

Structural factors for public dental health services in Regional Health Care Network 13: an analysis of the Brazilian National Program for Improving Access and Quality of Primary Care

Fatores estruturais para a assistência pública à saúde bucal na Rede Regional de Atenção à Saúde 13: uma análise a partir do Programa de Melhoria do Acesso e da Qualidade da Atenção Básica

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Resumo

Introdução: O Programa de Melhoria do Acesso e da Qualidade da Atenção Básica busca induzir a instituição de processos que ampliem a capacidade das gestões federal, estaduais e municipais e das equipes de Atenção Básica em ofertar serviços que assegurem maior acesso e qualidade. **Objetivo:** Identificar a estrutura disponível para a assistência à saúde bucal das unidades de saúde com equipes de saúde bucal da Rede Regional de Atenção à Saúde 13, sob a perspectiva da Avaliação em Saúde. **Material e método:** Trata-se de um estudo descritivo e de corte transversal que se valeu do banco de dados do Módulo V do instrumento de Avaliação Externa de 156 unidades de saúde dessa região participantes do 2º ciclo do programa, com enfoque na modalidade das equipes de saúde, estrutura e ambiência do consultório odontológico, o horário de funcionamento, equipamentos, instrumentais e insumos odontológicos. **Resultado:** De forma geral, as unidades de saúde com saúde bucal deste estudo possuem consultórios odontológicos em boas condições estruturais e equipamentos e insumos suficientes para a realização de atividades clínicas, exceto os relacionados à reabilitação protética, possivelmente devido à permanência deste serviço na atenção secundária. No entanto, apontam que ainda são necessários avanços no acesso e na cobertura pelos serviços de saúde bucal. **Conclusão:** Embora o tema comporte outros estudos e reflexões, o presente trabalho poderá subsidiar discussões acerca da condição presente, sendo recomendada a ativa participação de todos os atores envolvidos no cuidado, na busca da qualificação dos serviços de saúde bucal nessa região.

Descritores: Atenção primária à saúde; avaliação em saúde; saúde bucal; serviços de saúde bucal.

Abstract

Introduction: The Brazilian National Program for Improving Access and Quality of Primary Care aims to induce the institution of processes that expand the capacity of federal, state and municipal administrations and Primary Care teams to offer services that ensure greater access and quality. **Objective:** To identify the characteristics of infrastructure for the dental health care of the health units from the Regional Health Care Network 13, from the perspective of a health evaluation. **Material and method:** This is a descriptive and cross-sectional study in which is used the Module V database of the External Evaluation instrument of 156 health units of this region that participated of the 2nd cycle of the referred program, which discuss the modality of the health teams, structure and environment of the dental office, the hours of operation, equipment, instruments and dental supplies. **Result:** In general, the oral health units of this study have dental offices with good structural conditions and sufficient equipment and supplies to carry out clinical activities, except those for dental prostheses, possibly due to the permanence of this service in secondary care. However, they point out that advances in access and coverage by oral health services are still necessary. **Conclusion:** Although the theme includes other studies and reflections, the present work may contribute to discussions about the present condition, and it is recommended the active participation of all the actors involved in the care, in the search for the qualification of oral health services in this region.

Descriptors: Primary health care; health evaluation; oral health; dental health services.



INTRODUCTION

Among its multiple conceptions, the health evaluation can be considered as a judgment made on a sanitary intervention - policy, program or practice – solving health problems, aiming to assess the value, effort or merit of a given intervention or its product, for its modification or improvement¹.

In this study, the health evaluation constitutes the main methodological theoretical reference, understood as an instrument of dialogue and learning, essential to support management by its ability to support decision-making processes, increasing efficiency and effectiveness of actions developed by services or organizations^{1,2}.

In this context, the Ministry of Health (MS) instituted the Program for Improving Access and Quality of Primary Care (PMAQ-AB) in 2011, seeking to induce processes that ensure greater access and quality of Primary Care and more adequate responses needs of the population. For this purpose, it proposes a set of qualification strategies, monitoring, and evaluation of the work of the health teams, linked to a variable monthly financial incentive through the results achieved by the teams and municipal management³.

