DOI: http://dx.doi.org/10.17921/2447-8938.2019v21n2p139-143

Oral Health in Primary Care through the Family Health Strategy

A Saúde Bucal na Atenção Básica Através da Estratégia Saúde da Família

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Recebido em: 14/09/2018
Aprovado em: 11/02/2019

Abstract

The purpose of this article is to carry out a literature review on oral health team in primary care with their inclusion in the Family Health Strategy (FHS). The publications were consulted in national papers, official documents and other publications of Health Ministry (MS). In the literature it is observed that with the creation of the Unified Health System (SUS) a process of health restructuring services in Brazil began. The Primary Care National Policy (PNAB) is the result of several historical facts involved with the development and consolidation of SUS. The Family Health Program (PSF), now called the Family Health Strategy (ESF) was created in 1994 aimed at reorienting health care with new bases, centering family focus and attempting to achieve improvement in quality of life of Brazilians. In 2000, oral health teams were included in the PSF to extend access of the Brazilian population to health promotion actions, prevention and recovery of oral health, improve health indicators and encourage the reorganization of dentistry in primary care. ESF is a unique strategy in the reorganization of the Brazilian health system and the inclusion of the ESB an important complement in primary care, aiming an integral dental practice.

Keywords: Primary Health Care. Family Health Strategy. Oral Health.

Resumo

O presente artigo tem o objetivo de realizar uma revisão de literatura sobre a equipe de saúde bucal na atenção básica, através da sua inserção na Estratégia Saúde da Família (ESF). As publicações consultadas foram artigos científicos nacionais, documentos oficiais (leis e portarias) e outras publicações do Ministério da Saúde (MS). Na literatura observa-se que com a criação do Sistema Único de Saúde (SUS) iniciou no Brasil um processo de reestruturação dos serviços de saúde. A Política Nacional de Atenção Básica (PNAB) é resultado da experiência acumulada de vários atores envolvidos historicamente com o desenvolvimento e a consolidação do SUS. O Programa Saúde da Família (PSF), atualmente denominado Estratégia Saúde da Família (ESF), foi implantado em 1994 visando a reorientação da prática da atenção à saúde sob novas bases, centrando o foco na família, na tentativa de alcançar uma melhoria na qualidade de vida dos brasileiros. Em 2000, as equipes de saúde bucal foram inseridas no PSF com o objetivo de ampliar o acesso da população brasileira às ações de promoção, prevenção e recuperação da saúde bucal, melhorar os indicadores de saúde, além de incentivar a reorganização da odontologia na atenção básica. A ESF consiste em uma estratégia ímpar na reorganização do sistema de saúde brasileiro e a inclusão da ESB um importante complemento na atenção básica, visando uma prática odontológica integral.

Palavras-chave: Atenção Primária à Saúde. Estratégia Saúde da Família. Saúde Bucal.

1 Introduction

The discussions of changes in policies of health in the world have great emphasis from the international conference of Alma Ata, 1978, reaffirming the health as a fundamental human right[1]. In Brazil, the proposal to reform the health sector began to take shape in the mid-70 and a broad social movement grew in the country, gathering initiatives in various sectors of the society - the Sanitary Reform[2,3].

In 1988, with the new Brazilian Federal Constitution the consolidation of the Single Health System (SUS) was created and with its regulations by means of the Organic Law 8.080/1990, the of health services restructuring system began in Brazil[4]. The Brazilian model of health attention was characterised by a combination of actions and services promotion, protection and recovery of health, being organised in a regionalised and hierarchical way. Its main entrance door is the basic health care, which must be the authorizing body of the care network [5].

The first models of oral health care in Brazil showed inefficiency, not responding to health problems of the population. Historically constructed in Dentistry they prioritised the curative service and few initiatives for prevention and health promotion. By the focus given to the biological aspect, prioritized the provision of restorative services or extraction of dental elements, assuming a mutilator and invasive character, in addition to the high cost of implementation and very low income. For many years the social, economic and cultural factors were down-graded, which are also determinants of the etiopathogenesis of these diseases[6].

In 2000, with the insertion of dentistry in the Family

Health Program (FHP), currently known as the Family Health Strategy (FHS), there was the strengthening of actions of promotion, prevention and recovery of health and represented the initial step in the expansion of the supply of public services in the area[7]. The oral health actions in the ESF should be guided by the principles and guidelines of SUS that seek, in addition to the expansion of the population's access to actions and the resolution of installed oral health-disease and the intervention on the determinants of health[8].

Due to the reasons above mentioned, it was intended with this study to answer the following questions: Does the inclusion of the team of oral health in primary health care contemplated the necessary demand of assistance? And how was such fact reorganised in the health system? In this context, the objective of this study was to investigate how the process of inclusion of the team of oral health in primary care occurs, by means of their insertion in the Family Health Strategy.

