bad/very bad and the identified reasons for the classification were: presence of disease, health care, pain, health education, negligence in health, time and fear. As for team and service evaluation, suggestions for improvement concerning infrastructure, access, humanization and education in health were made. It was found a significant association between health care and positive perception of oral health. The presence of disease, neglect, time and fear affected negatively the self-assessment. The recommendations for service improvement, 15.4% interviewed users pointed to infrastructure; 8.2% access; 6.9% humanization and 1% education in health. It is concluded that healthcare was the most frequent factor associated with good oral health. There were few recommendations for quality improvement and outcome of service provided.

Keywords: Health Evaluation. Self-Assessment. Oral Health.

Resumo

A participação social é uma importante ferramenta para o aprimoramento do Sistema Único de Saúde (SUS), fortalece a instituição de processos de avaliação do desempenho e contribui para a ampliação do acesso e qualidade dos serviços prestados. O objetivo foi avaliar a percepção dos usuários sobre a saúde bucal e as recomendações para melhoria do serviço público odontológico. Trata-se de um estudo transversal, tipo inquérito, com 390 usuários do SUS. As variáveis analisadas foram: autoavaliação da saúde bucal; avaliação da equipe e do serviço odontológico prestado. Realizou-se análise qualitativa das questões discursivas e teste estatístico de associação Qui-Quadrado ou Teste G, ao nível de significância de 5%. A autoavaliação da saúde bucal foi categorizada em muito boa/boa, regular, ruim/muito ruim e os motivos identificados da classificação foram: presença de doença, cuidado com a saúde, dor, educação em saúde, negligência com a saúde, tempo e medo. Quanto à avaliação da equipe e do serviço foram feitas sugestões para a melhoria, relacionadas à: infraestrutura, acesso, humanização e educação em saúde. Constatou-se associação significativa entre o cuidado com a saúde e a percepção positiva da saúde bucal. A presença de doença, negligência, tempo e medo influenciaram negativamente na autoavaliação. Como recomendações para melhoria do atendimento, 15,4% dos entrevistados apontou a infraestrutura; 8,2% o acesso; 6,9% a humanização e 1% a educação em saúde. Conclui-se que o cuidado com a saúde foi o fator mais relacionado a uma boa saúde bucal. Houve poucas recomendações para o aprimoramento da qualidade e resolutividade do serviço prestado.

Palavras-chave: Avaliação em Saúde. Autoavaliação. Saúde Bucal.

1 Introduction

Users in the health sector play an essential role in the planning of strategies and programs of assistance, because they establish a daily relationship with the health services and with professionals working there. This action goes beyond the simple demand for the service. It is included in a multidimensional practice and assumes a political dimension[1,2].

With advent of the Single Health System - SUS, there was the strengthening of popular participation and policies of evaluation, and thus, the social control represents the most vivid expression of society in decision-making by the State, assuming the user's design with competence to assess and intervene, modifying the system itself[3].

According to Ceccin and Merhy[4], the knowing that users acquire the concrete use of basic health services may occupy an important room in the improvement of the healthcare provided in primary care.

To assess the user's perception of the health service provided is of fundamental importance, since the assessment

has been used in different areas and in different ways, sometimes as an external action that analyzes a certain intervention or problem, sometimes as a step in planning the management of the institutions, programs and projects, accompanying the actions aimed at the changes since its first drawing[5].

The user's perception in the health-disease process is characterized according to the time in which it is established; it is based on the way of life and covers a variety of contexts marked by cultural, social, economic and individual differences[6]. Each user has a certain perception about quality and, many times, this difference has a relationship even with the "state of mind" at the time of service delivery. People have different standards of quality in different moments of their life[7].

In recent years, the Ministry of Health has been the main responsible for the evaluation process in the field of primary care, developing a set of initiatives for evaluation and monitoring of health services, providing instruments for quantitative and qualitative research, for the changes that occur at the local level quickly and objectively, seeking a comparable quality standard nationally, regionally and municipally[8].

