Oral health technicians in Brazilian primary health care: potentials and constraints

Técnicos em saúde bucal na atenção primária à saúde no Brasil: possibilidades e limitações

Técnicos en salud oral dentro de la atención primaria de salud en Brasil: posibilidades y limitaciones

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Abstract

Different perspectives on the role of mid-level workers in health care might represent a constraint to health policies. This study aimed to investigate how different agents view the participation of oral health technicians in direct activities of oral healthcare with the goal of understanding the related symbolic dispositions. Theoretical assumptions related to interprofessional collaboration and conflicts in the field of healthcare were used for this analysis. A researcher conducted 24 in-depth interviews with general dental practitioners, oral health technicians and local managers. The concepts of Pierre Bourdieu supported the data interpretation. The results indicated inter-professional relations marked by collaboration and conflict that reflect an action space related to different perspectives of primary care delivery. They also unveiled the symbolic devices related to the participation of oral health technicians that represent a constraint to the implementation of oral health policy, thus reducing the potential of primary health care in Brazil.

Primary Health Care; Health Personnel; Interprofessional Relations

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Resumo

Diferentes perspectivas sobre o papel dos trabalhadores de nível médio na atenção à saúde podem representar um gargalo para as políticas de saúde. Este estudo buscou investigar como diferentes agentes olham para a participação de técnicos em saúde bucal no desempenho de ações diretas, com o objetivo de compreender as disposições simbólicas associadas. Pressupostos teóricos relacionados à colaboração interprofissional e ao contexto conflitivo do campo da saúde foram usados para interpretação do material. Um pesquisador conduziu 24 entrevistas em profundidade com dentistas, técnicos em saúde bucal e gerentes de unidades de saúde. Conceitos de Pierre Bourdieu apoiaram a análise. Os resultados indicaram relações interprofissionais marcadas pela colaboração e conflito, que refletem um espaço de ação associado a diferentes perspectivas de cuidado primário e desvelam dispositivos simbólicos que representam restrições à implementação da política de saúde bucal, reduzindo o potencial da atenção primária à saúde no Brasil.

Atenção Primária à Saúde; Pessoal de Saúde; Relações Interprofissionais

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Introduction

The 2008 World Health Report [1] emphasized the importance of primary health care as a strategy for promoting reforms in national health systems worldwide, and health care workers are an important component of these reforms [2]. In this regard, inter-professional collaboration is a useful strategy for solving problems across health care models and among health care workers, as well as for increasing the effectiveness of health systems [3].

In Brazil, the establishment of the Family Health Program (FHP) put primary health care on the list of priorities of the central government. From the initial stages targeting those areas with the greatest social risk, the FHP has expanded to become the Family Health Strategy (FHS), which is committed to ensuring universal and comprehensive healthcare [4]. However, the availability of professionals able to work within this model is low, and professional training remains based on a traditional medical approach and a fragmented health system characterized by the poor coordination and planning of care [5]. Under these circumstances, specific professional interests [6] discourage the delegation of tasks and the sharing of information, thus resulting in higher costs and poorer service coverage.

In the year 2000, specific policies designed to implement oral health interventions within the primary health care setting were introduced, among which the policy supporting oral health teams stands out [7]. These oral health teams include a dental surgeon (DS), an oral health technician (OHT), and an oral health assistant. The Brazilian OHTs are assigned direct actions for both individual dental care and community activities for disease prevention and health promotion. Calculus and extrinsic stain removal and placement/finishing of dental restorations stand out among the clinical dental hygiene services provided by Brazilian OHTs since the first normative rule issued by the former Federal Board of Education in 1975. In the 1980s, the Federal Council of Dentistry approved Decision 26/84 reproducing the defined skills in order to guide professional practice. 'Act 11,889' regulated the profession in 2008 [8].

The relevance of mid-level workers' participation in the oral health team is well documented with respect to the coverage and quality of services and the reduction of costs [9]. The importance of the OHT is associated with, among other factors, the tasks assigned to the OHT for direct patient care, which allows the DS freedom to focus on more complex activities [8,10]. However, as in other countries [11], there might be conflict over the performance of mid-level workers in provision of direct actions for the patients. The output might be underutilization of OHTs, contributing to restricted access to dental care, and consequently, to lower levels of coverage and social impact.

