

Promotion of Oral Health in the Public and Private Context[§]

Lilian Marly de Paula^(a)
Nilce Santos de Melo^(a)
Heliana Dantas Mestrinho^(a)
(organizers)

^(a)PhD, Department of Dentistry, School of Health Sciences, University of Brasilia (UnB), Brasilia, DF, Brazil

Chairman: I would like to invite Dr. Lilian Marly de Paula, Dr. Gilberto Pucca, Dr. Rui Oppermann, Dr. Cassius Torres, Dr. Mariza Maltz and Dr. Nilce Tomita to take their seats at the table.

Lilian Marly de Paula (President of ABOPREV): Good morning to all and thank you for coming. The purpose of this symposium is to provide a forum for the discussion of the topics presented during our event.

Participant: Prof. Cassius, why is it so difficult to put the health promotion policies, such as those dealing with oral health and tobacco smoking cessation, into practice?

Cassius Torres: Generally speaking, people are familiar with the health determinants. As Prof. Kowalski mentioned during his presentation, there are various reasons why people do not seek a professional when they have a problem: “I was foolish not to go to the doctor” or they think “it won’t happen to me”. Patients cannot be dealt with in a simplistic manner, in terms of oral cavity prevention, nor can we disregard their context or environment. Our approach must be professional, but this is not usually a relationship we invest too much in. Dealing with this duality, which is part of what is so difficult about working in the health sector, means taking the person as a whole into consideration. It is important to understand if the environment the person lives in puts them at risk, what is their lifestyle and if there is any way to promote change. It is also necessary to understand that at times it is impossible to convince a person to change their lives because they need to make the decision themselves. We need to understand the addiction mechanisms in order to stage an intervention, and we are not trained to do this. We need to understand that addicts, whether they are addicted to tobacco or crack, are solely responsible for the decision to quit their habit, and sometimes the solution to the problem is out of our hands.

Participant: Is it true that the two oral health indicators were taken out of the 2010 health pact? How are the issues of the first appointment and the collective procedures being dealt with? And how does the Ministry of Health see the sustainability of government policy in transforming these actions into public policies? Professor Nilce, how can social control mechanisms support our initiatives? How can we act as a mechanism for social control in health, whether within institutions, health councils or social movements? For example, how can we ensure universal access when there is such a large discrepancy among health professionals, when dentists are outnumbered by doctors? And lastly, taking the case of oral health, how are we going to make sure that oral health promotion is included in the national policy for the promotion of health?

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Corresponding author:

Lilian Marly de Paula
Faculdade de Ciências da Saúde da
Universidade de Brasília
Campus Universitário Darcy Ribeiro
CEP: 70910-900
Brasília - DF - Brazil
E-mail: paula20@unb.br

Gilberto Pucca: We currently do not have any agreement upon oral health indicators. In 2003, when the Smiling Brazil (“Brasil Sorridente”) program was launched, we agreed upon two indicators: supervised brushing and the first appointment. It is worth noting that the purpose of indicators is to monitor the impact of the implemented measures and to follow up on the results achieved, the outputs and effects. In dentistry, however, there is no single indicator that is capable of summing up the care actions (those performed directly between the professional and the patient) and promotion actions (those with an educational character). That is why we have chosen the indicator of supervised brushing in order to monitor the health promotion actions. With the second indicator, our purpose was to measure the care provided, the clinical act itself, as well as the behavior inside the office, and that is why we chose the first appointment. This indicator was chosen based on the rationale that the patient would be registered in our system every time they came in on a planned basis. This same patient would not be registered, therefore, if the appointment was an emergency one. We have invested in planned actions that must be interdependent in order to have an epidemiological impact. It is critical that the service be planned, rather than be based on the model in which the dentist waits for the patient in his office. There is a need for the professional to be part of a team effort. The first appointment indicator is intended to reflect entry in a planned manner. In Brazil, we have a long tradition of providing pre-natal care and individual care in an unplanned way. There are a myriad of indicators for the health fields in which the indicators are agreed upon in a tripartite way (Unified Health System – SUS, State and Municipalities) and there is a movement within the Ministry of Health to clean them up because, with so many indicators, we have lost sight of quality control. Thus, in the negotiation process, it was decided that there would be only one indicator for the oral health field. Since the Ministry of Health was investing in the implementation of new services and in setting up a care network, we made the decision to include the care indicator in order to measure the pace at which the network was growing. The logic behind the orga-

nization of the services emphasizes the Oral Health Teams, but they should work within the basic care guidelines and that is not always the case. Setting up an Oral Health Team (OHT) is the responsibility of the municipality. The Ministry of Health transfers the funds, and the municipality then decides whether or not they will set up an OHT, but this does not imply the reorganization of basic care, which is the most important aspect. The fact that OHTs are implemented in the sphere of the family health strategies does not automatically entail planning; that is to say, the municipalities have the autonomy to reorganize the basic care system. In the view of the National Council of the Health Secretariats (CONASS) and the National Council of Municipal Health Secretariats (CONASEMS), the oral health indicator should be the number of OHTs, but I do not share that view. Given the salutary tension that took root, it was not possible to include the oral health indicator, but we will renegotiate this aspect and we will probably include the number of teams, but I believe we still have to further discuss what it means to promote health.

