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Brazilian oral health coverage characteristics and the populational access to public dental services

Configuração da cobertura de saúde bucal brasileira e o acesso da população ao serviço público odontológico

Configuración de la cobertura de salud bucal brasilera y el acceso de la población al servicio público odontológico

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The aim of this study was analyzing the Brazilian oral health coverage and the population access to the odontological public service between 2008 and 2012. It is an ecological and comparative-descriptive study, made from indirect records. The means of the Oral Health Teams (OHTs) in the Brazilian public services varied according to the regions. In the evaluated period, the Northeast presented higher OHT means (64.0); followed by the South (56.0); Midwest (53.0); North (44.0) and Southeast (43.0). The Northeast region has the highest number of population means who never underwent odontological consultations, even though this is the region with the highest offer of odontological services. The lowest means are concentrated in the South, which, after the Northeast, has the highest offer of public odontological services. There was a difference between the proportion of people who never underwent odontological consultations and those who have health insurances (p=0.009). The access and use of public oral health services by the Brazilian population, in the different geo-economic regions, as well as the amount of oral health teams is unequal. Those who have private health insurances, are female and live in urban areas are the ones who seek oral health care the most.
Descriptors: Family Health Strategy; Oral health; Health services accessibility.

O objetivo deste estudo foi analisar a cobertura de saúde bucal brasileira e o acesso da população ao serviço público odontológico entre os anos de 2008 e 2012. Trata-se de um estudo ecológico, comparativo-descritivo, por documentação indireta. As médias de Equipes de Saúde Bucal (ESB) do serviço público brasileiro variam de acordo com as regiões. No período avaliado, o Nordeste apresentou maior média de ESBs (64,0); seguido das regiões Sul (56,0); Centro-Oeste (53,0); Norte (44,0) e Sudeste (43,0). A região Nordeste concentra as maiores médias populacionais que nunca realizaram consulta odontológica, mas essa é a região que apresenta a maior oferta de serviço odontológico. As menores médias concentram-se no Sul, que após o Nordeste é a região com maior oferta de serviço público odontológico. Verificou-se diferença entre a proporção da população que nunca realizou consulta odontológica e a proporção da população com cobertura de plano de saúde (p=0,009). O acesso e a utilização dos serviços públicos de saúde bucal pela população brasileira, nas diferentes regiões geoeconômicas, bem como a quantidade de equipes de saúde bucal é desigual, havendo maior procura pela atenção em saúde bucal entre os usuários que possuem plano de saúde privado, que pertencem ao sexo feminino, e residem na área urbana.
Descritores: Estratégia de Saúde da Família; Saúde bucal; Acesso aos serviços de saúde.

El objetivo de este estudio fue analizar la cobertura de salud bucal brasilera y el acceso de la población al servicio público odontológico entre los años de 2008 y 2012. Se trata de un estudio ecológico, comparativo-descriptivo, por documentación indirecta. En el periodo evaluado, el Noreste presentó mayor promedio de ESBs (64,0); seguido de las regiones Sur (56,0); Centro-Oeste (53,0); Norte (44,0) y Sureste (43,0). La región Noreste concentra los mayores promedios poblacionales que nunca realizaron consulta odontológica, pero esta es la región que presenta la mayor oferta de servicio público odontológico. Se verificó la diferencia entre la proporción de la población que nunca realizó consulta odontológica y la proporción de la población con cobertura de plan de salud (p=0,009). El acceso y la utilización de los servicios públicos de salud bucal por la población brasilera, en las diferentes regiones geoeconómicas, así como la cantidad de equipos de salud bucal es desigual, habiendo mayor búsqueda por la atención en salud bucal entre los usuarios que poseen plan de salud privado, que pertenecen al sexo femenino y residen en el área urbana.
Descriptores: Estrategia de Salud Familiar; Salud bucal; Accesibilidad a los servicios de salud.

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INTRODUCTION

The implantation of the Family Health Strategy (FHS), in 1994, was an attempt at making a health model that was universal, integral, participative and decentralized. Since its creation, it has been improving public health in Brazil. Initially, the program was made up of an integrated team of physicians, nurses technicians and community health agents[1].

