

# Municipalization of health services according to oral health professionals in an upstate São Paulo municipality in Brazil

## Municipalização de serviços de saúde segundo profissionais de saúde bucal em um município do interior do estado de São Paulo, Brasil

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## **Resumo**

No período de construção institucional do Sistema Único de Saúde (SUS), o processo de descentralização teve na municipalização dos serviços de saúde um dos seus principais vetores estratégicos. Contudo, são raros os estudos que se ocuparam da percepção que os trabalhadores do setor têm sobre esse processo, notadamente na área de saúde bucal. Neste artigo coloca-se em relevo a opinião de profissionais de odontologia do município de Itapira (SP) a respeito da municipalização da saúde e seu significado. Os dados foram obtidos mediante entrevista individual e semiestruturada com um grupo de oito informantes-chave, composto por cirurgiões-dentistas e auxiliares de saúde bucal, com trajetória de atuação no serviço municipal de saúde anterior à criação do SUS. Fez-se análise de discurso empregando-se a técnica do discurso do sujeito coletivo. Constatou-se que, em relação à municipalização, os entrevistados apresentaram dificuldade em conceituá-la e identificaram-na como favorecedora de uma presença mais bem organizada da odontologia no SUS, tais como a proximidade com instâncias gestoras beneficiando, por exemplo, a implantação e acompanhamento de programas e a aquisição de equipamentos e materiais. Além disso, reconheceram que a municipalização: 1) impulsionou a qualificação dos cuidados básicos; 2) possibilitou uma gradativa ampliação da resolutividade dos serviços contribuindo para responder às demandas mais prevalentes; e 3) criou condições favorecedoras da superação da excessiva valorização de procedimentos mutiladores, que caracterizou o setor no

período pré-SUS. Conclui-se que os entrevistados perceberam, na concretude de sua ação cotidiana, o impacto positivo da municipalização na organização do serviço público odontológico.

**Palavras-chave:** Serviços de saúde; Descentralização; Saúde bucal.

## Abstract

During the setting up of the National Health System (SUS), one of the main strategic vectors in the process of decentralization was the municipalization of the health services. However, few studies have addressed the perceptions of this process, particularly in the field of oral health, held by workers in this sector. This article highlights the opinions of dental professionals in the municipality of Itapira (São Paulo) on the significance of the municipalization of health. Data was collected through individual semi-structured interviews with a group of eight key informants, consisting of dentists and dental health assistants already working in the municipal health service before the introduction of SUS. Discourse analysis was undertaken using the collective subject discourse technique. As regards municipalization, it was found that respondents had difficulty conceptualizing it and identified it as favoring a better organized dental service in the SUS, involving such areas as the proximity with management levels which benefit, for example, the implementation and monitoring of programs and the acquisition of equipment and material. In addition, they recognized that municipalization: 1) boosted the qualification of primary care, 2) allowed for a gradual expansion of the resolvability of services and thereby contributed to meeting the more prevalent demands, and 3) created favorable conditions for overcoming the problem of excessive appreciation of mutilating procedures which had characterized the sector in the pre-SUS era. This study concluded that the respondents perceived the positive impact of municipalization in the organization of public dental services in the reality of their daily activity.

**Keywords:** Health Services; Decentralization; Oral Health.

## Introduction

The National Health System (SUS) was not created in a precise moment in history; SUS has instead been developed by comprehensive deliberations as a result of intensive discussions conducted since the mid-1970s, “when, during the military dictatorship, the underlying political agenda was formulated” (Escorel et al., 2005, p. 59). Health-related initiatives implemented at that time were characterized by the dominance of bureaucratic spheres of social security that acted in the interest of the growing commercialization of the sector (Mendes, 1994, p. 36). In that political context, the three spheres of governance (federal, state, and municipal) operated in a piecemeal manner and this dynamics reflected on the health sector.

Municipalization of health is an ongoing process in Brazil, with conflicts and contradictions, that represents an achievement and a great challenge, as well as a recognized fundamental strategy for the implementation of decentralization as the organizing principle of SUS. It involves the expansion of execution and decision-making capabilities at the local level, along with the incorporation of various social actors with distinct interests in the political scene (Silva, 2001). Teixeira (1991) highlights the often intentional imprecision in the use of the word and distinguishes it from other words, which are frequently and erroneously considered as synonyms, such as delegation and privatization. The most visible milestone of the first official debates on municipalization occurred during the 3<sup>rd</sup> National Health Conference in December 1963. The final report expressed a clear municipalist and decentralizing concern (Escorel and Bloch, 2005, p. 92).

