Original Research
Community Dental Health

Oral health policies and decision-making process in Brazil, Colombia and Chile

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Declaration of Interests: The authors certify that they have no commercial or associative interest that represents a conflict of interest in connection with the manuscript.

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https://doi.org/10.1590/1807-3107bor-2023.vol37.0051

Submitted: February 4, 2021
Accepted for publication: October 28, 2021
Last revision: November 23, 2021

Abstract: Public health policies are crucial for the well-being of the general population; however, the health systems of developed countries still do not include oral health in its system. Thus, it is necessary to understand the process of decision-making in oral health policies to create opportunities for countries to achieve an overall positive health outcome, including oral health. This study aimed to identify the factors influencing the inclusion of oral health on the political agenda in Brazil, Colombia, and Chile. The study sample involved decision-makers at political, technical, and academic levels. The extracted data were analyzed using the software Maxqda® and Kingdon´s theoretical model; defining interactive variables that produce a "window of opportunity" to define the agenda and the insertion of theme in formulating public policies. The decision-making process regarding oral health is influenced by many factors like the need to improve the overall oral health of the population, identified through national epidemiological studies, and the importance of individuals in positions involving political decision-making, who advocate for oral health. Strategies were developed in partnership with the academy that focused on the health rights of the population provided by law; territorial and national programs were also developed. The inclusion and creation of oral health policies depend on actors who advocate for thematic and scientific evidence to support decision-making. A close relationship between academia and stakeholders and knowledge translation is important for the development of public policies that can be effective for health systems.

Keywords: Decision Making; Policy Making; Public Health; Oral Health.

Introduction

Despite there being more than three billion people worldwide with oral health needs, it is unseen in healthcare systems.[1,2] The decision-making process for oral health of the overall population is complex and involves different actors; however, data that allows an understanding of the decision-making process for the implementation of oral health policies in countries that have adopted it as a public health policy to guarantee access to the population is scarce.

Several authors consider the term "public policy", as what governments "choose to do or not do". This definition broadly applies to reach numerous

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government actions; however, it also precisely attributes the concept of public policy to a specific agent.[3] Thus, it is necessary to highlight the need for dentistry to be included in the political agenda.[4]

Latin America has various types of healthcare systems, and oral health is included as a right guaranteed by law in some countries of this region; among them, Brazil has a unified health system (Sistema Único de Saúde - SUS),[5] Chile that presents the "Explicit Health Guarantees" (Garantias Explicitas en Salud - GES) for the population,, and Colombia included oral health in the public policies with the implementation of Health Policy Reform and inclusion of oral health with Law100.[7]

According to the Kingdon model,[8] a window of political opportunity is created when there is the simultaneous occurrence of three streams: current of problems, alternatives or proposals, and policies. This study aims to understand the factors that contribute to the inclusion of dentistry on the countries' agenda (Brazil, Chile, and Colombia), resulting in the incorporation of oral health in the respective health systems as a citizen's right.

Methodology

This is a qualitative, cross-sectional study that observes the experiences of implementation of oral health policies in the political agenda by three Latin American countries, Brazil, Colombia, and Chile. A convenience sample of 14 interviewees was identified through key informants from each country (Brazil: 3, Colombia: 5, and Chile: 6), which is shown in Table 1. The selected informant participated in different decision-making levels: a) at the political level, decision-makers at the position for making a political decision were included (*e.g.*, oral health coordinators); b) at the directive level, positions such as oral health director were identified; c) at the technical level, positions directly working with the political level were identified, (*e.g.*, oral health advisor; d) at the academic level, professors and researchers involved with the technical and/or political level were identified, and e) at health services level, workers providing clinical care directly to the community were identified.

The interviewees are described in Table 1. Many interviewees worked in more than one position, according to the categorization performed by the authors.

This study was approved by the Faculdade de Odontologia da USP (University of São Paulo) research ethics committee (CAEE 92350418.1.0000.0075). The project was developed within the context of collaboration in the development of the network of the Iberoamerican Observatory of Public Policies in Oral Health. A semi-structured script was elaborated with 10 open questions covering the theoretical model of Kingdon[8], which was prepared and validated by experts in the field of public policy from the three countries included.