Nilce Tomita: In regard to the issue of social control, we need to understand what the people perceive to be their needs, their own view on their oral health and what responses the health system must provide in light of these. Another important issue is to understand the historical reasons that led to the discrepancy between the number of professionals in a certain sector – medicine – and that observed in another sector – dentistry. There are historical reasons why the Oral Health Teams turned to a traditional care model without incorporating the precepts of Oral Health Care. However, more important than statistics is the issue of work organization. I can imagine that there is a corresponding number of OHAs (oral health auxiliaries) and OHTCs (oral health technicians) working alongside these dentists and that they operate according to the logic of the Oral Health Teams by reorganizing the care provided, offering high-quality services and with a coverage in proportion to the number of professionals. In regard to formal social control, the role of the councils is critical. It is important to make sure dentists participate in these councils in order to advocate for

the issues involving oral health, with epidemiological indicators that portray the health of the population in view of the services available. As far as the means of “informal” social control, we have the media and the press which provide a forum for the users to be heard, and translate the demands of society in order to induce discussion.

Rui Oppermann: In reference to the issue that was raised about the discrepancy between the two categories, I believe that the central aspect is to make the dentist work in a productive way, which is something that entails knowing how to delegate tasks, the ability to plan and to work in a goal-oriented way. In public health, we need more doctors than we need dentists. I am not undermining the importance of the field of dental care, but I am looking at it from a different perspective.

Marisa Maltz: Dr. Pucca, until now, we have only been discussing the service indicators. But how is the discussion about problem resolution being carried out in the Ministry? Wouldn't it be more appropriate to work with indicators that emphasize the short-term rather than to take stock of the situation in ten-year increments? Wouldn't this allow us to better assess the service?

Gilberto Pucca: Indicators are a powerful and indispensable evaluation tool and they are useful in evaluating policies, in particular public policies. But the indicators need to be considered in light of the Brazilian perspective because they measure trends, and that is something we should bear in mind. We live in a country comprised by 26 states and one Federal District and which has over 5,000 municipalities. We cannot expect indicators to paint an exact picture of reality. Which trends are we going to measure? There are indicators specifically designed for each of the distinct levels. We need to design a set of indicators that will provide information on the state and municipal systems. Since there is no indicator pertaining to oral health in the SIAB (Basic Care Information System), we came up with a file that has recently undergone public scrutiny and that we hope will be available by the end of this year.

Lilian Marly de Paula: Is there any proposal currently under consideration by the Basic Care Secretariat for a National Network for Research in Ba-

sic Care along the same lines as the National System of Clinical Research? I would also like to note that an oral health indicator serves no purpose if it is not linked to the basic care system.

Gilberto Pucca: There is. This is another aspect in which we are making significant progress, which is the production of knowledge in oral health policy. However, we need the funds to accomplish our goals. The Ministry of Health, by means of the Oral Health Coordination, is sponsoring research in Oral Health which was previously funded exclusively by the CNPq (National Council for Scientific and Technological Development). There have been two grant calls already and we already have plans for a third one, and the oral health indicators are one of the main topics for funding.

Participant: I am concerned about the prevalence of oral cancer among patients that had a bone marrow transplant for one reason or another. Therefore, I would like to know what is the prevalence exactly, and for how long should we monitor these patients?

Cassius Torres: I don't have an exact number to give you. But a depressed immunological function is a risk factor for a malignant neoplasm. The patient, who is already vulnerable due to a blood-related malignant neoplasm, is submitted to aggressive treatment (radiotherapy, chemotherapy and bone marrow transplant). These are highly relevant chronic factors. The first bone marrow transplant in Latin America was performed in Curitiba in 1979. In our case history, we have the patients with the highest survival rates, but we do not have the data that could provide an answer to your question.