In the early 1980s, the crisis of the healthcare policy that was in force culminated in the formulation of the Healthcare Reorientation Plan, known as the CONASP Plan, because it was proposed in the context of the *Conselho Consultivo de Administração da Saúde Previdenciária* (CONASP). This plan is considered as the embryo of the Integrated Health Actions, which were later acknowledged as an essential element in the process of health decentralization and established as one of the guidelines

for the integration of federal, state, and municipal institutions within a regionalized and hierarchical system, with complete use of the existing basic public services network through trilateral agreements (Muller-Neto, 1991, p. 61). Subsequently, the Federal Law 8.080/90 defined planning, organizing, controlling, and assessing health actions and services as responsibilities of the municipality (Brasil, 1990). Today, municipalization is thus firmly rooted in political and legal instruments.

In general, it is agreed that decentralization is one of the crucial points for structuring an effective, efficient, fair, and democratic health system. To that effect, municipalities perform essential functions at the local level. This municipalization process has been slowly but steadily outlining a range of transformations that include oral health initiatives developed by the public sector. In this context, this article analyses the perception of dental professionals of Itapira (SP), a medium-sized municipality (in terms of population) of the southeast region in the State of Sao Paulo, with regard to municipalization of health services and its importance in oral health practices. The aim of this study is to obtain a record of the municipalization process through the interviews of the professionals who were practicing during the period under study.

## Materials and methods

The present study is a descriptive study that uses the qualitative research method based on a case study, which is appropriate for the in-depth analysis of a contemporary phenomenon (Yin, 2010, p. 39). The case under study is the process of municipalization of health services in the municipality of Itapira, situated within the state of São Paulo, approximately 170 km from the capital. According to the Brazilian Institute of Geography and Statistics, in 2010, the city had a population of 68,537, of which 92.7% resided in the urban area. Fluoridation of public water supplies was initiated in 1976.

Data were collected in 2006 through individual semi-structured interviews with a group of eight key informants composed of six dentists (D) and two oral

health assistants (OHA) with a professional history in the municipal health service before the creation of SUS. To that effect, a questionnaire with five open questions was used. Questions to this questionnaire were added according to the answers, without extrapolating the scope of the topic. The interviews were audio-recorded.

During the research, the staff of the municipality was composed of 26 SD and 14 OHA. The selection of the eight respondents was based on the finding that only these professionals had been integrated in the health service of Itapira during the period that preceded the creation of SUS and on the assumption that, in a qualitative approach, data collection is concluded when saturation is reached, i.e., when the ideas shared with the researcher become repetitive (Marcus and Liehr, 2001). The place, date, and time of interviews were selected by informants who were contacted in person. The interviews were conducted by a single researcher, which contributed to verbal behavior uniformity throughout the meetings.

For data interpretation, the collective subject discourse (CSD) technique was used, which aims to represent the perception of different subjects within a group by grouping the discourse contents of similar meaning expressed by these subjects through summary statements. As recommended by Lefèvre and Lefèvre (2003), the distinct phases of CSD were implemented in the following order: (1) identification of key expressions, which are excerpts of the statements that reveal the essence of discourse content; (2) formation of semantically equivalent groups of key expressions and summarization of a main idea; and (3) drafting the discourses of the collective subject.

The research that was at the base of this article met the criteria established in Resolution 196/96 of the National Health Council, and the project was submitted and approved by the Research Ethics Committee of the School of Public Health, University of São Paulo (under number 1.411/05). All respondents were informed of the objectives of the study and invited to sign the Informed Consent document after having read and agreed to. The authors declare no conflict of interests.

## Results and discussion

The mean age of the respondents and the mean duration they had been in the dental public service was 46.3 and 21.5 years, respectively, and 25% of the subjects were women.