In dentistry, the evaluation of the self-perception of oral health status and the need of care is performed to verify the importance of oral health and the need for treatment, as well as to improve adherence to treatment and encourage healthy behaviors. It has a multidimensional aspect, depending on the individual's understanding of what is normal in oral health and specific symptoms that it presents, referring to a subjective experience of the individual on his or her functional, social and psychological well-being. Thus, indicators developed to measure subjective perceptions include the self-assessment of oral health, the perception of the need for treatment and the satisfaction with the state of oral health[9.10].

Researching about the user's satisfaction, especially in primary care about the service provided is an essential task for the management, once its understanding can provide an assessment of performance under the perspective of the user, indicating both operational and strategic decisions that will influence the level of quality of services provided by the organization.

In a review of the literature to analyze the changes in work in the dental industry after the launch of the guidelines of the National Oral Health Policy, it was observed that, in general, the main participants of the studies were employees of the Family Health Strategy - FHS, highlighting the surgeon dentist - SD, about 1/3 included managers and users[11], a result which highlights the need to intensify the qualified listening of users, given its relevance and contribution.

The perception is verified by means of its tangible and intangible components. The tangibility of a service is what the user sees and feels such as the physical appearance of the work place . The intangible components are courtesy and friendliness of the staff of dentistry, i.e., they are directly linked to the relationship of the professional team with the users[12].

Therefore, understanding the subjective concept of oral health allows to know what the factors are related to positive or negative self-assessment of the population oral health conditions. The negative self-assessment may be associated with the feelings of pain, malaise and social interactions, cultural, psychological and environmental factors and the positive good treatments, the resolubility of services and the humanization, mainly sheltering and in the creation of bonds between professionals and users[13].

In this article, our aim was to evaluate the user's perception on the own condition of oral health, satisfaction with dental services provided on the public network of primary care in Brazil and the recommendations for the improvement of services.

2 Material and Methods

This work is part of a multicenter research, carried out in three municipalities of different states of Brazil, on optics for evaluation of user's satisfaction regarding the dental service provided in the scope of Basic Care in Brazil.

This is an epidemiological study, type inquiry and transversal. The data used in this research are the answers of the interviews conducted with 390 users of public service dental care in primary care in the municipality of Aquidauana, MS. The sample size was determined considering the estimated prevalence in the region to a prevalence of 50% of adults satisfied.

As an exclusion criterion it was defined that patients who were waiting to schedule their initial appointment, those who were performing the first appointment and those who had any inability to respond to the instrument used should not be interviewed.

The analyzed questions are part of a questionnaire consisting of 33 questions, being 30 closed and three open questions, adapted from the instruments proposed by the National Program of Evaluation of Health Services (PNASS) and the Program for the improvement of access and quality of care (PMAQ-AB)[8.14].

Qualitative analysis was performed for the responses of discursive questions. The following questions were analyzed 'In your opinion, how is your oral health?' and 'Why?'; 'Say, please, what needs to be improved in dental care this Unit of Health'; 'what could the dentist of this health unit and the IT team do so you (a) feel more satisfied with your oral health?'

To better understand the user's perception about his

or her oral health conditions and the recommendations for improvement of the care provided, the method of content analysis was adopted, which consists of the classification of constitutive elements of a set by differentiation and, subsequently, by regrouping according to gender (analogy), with criteria previously defined, which bring together a group of elements with common characters[15].

key words were identified and organized in groups of responses to allow for aggregation, numbering and the restatement of the content. Thus, the open questions were transcribed separately according to the speech of the subject and subsequently divided into categories.

A descriptive analysis was performed of the responses of closed questions regarding the profile of the sample and the responses of the closed question on the perception of their own oral health conditions, the participants were divided into three groups: very good and good, regular, bad and very bad. The responses from each group were separated and the following categories were identified: health care, the presence of the disease, pain, fear, neglect with health, time, health education.

The Chi-square statistical test or G test, at a significance level of 5%, to verify the association between the perception of their own oral health conditions and the factors identified for the classification.

The responses of the open questions about what needed to be improved in dental care at the Health Unit, both in the organization by management as the team of oral health, were grouped into five categories: nothing, infrastructure, access, humanization and health education.

In the socioeconomic characterization of the interviewed users, the actors were grouped according to gender. Quantitative data were processed using the Epi Info statistical program, version 3.5.2 (Centers for Disease Control and Prevention, Atlanta, USA), using precision of 5%, a confidence interval of 95% and a correction factor 01.