Some authors have postulated that this picture might express a conflict between two major, but opposing, health projects in Brazil; one derived from the national public health system tradition marked by public policies for oral healthcare and the other from the private healthcare tradition driving the dental market [5,12,13,14]. According to this hypothesis, Brazilian primary health care is placed in an arena where elements of both traditions are mixed and in conflict.

Such situations might possibly arise from factors associated with the interaction between the managers of the primary care units, the DS, and the OHT; however, there are no studies on this subject that take the perception of these individuals into account. An understanding of the forces that shape professional interactions and hinder or facilitate the relinquishing of competitive attitudes and the developing of collaborative ones is important for a healthcare model centered on patient needs.

Although professionals collaborate to provide better patient care, they have personal interests and want to retain some degree of professional autonomy and independence. Understanding from a sociological perspective, how professional interests and skills are used to justify positions and movements within the social space is important for approaching problems relating to healthcare workers and access to dental care within primary health care.

The aim was to investigate how different social agents involved in primary health care view the participation of OHTs in direct activities of oral healthcare with the goal of understanding the related symbolic dispositions.

Methods

A qualitative study using a purposive sample was conducted. The sample was selected from four Brazilian municipalities: Maracanaú (Ceará State); Recife (Pernambuco State); Belo Horizonte (Minas Gerais State); and Curitiba (Paraná State). Maracanaú and Recife are located in Northeastern Brazil, and Belo Horizonte and Curitiba are in Southeastern and Southern Brazil, respectively. Maracanaú was the least populous municipality (approximately 200,000 inhabitants) and exhibited the lowest Human Development Index (0.736) of the four municipalities.

These four municipalities were selected for having received extensive financial resources from the Federal Government because of the number of oral health teams including OHT that they employed. Since 2004, a specific oral health policy has provided additional dental equipment to such teams [15]. All four of the municipalities applied standard procedures for hiring professionals, had established oral health teams at least one year previously, and exhibited a satisfactory primary care service structure that complied with FHS principles.

A purposive sample of extreme cases was selected within each municipality. The person responsible for oral health policy in each municipality presented two lists of up to three primary care centers offering dental services. Each list represented teams that were either closer or more distant to the requirements of the oral health technician training guidelines within the health system [16]. The guidelines convert the current regulatory devices into training goals and pedagogical activities, and since the 1990s, the guidelines have been the reference used by technical schools that train OHTs. One team of each list was randomly selected to be interviewed in each municipality. In total, professionals from eight FHS units participated in the study to investigate the deeper devices located at the extremities of the symbolic universe that encompass the topic.

One DS, one OHT, and one manager (identified in the results by the letter "C") responsible for coordinating the unit's activities and programs were interviewed from each unit. These agents were selected because of their different functions within the primary care units on the assumption that they could supply different perceptual schemes of the investigated problem, the organization to which the units belong, and the general social structure.

One of the authors (D.M.L.A.) conducted in-depth interviews to understand the interviewees' perspectives [17] on the participation of OHTs in providing direct patient care [8]. All of the interviews were performed in a specific room at the interviewees' workplace reserved for this purpose.

One of the authors (D.M.L.A.) taped and fully transcribed the interviews. Next, two of the authors (D.M.L.A. and P.F.) thoroughly read and selected the narratives in a systematic manner and indexed by consensus, taking into account the fact that agents are continually guided by the interpretative contexts within which they are embedded to construct their discourse [18].