According to Macinko et al.⁴, PMAQ-AB can be considered as one of the largest global initiatives to improve the performance of Primary Care and it has led to double the federal investments in the area. According to the authors, the data generated are beginning to be used to understand the structural and operational constraints faced by health professionals.

As subject of this study, the External Evaluation comprises one of the four phases of the program, focusing on the structural conditions of health units and care processes, through documentary evaluations and questionnaires aimed at professionals and users of health units³.

The instruments used in this program were organized in modules based on the logic of the Donabedian systematized an approach to quality of care², supported by the “structure, process and results”. In this reference, the structure is the stable elements (material, human and organizational resources) and it is an indirect indicator of the quality of the assistance, since, even if the availability of adequate structures promotes conditions essential to the achievement of good performance in the related aspects process and results of care, it does not ensure that a particular process is satisfactory.

In the evaluative processes focused specifically on oral health, the literature has pointed out that this area has only recently been taken as an object of research, with wide methodological diversity and distant from health practices and services⁵. It is also pointed out as a right that has been subtracted from the citizens and in this sense, it has been complaint⁶.

The gaps in the evaluation of public oral health services hinder to improve the quality of the services provided to the population, which is why the identification of aspects related to the available structure and the work process of the oral health teams (ESB) are fundamental to principles of the Unified Health System (SUS), mainly in relation to integrality in health care networks⁷⁻⁹.

This study sought to strengthen oral health evaluation initiatives in a region of the state of São Paulo using the External Evaluation carried out with the ESB participants of the 2nd cycle of the PMAQ-AB, in which the authors participated in the field activities.

MATERIAL AND METHOD

This is a descriptive study, data survey type, with a cross-sectional in time, using a secondary source from a collection carried out with the ESB participants of the External Evaluation phase of the 2nd cycle of PMAQ-AB, held in the year of 2014.

The study covers the Regional Network of Health Care 13 (RRAS 13) in the state of São Paulo, composed of four Regional Health Departments (DRS) - regional structures of the State Health Secretariat - with a total population of 3,307,320 inhabitants, distributed in 90 municipalities, where oral health care is present in 74 of them, through 323 teams working in 292 health units⁹.

A total of 156 health units with 169 ESB were enrolled in the second cycle of PMAQ-AB, distributed in 46 municipalities. In this study, the entire universe of health units with ESB from RRAS 13 was considered as participants in the evaluation process.

The External Evaluation is based on a set of variables aimed at ascertaining the accessibility and quality of Primary Care provided by the set of UBS of the program³. In this study, the structure of health units with ESB was analyzed through descriptive statistics, based on the theoretical reference of the Health Evaluation. There were 93 variables used in Module V, focused on Observation in the Basic Health Unit, focusing on the modality of the ESB and its professionals, structure, and ambience of the dental office, hours of operation, equipment, instruments and dental supplies.

The research was approved by the Research Ethics Committee of the Hospital das Clínicas of the Medical School of Ribeirão Preto of the University of São Paulo (opinion number 1,332,686 of November 23, 2015, CAEE 47995115.7.0000.5440).

RESULT

It was identified that most of the oral health teams of RRAS 13 (92.3%) were organized according to modality I, that is, they have a generalist dental surgeon (DS) or specialist in family health and health aide (HA) or oral health technician (OHT). There were 6.4% in modality II - generalist DS or specialist in family health, HA and TSB or other HA (Table 1). Only 5 (3.2%) reported working on Saturdays, with none meeting on Sundays. Most of the dental offices of the units of this study had good illumination and electrical network in an adequate condition (91.7%) (Table 1).

The availability of dental equipment under conditions of use of RRAS 13 in the DRS health units was high. However, 52.8% of the dental offices of DRS XII had an autoclave. In DRS V, educational materials relevant to the development of preventive actions, such as a macro model of dental arch and brush, were available in only 43.2% of the offices (Table 2).