The study was approved by the Committee for Ethics in Research, being as the proponent institution the Faculty of Dentistry of Campus Araçatuba, CAAE: 05567113.8.1001.5420, Opinion 353.893.

3 Results and Discussion

In this study it was observed that a high percentage of SUS users consider their oral health good and a great party, stated that the dental service was not modified.

The interviewee's profiles was: 73.1% were women; 47.2% were in the age range of 20 to 39 years; 44.4% earned from 1 to 2 minimum salaries; 25.4% with five years of study and 63.3% are married or are under commonwealth as it can be observed in Table 1.

Table 1 - Users' profile of the SUS dental service, according to gender, age, socioeconomic condition, marital status and schooling, Aquidauana - MS.

Users' Profile	N	%
Gender		
Male	105	26.9
Female	285	73.1
Age Range		
15 to 19	35	9.0
20 to 39	184	47.2
40 to 49	86	22.0
50 to 59	40	10.3
More than 60	45	11.5
Socioeconomic condition		
Unemployed	67	17.2
Income less than 1 minimum wage	67	17.2
Income from 1 to 2 minimum wages	173	44.3
Income from 2 to 5 minimum wages	26	6.7
Income from 5 to 10 minimum wages	3	0.8
Does not know/did not answer	54	13.8
Schooling		
Illiterate	7	1.8
Elementary school (1st to 5th series)	99	25.4
Elementary school (6th to 9th series)	79	20.3
Incomplete High School	63	16.1
Complete High School	83	21.3
Incomplete Upper Education	19	4.9
Complete Upper Education	20	5.1
Does not know/did not answer	20	5.1
Marital Status		
Married/Commonwealth	247	63.3
Single	107	27.5
Widower	16	4.1
Separated/divorced	20	5.1
Total of interviews	390	100

Source: Research data

In Table 2 it is noticed that among the users who do not have time set to work, 87.4% are females, which may explain the predominance of women in care service provided in SUS. Women are still considered, by most of the studies, the ones that are concerned with the health and seek more the service[16].

Table 2 - Distribution of the percentage of users of SUS dental service, according to gender and occupation, Aquidauana - MS.

Gender	Profession		Total n (%)
	Work without Time Set n (%)	Work with Time Set n (%)	
Male	23 (12.6)	81 (39.5)	104 (27.0)
Female	159 (87.4)	124 (60.5)	283 (73.0)
Total	182 (47.0)	205 (53.0)	387 (100)

Note: 03 Users refused answering this question.
Source: Research data

As to the relationship between the perception and the degree of schooling, it was observed that 53.6% consider their oral health very good and good, 36.4% regular and 10% bad and very bad. Among those who considered the oral health very good/good, 25.4% has complete high school education; of those who responded, 26.1% attended regularly until the fifth year of elementary school education and those who rated bad/very bad, 33.3% also has until the fifth year of elementary

school education, corroborating with the study by Moura et al.[13], who found a better self-assessment of oral health among individuals with higher education.

Araújo et al.[17] emphasize that the higher income and schooling, the more these factors influence positively on access, and that the increased use of oral health service takes place among individuals who rated their dental condition as good or very good. Table 3 presents the results obtained regarding the perception and level of schooling.

Table 3 - Distribution of the percentage of users, according to schooling and self-perception of oral health, Aquidauana - MS.

Schooling	Self-Perception of Oral Health			Total n (%)
	Very Good/ Good	Regular	Bad/Very Bad	
	n (%)	n (%)	n (%)	
Illiterate	4 (1.9)	0 (0.0)	3 (7.7)	7 (1.8)
Elementary school (1st to 5th series)	49 (23.4)	37 (26.1)	13 (33.3)	99 (25.4)
Elementary school (6th to 9th series)	40 (19.1)	32 (22.5)	7 (17.9)	79 (20.2)
Incomplete High School	33 (15.8)	22 (15.5)	8 (20.5)	63 (16.2)
Complete High School	53 (25.4)	26 (18.3)	4 (10.3)	83 (21.3)
Incomplete Upper Education	10 (4.8)	8 (5.6)	1 (2.6)	19 (4.9)
Higher Education	7 (3.4)	13 (9.2)	0 (0.0)	20 (5.1)
Did not answer	13 (6.2)	4 (2.8)	3 (7.7)	20 (5.1)
Total	209 (53.6)	142 (36.4)	39 (10)	390 (100)

Source: Research data.