Content analysis was performed to analyze the data[9] before two independent evaluators coded it using the Maxqda® (Berlin, Germany) software. Kingdon's theoretical model was used to perform the analysis. This model consists of the theory of currents, which suggests that the decision-making process in public policies is the result of the union of three streams that generate a window of opportunity for the implementation of the policy: problems, alternatives or proposals, and policies. It can be said that there is an element called "policy entrepreneur," which is composed of key or hidden participants in the decision-making process and that can influence this window of opportunity.

Table 1. Characteristics of respondents, according to the position held.

Country	Interviews (number)	Political Level	Directive level	Technical level	Academic level	Health service level
Brazil	n = 3	n = 3	n = 3	n = 1	n = 1	n = 0
Colombia	n = 5	n = 1	n = 2	n = 3	n = 2	n = 1
Chile	n = 6	n = 4	n = 3	n = 5	n = 2	n = 1
Total	n = 14	n = 8	n = 8	n = 9	n = 5	n = 2

*Respondents worked at more than one level..

To complement the qualitative analysis, and ensure the triangulation of methods, clarifying meanings by identifying the different ways in which a case is seen. It considered the participant's observation of the object of study, the interviews were conducted in person, which allowed the interviewer to get involved and understand the culture and health system of each country. Finally, this study included documentary analysis, for the identification, organization, and evaluation of the information and contextualize the facts at a certain point in time. Documents such as regulations, laws, and other documents relevant to the scope of the research, that analyzed and evaluated the reports are available on government websites.

Results

The findings of this study presented the common themes of the three countries that were identified within each stream as per Kingdon's theoretical model, as described in Table 2.

Problems stream

Among the factors related to the problem stream in the three countries, we identified that the issue of financial resources and political interest played a major role in the development of public policies related to oral health.

> *"A bit of the underlying problem is the structural problem of the health system, that with all the actors it has and the scattered responsibilities they have and a poor governing capacity that the ministry has." (Colombia-Directive Level)*

Chile highlighted the role of local initiatives in influencing oral health.

> *"Given that primary care is municipalized, it also has to do with local realities and the political will of the people, of the priorities that are established in the same health establishment, the policy that is generally modelled by will is at the local level and politicians interesting point" (Chile – Political and Technical Level)*

The need to organize oral health information and carry out national studies was crucial to depict the oral health situation of individuals, which was found to be unequal. As such, there is a pressing need to develop oral health in Chile.

> *"In the year 1993 or maybe in 1994 or 1995, I had to talk about the (epidemiological)studies of 1977-1980, we did not have any updated data so that seemed incredible and we thought we should update that information, so the decision was made to carry out the national oral health study, ENSAB III". (Colombia-Directive Level)*

In Chile, a health survey, not specifically on oral health, impacted the development of policies and initiated the need to systematize data from successful local programs

> *"From the health survey of 2003, a question from a national survey, which allowed us to give everything to what is being developed today (...) There is a lack of systematization to be able to say with certainty if the territorial impact has on the development of public policy (...) there is no evidence, and if there is, they are technical guidelines, when the document comes down from the ministry, you do not see the evidence of studies." (Chile–Political, Directive, and Technical Level)*

In Brazil, an epidemiological survey demonstrated the importance of oral health.

Table 2. Themes classified according to Kingdon's Theoretical Model.

Stream	Colombia	Chile	Brazil
Problem stream	Financial resources, political interest, information system organization; epidemiological survey	Local leadership; information system organization; epidemiological survey	Epidemiological survey information
Policy stream	Territorial policies; health rights guarantee	Local strategies; school programs; GES	Oral health situation
Politics stream	Successful territorial policies;	Political resumption after dictatorship; President induction	Induction Ministry Health
Entrepreneur	Academy	Academy; political interest	Academy; political interest

> *"I think the first data that is already important (....) was objectively extracted from PNAD 1998 (*National Household Sample Survey*), which stated that approximately 30 million Brazilians, that is 20%, had never been to the dentist (Brazil – Directive Level)*

Alternatives / Proposals streams

The policy streams regard proposals for change before a problem can reach the decision stage. At least one alternative solution must be provided to the decision-makers for any given problem[10]. In Colombia, after the introduction of oral health care in the healthcare system (which started in 1993 with the reform that created the general social security system) and the subsequent reforms that have affirmed the fundamental character of the right to health (which was consolidated with Law 1751 of 2015), the idea of considering oral health as a relevant component of this right started gradually gaining importance. The policy creation process focused on guaranteeing rights for the entire population while considering the importance of oral health as part of the general health of the citizens.