Table 3 shows the dental instruments available in the DRS health units of RRAS 13. In DRS V, 56.8% of the offices had adequate endodontic files. It is noteworthy that only 28.2% of the dental offices of RRAS 13 had a spatula for gypsum and alginate, as well as trays only in 19.2% of the offices.

The dental supplies available in RRAS 13 of the DRS health units are described in Table 4. In DRS V, 21.6% of the teams did not have an anesthetic without vasoconstrictor or sealants in sufficient quantity.

Table 1. Modality, structural characteristics and ambience of the dental office and hours of operation of the health units of the Regional Health Departments of RRAS 13, participants of the 2nd cycle of PMAQ-AB

	DRS				RRAS 13
	III	V	VIII	XIII	
Identification of the modality and professionals of the Oral Health Team					
Modality of the Oral Health Team					
Oral Health Team modality I	50 (94.3%)	35 (94.6%)	25 (83.3%)	34 (94.4%)	144 (92.3%)
Oral Health Team modality II	2 (3.8%)	2 (5.4%)	5 (16.7%)	1 (2.8%)	10 (6.4%)
Parameterized Oral Health Team	1 (1.9%)	0	0	1 (2.8%)	2 (1.3%)
Structural Features and Dental Office Ambient					
It has good ventilation or air conditioning	40 (75.5%)	31 (83.8%)	27 (90.0%)	28 (77.8%)	126 (80.8%)
It has good lighting	49 (92.5%)	32 (86.5%)	29 (96.7%)	33 (91.7%)	143 (91.7%)
The floor and walls are smooth and washable	47 (88.7%)	28 (75.7%)	23 (76.7%)	32 (88.9%)	130 (83.3%)
The environment is in adequate condition from the point of view of acoustics	45 (84.9%)	27 (72.9%)	23 (76.7%)	29 (80.6%)	124 (79.5%)
It allows user's privacy	49 (92.5%)	32 (86.5%)	29 (96.7%)	29 (80.6%)	139 (89.1%)
The hydraulic and sanitary network is in the right conditions*	43 (81.1%)	29 (78.4%)	24 (80.0%)	28 (77.8%)	124 (79.5%)
The power grid is in proper condition*	51 (96.2%)	33 (89.2%)	28 (93.3%)	31 (86.1%)	143 (91.7%)
Oral Health Team Hours					
What are the service shifts?					
Morning	2 (3.8%)	1 (2.7%)	1 (3.3%)	0	4 (2.6%)
Morning and afternoon	44 (83.0%)	34 (91.9%)	24 (80.0%)	29 (80.6%)	131 (83.9%)
Morning, afternoon and night	7 (13.2%)	2 (5.4%)	5 (16.7%)	7 (19.4%)	21 (13.5%)
It works at lunchtime (12 a.m. to 2 p.m.)	21 (39.6%)	10 (27.0%)	11 (36.7%)	14 (38.9%)	56 (35.9%)

*According to the criteria established in the external evaluation instrument of the 2nd cycle of PMAQ-AB**Table 2.** Dental equipment of the health units of the Regional Health Departments of RRAS 13, participants of the 2nd cycle of PMAQ-AB

	DRS				RRAS 13
	III	V	VIII	XIII	
Equipment (in conditions of use)					
Amalgamator	52 (98.1%)	34 (91.9%)	28 (93.3%)	35 (97.2%)	149 (95.5%)
Dental rx apparatus	27 (50.9%)	13 (35.1%)	18 (60.0%)	23 (63.9%)	81 (51.9%)
Air conditioning	24 (45.3%)	22 (59.5%)	19 (63.3%)	15 (41.7%)	80 (51.3%)
Autoclave	51 (96.2%)	34 (91.9%)	22 (73.3%)	19 (52.8%)	126 (80.8%)
Lead apron	29 (54.7%)	14 (37.8%)	12 (40.0%)	20 (55.6%)	75 (48.1%)
Dental chair	53 (100.0%)	37 (100.0%)	30 (100.0%)	36 (100.0%)	156 (100.0%)
Cuspidor	53 (100.0%)	37 (100.0%)	30 (100.0%)	36 (100.0%)	156 (100.0%)
Sucker	53 (100.0%)	37 (100.0%)	30 (100.0%)	35 (97.2%)	155 (99.4%)
Reflector	53 (100.0%)	37 (100.0%)	30 (100.0%)	35 (97.2%)	155 (99.4%)

Table 2. Continued...