Participant: One of the greatest problems we have been dealing with is the absence of a computerized system to record patient information and to keep track of the procedures performed. This has led to data loss, difficulties in scheduling follow-up appointments and problems in gathering epidemiological data. Is there any effort currently undertaken to computerize the basic care units and the hospitals that provide oral care? Also, in your opinion, what has yet to be achieved in the oral health sector?

Gilberto Pucca: The Oral health Policy reflects how a society is organized and which are its pri-

orities. As an example of this relationship we have the prison health policy, for which we are already setting up multi-professional teams comprised of doctors, nurses, dentists and assistants, and that is co-funded by the Ministries of Health and Justice. The health of the native population is also another complex problem. We have approximately 500,000 Indians living in our country, and the provision of health services to them is difficult because there is no central command. What we have is a great number of NGOs (non-governmental organizations) and therefore the governability of Indian health is low. We created a Secretariat for the Health of Indians in the Secretariat for Healthcare, organizing it according to the SUS logic, because it was a parallel system. In regard to oral cancer, it was made one of our priorities. And in the CEOs (Centers for Dental Specialties), one of the areas that must be necessarily implemented is stomatology for oral diagnosis. Another important advance was offering dental care services in the CACONS (High Complexity Oncologic Care Centers) and UNACONS (High Complexity Oncologic Care Units). We are on the verge of finalizing a consensual National Oral Cancer Policy within the Ministry of Health and with the participation of the INCA (National Cancer Institute). It is the first step to effectively deal with oral cancer, but we have great potential given that we are putting together a network. What we now have to do is organize the service. There is an effort to computerize, starting with the CEOs, all of the forty thousand basic healthcare units throughout the country, which is a highly complex undertaking because they are spread out.

Nilce Tomita: Even though there have been significant and worthy accomplishments, we need to provide an answer to a highly challenging question: “What have we yet to achieve?” Despite the growing numbers, we have not yet reorganized the work process of the dentist within a team comprised of at least one oral health auxiliary and one oral health technician. There is limited availability of technical-level professionals to work in the oral health teams. Given this strategy, but also beyond it, how can we bring together the efforts of the Oral Health Coordination and the SGTES (Secretariat for Labor &

Education Management in the Health System) in order to train these professionals?

Lilian Marly de Paula: In addition to the problem of the OHA and the OHTC, in organizing the Brazilian Unified Health System (SUS), we also have to deal with the issue of the future professionals and the reallocation of the professionals that are currently in the network. Despite the efforts of the Oral Health Coordination and the SGTES (just remember the PRÓ-SAÚDE model) to show the universities that their curricula should be changed, we still have a long way to go before we are able to achieve these goals. This is not an effort that will yield results in the short-term, but rather it is contingent on the local partnerships and on the pressure exerted by the professionals for a higher quality service. The management is not compatible with the current model and the public network professionals work as if they were in the private sector. This is an effort that is the responsibility of the health professionals. Nothing will happen if the professional does not believe in what he is doing. We have to rethink the professionals in the network and this is something that can only be done internally and locally.

Cassius Torres: In some municipalities, this movement has already taken hold. When we understand how these actions are organized, we can see that a good manager in Brazil today is capable of grasping how the system was devised and set up, and immediately putting into practice very interesting actions, even though for the oral health public policy we lack solid evidence to make certain decisions. In regard to self-examination, I consider it to be a questionable strategy: is it worthwhile to go out prematurely, without sufficient evidence and prepare instructional material to generate cases? But I know it is possible, with a family health strategy, to plan actions, and even with a rudimentary resource such as the SIAB (Basic Care Information System) we can identify the target audience to promote an active search. Sometimes I think there is a disproportionate expectation in regard to what the Ministry should provide. About the supplementary health program, until the second to last review of the list of procedures, there was no charge for the anatomic pathology tests. There are subtle modifications.

Participant: In reference to the promotion of health in the private context, it is the first time we have brought up the ANS (National Supplementary Health Agency). There are health providers that operate under the philosophy of health promotion and there are providers that have always covered anatomic pathology tests. I would like to know if the private sector acknowledges all of the actions of the Ministry of Health developed with the intention of improving oral health, however, with the understanding that the new list of procedures actually entails a transfer of responsibilities. When patients cannot solve their health problems within the public sector, they subscribe to health plans offered by the health providers and the ANS is passing along to them what would actually fall under the responsibility of the SUS. The 1988 Constitution dictates, in a way, that the promotion, the recovery and the rehabilitation of patients is the responsibility of the SUS. Prosthetics are part of the rehabilitation process and it is a way of reintegrating an individual into society, but this responsibility is being passed along to the providers. Is that advisable? It is. But I would like to know what role the Ministry of Health had in arriving at this solution, whether the Ministry of Health had any influence or if this was solely an initiative taken by the National Supplementary Health Agency.