> "This approach to rights that the statutory law gave it's very important to support because achieving health as a right from the constitutional point of view generates great possibilities for the following development of that intention of politics" (Colombia – Directive Level)

School programs specifically targeted to achieve positive health outcomes of school-going children have also been developed at the community level. This program is offered together with the Ministry of Education, such as "Sembrando Sonrisas (Sowing Smiles)"

> "There is focus on equity, in children, in *sembrando sonrisa*, they go to kindergartens, from 2 to 5 years old (...) there is quite an important coverage, that is, 100% of the kindergartens" (Chile – Political, directive and technical level)

The creation of explicit guarantees in health (GES - Garantias Explicitas en Salud) allowed access to oral health across the overall population. It is prioritized by age or health condition. Through Law No. 19.966 of 2004, the National Health Fund (FONASA) and social security health institutions must guarantee access to e their respective beneficiaries.

> "By the way, there is a right to care... where the law allows only a co-payment of 20% of the total treatment for Fonasa C and D, or 10% for Fonasa B, and Fonasa A is free... It is a right... " (Chile – Political and technical level)

In Brazil, the oral health status of the population before the creation of the national oral health policy was a trigger point to include oral health in the political agenda.

> "When I joined in 2003, we had an ordinance, recommended by law, which was to prioritize the age group up to 12 years old and pregnant women. This was the first big leap, we stopped talking about prioritization, and began to set up a policy that was based on a life cycle (...) we had 3 procedures, extraction, topical application fluoride and low complexity dentistry, 95% of the procedures that were done in SUS until 2003, were these 3 procedures" (Brazil – Political Level)

Politics streams

In the political flow of the multiple flows model, three elements are considered: national mood, organized political forces, and changes in government. In Colombia, territorial policies created by local governments have increased the population's awareness of their rights and how oral health should be interpolated into the system.

> "What is learned and what is achieved in the territory... if it can influence very positively the decisions for the country." (Colombia – Technical Level)

The process of developing and creating policies involves the participation of members of the academy, policymakers, and the entire population.

> "A very important regional call was made, at the end, this participation led to the formation of a dimension that the Colombian people had provided for and within these dimensions there was of course a space with an

important participation of the people in the face of the need to be clearly expressed concerning oral health issues" (Colombia – Directive Level)

In Chile, the resumption of oral health after the military dictatorship was reported, and the inclusion of oral health as a governmental goal was fundamental.

"Oral health was reborn in 1991 within the political context of Chile in those years. 1973 is when the military coup occurs, the year 91 is when democracy returns..." (Chile – Directive and academic level)

"The programs presentations, President Bachelet included "*Más sonrisas para Chile*" and installs it as one of the goals of the first 100 days (...) imagine a goal in oral health, program to install a program of the first 100 days, there is highlighted the relevance that she printed to everything that oral health" (Chile – Political, Directive and Technical level)

In Brazil, the Ministry of Health induced the creation of the national policy, Brasil Sorridente before there were focused programs.

"And this result from PNAD (that 24% population has never been to a dentist) lit up a signal, to the managers, to the minister and other people in the government at the time, or even an embarrassment around this data, Brazil is a country with many graduated dentists, trained and so many people without access, so I think that at the time it had this perception, the FHS was since 1994, gaining strength and size within the strategies induced by the federal government. My perception at that moment was this "we have to do something!" It is a shameful fact, how can we do it?" (Brazil – Directive level)

Policy entrepreneur: participants

In Colombia, academia played a leading role in creating policies.