	DRS				RRAS 13
	III	V	VIII	XIII	
Office chair	52 (98.1%)	36 (97.3%)	30 (100.0%)	35 (97.2%)	153 (98.1%)
Dental cart	52 (98.1%)	37 (100.0%)	29 (96.7%)	35 (97.2%)	153 (98.1%)
High rotation pen	52 (98.1%)	34 (91.9%)	30 (100.0%)	36 (100.0%)	152 (97.4%)
Low-rotation pen	53 (100.0%)	31 (83.8%)	29 (96.7%)	35 (97.2%)	148 (94.9%)
Air compressor with safety valve	53 (100.0%)	35 (94.6%)	29 (96.7%)	35 (97.2%)	152 (97.4%)
Photopolymerizer	53 (100.0%)	35 (94.6%)	30 (100.0%)	36 (100.0%)	154 (98.7%)
Bicarbonate jet	31 (58.5%)	15 (40.5%)	20 (66.7%)	26 (72.2%)	92 (58.9%)
Macro dental arcade model and brush	44 (83.0%)	16 (43.2%)	10 (33.3%)	16 (44.4%)	86 (55.1%)
Dental Ultrasound	32 (60.4%)	15 (40.5%)	20 (66.7%)	23 (63.9%)	90 (57.7%)
Revelation Box	30 (56.6%)	15 (40.5%)	18 (60.0%)	24 (66.7%)	87 (55.8%)
Greenhouse	3 (5.6%)	3 (8.1%)	11 (36.7%)	15 (41.7%)	32 (20.5%)
X-ray viewer	34 (64.2%)	7 (18.9%)	10 (33.3%)	18 (50.0%)	69 (44.2%)
Sealing machine	17 (32.1%)	6 (16.2%)	17 (56.7%)	5 (13.9%)	45 (28.9%)

Table 3. Dental instruments of the health units of the Regional Health Departments of RRAS 13, participants of the 2nd cycle of PMAQ-AB

	DRS				RRAS 13
	III	V	VIII	XIII	
Dental instruments (in sufficient quantity)					
Extraction forceps	49 (92.5%)	30 (81.1%)	24 (80.0%)	32 (88.9%)	135 (86.5%)
Calcium Hydroxide Applicators	52 (98.1%)	33 (89.2%)	30 (100.0%)	34 (94.4%)	149 (95.5%)
Levers	53 (100.0%)	34 (91.9%)	30 (100.0%)	35 (97.2%)	152 (97.4%)
Steel Trays	41 (77.4%)	34 (91.9%)	29 (96.7%)	31 (86.1%)	135 (86.5%)
Burnisher for amalgam restoration	53 (100.0%)	33 (89.2%)	27 (90.0%)	36 (100.0%)	149 (95.5%)
Scalpel Cables	51 (96.2%)	33 (89.2%)	27 (90.0%)	34 (94.4%)	145 (92.9%)
Box with lid in stainless steel	45 (84.9%)	26 (70.3%)	24 (80.0%)	21 (58.3%)	116 (74.4%)
Endodontic aspiration cannula	41 (77.4%)	13 (35.1%)	14 (46.7%)	15 (41.7%)	83 (53.2%)
Condensers for amalgam restorations	52 (98.1%)	34 (91.9%)	29 (96.7%)	34 (94.4%)	149 (95.5%)
Surgical cures	52 (98.1%)	32 (86.5%)	28 (93.3%)	35 (97.2%)	147 (94.2%)
Periodontal Cures	53 (100.0%)	33 (89.2%)	27 (90.0%)	31 (86.1%)	144 (92.3%)
Denture Excavators	51 (96.2%)	32 (86.5%)	28 (93.3%)	36 (100.0%)	147 (94.2%)
Excavators for pulpotomy	45 (84.9%)	23 (62.2%)	18 (60.0%)	32 (88.9%)	118 (75.6%)
Sculptors	50 (94.3%)	32 (86.5%)	28 (93.3%)	34 (94.4%)	144 (92.3%)
Resin insertion spatula	47 (88.7%)	29 (78.4%)	27 (90.0%)	26 (72.2%)	129 (82.7%)
Spatula for gypsum and alginate	13 (24.5%)	10 (27.0%)	11 (36.7%)	10 (27.8%)	44 (28.2%)
Clinical mirror	52 (98.1%)	33 (89.2%)	30 (100.0%)	36 (100.0%)	151 (96.8%)
Nerve-sparing	44 (83.0%)	22 (59.5%)	26 (86.7%)	30 (83.3%)	122 (78.2%)
Forceps (infant)	53 (100.0%)	34 (91.9%)	24 (80.0%)	34 (94.4%)	145 (92.9%)
Forceps (adult)	53 (100.0%)	33 (89.2%)	30 (100.0%)	36 (100.0%)	152 (97.4%)
General gral	9 (17.0%)	7 (18.9%)	10 (33.3%)	11 (30.6%)	37 (23.7%)