According to the integrality axis of the Unified Health System (SUS), and to the demand, the increase in the number of professionals and their previous actions in some programs, the dental surgeons was included as a member of the multiprofessional FHS team from 2000 on, due to decree 1,444 and n. 267/2001 from the Ministry of Health. The FHS teams also had their practice aided by financial and structural aid for the expansion and improvement of oral health in the country[2-4].

Later, according to the directives of the National Policy of Oral Health (PNSB), and as a way to consolidate secondary attention in odontological, the program "Brasil Sorridente" ("Brazil Smiles") was created in 2004, through the implantation of the Odontological Specialty Centers (CEOs)[5,6].

Since then, oral health has been a specialized primary care service, bringing odontological practices closer to destitute and needy parts of the population. At the same time, some aspects of the odontological practice have improved, such as the diminution in the prevalence of cavities in deciduous and permanent teeth and the consequent reduction of early teeth losses. The access to early diagnostic to oral disease has also been increased[7,8].

On the other hand, the access to oral health public services still has its week spots, in addition to difficulties that are inherent to the system, such as the lack of investment, and that of services that are not offered by SUS yet. However, there has been an increase in the number of users under the coverage of private health insurances, who, indirectly, seek odontological services through such services[7,9,10.]

According to the National Research of Sample by Residence (PNAD), these users are not equally distributed among Brazilian regions. Most of them are focused in the Southeast and their residences are in urban areas[11]. However, not all population has access to this type of service and many depend on actions from SUS[10].

Therefore, the aim of this study was analyzing the Brazilian oral health coverage and the population access to the odontological public service between 2008 and 2012.

METHOD

This was an ecological study, with an inductive approach and comparative-descriptive procedure, made from indirect records[12]. Data referring to the oral health coverage and its relationship to the access of the Brazilian population to such public odontological services was considered.

The age groups previously determined by the information systems were used: from 0 to 9, from 10 to 19, from 20 to 39 from 40 to 59 and 60 years old or older, considering the five Brazilian regions, sex, income and location.

Data were obtained from the registers in the Informatics Department of the Unified Health System (DATASUS), from 2008 to 2012[13]. Data referring to the Oral Health Teams (OHT) was filtered, as well as data regarding people who had never undergone odontological consultations, those whose last consultation took place less than a year ago, and the rate of the population who is under the coverage of private health insurances.

After collection, the Microsoft Office Excel® software was used to tabulate the data, which was later exported to the IBM SPSS (Statistical Package for Social Sciences) software, version 20.0.

Data was treated and analyzed descriptively — results were disposed as charts and tables with absolute and relative frequencies — and inferentially, using the Chi-square test, to evaluate the association between the variables, with a significance level of $\alpha=5\%$.

All values found in the databases are presented as arithmetic means. Since this data

is secondary, the dispersion measure that was initially adopted was maintained, to avoid changes and distortions in the results. The absence of this information in other data systems was one of factors that led to the choice of this data in this data from this platform.

RESULTS

The means of the OHTs in the Brazilian public services varied according to the regions. From 2000 to 2012, the Northeast presented higher OHT means (64.0); followed by the South (56.0); Midwest (53.0); North (44.0) and Southeast (43.0). With this unequal distribution of the odontological service offered to the population, one must take into account the organization and offer of professionals, the availability of services and the number of users per region.

Based on information from Table 1, one can see that the highest number of population means who never underwent odontological consultations is in the Northeast region, which, however, is the region with the highest offer of odontological services.

The population analyzed is mostly formed of females (19.6); who live in urban areas (26.5); with an income of up to 0.74 minimum wages, and frequently are from any age group. The lowest means are concentrated in the South, which, after the Northeast, has the highest offer of public odontological services.

Table 1. Populational means in Brazilian regions, from 2008 to 2012, of people who never underwent odontological consultations. According to sex, age group, zone of residence and income.

Variables	North	Northeast	Southeast	South	Midwest
Sex					
Male	16.0	15.5	7.8	7.0	9.1
Female	18.3	19.6	9.2	8.2	10.4
Zone of residence					
Urban	24.0	26.5	12.1	9.6	13.1
Rural	15.2	14.1	8.1	7.1	9.2
Age group (years)					
0 a 9	59.3	62.2	46.7	41.0	44.4
10 a 19	13.6	17.5	5.5	4.2	6.1
20 a 39	3.8	5.0	1.6	1.4	2.2
40 a 59	3.3	4.2	1.3	1.5	2.0
60 years old or more	5.7	6.5	2.6	2.6	3.6
Family Income (MW)*					
0 a 0.74	23.4	22.5	15.5	15.0	15.9
0.75 a 1.99	9.0	7.5	6.3	5.3	6.9
2 or more	4.2	3.9	2.8	2.5	3.1
Did not answer	15.2	15.4	5.1	6.4	8.3

* Minimum Wage (MW): analysis based on a minimum wage of R$ 622.00, which corresponds to the value practiced at the time of the study.