"I think there was also something that served as input for the management to make those decisions; since they are national survey because they have made it possible to make it visible the oral problem of the population" (Colombia – Academic level)

The role of academia as a policymaker can also be seen in Chile,

"Mainly the advances that have been made in dentistry, has been attributable to the support of the academic sector that integrates the universities, opportunistic as the opinion of experts" (Chile – Political, Directive and technical level)

The participation of the academy and the political will of the managers have influenced the process of including oral health in Brazil.

"I think that the political situation is absolutely determinant, you have in 2003, a government, with a president, in the case of Lula, who pointed out some priorities, in the perception of the presidency of the republic, pointed out some priorities that have already started, and we were already working on this, including the presidential campaign, but just like other sectors were already working, this is not the point" (Brazil – Political level)

From the results, we can observe a timeline in the evolution of oral health policies, which stems from the national constitution of each country, and proceeds to the creation of programs focusing on life cycles, national and territorial programs. Epidemiological studies that serve as indicators of the oral health situation in the countries were also observed (Table 3).

Discussion

According to the results the discussion will be presented below.

Problems stream

The key informants stated that epidemiological studies proved to be capable of inducing oral health policies in Colombia, Chile, and Brazil after national studies were carried out that exposed the oral health problems of the populations. Improvements were generated in the existing programs and even the creation of national policies. The expenditure on health can be influenced by costs in oral health. Oral health related diseases are the fourth most expensive

Table 3. Timeline of oral health policies and national studies in Brazil, Colombia and Chile.

Brazil	Colombia	Chile
1988 Constitution	1991 – Constitution;	1980 Constitution
1994 Programa Saúde Familia (Family Health Program)	1993 – Law 100	1985 Law 18469
2000 Oral Health Family Team	1996 – Resolution 4288	2004 Law GES
2000 PNUD (National Household Survey)	1998 – III National Oral Health Survey	2003 First National Health Survey
2004 National Oral Health Policy	2004 – Territorial Policy Bogotá	2006 Health Quality Survey
2010 National Oral Health Survey	2005 –National Oral Health Plan)	2013 Plan PAD (Pago asociado a diagnóstico)
	2007 – Territorial Policy Manizales	2018-2030 National Oral Health Plan
	2007 – Reform to Law 100 (Law 1122)	2014-2018 Oral Health Programs NO GES
	2011 – Reform to Law 100 (Law 1438)	
	2012-2021 – Decennial Health Plan	
	2013 – Territorial Policy Medellín	
	2014 – "Soy Generación Más Sonriente" Strategy	
	2014 – IV National Oral Health Survey	
	2015 – Health Statute Law (Law 1751).	
	2016 - Comprehensive Health Care Policy (Resolution 429)	
	2018 – Comprehensive Care Routes	

disease to treat in most industrialized countries; hence, it is important to strengthen public health programmes.[11]

Epidemiological surveys are essential for planning and monitoring oral health programs; however, countries must carry out these studies with data that can be comparable and useful for subnational stakeholders to produce scientific evidence that serves as a basis for political decision-making. Contrarily, the role played by the informants related to the countries' information systems proved to be a point that needs improvement as difficulties in finding information are still reported. However, the development of information systems depends on financial investment, another problem pointed out by the informants, human resources, and the technical capacity.[12]

Advocacy is defined as any action that speaks in favor of, recommends, argues for a cause, supports or defends, or pleads on behalf of others. There are still few studies that focus on this topic specifically in oral health.[13] Oral health advocacy is a vehicle for direct or indirect policy-related transformation, to redress oral health disparities. According to Benzian, the political priority for global oral health is low, resulting from a set of complex issues deeply rooted in the current global oral health sector.[14] We observed that the role of local leadership in advocacy was crucial to the process of implementing oral health policies in the countries studied.

Policies stream

In Colombia, territorial policies are valid as public policy and government networks, with political effects potentially for the insertion or reinforcement of dentistry at the national level. The Colombian health system is organized considering that public health is the responsibility of the state, and collective actions are the responsibility of territorial governments (departments, districts, and municipalities). Ten-year public health plans were developed to improve the population's oral health conditions; the last plan made was for the years 2012-2021.[15] The territories are responsible for implementing this plan and its execution depends on their technical, financial, and operational capacity[7].