Tables 4 and 5 present the answers and the percentages concerning the question: 'Why do you consider your oral health as good/very good, regular or bad/very bad?'

Table 4 - Percentage distribution of responses according to the classification of oral health and categories of responses of the reasons presented, Aquidauana - MS.

Categories	Groups			p value
	Very good/ Good	Regular	Bad/ very bad	
	n (%)	n (%)	n (%)	
Presence of the disease	23 (11)	30 (21)	17 (43)	23 (0.0001)
Health care	100 (48)	11 (8)	2 (5)	23 (0.0001)
Pain	17 (8)	9 (6)	1 (3)	0.3640ǂ
Health education	2 (1)	1 (1)	1 (3)	0.3640ǂ
Health care	2 (1)	30 (21)	9 (23)	0.3640ǂ
Lack of time	6 (3)	18 (13)	4 (10)	0.3640ǂ
Fear	0 (0)	3 (2)	0 (0)	0.3640ǂ
Did not answer	59 (28)	40 (28)	5 (13)	23 (0.1195)

* Test X^2 Test ǂ G

Source: Research data.

We found a significant association between the presence of disease, neglect, lack of time, fear and negative perception of oral health status. Among users who assessed their oral health positively, the health care prevailed in the answers and had statistical significance, corroborating with the study of Reis et al.[6], in which the interviewees indicated an association between oral health and care, with this assuming greater importance in the health maintenance.

Table 5 - Answers of dental service users about the reasons for the classification of oral health, Aquidauana - MS. Continua...

Categories	Groups		
	Very good/good	Regular	Bad/very bad
Presence of the disease	I do not have caries, tartar, I use floss and brush my teeth. A mouth without caries is very good. I have some rotten teeth.	I have caries. I have some missing teeth and other obturated and treated. Occasionally I feel a taste, I do not know whether it is the mouth or stomach. I'll have my tooth pulled out , but I am having them treated.	Because I have many caries. I have plenty to do (canal, pull some out). I would like to have all of them pulled out, but they do not do it. We brush but I have bad breath, the problem is at the root, I only have 7 teeth. The teeth are dropping, and everything is spoiled.
Health care	I always come to the dentist. Because I take care. Because I am brushing, flossing. Before I have any problem, I come and have prevention. I have no tooth to treat, all continued in the same way since the last time I went to the dentist.	I am having them treated. Because it is only now that I am seeking treatment.	
Pain	I do not know, I used to fell pain, not anymore now. I am a person who does not have toothache, I go to the dentist every 6 months. Thank God I don't feel anything.	Have canal treatment, pain, it took me a long time to come. I had toothache. The restoration made by the dentist hurts. I am in pain.	I am in pain.

Continuação.

Categories	Groups		
	Very good/good	Regular	Bad/very bad
Health education	I had almost all teeth pulled out, if I had the information of how to treat the teeth, I would not lose so many teeth.	I do not know how to brush correctly.	I am 61 years old, in childhood when the teeth hurt, parents ordered to show the root to the sun. Most teeth were pulled out by someone who had no diploma.
Negligence with Health care	Laziness to go to the Unit. It is not the dentist's fault, but my fault.	I have never been to the dentist. Because I have never had regular treatment. Carelessness I wake up in the morning and lunch I do not brush my teeth, I only brush my teeth at night.	Al teeth spoiled, and it is my fault, I will have to wear a denture in my mouth. I did not go to the dentist for some time. I didn't care when a child, there was no interest to wear a bridge. The dentist who sought, since I started treatment and did not finish.
Time	Because of the time that we have is little to take care of our health. I do not have much time since I travel a lot.	It has been a long time that I do not go to the dentist. I don't have time to have treatment.	It has been a long time that I do not go to the dentist. I have no time
Fear		I am afraid so it takes me time to come back. Now I can have a treatment, I used to be afraid, but not anymore, I must have all my teeth pulled out.	

Source: Research data.