Gilberto Pucca: On the topic of the training of OHTCs and OHAs, beginning in 2003, the Secretariat for Labor & Education Management in the Health System was created. It was created as a result of an understanding in the Ministry of Health regarding the need to improve training and to invest in this field. But the discussion surrounding the topic of training is one of the greatest challenges. We have to attempt to bring the academic world and the realm of knowledge closer to the world of service provision. This is a daily challenge we face. And the speed at which the construction and incorporation of new knowledge is made by academics is not enough to meet the needs of the service sector. The service sector is more pragmatic and has to provide answers at a faster pace, but in training, the process is undertaken with a distinct logic. This has to be respected, of course, but it also has to be called into

question so that both sides start moving at equal paces, or at least at less unequal paces. The SGTES, by means of the PRÓ-SAÚDE, has invested in a curricular reform. To review curricular guidelines is a daunting task. It is like the old story of arriving at a consensus. Everybody agrees in theory, but when the time comes to put the plans into action, it is a different story, but we are dealing with it. We are setting up an oral health policy very quickly, but we do not have professionals with adequate training to act within it. It is complicated, but we cannot expect the universities to change their curricula to fit the strategy. Therefore, it is a thorny problem that has to be dealt with in light of the Brazilian perspective and characteristics. This is the challenge we must face on a daily basis. In regard to the issues pertaining to the ANS, I think that the procedure list is an advance taking into consideration the situation that existed previously. But I fully agree with you. The Constitution says that the private sector is complementary. This must be taken into consideration and everything must be built within this logic, but we have an enormous historical deficit. I am aware that the complementary sector does not fall under the responsibility of the Ministry of Health, but rather of the Ministry of Justice, and not in the punitive sense, but in the sense that they must decide on these issues instead of exempting the government from the investments it is obligated to make. The private sector has an important role to fulfill, which is complementary and that cannot prevail over the public sector, much less in the realm of regulation, which is the sole responsibility of the public sector. Lastly, I would like to ask Rui to comment on the recently published statement that people who do not brush their teeth at least two times a day are 70% more likely to suffer a heart attack.

Rui Oppermann: Since most of the population brushes their teeth at least three times a day, we are outside the risk zone. We should be cautious in relation to the information we derive from the epidemiological analyses. It has been a while now that the theory that those people who do not floss are more likely to suffer a myocardial infarction has been established. But what is relevant is the fact that the person who flosses is likely to have other associated

healthy habits and so the indicator is not the cause. Epidemiological associations are rarely causal. In order to determine causality, we need a randomized clinical trial including everything else that is necessary to provide evidence. The second aspect is that the associations also have to be relativized. I am not familiar with the odds ratio of brushing. If it is seventy percent, then the association is 1.7. Professor Kowalsky shared with us a host of associations between eating habits and head and throat cancer. I cannot go into details, but the associations are statistically very weak. In a 1.7 association, the seven stands for the seventy percent risk that the epidemiologist claims exists. But the bottom line is that for an association of this nature to have any chance to affect the outcome, such as cardiac events, the odds ratio should be higher than 3. And above 3, in terms of cardiac events, is found exclusively with smoking, sedentary lifestyle, serological lipids count and diabetes. People who brush their teeth religiously are sure to take better care of themselves and are more concerned about their health, and therefore will also take care of their heart. In regard to the topic of the curriculum and the PRÓ-SAÚDE, I would like to mention that we were in the process of reviewing the curricular guidelines in our school when the PRÓ-SAÚDE was launched. So we did not change our curriculum because of the PRÓ-SAÚDE program, but rather PRÓ-SAÚDE came to help us by providing us with resources. The first PRÓ-SAÚDE referred to the academic units, but the PRÓ-SAÚDE II was institutional: the university submitted a proposal for a teacher-centered care district that is providing care to almost 600 thousand people in the city of Porto Alegre. This changes the situation completely because the health system as a whole is committed. In addition to this, it became very clear to us that there was a need to encourage the network work closely with the service providing sector. And that is where the PET-SAÚDE came in. This program provides a stipend to students and teachers and to one dentist in the network, the so-called preceptor. This is an important aspect because it serves as motivation. In August we will open a dentistry course that will be offered at night, and I believe it will be the first in the federal university system. This is a course with