The categories were mapped and interpreted from a sociological perspective based on the contribution of Pierre Bourdieu [19] that proposed the notion of symbolic field as a microcosm with its own laws that, although it can never escape determination by the macrocosm, exhibits more or less partial autonomy to address more general external pressures. The field corresponds to a universe in which are embedded the agents and institutions that produce, reproduce, or disseminate the values that give meaning to a set of dispositions incorporated in its subjects. This set of dispositions, which Bourdieu calls *habitus*, concerns structures at the intermediary level that generate the intrinsic and relational characteristics of a social position and re-translate them into a lifestyle. In addition, we used emergent notions related to the tension involved in interprofessional collaboration [20] and to conflicts in the primary health care field [5]. The selected excerpts emphasize the main contrasts among the narratives to illustrate the opposing elements related to the mapped categories. The data were compared to the guidelines for OHT practice as well as the oral health program whenever they were available in the municipalities' regulatory documents. The Ethics Research Committee of the School of Public Health of the University of São Paulo approved the present study (Protocol 1726).

Results

Six individuals including managers, DSs, and OHTs were interviewed in each municipality for a total of 24 interviews; the interviewees were aged between 26 and 49 and only two of them were male. Among the DSs, four had graduated at least 11 years previously, and five were specialists in public health. Among the interviewed OHTs, four had graduated two to five years previously. Of the managers, six had higher education degrees in the field of health and had attended specialization programs. Several different perspectives appeared in the interview narratives, as indicated by the categories: "professional interaction" (Figure 1), the ongoing "primary health care projects" at the corresponding unit (Figure 2), the "support resources" provided by organizations (Figure 3), and the "general norms" facilitated by the social structure (Figure 4). To ensure confidentiality, letters were used to indicate the positions/professions, and numbers were randomly attributed to each individual's narrative.

Whereas some narratives illustrate the lack of preparation of the DS to perform teamwork with the OHT (DS5), others emphasize their high level of cooperation and integration (DS6).

Figure 1 shows excerpts related to the professional interaction. One interviewee was sur-

Figure 1

Excerpts related to professional interaction.

"(...) if the dentist had learned how to work with this professional [the OHT], *the activities wouldn't be so much centered on us. This is even part of our training (...) we weren't trained to work with the OHT like this… getting from him the best he can give. Last week, my OHT even told me she was a little anxious about her work at the program because she believed… she could do even more"* (DS5).

"(...) Sometimes while I'm with a patient and realize that only scaling is missing, it is scheduled right there and is automatically referred to her [to the OHT]*… this gives the team a very good rhythm. As productivity is one of the indicators we're so much pressed to provide, she plays a very important role. In the time I'd normally perform one or two procedures, thanks to her I can do twice as many or more, depending on what is needed"* (DS6).

"(...) here the OHT is very active, you know? I was even surprised. Because they do the scaling, they attend to patients, they give lectures (...) I believe this kind of professional can only be helpful. This kind of professional can attend to patients at the chair, do prevention, health promotion, and community oriented actions…" (DS3).

"Because we spend some time learning, then we're able to do something. They could delegate tasks to us slowly, until they sense we're strong in what we're doing, until they could give a vote of confidence to the OHT" (OHT5).

"(...) At some units, the technicians perform one single activity, and it seems that this is the actual job description, even to the health secretary… the idea is for them to do more community oriented actions, and they do, more collective [actions] than chair work. However, I think it's important within the system, I believe it professionally, and because they know they have such skills, the technical part, I think it's important they do procedures. They don't do the procedures they don't know. They do very high-quality procedures" (C1).

"(...) I'd like to see the OHT doing more external work. I did all I could to try and get the OHT out of the unit (...) Including house calls to patients with locomotion problems or special hospital patients, before the dentist's calls, we've been doing previous triage with the OHT… a handbook for the OHT's activities is being prepared… The discussion centered around the cluttering up of the material. (...) What does an OHT know about occlusion? High restorations and everything else? (...) " (C6).

prised by the OHT's ability to attend to patients in the dental chair, as well as to collaborate in disease prevention and health promotion by means of community oriented actions (DS3). However, the lack of preparation and of a method to delegate tasks might make the DS mistrust the OHT (OHT5).

The managers also exhibited varying perspectives. One interviewee acknowledged the importance of the OHT in individual care without this impairing their participation in community oriented actions (C1). The main concern of another manager was to "get the OHT out of the unit" (C6), which in this context meant to remove him from direct patient care. His narrative seems to dismiss the technical skills of the OHT to insert restorative material inside a dental cavity, described here as "cluttering up".

