Programmatic actions in oral health: coping with social inequities

Abstract: Inequities are health imbalances that are avoidable, unfair and unnecessary. Studies on health inequities address the need for emergency care related to oral-dental lesions from external causes, toothache or prevalence of oral lesions, taking into account the differences between individuals and/or populations in terms of risk conditions to acquiring disease or access to health services. Inequities may be caused by the health service itself, because diseases affect socially deprived individuals more frequently and severely, especially because of multimorbidity. In the current Brazilian public health situation, programmatic actions are based on technological knowledge, especially epidemiology, focused on specific pathologies or disease risk groups, and relate closely to the organization of programmed demand. Moreover, programmatic actions should strategically use technological devices, without disregarding technical and policy flexibility, and should be closely related to inter-subjectivity and ethics, in order to develop emancipating capabilities. An action having this structure could make it easier to achieve Universality, Equity and Integrality.

Descriptors: Health Promotion; Socioeconomic Factors; Oral Health.

Introduction

Programmatic action in the field of health is defined as an organization of health work based on health integration (organization of collective work in healthcare services) and the utilization of epidemiological technologies. This model of action was established in order to extend coverage. It gives special attention to groups with a greater disease burden or higher risk of acquiring disease, and aims at preventing disease, and promoting and recovering health in these groups.

In the 1970s, the precursor of programmatic actions emerged in São Paulo; it was known as Programmatic. Driven by the social security crisis, the Brazilian government began establishing measures designed to extend medical coverage to that portion of the population excluded because of noncoverage of social security. Programmatic was created with the same intention in São Paulo, i.e., as an action aimed at organizing healthcare services. Although healthcare units confirmed their engagement, Programmatic was unable to achieve the planned increase in coverage and the proposed diversification of activities, primarily due to lack of proper funding.

In the 1980s, at the peak of the health reform movement, which ultimately led to the creation of the Brazilian Unified Public Health System
(Sistema Único de Saúde - SUS) in 1988, new measures were implemented in Brazil. Based on the experience gained from Programaction, the Primary Care System was conceived at the Butantã Health Center School of the Department of Preventive Medicine, University of São Paulo.\(^1\)

The creation of the SUS led health policies, programs and actions to be restructured according to the institutional reform of the Brazilian health system, and was supported mainly by the principles of the SUS doctrine: \textit{universality}, assuming equal access to health services and actions; \textit{equity}, promoting justice; and \textit{integrality}, requiring inter-sector actions and new management of public policies.\(^3\)

The programmatic actions for healthcare emerged against this backdrop, and were designed to integrate collective and individual care. This integrated care system prevailed, once the existing health policies were considered ineffective because of their exclusive nature. An attempt was made at this time to recover the organizational process of collective health service work, promoting the needed dialogue between clinical actions and collective health actions.\(^1\)

Bearing in mind the need to meet the doctrinal principles of SUS, programmatic actions should also contribute to organizing demand, by coordinating clinical and epidemiological rationales. Spontaneous demand (medical-centered)—a common practice in services—should co-exist with programmed demand. Moreover, programmatic action should contribute to organizing services, so as to address not only the optimization of resources and the extension of population healthcare coverage, but also the concern regarding satisfaction of individual needs.\(^4\)

**Programmatic actions in the SUS**

Against this new Brazilian public health backdrop, programmatic actions are based on technological knowledge—especially related to epidemiology—focused on specific pathologies or disease risk groups closely related to the organization of programmed demand. The actions displaying these characteristics should be related to primary care, and combine epidemiological aspects (control of physical, biological and social environment) and clinical aspects (care to population groups), prioritizing the focus on risk.\(^4\)

Bearing equal relevance, programmatic actions should strategically use technological devices without disregarding technical and policy flexibility, and should be closely related to inter-subjectivity and ethics, in order to develop emancipating capabilities.\(^1\)

Figure 1 represents the conceptual scheme of programmatic action. Collective actions are integrated in healthcare, relying on epidemiology as a technological support, insofar as determinants of the disease must be coped with. The action must have an emancipative potential in order to provide the autonomy needed to control the disease, for which ethical and inter-subjective support are essential. An action with this structure could make it easier to achieve universality, equity and integrality.

The ideal scenario for programmatic actions is the Family Health Strategy (Estratégia Saúde da Família - ESF), grounded on a base of health promotion and investment in territorialization and inter-sectorality, and focusing on the problems of a given collectivity. For this reason, programmatic actions are combined with actions of primary healthcare, thus guiding the demand instead of simply aiming to offer a menu of actions.

**Inequities**

Inequities are health imbalances that are avoidable, unfair and unnecessary.\(^5\)
acquiring disease. In regard to dental caries, a comparison of the epidemiological surveys of 2003 and 2010 reveals that children aged 12 years presented different percentages, as compared to the population of healthy individuals, i.e., caries-free (Table 1). The variation is related to the macro-region of origin. The percentages presented a variation of 28% (Northern region) to 48% (Southeastern region). The existence of national policies for infants and adolescents of the Brazilian Unified Public Health System reinforces the perception of inequities, based on the variation observed.

Observing the column representing the difference between the two periods, we can notice that it ranged from 10.8% in the South to 40.7% in the Northeast. This result may be attributed to the investment made in public policies, aiming at correcting this injustice. Even though the problem may not be solved solely in this manner, it is a necessary action. In 2009, a total of 17,641 oral health teams were established and operating in Brazil, 48.2% (8,508) in the Northeast, and 23.5% (4,141) in the Southeast.