In Itapira, the process of municipalization of health services was initiated at the end of the 1980s with the creation of the Regional Office for Health - 28, in Mogi Mirim. This state agency was responsible for providing technical advice to municipalities comprising seven localities (Itapira, Mogi Guaçu, Mogi Mirim, Santo Antônio de Posse, Jaguariúna, Pedreira, and Artur Nogueira).

At that time, a dental center (a legacy of the Department of School Assistance, an agency of the Secretariat for Education of the State of São Paulo created in 1976) and three municipal healthcare units, which hired SD and OHA, made up the municipal network of dental service providers. Observing the programming technique of the incremental system, oral health care was usually aimed at the school-aged population, considered more vulnerable from an epidemiological point of view. According to Pinto (1992, p. 43, author's emphasis), this model of dental practice was basically characterized by the implementation "of horizontal measures by means of a *preventive program*, which reduced the incidence of problems, and vertical measures by means of a *curative program*, which solved the prevalent problems."

*In the 1980s, the dental service of Itapira only treated school children between 6 and 12 years. From the end of the 1980s, with the creation of Center for School Dental Care, a greater emphasis was laid on prevention because the objective was to initiate development of better oral hygiene skills in school children. Thus, the service was already developing the guidelines for the implementation of educational initiatives in oral health. However, prevention (self-care) was very much valued as an individual responsibility, as opposed to a collective issue. Subsequently, measures were developed to address oral health problems from a collective perspective, such as fluoridated mouth rinses and supervised tooth brushing.*

At that time, the objective was to abolish the need for treatment (curative phase) by simultaneously moving the group into a preventive phase. After performing pending treatments, each school child received periodic maintenance treatment. Therefore, an Initial Group including children who received care for the first time [...] and a Maintenance Group that included patients who had been treated before (Pinto, 1992, p. 44, author's emphasis) were identified. The aim was thus to integrate curative therapy and preventive maintenance.

*It was recommended that children return often to the center. At present, children return on an average of once or twice a year.*

As previously mentioned, the priority was professional practice aimed at school children because of their prevalence in schools and the epidemiological vulnerability typical of this age group (Pinto, 1992). In principle, all school children between 6 and 14 years enrolled in state schools belonging to the program's coverage area should be included. However, considering the imbalance between the limited resources and the size of the target population, care was often restricted to the range 7-12 years. It should be noted that the historically consolidated conception of school as a social space for the development of educational and preventive actions in oral health (Mialhe and Silva, 2011, p. 1557), which continues to prevail in the minds of many CDs and some political actors, is basically a consequence of initiatives developed during that period.

*We frequently performed oral hygiene activities in schools; the activities consisted of a period at practice and another period teaching how to brush. When a child missed school, he/she would perform the activity on a dental chair.*

*At first, the dentist would talk about prevention with children and conduct school meetings aimed at their parents in the evening. Then, these activities became more difficult to perform, we would go to the schools but the teachers would not cooperate. I think things improved considerably after the municipalization process, at least in the municipal schools, because until today it has been difficult to go to state schools. Prevention activities consisted of talks and distribution of toothbrushes to both*

*children and their parents.*

Prevention and education programs were seen as components inseparable from the incremental system. The idea of reversing the prevalent curative nature of dental care was thus emerging. Nevertheless, CSD indicated a predominance of strategies based on the positivistic discourse on individual behavior changes through the supply of guidelines and information by the professional (Mialhe and Silva, 2011, p. 1558). Therefore, health education was viewed as the teaching of oral hygiene techniques. Although at that time there was already enough information on the effect of diet on the etiology of dental caries, which was the main oral health problem, the fact was that

*The focus was much more on brushing, the use of dental floss (self-care), and professional prophylaxis and much less on diet guidance, such as the importance of avoiding carcinogenic foods, as a method of complementing those preventive measures. There was no guidance or guidelines from the administration on how to approach this subject. Some colleagues worked on prevention in schools, but it is not known to what extent diet was part of that activity.*

Pinto (1992, p. 58) highlights that, long after being implemented, some of the incremental systems did not promote improvements in oral health conditions among the target population. According to the author, in most cases, the reason for failure was the refusal to adopt effective and sustainable preventive and educational actions, a fatal mistake for any model of dental care. The consequence was the adoption of an essentially mutilating and ineffective treatment, reducing dental care to teeth extraction.