In Table 2, one can see the population means of users who had odontological consultations less than 1 year before. Regarding the frequency of the service, the female population from the South (50.5), who live in urban settings (49.5), from any age group, are the ones who seek the service the most. The male population in the North is the one who is the most absent from the service, mostly those who live in urban settings (34.9%) and are 60 years of age or more.

Table 2. Populational means in Brazilian regions, from 2008 to 2012, of people whose last odontological consultation was less than one year ago, according to sex, age group and zone of residence.

Variables	North	Northeast	Southeast	South	Midwest
Sex					
Male	30.2	31.5	39.4	45.4	39.6
Female	35.6	38.0	44.7	50.5	44.9
Zone of residence					
Urban	34.9	38.4	42.6	49.5	43.5
Rural	25.8	25.4	36.6	41.1	34.5
Age group (years)					
0 a 9	27.5	26.9	39.3	45.5	40.8
10 a 19	43.7	44.5	53.2	62.4	51.8
20 a 39	37.8	43.5	48.2	55.1	47.0
40 a 59	26.0	29.0	38.4	42.3	37.2
60 years old or more	10.2	13.1	22.7	24.9	20.8

* Minimum Wage (MW): analysis based on a minimum wage of R$ 622.00, which corresponds to the value practiced at the time of the study.

By considering the rate of the population who has health insurance (Table 3), there is a small difference regarding sex, most users being females, when compared to the number of males; not to mention a higher concentration of users in the age groups from 40 to 60 years of age, who live in urban settings, for all regions of the country.

There was a significant difference between the proportion of people who never underwent odontological consultations and those who have health insurances (p=0.009).

Table 3. Populational means in Brazilian regions, from 2008 to 2012, considering private health insurance coverage. According to sex and age group.

Variables	North	Northeast	Southeast	South	Midwest
Sex					
Male	12.7	12.4	34.7	29.1	23.3
Female	13.8	13.9	36.5	30.9	25.9
Age group (years)					
0 a 9	10.4	10.2	32.5	26.4	21.1
10 a 19	10.9	9.9	30.3	24.6	20.5
20 a 39	14.8	14.6	37.6	31.8	25.2
40 a 59	17.6	17.2	36.6	33.3	30.0
60 years old or more	15.0	15.1	38.3	31.9	30.9

* Minimum Wage (MW): analysis based on a minimum wage of R$ 622.00, which corresponds to the value practiced at the time of the study.

DISCUSSION

In this research, the users from all five geo-economic regions in Brazil were analyzed to include the different populations, cultures and beliefs of this miscegenated continental country, that may influence in the access and communication to the system[14].

All age groups are present, so that the most common diseases in certain periods of life are not excluded. Also, the age groups standardized by the WHO to measure some indexes (5 and 12 years of age) are still being analyzed[15].

The Brazilian population is divided according to zone of residence, urban or rural, so that location and difficulty of access to the service must be taken into account in the study of the access to the services offered by

SUS. Additionally, the income may influence in health, so that all these types of data must be included for the objectives of a study like the one presented here may be contemplated.

The number of OHTs varies among Brazilian regions. However, the number of cities, of Family Health Strategy Units, and of users available for each region, is different.

It is not sensible that the Northeast of the country, which has the second highest population and the third biggest territory and GDP among the regions, presents socioeconomic conditions, or even the need, of having the same number of OHTs as the South, for instance, where the territorial coverage is much lower, and the GDP is much higher[17]. However, data does not specify the distribution of these OHTs in states and municipalities, and this is another factor that may influence in the access and in the frequency with which the users go to the services[18].