The Ministry of Health, by means of legal determinations, promotes and establishes the self-care as a tool for the management of health care. The Guidelines of the National Oral Health Policy[18] encourage the reorganization of oral health care through the construction of sanitary consciousness that necessarily implies, both for managers and professionals as well as for users, the awareness of the aspects that influence and determine a given state of health and of existing resources for its prevention, promotion and recovery. The National Policy of Basic Care[19] proposes among other characteristics of the work process of the teams, the development of educational actions that may interfere with the health-disease process of the population, in the development of individual and collective autonomy, and in the search for quality of life by the users.

Afonso-Souza et al.[20] suggested two hypotheses for the positive evaluation: the first is the result of a good treatment, a greater opportunity to receive preventive treatments with positive results in the clinical conditions of oral health; the second would be related to the occurrence of a psychological well-being associated to health care.

Similar results were found in ratings of secondary care in buccal health. In a study conducted to evaluate the satisfaction of users of Centers of Dental Specialists[21], it was observed that the best self-perception of oral health and less time waiting in the office were associated with satisfaction with the quality of dental services offered.

However, among those who have evaluated the condition of oral health as regular, bad and very bad, the presence of periodontal diseases emerged, with reference also to the pain. It is worth pointing out that imbalances in oral health conditions of the population can trigger behavioral changes, especially when related to pain with the oral health/disease process, mobilizing people sometimes to take care of their descendants so that they do not go through the same situations of discomfort and pain[6].

Another point raised by users who evaluated the conditions of negative oral health is the fear factor, because the curative care in dentistry cause sensitivity, being sometimes necessary to use local anesthesia, which have already demonstrated a high evasion of the treatment. In a study conducted in Canada, the results show that the fear and anxiety are common reasons in cancellation of dental appointments[22-24].

The fear arises in individuals from two distinct forms, or combined, namely: through their own experiences and expectations and experiences of others. That is, the individuals experience fear or are already established and assimilate it. The traumatic dental situations experienced by patients influence their current posture in front of the professional[22].

In this sense, it is known that the living and working conditions qualify differentiated forms the way by which individuals think, feel and act regarding their health[12], thus, self-evaluating health is also defining the quality of life.

Concerning the answers on the question 'Say, please, what needs to be improved in dental care at the health unit?', 52.8% evaluated positively the service. Concerning the answers of the question 'What could the dentist of this health unit and the IT team could do for you to feel more satisfied with your oral health?', 63.8% said that the team should continue with the same care. Some of the speeches in this category are highlighted:

> Does not need to be improved, I come once a week.
> Nothing needs to be done, everything is all right.
> Nothing, they are attentive and great professionals.
> Despite having had leaves several times and missed, the dentist is excellent and does his or her very well done.

The positive assessment of the oral health service is to a

great extent due to the advancement of public health policies, especially after the implementation of SUS and the realization of FHS as main model of attention to health, offering continuous and integral attention to the users, surpassing the previous models of attention, traditionally considered little resolutory[25].

Another aspect for a good assessment is the fulfilment of the guidelines recommended by ESF which provides a minimum team of professionals with a regime of 40 weekly hours, increasing the chances of promoting a greater bond with users, exercising caution in a longitudinal way and make an offer of services combined with the entire network of health services[25].

The health professionals included in basic care work with recruited population, are familiar with the conditions of the territory such as food, income, housing and sanitation, essential information to respond adequately to the needs of health and meet the expectation of the user.

In addition to the developments in the national health system, other factors, such as socioeconomic characteristics and educational activities, may influence the perception and attitude of the users before the evaluation of services.

Satisfaction surveys with users have obtained a high percentage of positive assessments in several health areas, as in the study of Cabulon et al.[26] in which 99% of the participants rated the service as excellent and good.

The high rate of adoption of services by users, highlights the need to look for the profile of the sample, since although advances have occurred, it is well known that many public health services have structural, organizational and access problems.

In this study, despite the high user satisfaction, both with the service provided and the care given by the team of oral health, some suggestions have been identified for the improvement of the quality and resolvability of dental services as: infrastructure, access, humanization and health education.