Some narratives described the participation of the OHT as a source of satisfaction in areas where oral health actions seemed to result from a collective effort. Managers and agents shared a similar perspective on the challenges presented by the project and expressed mutual support in overcoming obstacles and applying the project in practice (Figure 2).

Conversely, other narratives are negative, either because of a lack of human resources or because of the pressure to meet productivity goals. When the health secretariat did not guarantee the inclusion of an assistant on the team to support the DS and the OHT, the clearest effect was that the OHT had to perform the assistant's tasks, including those related to the control and sterilization of materials and instrumentation for the DS.

Contrasts were found in the narratives. Some narratives spoke about proper work organization, the use of instruments to control patients at risk of disease activity (OHT2), and room for sharing oral health actions and other actions aimed at horizontal integration. However, other narratives indicated feelings of anguish resulting from the lack of gloves and assistants, and managers strongly focused on compelling the DS to achieve maximal productivity. The DSs were often forced to increase the number of consultations per hour, leaving little room for the OHT to perform direct actions of individual care.

Along these lines, one OHT perceived an imbalance in the time available for his several skills, thus frustrating his expectations of performing

Figure 2

Excerpts related to primary health care projects.

"(...) Then, we began discussing and making a single appointment calendar… one feels (...) based on individual issues, the family health teams (...) work in a completely different way, some of them aren't too close. And the gap could be worse if one considers the isolation of oral health professionals. Then, we (...) are putting all that together. Because, for instance, we used to discuss a lot about prevention matters, promotion, prevention, and even intervention when it's needed: to carry out a procedure on a pregnant woman, why don't we schedule the oral health visit at the same time she goes there for the prenatal visit? At the same date? (...) Then, there are those days when children aged between 0 and 2 years come for child well-being (...) We try to match both appointment calendars by discussing the work process, everything is agreed on" (C5).

"(...) The dentist makes the schedule together with the team. For some activities, the care will be performed by a dental assistant, for others by the OHT, and for still others by the higher level professional himself, the DS (...) Then, for all the activities we do (...), nurses participate in ours and we in the nurses'. Therefore, those that we elaborate are the specific activities proper to each function. However, for the other ones, in general, the multidisciplinary activities, dentistry is always included. Be it an activity led by us or by anyone in the medical or nursing team" (DS2).

"(...) We do the scaling and made cards for the patients. Then, we note down the teeth there (...) I note down in case of doubt. However, they usually match (...) We note down, the patients come with the card, and thus when they come the examination is almost done" (OHT2).

"(...) The actual truth is (...) among the modality II teams, the ones that operate well (...) where the OHT does the work of an OHT, I can say that there are about three out of a total of seven or eight. The actual truth is that due to the lack of dental assistants, the OHT has to act as a dental assistant" (C6).

"(...) One thing I hoped for… was that issue of interacting at the office (...) The district, it presses dentists heavily to perform a certain number of procedures. So, in the end there's no room for us, the OHT, to interact, to do [the patients'] prophylaxis, for the dentist to open the cavity… We (...) get a little frustrated. (...) I also had hoped we would've had more room to work… We're sort of loose. In the end, we're just an improved dental assistant…" (OHT5).

"(...) Sometimes, the reason of all that anguish and everything else is the lack of resources (...) Without gloves you can't do clinical assistance (...) For instance: this issue with the gloves, they say we use too many gloves. (...) once I had to send a report with the record (...) of how many patients we saw in such period (...) There it says how many gloves are used: how many I use, how many the OHT uses when she sees patients, how many the assistant uses, because that number must be used…" (DS6).

clinical actions. The dimension of professional interaction therefore emerges as being linked to the perception of a project that translates into standards and goals and generates different expectations and responses among the participants (Figure 2).

By assessing the relationship between the agents and the available resources, it was possible to understand the difference made by the ability of a professional (DS6) to take the initiative and profit from the work of the OHT in clinical activities, even in an unfavorable environment lacking two chairs that would have allowed both the DS and OHT to work simultaneously (Figure 3).