*At first, during the period between 1985 and 1990, extraction of permanent teeth in children aged between 6 and 12 years was a current practice, the permanent tooth was restored or extracted. To cut costs, intermediate restorative material (IRM) was mostly used for primary teeth and not amalgam. Nowadays, the Center for Dental Specialties (CEO) performs root canal procedures in children and adults; thus, the extraction of permanent teeth in children is not that frequent.*

The emphasis on the individual through actions aimed solely at a specific segment of the population, as noted in CSD, did not allow this care system to become a major inclusion mechanism. Moreover, most programs that adopted this system limited their preventive phase to the process of fluoridation of public water supplies or [to] weekly mouth rinsing sessions with fluoridated solutions, which may lead to mistakenly focusing on a single preventive method [...] (Narvai, 1994, p. 95). Although the incremental system was object of criticism, we should recognize its importance in designing and implementing dental health measures in a specific historical context and as an important effort to use dental public health programming techniques.

Decentralization of health policy, a principle included in the 1988 Constitution, makes local governance responsible for empowering democracy and SUS. Municipalization, also called *territorial decentralization* or *political and administrative decentralization*, translates into the transference of centralized authority to more peripheral layers (Silva, 2001). It is therefore viewed as an essential factor for the success of decentralization. Overall, the respondents could not conceptualize municipalization, which reflects, among other aspects, the little importance given to continued training of health workers in aspects of SUS organization and functioning. However, as discussed below, they thought it favored a better organization of dental services within SUS.

The CSD technique showed that the shift in authority caused by municipalization had a positive effect on the health care model and contributed to better addressing of health rights. The respondents highlighted improvements in the access to health services, as well as in the organization of training courses, recycling, and professionalization. Similarly, reflecting the improvements that resulted from municipalization, Ferreira and Mishima (2004) also recognized the benefit of increased access, which has two dimensions that are inseparable: the expansion of access to health services and the quality of the assistance offered to the population.

*There was an evolution in our service after it was municipalized, including a greater determination of coordinating bodies in promoting empowerment.*

*School-aged children started receiving more complete care, with prevention performed through tooth brushing, dental floss use, acquisition of basic hygiene notions, and permanent and deciduous teeth restoration, cleaning and treatment of caries started becoming common procedures. Thus, in general, there was a great improvement in youngsters' and children' teeth health.*

In 1985, a great improvement was noticed. Changes and innovations were introduced in the service, and the initial range of 6-12 years was widened. Today, treatment is provided to all, from small children to adults. In addition, there has been increased access to these treatments, which are now available in various centers, and reduction in treatment waiting time, i.e., more people receive quality care. It is obvious that things have improved in every aspect.

The professionals highlighted mainly the increase in basic care quality. There was a gradual increase in the potential of problem solving in the daily practice of oral health services, marked by a biological reductionism that was incapable of adequately addressing the most frequent requirements and an excessive valorization of mutilating procedures. Moreover, CSD indicated that the increase in management autonomy triggered a change in the profile of human resources and expedited maintenance or acquisition of consumables and equipment, overcoming frequent difficulties that prevented elementary dental care procedures.

*When the equipment was faulty, during the period when the State was responsible dental care, there was a lot of bureaucracy to get funding, service the equipment, call in a technician to assess the state of the equipment. The conditions were not good. When I first started in the service, the assistant did not wear gloves or a mask, these were only for the dentist. We used the same aspirator several times, we would immerse it in glutaraldehyde and wash it to use it again the next day. In addition, there was no reflector, sterilization was performed using boiling water, and there was no low-speed drill. When new people started coming in and complaining everything began changing.*

*At first, the material came from São Paulo and we could not choose or give an opinion, i.e., they were*

*delivered and we had to use them. As for the equipment, if something was faulty it took a long time to repair. With municipalization, the equipment improved and there is some flexibility in deciding what material will be purchased because the buyer is the municipality. Thus, we do not have to wait for the equipment to come from some other place. For example, we could not perform surgeries. Sometimes, we wanted to solve a problem, but there were limitations because there was no material available. Nowadays, we still have to face some difficulties with regard to the supply of consumables. In short, when the State was administrating the dental services, it was harder to manage the consumables.*

The improvements mentioned by the respondents were a consequence of the advances achieved in the course of years of municipalization in Brazil, in particular during the 1990s, with the publication of the Basic Operational Norms (NOB). The operations initiated by the fall of the government of Collor in 1992 were followed by a gradual increase in the discussions on a proposal of decentralization within the Ministry (Silva, 2001). The immediate unfolding of that process consisted in the May 1993 publication of the NOB-SUS 01/93, which established norms and procedures regulating the process of decentralization regarding the management of healthcare actions and services (Brasil, 1993). The NOB-SUS 01/96 of November 1996 extended municipalization and listed the responsibilities assigned to the municipal management, such as the monitoring and control of basic care services.