very evident social connotation. We received a generous budget from the Ministry of Education and we are waiting for the resources from the Ministry of Health. But now we need funding for this network. There is a considerable issue, which is that, as Cassius described, we are a federation that is highly dependent on the federal sphere of government. But the government has its own policies and its own way of stimulating the discussion of certain issues. However, in regard to the implementation of certain health policies, we have to deal with the municipal- and state-level policies in the state of Rio Grande do Sul. Even though we would like to work with the national-level issues, the local policy determines what will happen. In the city of Porto Alegre, the number of oral health teams in the family health program is minimal, and the dentistry schools focus their curricula on the PSF (Family Health Program). It is therefore necessary to look at the issue as a whole. We have the important federal policies, which are provided in the Constitution. If we don't have the corresponding municipal and state policies that allow us to apply the federal policies, a very difficult situation is created. Take the example of the state of Paraná, for instance. Despite the several governments in power, they have been able to deal with the issue in a quick, dynamic way that is more attuned to the issues that are important to the people. We also have to act locally in this direction.

Marisa Maltz: I believe that this issue of the relationship between the three spheres of government is also very important when we consider the resources for research. The serious problem of academic research conducted with the service provision sector is that the researcher is considered the sole responsible for the research outcomes. The network has to be responsible and must be evaluated in the use made of these resources and for the final outcome of the research in the same degree as its academic partners.

Participant: In the recent past, in a daily practice situation, the access indicator used was the first dental appointment. When a patient is submitted to a full dental treatment, several appointments are required to complete the treatment because he has many previously unattended needs to be filled. And

if this patient is seen several times by the dentist, then the access indicators will be lower. But if we distribute tickets, the patients will be entitled to one or two appointments only, and then they will have to take another ticket in order to continue their treatment. And so the access indicators in this context tend to be higher. What is the best solution in this case? And how should we deal with this in terms of risk groups?

Marisa Maltz: I would like to add to your question. In the state of Rio Grande do Sul, during a study involving academic and service sectors, it was found that there was a high number of follow-up appointments, which gave rise to an order establishing that each patient could be seen at most 3 times.

Gilberto Pucca: This has to do with what is considered to be important, at the central level of the SUS, to the Ministry of Health. What you have stated is pertinent, but we have to think about this issue at the local level. Because at the level of the Ministry of Health, what we need to measure and understand about public policies is the level of access. For example, how many people had access to the service? Going into this level of detail is strategic and we need an indicator that will be discussed at the local level. That is why it is important, in light of these indicators that we will have or already have, that the States, Municipalities and Federal government agree upon oral health indicators that are clear for the local sphere of management. The problem with this first appointment indicator that began in 2003 is that it was not clear. A patient would present himself as being a first-time patient, but that was not exactly the case. Our first effort was to redefine this indicator.

Participant: Wouldn't it be wise to appoint auditors at least in the capital cities in order to monitor the application of the resources granted to the units located in the States and Municipalities? How is the spending by the units monitored?

Gilberto Pucca: Yes, I agree that it is indeed important. Civil society must take ownership of the monitoring mechanisms. The municipal councils are one of the most salient instances of social control. But it is a new experience for oral health as well. Three years ago, we began a project with DENASUS

(National Department of Auditing of the Unified Health System) to create an audit instrument rather than a monitoring instrument, and last year we audited 20 Brazilian municipalities drawn by a lottery system. It is still incipient but it is already working. As a result of this growth we need auditors, whether they are dentists or not, in order to audit the three spheres: State, Federal and Municipal.

Participant: How do you view the design, management and implementation of the SB Brazil 2010 [National Oral Health Survey]? The backdrop to this question is the following: in the SB Brazil 2003, 50 municipalities were listed by macro regions and drawn by a lottery. But the capitals were not; they were placed in context. And when they are not drawn, we violate the basic principle of biostatistics by which each basic care unit must have the possibility of being drawn and should be listed in a group of municipalities. Since this was not done, the biostatistical methods that should have been applied were not. What is now being done in Brazil 2010 to change this? The second question has to do with the oral health of the Indian populations. We always deal with the oral health of Indian populations as a sub-system of oral health. I would actually like to make a request because we have 34 sanitary districts for the Indian populations and little under 500 thousand Indians in their own communities and, according to data from the IBGE (Brazilian Institute of Geography and Statistics), there are slightly over two hundred thousand Indians in urban areas and we have a healthcare system for Indians that includes a module of oral health which has been operational since 2007 and, yet, this population is invisible from the epidemiological point of view.