2 Development

2.1 Methodology

The method used in this study was qualitative and bibliographic research that counted with the selection and review to answer to the problem and objective proposed in this study, with the purpose of explaining the hypotheses and assumptions made by the researcher regarding the matters to be investigated.

The main terms used for the realization of the searches in the data bases were: Unique Health System, basic care, family health strategy and team of oral health.

The treatment of the results and interpretation, after the previous steps followed the criteria of Bardin[9], which is "the analyst, having at its disposal significant and faithful results, and may then propose inferences and interpretations in advance to the purpose of the objectives, or which relate to other unexpected discoveries". After the excerpt process, the data were classified and exposed on the topics to be discussed along the text.

2.2 The basic attention to health

The Primary Care National Policy (PNAB) is the result of several historical facts involved with the development and consolidation of SUS, such as social movements, users, workers and managers of the three spheres of the governmnent.

In Brazil, the hegemonic medical model[1] was an important vector for the search of changes, because it presented itself as one of the factors of inefficiency and enhancement of the system and pointed to the need of the process of Brazilian sanitary reform[11]. Mainly,in the economic crisis and the process of democratisation, occurring in 80 years, which positively influenced the political debate in the area of health, whose reflex was noticed in the Federal Constitution of 1988, where the universal access of the population to health services was legally guaranteed[12]. Within this proposal is SUS with its principles based on the integrality of care, fairness, universality and social control of health actions[13, 14].

In this context, the Basic Attention is characterized as a set of health actions, in the individual and collective range, that cover the promotion and protection of health, disease prevention, diagnosis, treatment, rehabilitation and maintenance of health[15]. It is developed through the exercise of managerial and sanitary democratic and participatory practices, in the form of teamwork, directed at populations of well delimited territories , which assumes the sanitary responsibility, considering the dynamics existing in the territory where these populations live[16].

The Basic Attention is guided by the principles of universality, accessibility and coordination of care, of the bond and continuity, integrity, accountability, of humanization, fairness and social participation[17]. The work process of the teams of Basic Care has as characteristics: definition of the territory of UBS operations; programming and implementation of activities; development of educational actions that may interfere with the health-disease process of population and expand the social control in defense of the quality of life; development of actions focused on high-risk groups and behavioral risk factors, food and/or environmental care; full basic and continuous training, organized to the assigned people , with guaranteed access to diagnostic and laboratory support; implementation of the guidelines of the National Policy of Humanization; completion of first care to medical and dental emergencies; participation of teams in planning and evaluation of actions and development of intersectorial actions[16.18].

2.3 The Strategy Family Health

The Basic Attention is the Family health has as a priority strategy its organization in accordance with the precepts of SUS. The success of the program of Community Health Agents (PACS), created in 1991, stimulated the conception of the Family Health Program (FHP), in 1994, currently known as the Family Health Strategy (FHS) [19]. FHP was implemented with the aim of reorganizing healthcare practice in new bases and criteria, replacing the doctor-centered model oriented toward curing diseases and hospital care for a model focused on family[20].

FHS assumes the commitment to assist universal, comprehensive egalitarian, continuous assistance and above all, precedent to the population, at the health unit or at home, always in accordance with the real needs[21].

The focus on the family nucleus is justified by the fact that the family is the context in which they originate and reinforce habits, beliefs and values, proposes to be a project promoter of SUS. FHS seeks to break with the prevailing health model, assuming an amplified conception of health, in which it is seen as a result of the conditions of life in which the individual is inserted, has the family as the central nucleus

of attention, works the humanization of care, the population is restricted and the epidemiological concept of responsibility on its territory of performance[22].

This model is structured from the Basic Family Health Unit that prioritizes actions for health promotion and disease prevention and rehabilitation of injuries, through its multidisciplinary team, responsible for an employed population that varies from 2400 to 4500 people and is formed by at least one medical practitioner, a nurse, a nursing assistant and four to six community health agents (ACS)[23].

FHS is guided by the principles of the policy of primary care or basic care[24]. The basic attention goes beyond the curative individual intervention through the incorporation of the living conditions of the subject and his or her social context in health care[25-27].

The holistic approach of the family presupposes the integral approach of people, seeing them in their socioeconomic and cultural context, with ethics and respect. The team should aim to understand the family as a space of individual and group development, dynamic and susceptible to crises. Professionals should be prepared to provide solutions to major health problems in the community, organizing their activity around planning actions; attention, promotion and health surveillance; interdisciplinary work and integral approach to the family[23.28].

2.4 Performance of the oral health team

In Brazil, for many years the dental care within the public service was characterised by assistance to population groups, restricted through programs for dental caries and periodontal disease. With these assistential health care models, part of the population was excluded and dependent on curative and mutilator services, which resulted in a low coverage of care[29].