This statement was corroborated by other agents (OHT6 and OHT7) and expressed a feeling of competence by the DS when facing adverse conditions. Problems related to the structure of the dental clinic setting demand integrated corrective actions involving the units in charge of budgets, equipment/material supply, and building support/maintenance. Therefore, this type of attitude does not solve the specific problem, although such a disposition by the DS expresses important support for the participation of the OHT in direct actions in the clinical setting. This disposition contrasts with those of other agents that conform to the lack of expected conditions (DS5 and DS7). No ongoing project to solve the inadequacy of the technical conditions was reported (Figure 3).

One of the support elements identified in the narratives concerns professional regulation and a definition of the tasks an OHT ought to perform at the national and municipal levels (Figure 4). Another support element involves acknowledging the improved effectiveness and quality of patient care resulting from the participation of OHTs in clinical activities. Some features were mentioned to explain why the OHT did not perform their tasks, among which were the guidelines issued by the health secretaries and the lack of support by the professional practice regulatory agency. Although from the interviewee's perspective both guidelines discouraged the DS from delegating direct action at the dental chair

Figure 3

Excerpts related to support resources.

"(...) *One feels the other chair is free, and then we arrange the schedule so that she can be at the office and do clinical activities. Some* [patients] *even go straight to her* (...) *Then, there's this issue: whenever it's possible, I like to delegate, to make it possible for her to do the procedures"* (DS6).

"(...) *The dentist where I work makes a lot of room; she makes the appointment calendar and makes room for the OHT. Now we have a resident* [dentist]*… And when the resident started,* [the dentist] *told her: look, we have an OHT, and there must be room for her to work at the chair, and she prepared the full appointment calendar with this is mind… Room enough for everyone"* (OHT6).

"(...) *At the office, I… and the dentist allows me to apply the sealing, do the scaling, the prophylaxis… All this I do at the office.* (...) *X-rays, we take the x-rays…* (...) *Not at this moment* [alluding to the availability of a chair for her exclusive use]. *There are two dentists and both chairs are taken. When they get up, they lend me the chair.* (...) *Because hardly any dentist wants to give up the chair for… the OHT to work"* (OHT7).

"(...) *In fact, we have a technical problem: our room is too small for two chairs, and with our compressor we only [have room] for one chair. Therefore, as a fact, we aren't able to see patients together, the dentist and the OHT, because both chairs can't be used at the same time…* (...) *Perhaps we would be able to work in a more productive manner* (...) *but productive with regard to solving the patients' problems. But to do that, they should give us good technical conditions… Because it looks like the OHTs were hired, but the units were not prepared from the technical point of view to receive them to do clinical assistance"* (DS5).

"(...) *I believe it would be a major step forwards…* [alluding to the participation of OHTs in clinical activities] (...) *Because she'd have her patients to begin or finish the treatment, she'd do the scaling… It's as good for the patients because their treatment is faster, as it is for us. However, the physical* [structure] *is lacking…We don't have environmental conditions: we don't have a place to advise on oral hygiene, don't have a chair just for her…"* (DS7).

"(...) *We don't have such an opportunity, no, we don't…* [alluding to the participation of OHTs in clinical activities]. *And now I won't be able to act because a resident came. Therefore, they're dividing the schedule between them. And so I do visits and schools"* (OHT5).

Figure 4

Excerpts related to general norms.

"(...) *And recently, when the regulations for assistant staff* [were released] *I brought them here for everybody to read and learn what they say… It's much better for us to work with the OHT, when you put him to do his tasks.* (...) *at the office, you get to increase the rhythm of work a lot and you don't get as tired as when you have to do everything by yourself"* (DS6).

"(...) *They do as much technical work at the chair with the patients as they do… I think it's an important role, also because if we only had the dentist and the dental assistant, the patients would lose out for sure. Because now, with the technician, we're able to provide better assistance* (...) *I believe there's an increase in the quality of patient care…"* (C1).