Gilberto Pucca: The SB 2010 is different. What is important is that we, oral health professionals, are building an epidemiological survey from the SUS perspective and not from the perspective of the Oral Health National Coordination. The SB 2010, ever since it was first conceived, was based on the close interaction between the Municipalities and the States. To be clear, it is the responsibility of the SUS. In the Municipalities, the stakeholders are discussing the SB, they would like to expand it. It is important not only for dentists but also for health person-

nel in general. The idea is that we would be able to include the national epidemiological surveys within the framework of health surveillance policies. The survey and the SB would then become instruments and components of the National Health Policy, which is the health policy at the national level that has an oral health component. It would therefore be seen under a different light. It would become indeed a policy for health surveillance and that, in my view, is a breakthrough. We reexamined the sample and the methodology. The SB 2003 itself was submitted to criticism, which is also good, and was also the topic of discussions and scientific papers. It was a process by which it earned its stripes. The SB, in the Brazilian model, includes over 110,000 people. I don't think there is an epidemiological survey along the same lines anywhere else in the world. And we are talking about technology. We have been perfecting it. For the SB 2010, we have put together an advisory board for the sample. This sample was reviewed and redefined.

Cassius Torres: For all of the capital cities to be included, which was indeed a precondition, the sample calculation was changed as well as the lottery principle for the other municipalities. Therefore, the lottery system is drawing many more municipalities than would otherwise be necessary.

Participant: Will all of the SB 2010 data be available?

Rui Oppermann: The government service provision sector and the people responsible for the implementation of the oral health policies have expressed an interest in using the survey as a guide for policies and for their evaluation. There is also an academic interest in this data, not necessarily for the purpose of public health, but to know, for example, if two brushings a day aid in prevention. There is an academic interest in the SB database so we can also derive other types of associations that are not necessarily of immediate interest to the manager, but which are of academic interest. As an academic and a researcher, I would like to be granted access to this database in order to identify a series of correlations and associations that are of value to further the scientific knowledge about the distribution of oral diseases among the population. This has been

confirmed.

Participant: 150 municipalities were drawn in the lottery but the 27 capitals did not take part in the lottery, so we have two reference points: one at the macro regional level, in which we drew 30 municipalities per macro region. This allows us to make two inferences: one macro regional inference and other inferences for the capitals.

Nilce Tomita: I would like to congratulate you, Dr. Pucca, for setting up the centers in the North-eastern part of Brazil as you described yesterday during your lecture and that work with these indicators and in oral health surveillance. It is both important and necessary in our country. I must say that I was a calibration instructor in a municipality in the State of São Paulo and that I have witnessed what takes place in certain municipalities, where the patient files indicate that fewer examinations have been performed than the target. It seems to me that this has also occurred in other states. If the sample is smaller than the one estimated according to the parameters listed in this first draw, what will be the political decision in regard to the survey?

Gilberto Pucca: Everything that has to do with the sample, especially the aspects you have raised, really does occur in certain places. These situations, when they are found in practice, will have to be dealt with and there is no way around it. This has already been included in our planning agenda. If it has an impact on the final object, it will have to be reviewed.

Marisa Maltz: But, Dr. Pucca, in the survey plan, you also include the non-answer, which must already have been computed.

Gilberto Pucca: Yes, it has already been computed.

Participant: What are the perspectives, the possibilities and the difficulties in developing a vaccine against dental caries?

Marisa Maltz: A vaccine against dental caries was widely discussed during the 80s. The prevalence of dental decay was drastically reduced during the 70s, 80s and 90s. Research indicates that given the lower prevalence of dental decay and the possibilities to control it by other means, a vaccine would not have a significant impact on its epidemiological

control.

Participant: Given the explanation that was given about the link between mouthwash and oral cancer, I would like to know what guidance the panel has to give about the use of mouthwash.

Rui Oppermann: Both Dr. Kowalsky and Dr. Sheila broached the topic of alcohol-based mouthwashes. There is a wide array of oral antiseptic solutions currently available on the market that, when used in conjunction with brushing, are highly effective in reducing biofilm and gingivitis. We recommend that certain patients use mouthwashes as a means to aid in oral hygiene, especially those people with recurrent gingivitis and that cannot control the problem with brushing alone. The issue with alcohol was made clear by Dr. Kowalsky, who said that there is no scientific evidence that alcohol-based mouthwashes have a role in oral cancer. I do not agree with Dr. Kowalsky's recommendation, however, in the sense that if there is a lack of evidence, then it is better not to recommend its use. One study established a link between rinsing and head and throat cancers, in particular oral cancer. This study showed that people with cancer declared that they rinsed more frequently than those people who did not have cancer. Nevertheless, Kowalsky himself later demonstrated that when people have oral ulcers they tend to rinse their mouths with homemade tea or an over-the-counter drug. It is not surprising, therefore, that the correlation was made. Secondly, this study did not infer whether the mouthwash was alcohol-based or not. Another study performed a meta-analysis of 1500 published works and concluded that there is not sufficient evidence of a correlation between rinsing with an alcohol-based mouthwash and oral cancer. I reaffirm that the fact that there is no evidence does not mean that the correlation does not exist. We will wait for this evidence to be produced. In the meantime, we should make use of these mouthwashes that are recommended by the dental health organizations. The American Dental Association, for example, has been recommending its use for over one hundred years. Therefore, I believe we have a resource that can be clinically used to improve the hygiene standards when there is a problem with gingivitis, and, when indeed gingivi-

tis is a problem, it can be recommended. There are signs that point to the fact that there might be a correlation, but the researchers need to produce better evidence of this association.