Regarding the infrastructure 15.4% reported that the service should be improved and 4.9% that the oral health team should offer better conditions of service. In the aspect of infrastructure, the following were mentioned: acquisition of dental equipment, maintenance on the physical structure of the unit and equipment, purchase of consumable materials, as well as the organization of the service, among the recommendations that most prevailed, the following stood out:

> Improve the structure and equipment, sometimes there is no air in the equipment, water.
> More preparation, more resources, my husband had to make treatment, since the teeth were going loose and had to pay for private care.
> Increase the Unit, because when there are a lot of people it is a noise at the door of the dentist.
> The Unit is very well prepared, lacking physical conditions and materials, and thus there is nothing the dentist can do about that. It is a matter of public management.
> It would be good if we had in the PSF of the village the x-ray apparatus and apparatus so the doctor could perform d canal treatment for not being forwarded to another place.
> Arrange the delivery of materials to the health units, because sometimes there is no care because they lack material.
> They could have a more comprehensive service, change in the physical structure of the unit to meet the demand.
> The is not maintenance on the equipment.

To subsidize the municipalities in the health management, a Booklet was published for the submission of proposals to the Ministry of Health. It is an important work for the planning of proposals for strengthening of public health, where it is possible to find information about programs and strategic policies, in addition to other guidelines on financing of health actions[27].

Concerning access, 8.7% of the respondents mention that the local management of health should improve access and 3.3% indicate that the team should build better customer service to increase the access of users to the service. In this category, it was reported an increase in the number of vacancies, alternative schedules for people who work with set schedule, more professionals, agility in the marking of consultations and organization of the care agendas. In the most evidenced suggestions, the following stood out:

> Delay to be serviced, they schedule in a week and I am serviced in another.
> Faster appointment.
> Have night time.
> It is necessary to be more aware of the work of the dentist and the Unit, have more time for the appointments in the Unit.
> After you arrive, they no longer pay services in addition to the patients who are scheduled even if they have vacancies.
> Increase the number of vacancies, or professional.
> The number of people serviced need to be improved, they only service 4 people. Increase the vacancies.
> Increase the number of patients, because today some people had to come back home. If the elderly is preferable, he or she must have a special booth.

The access is influenced by several factors, highlighting the geographic factor (distance), lack of infrastructure, lack of services, organization of the schedule and the presence of vacancies, many of these were identified in this research. However, in relation to the distance there were no complaints or suggestions, which was already expected, since the health units in focus are located in the territory where the families filed therein reside [6,28].

One aspect that deserves attention is that the users when reporting the access, making mention to the attention of medium complexity, they make bad references, with frustrated experiences in access, showing the fragility of the articulation between the primary and secondary network. It should be noted that users identify in the basic network, professionals who cannot effectively do everything they deem necessary to ensure that the patients feel well taken care or have good oral health conditions. For improved access to the specialized service the users suggested:

> Improve the space and the conditions, because the room is tight. No teeth are pulled out here, one must be forwarded to CEO.

Delay to schedule a specialty.
Offer specialized care in the unit.
Having a day to pull out, so you don't need to go to CEO as the neighbor said.
In fact, when public, when we lose a tooth it would be good if the SUS put another in the place, but they do not provide this treatment.
Perform more other types of treatment.
Pull out teeth in the Unit, they do not perform canal treatment, only cleaning.

The organization of services rendered in SUS, in the logic of integral care, is structured in levels of increasing complexity, basic care, attention of medium and high complexity. Basic Care is characterized by the entrance door of the health system, where fewer complex procedures are performed, but with capacity for solving 80% of the health problems. The articulation among these 3 levels of attention is made through loco-regional arrangements, the health care networks (RAS). The organization of RASs, to be done effectively, efficiently and with quality, needs to structure itself based on the following grounds: economy of scale, resource availability, quality and access; horizontal and vertical integration; processes of substitution; sanitary territories; and levels of care[29].

Another factor suggested by the users is regarding the humanization of services, in which 7.5% indicate that management should implement a policy of humanization and 6.2% that health professionals should improve the form of care service. Many factors are related to the humanization, such as: the relationship between the professional and user, respect for opening hours and especially the reception, because this encompasses two dimensions, the first being the time of receipt of health services relating to the first contact of the user, and the second, the relationship with the work of the professional, i.e., the relationship between worker and user, performed at any time of care and that helps in the positive assessment by the users[30]. Among the most observed recommendations, the following stand out:

The Assistant needs to work harder.
Care service, lack of information.
Dentist's time of arrival.
The team could arrive earlier.