With the implementation of SUS, the principles that should guide the Brazilian health policy were defined, bringing a great challenge for collective oral health, which had to reformulate their practices to meet the guidelines in this system that is in force until the current days. With the enactment of the Federal Constitution in 1988 oral health started also to be considered as a right of all and a duty of the state, because that is part of the overall health of an individual or population[30].

Motivated by the need to improve the epidemiological indices of oral health, expand the access of the population, as well as overcome the traditional model of care and reorganize the actions, the Ministry of Health (MOH) has decided to refocus the practices of oral health from their inclusion in the FHS. Dentistry was inserted in the FHS by Ministerial Decrees numbers 1.444, 12/28/2000, and 267 of 09/29/2001, with the aim of seeking the construction of new work processes directed to the family[31,32].

Ordinance 267 establishes the standards and guidelines for inclusion of oral health in the FHS strategy that integrate the Plan of Reorganization of oral health actions in Primary Care and determines the list of procedures in the context of oral health, established through the Basic Operational Rule of the Unique System of Health - NOB/SUS 96 - and the Operational Rule of Health Assistance - NOAS[32].

The insertion of ESB in the FHS aims to encourage the reorganization of this area in basic care. The Plan of Reorganization of oral health actions in primary care aims to improve the conditions of the Brazilian population, orientation of care practices in accordance to the recommended for the FHS to ensure access to health promotion, prevention and treatment of oral diseases; training, formation and permanent education of the professionals of the team, in addition to assessing the quality and impact of oral health activities[32,15].

MS recommends that the FHS be composed by a general practitioner, a nurse, nursing assistants, community health agents and a team of oral health, which in turn can be composed of a dental surgeon and an auxiliary of oral health (type I), or even by a dental surgeon, an assistant and a technician in oral health (type II)[31].

The relation of ESB by FHS will be based on some parameters, each ESB must meet until 3500 inhabitants or 1000 families; be set up by an ESB for each ESF set up or in the process of implantation. The number of teams set up occurs at the discretion of the manager, provided that the number of ESB does not exceed the FHS[33].

In 2004, the guidelines were announced of the National Oral Health Policy (PNSB), a specific policy for Dentistry, known as "Smiling Brazil". Its goals pursue the reorganization of the practice and the qualification of actions and services offered, from the strengthening of basic care, bringing together a series of actions in oral health aimed at the citizens of all ages, with expansion of access to free dental treatment to Brazilians, by means of the Unique Health System15[15].

Through the incorporation of programmatic and intersectoral actions the PNSB has the concept of care as the axis of reorienting the model, a conception of health is not centered on the disease, but in promoting quality of life and intervention in factors that put it at risk[34]. Dentistry in the FHS received great encouragement from the PNSB and greatly expanded the capacity and quality of care, through global incentives, expanding and qualifying the basic care[6].

Dentistry in the FHS rescues the ideological matrix of the strategy, seeking to work the description of the clientele, with focus on the family nucleus and use of epidemiology as a tool for guiding decision, the criteria for prioritization, based on the concept of risk. It also searches to defend the multidisciplinary work; integrating the collective to the individual and prevention to cure, working the understanding of the social determination of health-disease process from a humanized practice[35].

The professionals of the ESB must plan, monitor and evaluate the actions, identifying the needs and expectations of the assigned population. Health promotion should be stimulated and conducted through intersectoral actions, accompanied by educational and preventive activities in oral health. It is also important to perform basic actions of

epidemiological surveillance in the area of coverage, as well as domicile visits. The organization of the work process and health plan must be scheduled and performed according to the guidelines of FHS[32].

In the daily practice of oral health team, as important as the care and clinical follow-up, is the participation of collective actions aimed at health promotion and the prevention of oral diseases, perform the actions of integral care, combining clinical practice to collective health, watching the families, specific individuals or groups, in accordance with the plan of local priorities. It is necessary to the search of techniques and methodologies that bring a change in health services, moving from a model centered on the disease to a model of integral attention[32,36].

With the inclusion of the ESB in the FHS, there is a need for a new dentistry, in order to overcome the character still deeply technicist of the dominant practice of the doctor's office performed by the surgeon-dentist in the public service, for the emergence of a professional asset that act on the actions of promotion, education and prevention, providing time to meet with the health team and with the population of the area where he or she operates, participating in the processes of planning and development in their region and the municipality as a whole, making visits whenever it is necessary to know deeply the people and their living conditions. Overcome this paradigm is to raise awareness of the importance of all team professionals to be involved in promotion and prevention actions in oral health[37].

3 Conclusion

FHS consists of a unique strategy in the reorganization of the Brazilian health system, with the focus on the family nucleus, proposing a new dynamic for the structuring of services, as well as to its relationship with the community and among the various levels and complexity of care. The inclusion of ESB in the FHS represents an important complement in basic health care, a dental practice that aims the promotion, prevention and recovery of oral health in full. Major challenges must be overcome in the performance of ESB for an integral and egalitarian attention in SUS.

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