Table 3. Continued...

	DRS				RRAS 13
	III	V	VIII	XIII	
Endodontic files	50 (94.3%)	21 (56.8%)	20 (66.7%)	26 (72.2%)	117 (75.0%)
Bone files	39 (73.6%)	26 (70.3%)	15 (50.0%)	27 (75.0%)	107 (68.6%)
Molds	8 (15.1%)	10 (27.0%)	9 (30.0%)	3 (8.3%)	30 (19.2%)
Periodontal curettes	41 (77.4%)	21 (56.8%)	10 (33.3%)	20 (55.6%)	92 (58.9%)
Clinical Forceps	53 (100.0%)	34 (91.9%)	30 (100.0%)	34 (94.4%)	151 (96.8%)
Glass plate	53 (100.0%)	32 (86.5%)	29 (96.7%)	36 (100.0%)	150 (96.1%)
Needle holder	52 (98.1%)	33 (89.2%)	29 (96.7%)	35 (97.2%)	149 (95.5%)
Amalgama holder	51 (96.2%)	34 (91.9%)	29 (96.7%)	34 (94.4%)	148 (94.9%)
Matrix holder	52 (98.1%)	34 (91.9%)	29 (96.7%)	36 (100.0%)	151 (96.8%)
Carpule syringe	53 (100.0%)	34 (91.9%)	28 (93.3%)	36 (100.0%)	151 (96.8%)
Syndesmotric	47 (88.7%)	32 (86.5%)	27 (90.0%)	33 (91.7%)	139 (89.1%)
Exploratory probe	52 (98.1%)	34 (91.9%)	30 (100.0%)	36 (100.0%)	152 (97.4%)
Millimeter probe	41 (77.4%)	10 (27.0%)	15 (50.0%)	19 (52.8%)	85 (54.5%)
Surgical cuspidor	30 (56.6%)	15 (40.5%)	15 (50.0%)	19 (52.8%)	79 (50.6%)
Surgical scissors	52 (98.1%)	32 (86.5%)	30 (100.0%)	34 (94.4%)	148 (94.9%)

Table 4. Dental supplies from the health units of the Regional Health Departments of RRAS 13, participants of the 2nd cycle of the PMAQ-AB