A tool connected to the humanization is the bond, being an important instrument because it promotes the creation of ties of commitment and co-responsibility among the professionals of the team and the population of the area of coverage, going beyond the establishment of a simple contact, but a real approximation of health workers[31]. According to Silva Júnior and Mascarenhas[32], the bond has three dimensions: the affectivity, the therapeutic relationship and continuity, i.e., the strengthening of the bond and mutual sense of trust between professional and patient. These dimensions are highlighted in the following discourses:

In the customer service it is ok, it is only needed to have the name of the dentist at the door because then I and other patients would know the name of the dentist.
Prepare and participate in projects for improving customer service.
Nothing, the form of catch in mouth of everyone is very slow I feel insecure.
Have more day care for adults, they only provide services two days.

In the face of local and national needs as the valorization of the patient's subjectivity, the establishment of a relationship of respect, collaboration and special attention to the particularities of each one, the Health Ministry proposed the National Policy for Humanization (PNH), determining that the humanization is the guiding axis of care and management practices in all instances of SUS. This proposal has as its priority objectives to increase the ease of access to the services provided by SUS, promote better resoluteness to the users' problems, ensuring the users' rights, participatory management, as well as continuous education to workers[33].

Another point raised by users is related to education, where 1% of users reported that the management of healthcare should provide educational information to the population and 3.1% blamed the health professionals in health education. Among the recommendations the following stand out:

If the dentist let me know more about how I prevent...
Explain and ask what the patient needs to improve customer service.
They could offer lectures to advice the patients.

According to the answers, there is a small portion of users who have suggested an improvement in health education activities. Contrary to the assertions of the study of Sala et al.[34], where the issues involving education received the worst percentages of positive responses. In a study conducted among dentists, dental students and users of SUS to assess the knowledge and practices regarding hygiene and storage of dental brushes observed that all groups demonstrated not having knowledge about the most suitable place and the ideal way to store their toothbrushes[35], underlining the necessity of permanent educational activities and education in health. Results of studies carried out in other levels of care reinforce the lack of standardization of practices related to health education. As an example, it was observed that in Intensive Care Units (ICU) that more than a third of Nursing teams are unaware of the oral hygiene protocol[36].

It is hypothesized that the Permanent Education in health become effective at the time in which transcend the linearity, the punctual and finalizing actions, preconceived to happen at a given site, with content and strategies previously defined[37].

As to the limitations of this study, initially one should consider that this is a transversal study, there are limitations inherent to this type of research. The study participants are users who received dental care in the municipal public service, although they have been informed that there would be the confidentiality of data and that the participation would not undermine the assistance in health services, it is possible to justify the high percentage of satisfaction with the fear of

reprisals as, for example, the difficulty accessing to health units.

Another aspect that may have influenced the responses was the time and place for the data collection, the study was subject to a population that has no schedule set to work. This characteristic of the sample might have influenced the results, by means of a specific perception as the influence of gender and health. According to Moimaz et al.[3], a similar situation is found in most studies in health services, in which the female audience is always predominant.

However, it was found that studies on subjective evaluation in health, especially in the dental sector, addressing content analysis, are fundamental to better understand the local reality of the population, because according to Minayo[38], the analysis of content is "understood more as a set of techniques". It is constituted in the analysis of information about human behavior, allowing a quite varied application, and has two functions: verification of hypotheses and/or issues and discovery of what is behind the manifested contents. These functions can be complementary, with application both in quantitative and qualitative research.

Thus, it is important to know how the population assigned to teams of health evaluates the care offered to rethink the professional practices or intervene on the form of organization of services, aiming at its improvement and the development of policies of health promotion, disease prevention and control of diseases[39].

4 Conclusion

A high percentage of users of public service rated oral health as very good and as good and the main reason identified was the health care, with a significant statistical association. The presence of disease, neglect, time and fear influenced negatively the users' evaluation. Few were the recommendations for the improvement of services, and these are related to infrastructure, access, humanization and health education. Most respondents consider that the care must not be modified, being satisfied with the care received. The user's perception is an important management tool, directs the health planning, contributes to the improvement of the quality of services and to the viability of policies of promotion, prevention and recovery of health.

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