The distribution of these dental surgeons is unequal in the Brazilian territories. Most of them are gathered in great urban centers and capitals, leaving unattended people from rural areas. In spite of that, the location factor does not seem to generate great problems for the user of the public service[2];

Although studies showing the access of the rural population to the odontological services are still scarce[19]. These users may be assumed to use urban services to clarify their doubts and needs when necessary, whether these are public or private services.

The Northeast has a visible inequality when it comes to the offer and the use of public odontological services.

This can probably be explained by the fact that the region has higher socioeconomic difficulties than the others, and its population from all age groups, with inferior financial conditions, must use prioritize their expenditures with necessities such as food and housing. In these cases, oral health only takes the forefront in moments of pain or discomfort. As a result, these people search for rehabilitating procedures, and the search for prevention does not happen[20].

The South has not only the highest OHT means, but also contains a high number of people covered by health insurances. Therefore, this region stands out as the one with the lowest number of users who never went to the SUS odontological services.

However, the presence of private health insurances may not explain the absence of users from the public service, since many health insurance companies do not provide odontological services to their users. Thus, many seek primary care public services especially for easily solvable procedures[10].

In the other regions, the results are similar. Women, low income, from any age group, who live in urban areas, and never used odontological services from SUS.

Maybe the fact that nowadays women accumulate many different functions, and the lack of available time during the working hours of the odontological services, in addition to the prioritization of the children, especially in the case of pregnant women, are relevant issues that can justify the absence and the frequency of the search for the services of dental surgeons[21].

The use of the public service may be guided by different profiles of attention, be they based on preventive methods to be carried out in primary care, in curative methods, or even in the use of the service as a gateway to specialized consultations, as those offered in the Odontological Specialty Centers (CEOs)[6,22].

This type of service may directly influence the return of the user for later consultations and their frequency to odontological services. Primary care must attend to its role as organizer of care, raising the awareness of the patient so that they will follow up with their treatment and not abandon it, allowing for the providing of health care to continue and for the system to work harmoniously[1].

Other preventive measures implanted by administrative organs, such as the fluoridation of tap water, the consolidation of educational programs in schools, domiciliary visits from the ESBs, and epidemiological surveys, make it so the rates of disease that affect the users decrease and, with it, the

search and the frequency of visits to the services[23].

Despite all changes and of the raising of awareness conducted by part of the professionals and managers, the main reason to search for the dental surgeon is still pain. Although there is public access to endodontic and restoration treatments, dental extractions are still common, and extensive dental losses take place among users[24].

The findings of this study show that the search for odontological searches is higher among the users who have health insurances. This might be due to the fact that these individuals seek health attention as a whole, understand the importance of oral health, and realize that they need odontological treatment, a treatment which is often times not covered by insurances. These users seek public services to deal with their demand for oral health care.

The number of users who never visited the dental surgeon is heterogeneous among the different regions of the country. The time frames around which ESF attention is scheduled frequently does not match those of the patient, who in most cases cannot leave work to go to a consultation. The availability of services in the night shift and weekends, and the ease of scheduling a consultation, including whether or not it is possible to schedule it in less than 24 hours or in time for a treatment, whether the scheduling can be done via telephone, the waiting time for the consultation, whether there is adequate equipment to diagnose the problem and even medication for a successful treatment, all these factors can influence, positively or not, the access of the Brazilian population to oral heath care[8,25].

All data used in this work is made available by the Ministry of Health and was obtained quickly through DATASUS consultations, but one of the limitations of the study is related to the fact that some information is based on secondary data, which cannot guarantee that the results are trustworthy or precise, since there have been reports of misnotifications or miscalculations that cannot be dismissed.

Despite such limitations, ecological studies, that use information from data systems, must not be dismissed. They are relevant for the planning and organization of health services, allowing for the creation of intervention strategies aimed at extending and improving the availability of oral health care and positively impacting epidemiological rates.

CONCLUSION
The results of his study show that the access and use of public oral health services by the Brazilian population, in the different geo-economic regions, as well as the amount of oral health teams is unequal. Those who have private health insurances, are female and live in urban areas are the ones who seek oral health care the most.

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CONTRIBUTIONS
Raphael Cavalcante Costa contributed in the concept, design, data collection and writing**. Isabella Lima Arrais Ribeiro** aided in the design and data analysis. **Larycia Vicente Rodrigues** took part in the data analysis. **Ana Maria Gondim Valença** took part in the design and critical review.

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