	DRS				RRAS 13
	III	V	VIII	XIII	
Inputs (in sufficient quantity)					
Acid and adhesive system	53 (100.0%)	34 (91.9%)	29 (96.7%)	34 (94.4%)	150 (96.1%)
Cotton Roller	52 (98.1%)	34 (91.9%)	30 (100.0%)	34 (94.4%)	150 (96.1%)
Amalgam (capsule)	45 (84.9%)	19 (51.3%)	16 (53.3%)	20 (55.6%)	100 (64.1%)
Amalgam (manual preparation)	14 (26.4%)	13 (35.1%)	13 (43.3%)	27 (75.0%)	67 (42.9%)
Topical anesthetic	50 (94.3%)	33 (89.2%)	29 (96.7%)	34 (94.4%)	146 (93.6%)
Anesthetics with vasoconstrictor	53 (100.0%)	33 (89.2%)	29 (96.7%)	35 (97.2%)	150 (96.1%)
Anesthetics without vasoconstrictor	51 (96.2%)	29 (78.4%)	27 (90.0%)	35 (97.2%)	142 (91.0%)
Scalpel blade	50 (94.3%)	28 (75.7%)	27 (90.0%)	36 (100.0%)	141 (90.4%)
Miscellaneous drills	53 (100.0%)	33 (89.2%)	30 (100.0%)	33 (91.7%)	149 (95.5%)
Miscellaneous cements	49 (92.5%)	34 (91.9%)	28 (93.3%)	36 (100.0%)	147 (94.2%)
Wedges	52 (98.1%)	33 (89.2%)	26 (86.7%)	35 (97.2%)	146 (93.6%)
PPE - gloves, goggles, masks, aprons, caps	50 (94.3%)	32 (86.5%)	26 (86.7%)	34 (94.4%)	142 (91.0%)
Dental Suture Yarns	53 (100.0%)	34 (91.9%)	29 (96.7%)	36 (100.0%)	152 (97.4%)
Fluoride gel	52 (98.1%)	32 (86.5%)	26 (86.7%)	36 (100.0%)	146 (93.6%)
Fixer and developer for radiography	31 (58.5%)	17 (45.9%)	17 (56.7%)	24 (66.7%)	89 (57.0%)
Gauze	52 (98.1%)	34 (91.9%)	29 (96.7%)	36 (100.0%)	151 (96.8%)
Temporary restorative material	53 (100.0%)	34 (91.9%)	30 (100.0%)	36 (100.0%)	153 (98.1%)
Matrix	52 (98.1%)	33 (89.2%)	29 (96.7%)	35 (97.2%)	149 (95.5%)
Intracanal medications (live and necrotic pulp)	47 (88.7%)	30 (81.1%)	27 (90.0%)	34 (94.4%)	138 (88.5%)

Table 4. Continued...

	DRS				RRAS 13
	III	V	VIII	XIII	
Microbrush	49 (92.5%)	22 (59.5%)	28 (93.3%)	26 (72.2%)	125 (80.1%)
Joint paper (carbon paper)	53 (100.0%)	32 (86.5%)	29 (96.7%)	35 (97.2%)	149 (95.5%)
Discard box for perforating material	53 (100.0%)	31 (83.8%)	27 (90.0%)	36 (100.0%)	147 (94.2%)
Photopolymerizable resins	53 (100.0%)	34 (91.9%)	30 (100.0%)	33 (91.7%)	150 (96.1%)
Sealants	52 (98.1%)	29 (78.4%)	28 (93.3%)	33 (91.7%)	142 (91.0%)
Disposable syringes for irrigation	46 (86.8%)	22 (59.5%)	22 (73.3%)	34 (94.4%)	124 (79.5%)

DISCUSSION

One of the main challenges for health systems is to promote the reduction of inequalities in access, allowing health care to be provided according to health needs, without differences in the use of services among population groups due to factors unrelated to health¹⁰.

Although the National Oral Health Policy (PNSB) proposes the availability of working hours compatible with the needs of the workers¹¹, the health units of this study worked mostly in the morning and afternoon shifts (83.9%) and only 35.9% worked at lunchtime (Table 1), showing barriers to access/accessibility to the oral health services of workers.

Gonçalves et al.¹² point out the hours of operation of the Family Health Units at a time similar to the work of most users as the main reason for absenteeism in dental consultations in the city of Piracicaba/SP. According to Mendes et al.¹³, the functioning of health units at alternative times could help reduce social inequities in oral health.