"(...) *I don't have the support of either the secretary or the Regional Board of Dentistry, and I won't do them as long as I'm not protected by the law* [alluding to the activities OHTs might perform at the chair]. *I do other tasks: I receive the patients at the unit, receive the dental patients, remove sutures, health education… I thought that with the legislation, we'd make a step forwards, but instead we made several steps backwards… And… I lost all motivation to work, so we'll see what they'll decide to do with us. I'm here, without any activity at the chair. I'm also not allowed to do the prophylaxis* [dental cleaning] *I used to do… Since the City Hall stopped it, I do nothing… at the chair..."* (OHT4).

"(...) *Recently, I received a document that described the attributions of the dental assistant, OHT, and dentists… And they're well aware, they read it, and discussed it together with the team… In fact, it was recently said that some attributions were removed from the OHT, but now, such functions have been recently reassigned to them, so that they can develop them"* (C2).

to the OHT, such guidelines could not be found in the official records. At one point, the clinical activities of the OHT were temporarily discontinued in one of the investigated municipalities while this subject was debated, but were subsequently resumed, as one manager (C2) reported (Figure 4).

Discussion

The results show that the relationships among managers, DSs, and OHTs are quite complex. The narratives indicate inter-professional relationships marked by both cooperation and conflict and reflect the existence of a space for action where definite investments occur among the agents and between the agents and the organization as mediated by different conflicting interests and projects.

A feeling of competence to develop oral health activities together with other team members shows a commitment to those solutions devised to implement institutional projects at the workplace, which is where the agents enjoy higher levels of governance. The willingness to collaborate, mutual trust, respect and communication are interactional determinants necessary for inter-professional collaboration [20].

Loignon et al. [21] encountered professionals who had not been trained in patient-centered care but had developed the competence to apply a humanistic approach in areas of social deprivation. The authors emphasize the role of openness and goodwill in the generation of conditions favorable to the development of empathy and communication skills. Such competence might result from the professionals' humanistic values as well as from a pragmatic attitude assumed to achieve a patient-professional relationship favorable for treatment.

The expectation of benefits as a result of collaboration when dealing with the complexity of work within primary health care contributes to making collaboration happen and thus represents a *habitus* favorable for the participation of OHTs. However, such a disposition of agents contrasts with how human resources are trained in Brazil, where university courses in dentistry focus on the acquisition of technical skills based on a model of private, individual, and autonomous clinical practice [22]. In addition, because inter-professional collaboration including the OHT is not a part of existing educational principles, the prevalent pedagogic model helps maintain the high cost of clinical care, which makes it inaccessible for most Brazilians, who consequently suffer early tooth loss.

Although some technical schools aim to develop OHTs able to understand and address ongoing and future changes [23], generally, learning remains focused on the narrow and immediate needs of the workplace, resulting in insufficient integration between learning activities and healthcare services. Such a structure of relationships might explain the narratives in which a feeling of incompetence prevails and thus limits the participation of the OHT in direct care actions.

A study conducted in Norway showed that dentists were not disposed to delegate tasks to dental hygienists. In addition, the odds of delegation increased when dentists had graduated abroad and decreased with age and employment in the public sector [24].

A study of Brazilian primary health care including oral health professionals showed that DSs do not appear to understand their role as team members. Their original training makes it difficult for them to integrate with other team members to perform health activities [25]. Such isolation does not appear to be an exclusive trait of DSs, but of most healthcare workers trained within a biomedically centered culture [26]. Such a culture, and the model of practice that perpetuates it, permeates dental care. The characteristics of DS training and the traditional model of care within which they practice their knowledge and skills result in a fragmented clinical approach focused on giving an immediate response to the patient's main complaint while leaving little room for interactions with other healthcare professionals and workers, including the OHT.

A lesson we might learn from the analysis of such relationships is informed by the two-way circulation between objective structures related to social fields and the incorporated *habitus*-related structures [19]. Despite their unfavorable training, some professionals find both the conditions and the competence required to undertake a style of practice where cooperation among team-members is the guiding principle. Contexts are not homogeneous, and the space is socially constructed by the structure of the social relationships within which professionals move as agents that negotiate in response to the reality of the world around them.

A conformist and paralyzed attitude expressing a disposition that shifts to other interests can be added to the feeling of incompetence. Symbolic devices that hinder putting the institutional project into practice were identified in another study where the lack of stable employment status represented a more adverse context [27].