Cassius Torres: If you want a guide for clinical conduct, the recommendation is to always recommend its use according to the clinical symptoms, and the treatment should last long enough to help resolve the patient's issues. In the case of gingivitis, it should be used as long as the problem is present and in association with other therapies. I have seen patients who overuse antiseptic mouthwashes. I have seen mouthwashes being offered in bars and restaurants, in dispensers located in the bathrooms. We need to ascertain whether the patient is overusing the product. If this is indeed the case, then we have to deal with this issue differently.

Participant: Would you recommend the partial removal of carious tissue in a public service facility? If the answer is affirmative, then how would we monitor patients?

Marisa Maltz: Any treatment indication is valid for both the public and the private sectors. It does not matter where the treatment will be performed. Secondly, I believe that the removal of carious tissue is worthless in and of itself. We are talking about decay that reaches the deeper layers of the teeth, but where? If I perform a total removal of the tissue, I will have problems related to pulp exposure and we have already discussed that if the pulp is exposed, with decayed tissue surrounding it, the prognosis is bad. Therefore, in principle, I would never recommend total removal in the case of deep carious lesions. There are many studies dating back to the seventies and eighties that show that the probability of exposing the pulp is very large. So the alternative is a treatment that is already considered classic, which is the removal of the decayed tissue in two steps, which is known as the expectant treatment. With the expectant treatment, which has been performed and has many reported cases in the literature, when we reopen the lesion, we find that the lesion has not evolved. There are studies about the hardness of the dentin and microbiological studies in support of our findings. They show that the carious tissue does not evolve when isolated from the oral environ-

ment. What we have today in terms of evidence and systematic review is one ten-year study on partial removal with very good results and that concluded that there is no unequivocal evidence that partial removal is sufficient. On the other hand, there is not enough evidence to support complete removal. I have shared with you long-term studies we have performed demonstrating a very good prognosis, even better than complete removal. Our randomized clinical work, funded by the SUS, has shown that after two years, the partial removal of decayed tissue has better results than those of the expectant treatment among a sample of patients in Brasília and Porto Alegre. In the study conducted with the service, we found that when we perform an expectant treatment and we use the temporary filling, we assume the patient will come back. However, that does not always happen because the patient no longer feels pain. Therefore, the results are actually worse. When we evaluate the patients that do indeed come back, we find that the expectant treatment produces similar results to those produced by the partial removal. Thus, the conclusion is that the partial removal of carious tissue in deep lesions can and should be used as treatment both by the public and private services because there is evidence that points to the fact that the prognosis is very good. But there is an associated cost. In the study we performed, we focused on the cost analysis and attempted to determine how much a basic health unit stood to gain if this type of treatment was performed. In addition to the benefits for the patient and the benefits that we will derive from the procedure, if we perform an endodontic therapy, the restorative treatment would be more complex and expensive; the treatment itself has a much lower cost.

Participant: I took part of a two-year study, published in the *Revista Gaúcha de Odontologia*, of the Conceição Hospital Stomatology service, and one of the issues that was raised was that the Ministry places an emphasis on oral cancer. In a sample of 435 patients, the prevalence of oral cancer was 4%, but if we added up the endodontic and periodontic diseases and other lesions, the sum of all of these would be much higher than the prevalence of oral cancer. I would like you to comment on this.

Cassius Torres: I will read the results of your study. To avoid a discussion on the topic of prevalence concepts, it is better to refer to this data, of the specific service, of “frequency of lesions”. It is only natural in a specialized service to which cases are referred, especially if it is a hospital-based service. So I am not sure if you are surprised by the 4% prevalence. Don’t be. In our outpatient department, within the university, it is 2.5%. But the characteristics that we find in regard to what you described as being the case among your patients are similar to those of other services like yours.

Participant: The central authorities emphasize cancer and sometimes we forget to deal with other lesions and even referral and counter-referral criteria. We have to work on this.