A critical aspect concerning health inequities in Brazil is related to access. An investigation based on data collected by the Surveillance System of Risk Factors and Protection against Chronic Diseases by Telephone Inquiry (VIGITEL 2009) included nearly 26 thousand respondents who analyzed the access to health services. Of the respondents, 84.8% declared they had access to services, and only 13.2% of these were assisted by public services, whereas the majority was assisted by private services (61.1%).

### Table 1 - Mean percentage (%) of caries-free individuals, aged 12 years, in 2003 and 2010, in Brazil, according to macro-region.

<table>
<thead>
<tr>
<th>Region</th>
<th>2003</th>
<th>2010</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>24</td>
<td>28</td>
<td>16.6</td>
</tr>
<tr>
<td>Northeast</td>
<td>27</td>
<td>38</td>
<td>40.7</td>
</tr>
<tr>
<td>Southeast</td>
<td>38</td>
<td>48</td>
<td>26.3</td>
</tr>
<tr>
<td>South</td>
<td>37</td>
<td>41</td>
<td>10.8</td>
</tr>
<tr>
<td>Central West</td>
<td>27</td>
<td>36</td>
<td>38.7</td>
</tr>
<tr>
<td>Brazil</td>
<td>31</td>
<td>43</td>
<td>39.7</td>
</tr>
</tbody>
</table>

Source: Brasil, 2004; Brasil, 2011.
and insurance systems (22.4%).

Inequity may be caused by the health service itself. Starfield\textsuperscript{12} indicates fundamental issues related to this possibility. First, the author highlights the need to identify inequity. Coefficients, indices and indicators are mostly presented as mean values, requiring stratification of data. The study by Mascarenhas \textit{et al.},\textsuperscript{7} cited previously, presents this stratification when concluding that oral-dental lesions by external causes were more widely observed in males, children aged under ten years, individuals of African descent and individuals with a low educational level.

The second point is the access itself, which should be assured in primary care (horizontal equity) and referrals to specialized services (vertical equity). A health service that accounts for 13.2\% of the demand\textsuperscript{11} may be considered an inducer of inequity per se.

The third point that must always be borne in mind is that diseases affect socially deprived individuals more frequently and severely, especially due to multimorbidity. It has been observed that specialists who prepare themselves for the mission of taking care of specific diseases are often unable to deal with the interactions of several types of diseases. The disease is aggravated by the higher probability of adverse events caused by isolated and incompatible interventions.

For these reasons, Starfield\textsuperscript{12} highlights that primary care should imperatively take on a greater importance in health systems, because it is much better to deal with multimorbidity over time.

**Programmatic actions and coping with inequities**

Coping with inequities by adopting programmatic actions requires a dialogic strategy, prompted by the very characteristics of these actions. Initially, we should consider the importance of integrating healthcare into collective actions. In this case, programmatic actions are adequate. Taking the data on caries-free Brazilian children\textsuperscript{9,10} as an example, the action of increasing the number of professionals involved in providing the care would be one way of coping. However, this action should be integrated into collective actions that may be specific to microspaces, or broad, as in inter-sector actions.

Programmatic actions are established on an epidemiological basis by addressing the determinants of a certain disease. They should be targeted to risk groups, and, transversally, to the programs existing in the service. As an example, a toothbrushing activity is a programmatic action that will be effective if dental caries results from deficient toothbrushing (inadequate action). If deficient toothbrushing is detected, the specific causal aspect must be determined: lack of a toothbrush, poor manual skill, life routine, or other difficulties. The integration of inter-subjectivity and ethics may lead to a successful action. Determining the cause affects the outcome.

As mentioned by Beato \textit{et al.},\textsuperscript{13} it is necessary to promote dialogue between propounders of two important collective health theories, namely health surveillance and protection of life, and associate health promotion and epidemiology to the concept of an extended clinic and reception, which complement each other.

Considering a multiprofessional team as inherent to the work process of primary healthcare, programmatic actions should be developed by all players involved. Remembering what Starfield suggested,\textsuperscript{12} it is necessary to learn how to cope with multimorbidity and its interactions, not only to avoid often harmful consequences, caused by isolated and incompatible interventions, but also because man is not the sum of his organs, and their individuality and totality should be considered.

The Department of Strategic Programmatic Actions (\textit{Departamento de Ações Programáticas Estratégicas} - DAPES), under the Ministry of Health, and connected to the Healthcare Agency (\textit{Secretaria de Atenção à Saúde} - SAS), aims at establishing public policies based on equity, humanization and integrality of actions and services of an emancipating nature, urging the formation of networks across the three levels of healthcare: basic, medium and high complexity.\textsuperscript{14}

Currently, the DAPES has been dedicated primarily to programs addressing mental health and the health of women, workers, young people and
adolescents, children, the elderly, prisoners, and individuals with special needs and suffering from trauma and violence. As such, it provides support to expedite municipal initiatives.

Conclusion
Considering all these aspects, it may be concluded that well-planned and well-performed programmatic actions constitute a powerful auxiliary tool for building up networks, providing viable access to services, improving the quality of provided care, and ultimately enabling the Brazilian Unified Public Health System to meet the principles of and to put into practice the healthcare precepts of Universality, Equity and Integrality of care.

References