In the present study, however, such devices were identified in a setting where professionals enjoyed stable employment status. Therefore,

more favorable objective conditions might not suffice to ensure the social agents' commitment to the project. When the professionals or public managers are not committed to the project or do not feel competent to promote the participation of OHTs, room is made for inter-professional conflict rather than collaboration. The narratives that allude to feelings of frustration and a lack of confidence by the OHT reflect such a situation.

The presence of this conflict in the field of primary health care is corroborated by other researchers. One study showed that the ethos of private dental practice is present in various ways, appearing in both the professionals' practice and expectations [28]. Although the primary health care institutional project did accomplish some changes in the agents' activity as much as supported by committed local healthcare management, the ethos of private practice still prevails. Therefore, maintaining the changes required to achieve a more effective practice demands additional effort.

The conflict exhibits different characteristics in different organizations. The agents' positions also depend on their social space, i.e., on the objective and subjective conditions of organizations. Different institutional projects reflect the conflicts that permeate that specific microcosm and can be the source of arguments among professionals. In this regard, one management perspective was identified that considered that the OHTs ought to focus on health promotion in the social area covered by the healthcare unit. We found narratives pointing to organizations where the technical requirements for the operation of the oral health team were not met (low number of assistants, physical limitations, and lack of work plans). Conversely, some narratives indicated that the accomplished activities resulted from collective planning efforts that crossed the strategic and tactical-operational levels of the organizations. The work was aimed at an all-encompassing primary health care, and the ability to practice it included the participation of OHTs in actions corresponding to both health promotion and individual care.

This picture appears to reflect the current state of change of the primary health care model in Brazil. One of its poles consists of healthcare units whose managers are looking for a more encompassing model, while at the other pole, managers are restricted to the administration of resources and exert little power over the caregivers' work. The healthcare units belong to organizations that depend on the efforts of their members.

In the case of health organizations, this dependence occurs in a radical manner because according to Dussault [29] (p. 10), "*they are professional organizations where knowledge and skills are formalized by the training process and the standards defined by professional associations*". Managers exert very little power over the work of the healthcare professionals, who define the work process as a function of their monopoly on knowledge and acquired skills without considering it an offshoot of the organization's mission and goals. The workers might be responsible for many decisions, and they tend to zealously protect the boundaries of their autonomy in each action they undertake. These are differentiated workers, especially because the performance of their tasks demands a certain degree of independence; no superior in the hierarchy can impose a specific behavior on the professionals.

The context of some narratives shows that strategies such as teamwork, systematic support from assistants, and the delegation of tasks were seldom used. Difficulties with equipment maintenance, lack of supervision, inadequate planning, and flaws in the supply system were reported by the interviewees and could impair the effectiveness of primary health care.

The managers of the units in which the participation of OHTs was not constrained played an active supporting role, reflecting both the characteristics of the oral health team and their degree of commitment to the primary health care project and responsibility for its direction. Every phase of healthcare is grounded on mutual relationships among people and is subject to the will of workers within the autonomous space where their practice is accomplished [30].

If by looking inside organizations it is evident that they depend on the efforts of their members, by looking outward it is clear that organizations are not isolated. They can interact and frequently share the characteristics of their environment or system of social action. One example is the corporate control to which professionals agree to subject themselves (the professional councils) and whose representatives they elect.

In some interviews, the constraint on the OHT to perform their assigned tasks was associated with insufficient support from the professional regulatory agency. Within the scope of the present discussion, emphasis should be given to the meaning that the shift of corporative interests in a given social field has for the development of the mission and goals of organizations as concerns the principles of an encompassing primary health care.

In Brazil, the professional regulation of OHTs is the result of efforts of social actors and entities committed to health reform seeking to construct a universal healthcare system, which is a quite

different perspective from that which motivated reforms in welfare state countries [7]. Despite its advances [6], Brazilian reform still meets resistance from the private healthcare tradition [5,12], one pillar of which includes professional corporatism. According to Nancarrow & Borthwick [31], conflict at the professional level permeates the construction of a universal healthcare system.