Cassius Torres: The CEO directive refers to this as “oral diagnosis with an emphasis on the early detection of oral cancer”. Indeed, it was over-emphasized in relation to other diseases. And there is a very clear reason for this. The morbidity and mortality statistics mention the prevalence, but we should think about the related costs. During the rehabilitation of the oral cancer patient, we do not see the logic that is found in treating fissures, at which we are much more competent.

Participant: As mentioned by Dr. Pucca, we do not have professionals to work with the Family Strategy and Dr. Lilian also mentioned two other problems: the lack of professionals with this profile to work with the Family Health Program and the training of the generalists. I would also include the training of the management. How are the managers being trained so that they are prepared to work with the teams in the field? How are the cases of oral cancer recorded in the system? Would they be included with other diseases, such as oropharyngeal diseases, or is there a way to select these cases to provide a more exact idea in regard to prevalence and incidence?

Cassius Torres: There are two main systems where we can collect this information: the first one is a system that collects data on mortality, the SIM (Mortality Information System). The other is the system on tumor pathology. They do not take into consideration all of the samples. They actually

omit important information. For example, there is a record of a death caused by sepsis resulting from osteomyelitis in a recently operated mandible. However, the fact that it is a result of a previous problem and is related to the morbidity of oral cancer is not mentioned. The notification of cases of oral cancer is not mandatory and some systems are lacking in this sense. For our purposes, the inclusion of oropharyngeal diseases is useful. The head and neck cancers all have a very similar background. It is worth grouping them together, we should not separate them. That is the source of the data that you find in the yearly estimates of the INCA, which might have some problems, but are actually quite good.

Gilberto Pucca: The more general and relevant problem pertains to training. We are lacking in this field. We are only now beginning to have professionals with this profile because the Brazilian dental system was set up in light of a specific market niche, and the educational sector conformed to this logic over ten years ago. The market did not actually have a place for them. The perspective we are referring to was one of setting up a private practice. There was a very fast change in the organization of the market and in professional opportunities. Today the educational sector is beginning to adapt. The opportunities open to those students who are just now beginning their education are very different. But to do these things with professionals that have not yet been adequately trained requires many things to happen simultaneously. The training of managers and of professionals has to conform to the local needs. This is critical. We need to figure out how to combine the needs at the local levels with the availability at the central levels. The local levels should plan their needs and present their proposals for training to the SUS. As the coordination level, we should advocate for the training proposals presented by the services so that they can be present in the SGTES/Ministry of Health or in the State Secretariat. And there are resources that can be invested in training. We need more joint efforts and more project proposals in order to optimize these efforts.

Cassius Torres: There should be studies to evaluate the impact of these training efforts currently being offered. The manager considers himself to be

ready because he took part in the training, but he did not necessarily change his practice. Offering the training is a positive step, but it is not enough. We need to consider what kind of training is being offered. There are two kinds of professionals. There is the professional who is already in the network, with a completely different language. And then there are the differences between the municipalities.

Participant: In the treatment with partial removal and in the expectant treatment, is the oral cavity cleaned with chlorhexidine or other antimicrobial agents?

Participant: Will the SB 2010 give us a specific idea by municipality of the influence of fluoridated water in cavity prevention?

Gilberto Pucca: The sample only allows us to do this at the national level. Some municipalities that were drawn by the lottery expanded the sample and in these municipalities we can make this inference. In the SB 2010, the database will be made public and access will be granted to all researchers.

Marisa Maltz: In response to the question of cleaning the oral cavity, a partial removal or an expectant treatment is performed when there is no spontaneous pain, but rather only provoked pain; otherwise the prognosis is not good. And there is no need to use an antiseptic, which would only prolong the treatment and make it more expensive.

Lilian Marly de Paula: The main purpose of the present symposium was the establishment of a debate concerning oral health in the public and private practices in Brazil. For the first time, a broad discussion was held on health promotion in a more integral way. Besides, other topics as oral cancer were approached.

An open debate between the public, mainly constituted by health providers, lecturers, students, and management agents, raised questions concerning the different problems, policies and management of oral health.

Definitely, this debate has opened a new communication between the different actors of the complex system of the SUS (National Unified Health System), and will contribute substantially for the improvement of the oral health system. However, this initial step needs to be maintained and we hopefully ex-

pect that this essential aspect of oral health service will continue to be discussed in future ABOPREV meetings.

Evidence-based data concerning the health-disease process, including the definition of risk factors and their repercussion in the individual's general

health need to be further discussed. Also, education practices that consider social disparities and cultural regional aspects are necessary in order to better impact behavioral general health changes, individually and in the population as a whole.