Difficulties in access to oral health services have also been identified in other studies^{5,7,9,14}. Bulgareli et al.⁷ and Faccin et al.¹⁴ point out that ESB responsible for a population attached much more than the recommendation by MS hamper access, bonding and adherence to dental treatment. The absence of dental equipment was one of the factors related to the dissatisfaction of the users participating in the study by Ferri et al.⁶ In the study by Hirooka et al.⁹, the low proportion of users who reported being able to check care with the DS of the health units, as well as the long waiting time for specialized consultations, highlight the barriers to access to dental services in a region of the state of São Paulo.

According to Colussi, Calvo⁵, inequalities in access and use of oral health services are mainly related to the work process of the teams. When analyzing the organization of ESB participants in the 1st cycle of the PMAQ-AB, Casotti et al.¹⁵ affirm that access would be qualified by organizing the oral health services offered according to the needs of the assigned area, with the agreement of risk criteria and vulnerability and the construction of care lines.

According to Warmling et al.¹⁶, one of the ways of increasing access to oral health promotion and prevention actions is related to

the incorporation of technical workers at primary and secondary levels, leading to changes in the conduct and organization of work.

In this study, it appears that most health units had ESB modality I (92.3%). These results are close to the national data released by the MS in 2015, in which only 9.2% (n=2,324) of the ESB was modality II¹⁷. According to Silva et al.¹⁸, the greatest expansion of ESB modality I in Pernambuco was related to the lag in the training of medium level human resources in the oral health area, specifically OHT. Warmling et al.¹⁶ point out that TSB are poorly absorbed in the dental services and, when inserted, it is limited to exercise the paper destined for HA.

Hirooka et al.⁹, when analyzing the oral health organization of a region of the state of São Paulo through the first cycle of PMAQ-AB, pointed out the existence of incomplete teams not compatible with the procedures established by the MS besides the low incorporation of OHT. It should be noted that the 2nd cycle only identified the ESB modality (I, II or parameterized), which does not allow the detection of incomplete teams.

Infrastructure problems are among the main problems identified in the oral health services, as pointed out by the evaluation studies⁵. In this study, although most of the dental offices evaluated showed adequate lighting and electrical network conditions, 20.5% presented problems with acoustic, hydraulic and sanitary network and 19.2% did not have good ventilation or air conditioning. In the study by Costa et al.¹⁹, carried out in DRS XV, the air compressor was installed in five of the 34 dental offices evaluated. The authors emphasize the importance of acoustic protection given the irreversibility of the damages caused to the health of the professionals.

It is also observed that 10.9% of the offices evaluated did not allow users privacy (Table 1). An essential factor in the act of listening and welcoming, the lack of privacy was pointed out in the study by Faccin et al.¹⁴ as a problem in the structure of health units of a municipality of the State of Rio Grande do Sul, with more than one ESB acting in the same space, causing wear on the team and compromising the user-professional relationship.

Oral health units generally have dental offices with equipment, instruments, and supplies listed in the PMAQ-AB in sufficient quantity to perform clinical activities, except for items related to the preparation of prostheses (Tables 2, 3 and 4). It is also observed

that a little more than half of the offices (51.9%) in this study had dental x-ray machines (Table 2).

Pimentel et al.²⁰ analyzed the structure and actions performed by the ESB in municipalities in the state of Pernambuco and showed that most offices had equipment, instruments, and consumables, except X-ray machines available for only 10.8%. According to Cantanhede et al.²¹, the Southeast region concentrates the highest percentage of dental X-ray equipment in public health units. The authors emphasize that the availability of the radiographic examination in the public dental service allows a more efficient and safe clinical planning, besides the expansion of the offer of conservative treatments.