Studies on Brazilian OHTs documented that in the second half of the 1980s, some national associations positioned themselves against their assigned tasks [10]. Despite the professional corporatism, the regulation of the OHT profession was enacted in 2008 [8]. Notwithstanding the long road remaining to be travelled before recognition can be completely achieved in all its dimensions [10], professional regulation was received positively [8] when advocating for the unconstrained participation of OHTs in the tasks for which they are trained. This positive reception occurred where managers and professionals share a more robust perception of primary health care under principles described by Starfield [32].

Although professional regulation mitigated some of the conflicts in the general professional system and proposed a new perspective in work management [8], the results of the present study show that resistance and conflict still remain at the organizational and agent level. Such conflict helps us to understand the symbolic devices that guide the opposing forces, and explains the wide variation in such participation.

Although we collected the narratives from individuals who practice in relatively well-structured municipalities of the Brazilian healthcare system, they do not represent the full scope of possible perspectives on the investigated subject, particularly those perspectives concerning situations further from the extreme cases and those healthcare unit contexts belonging to organizations maintained by municipalities with less well-established structures. The selection of interviewees with similar schedules, work patterns, and employment status within the healthcare system from several locations across Brazil helped to avoid approaching the identified support elements and constraints as particular events strictly related to individuals or to the organizations with which they are affiliated; rather, support elements were used as rules by the agents to justify their positions in the conflict arena.

In spite of the limitations inherent to interview-based studies, the results presented here support the idea that inter-professional collaboration is shaped by interactional, organizational, and social structures, among other factors. In addition, the results allowed mapping of the objective structure of the relationships among the positions occupied by the agents in each field, and investigation of the various systems of dispositions acquired by internalizing elements from national health system tradition and from the liberal and privately oriented tradition.

The main contribution of the present study is the description of some of the relationships among the systems of dispositions that are found during construction of a universal healthcare system where different primary health care projects are in conflict. These systems of dispositions are formed by taking into account the interactions among social agents who occupy different positions within the organization. Such positions are justified by devices and rules, partially derived from professional training and the field of practices that define more- or less-favorable conditions for the participation of OHTs in direct dental care actions within the primary health care setting.

Moreover, the empirical findings support the hypothesis that Brazilian health reform is embedded within a conflictive context, and further indicate the symbolic devices related to the participation of OHTs that represent a constraint to the implementation of oral health policy, thus reducing the potential of primary health care in Brazil.

Resumen

Diferentes puntos de vista sobre el papel de los trabajadores de nivel medio en la atención sanitaria pueden representar un obstáculo para las políticas de salud. Este estudio investigó cómo los diferentes agentes observan la participación de los técnicos de salud oral en la ejecución de acciones directas de asistencia odontológica, a fin de entender las disposiciones simbólicas asociadas. Los marcos teóricos relacionados con la colaboración interprofesional y el contexto conflictivo del campo de la salud se usaron en el análisis. Un investigador llevó a cabo 24 entrevistas en profundidad con dentistas, técnicos de salud oral y gerentes de salud. Los conceptos de Pierre Bourdieu han apoyado la interpretación de los datos. Los resultados indicaron relaciones interprofesionales que reflejan un espacio de acción, asociado a las diferentes perspectivas de la atención primaria y desplegaron disposiciones simbólicas, que representaron restricciones a la implementación de la política de salud oral, reduciendo el potencial de la atención primaria de salud en Brasil.

Atención Primaria de Salud; Personal de Salud; Relaciones Interprofesionales

Contributors

D. M. L. Aguiar participated in the conception and design, acquisition of data, analysis and interpretation of data; drafting the article and final approval of the version to be published. N. E. Tomita made substantial contributions to the analysis and interpretation of data; revising the draft critically for important intellectual content; and final approval of the version to be published. M. F. A. S. Machado and C. L. Martins contributed to the conception and design, analysis and interpretation of data; revising the draft critically for important intellectual content; and final approval of the version to be published. P. Frazão supervised the conception and design, acquisition of data, analysis and interpretation of data; revising the draft critically for important intellectual content; and final approval of the version to be published.

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