With regard to CSD, it is worth noting that the Oral Health National Policy (PNSB) recommends a model of integrated healthcare and acknowledges that, in order to achieve this, it is necessary to ensure that the appropriate working conditions are put in place, which includes the development of policies related to the supply of equipment and consumables and conservation, maintenance, and replacement of dental equipment [...]” (Brasil, 2004, p.7).

*Nowadays, the municipality is able to foresee what it needs to buy, what material will be needed, which is an improvement. There are still things to be done, those on the field know that, some shortcomings still exist. However, overall things have improved significantly because restorations in deciduous*

*teeth were not performed using good material, only IRM, the famous IRM. Nowadays, we use amalgam, ionomer, and light-sensitive resin. Therefore, the work produces better results. Previously, when the material was not satisfactory, which was often, there were complaints. We used to work with older equipment in 1982 [...]; the equipment was terrible. Now, we have all we need. There are gloves for the assistant. There have been considerable advances, both in terms of materials and equipment. Gradually, more practices were acquired, the centers became better equipped, and in 2006, CEO was created, which brought better equipment for the service.*

CEO is a reference unit for oral health teams that perform, according to the epidemiological reality of each region and municipality, clinical dental procedures that complement those performed in basic care (Brasil, 2004, p.15). After the implementation of PNSB, major changes occurred with regard to the increase in the offer of services of secondary oral health care, which was until then circumscribed and localized (Pucca-Junior et al., 2010).

The respondents believed that the proximity to higher management catalyzed the introduction and monitoring of programs and contributed to the optimization of public resources utilization. It led to the improvement of managers’ control activities, which promoted better regulation of service execution. In addition, the use of epidemiology and territorial data as a planning aid was identified as an important resource to address the health-related needs of the population. More participatory programming techniques in health made it possible to implement health promotion and prevention initiatives, thus allowing to overcome excessive emphasis on mutilating procedures that characterized the sector during the pre-SUS period, as epidemiological studies on oral health demonstrated (Roncalli, 2011).

*It seems that, or I’m sure that, when the health service was municipalized, the dental sector grew compared with the medical sector. We outline the guidelines and go to where the incidence of caries is high [...], which allows us to act in accordance with the needs of the population. The manager himself is now closer to the problem, which also allows a better value for money.*

The responsibilities that result from the municipalization of health services are not exclusive to municipal governance bodies; they involve other local actors, such as the civil society. Both comprise the so-called *local governance* (Silva, 2001). The modalities of people participation in debates on public health policies were regulated by the Federal Law 8.142/90, which recommends, among other aspects, the activity of Health Councils with deliberative, fiscal, and consultative functions in the three spheres of governance and that periodic health conferences are held at the national, state, and municipal levels. The shift of the axes of power that resulted from the municipalization process led to the incorporation of new social subjects and a greater engagement capacity from local stakeholders in the development of health policies, as the institutional channels of participation have been expanded (Silva, 2001, p. 52). However, the possibilities of public control of oral health policies, provided by councils and conferences, among other mechanisms, informally known as “social control,” were not mentioned by the respondents.

## Final considerations

Analysis of the perception of respondents indicated that they believe that municipalization (1) increased the quality of basic healthcare; (2) allowed a gradual expansion of the services’ problem-solving ability, which contributed to addressing the most prevalent demands; and (3) created conditions that allowed overcoming excessive valorization of mutilating procedures that characterized the health sector during the pre-SUS period. In conclusion, the respondents perceived, in the reality of their daily activities, the positive effect of municipalization on service organization and dental care, which expanded the effectiveness and efficiency of the public healthcare system.

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