Lorena Sobrinho et al.²² evaluated the Basic Health Units with ESB participants from the 1st cycle of the PMAQ-AB in Pernambuco and showed the absence of equipment to perform dental restorative procedures, such as amalgamators and photopolymerizers, in 17% and 12% of health units. They also identified the lack of inputs, which limits the performance of some clinical procedures. When analyzing the health units of the 16 regional health services of the State of Paraíba through the 1st cycle of the PMAQ-AB, Limão et al.²³ pointed out that the reduced quantity of some equipment and dental supplies found may compromise the provision of comprehensive care in oral health and emphasize that basic care still faces difficulties regarding the dental care structure. Also through the 1st cycle, Neves et al.⁸ showed that inputs related to the performance of preventive dental procedures were available for most oral health teams in the country.

Although PNSB¹¹ includes rehabilitation in basic care actions and the number of Dental Prosthesis Laboratories (LRPD) increased from 676 in 2010 to 1,955 in 2014¹⁷, these results indicate the lack of supply of these procedures in the basic units or these services exist as the attribution of secondary care. Studies point to difficulties in including prosthetic rehabilitation in Primary Care, due to the high demand of patients with needs for clinical activities, among other factors^{13,22}.

Although other studies present divergent results regarding the availability of equipment and inputs^{13,14,22}, they point to a problem that the external evaluation proposed by the PMAQ-AB is not able to identify: the discontinuity in the supply of dental supplies and/or lack of maintenance of damaged equipment, cited as the main factors that hinder the execution of clinical actions.

Analyses of the PMAQ-AB evaluation instruments pointed out their privileged focus on structure aspects, much more than process and result⁴. According to Merhy et al.²⁴, despite the importance of hard technologies (machines and instruments) for dental care, a care-producing service requires the work process to strongly value light technologies and light-hard technologies.

Although the relationship between the structure of health services and their effects is complex and involves several factors, it is necessary to value their components in the evaluation and management of services, their relationship with the quality of work processes and the achievement of health status results of individuals and population¹.

It is worth noting that the study by Hirooka et al.⁹ points out problems in access in this health region, which has only 323 ESB for more than 3 million inhabitants, besides to nonexistent in 16 of the 90 municipalities. The authors also warn that just over half of the Family Health Teams count on ESB, similar to the national proportion.

In its almost 30 years of implantation, SUS has known challenges to be overcome, but there are undeniable advances that have occurred along its trajectory. It is important to consider the gains from the publication of the PNSB¹¹, related to the expansion of the number of ESBs in the ESF, the expansion of access to specialized services and the greater contribution of public resources directed to the area throughout the country⁷.

The number of ESB increased from 9,459 in 2004 to 25,365 in 2015. In 2004, R\$ 197.5 million was invested, resources increased to R\$ 798.9 million in 2015¹⁷. It is opportune to express concern regarding the maintenance of these advances as opposed to the publication of the new National Policy on Basic Care²⁵, of September 2017, which may lead to a significant reduction in the insertion of dentists in Primary Care.

This study turned to the totality of the ESBs adhered to the external evaluation by the ministerial program. Thus, the fact that it cannot incorporate the teams present in that territory is present as a limitation, but they chose not to participate, corresponding to 46.6% of those in RRAS 13.

Although the evaluation of the oral health structure supports other studies and reflections, this work may contribute to relevant discussions about the present condition. It is desirable the active participation of all actors involved in care: managers, users, and professionals, in an attempt to services and the SUS in this region.

CONCLUSION

The results of this study show that RRAS 13 ESB health units that participated in the 2nd cycle of the PMAQ-AB generally have dental offices with structural characteristics and ambience adequate to the standards established by the program. Most of them had enough equipment, instruments, and supplies to carry out clinical activities, except those related to the manufacture of dental prostheses, suggesting that these services are still inserted in secondary care.

Even in view of the greater availability of oral health services after the implementation of PNSB in this region, efforts are still needed to expand and qualify access by expanding the number of ESBs for greater coverage, the inclusion of OHTs and extension of the operation.

Finally, as the object of this study, it should be emphasized that oral health care is not restricted to the structural component. Aspects such as the model of organization of practices and the process of production of oral health care also require new perspectives in other investigations, so these articulated elements have the power to overcome the curative model, in the search for integral care.

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CONFLICTS OF INTERESTS

The authors declare no conflicts of interest.

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