Some territorial entities have formulated and implemented participatory public policies of territorial scope, highlighting the oral health public policies of the cities of Bogotá (2004 e 2011), Manizales (2006), and Medellín (2013), that sought to guarantee the right to health, access to services, and improvements in the oral health situation through local strategies. Colombia

does not have an explicit National Oral Health Policy; therefore, tackling oral diseases affecting the population is strengthened by implementing public policies at the local performance level.[16]

It is important to highlight regional advances concerning these policies, the territorial oral health policy of Medellin 2013–2022,[17] had a participatory formulation process, with more than 40 institutions and social organizations, and academic institutions taking an active part. It is known that public opinion is important and should be considered for implementing any policy.[18] In a qualitative study carried out in Manizales, the importance of public policies as a way of activating the state was observed and that differences persist between what users and managers about the right to health.[19]

The introduction of dentistry in GES Policy is observed in the following plans: GES Pregnant Women, GES Urgency, GES 6 years, GES 60 years, and GES Cleft Palate.[6] However, social inequalities in the Chilean society are still observed in the perception of needing care, which can be related to the fragmentation of the health system, demonstrating that the Chilean health system should have universal coverage.[20]

Another point that stood out in the findings was the role of oral health activities in school-going children in Brazil before the introduction of the National Oral Health Policy (2004). Dentistry was inserted in SUS in the Family Health Program, and the number of oral health teams was reduced, with their role being limited to curative actions and school activities. Chile has strengthened the role of the "Sowing Smiles Program" for preschoolers. The care of women older than 20 years through the "More Smiles Program for Chile," the Program to Improve Access to Dental Care for Fourth-Year Youth of Secondary Education help to guarantee good oral health along with compulsory education,and has witnessed continuous improvement in its epidemiological indicators and coverage on promotional, preventive, and curative levels for various population groups[21]. For Colombia, the "Generación más sonriente" was adopted to guarantee access to health and to combat the high rate of dental caries and lesions in early childhood that was identified through national epidemiological studies[22]. Although coverage and inequalities in access to dental services have improved[23], difficulties in accessing health services still exist. It is necessary to perform processes aimed at the transformation of society, specifically achieved by the harmonious working of the health system and institutions, professionals, and caregivers.[24]

Politics and entrepreneurs

Several countries in Latin America had authoritarian governments during the 20th century, and national constitutions were elaborated only after the end of some of these regimes, in the years 1980, 1988, and 1991, in Chile, Brazil, and Colombia, respectively. Health systems of these countries have undergone some changes over the decades, and oral health has been inserted as a right in these countries.; However, not all health systems are universally accessible, since the decision to define which model of will be followed is often a political decision.[25]

In 2014-2018, Chilean president, Michele Bachelet created a government program that included oral health as one of her first 100 days goals in government and proposed improvements in focusing on oral health and its indicators. Political will is one of the determining factors for the insertion of a given theme in the political agenda, and this focus on oral health has resulted in the boosting of health programs for schoolchildren, women, and youth of the country.[26]

In Brazil, a similar phenomenon was observed after the election of Luiz Inácio Lula da Silva in 2002, and the elaboration of the document "Zero Hunger and Mouthful of Teeth" in which he prioritized oral health in his government and thus allowed the creation and implementation of the National Oral Health Policy. Lorena Sobrinho and Martelli identified that political changes at this time facilitated the inclusion of oral health on the Brazilian political agenda.[27]

Furthermore, it was found that the Academy has a major role in the induction and collaboration of health policies. It had great participation in the elaboration of the policies of the countries studied. The importance of national health studies to identify the situation highlighted the existing state of oral health in these countries. After the studies were conducted, changes were made to the current policies or programs. In Colombia, the third and fourth national studies contributed significantly to the

development of new 10-year oral health goals and plans.[28] Higher educational institutions have also guided the formulation of territorial public policies.

Interestingly, in Chile and Brazil, other national studies that addressed issues related to oral health, not specific to oral health were conducted. In Chile, a study was carried out in 2003 that found that 66% of individuals over 17 years of age had cavitated carious lesions. A total of 13.3% of individuals had missing teeth in one or both jaws, 5.5% of adults had total edentulousness, a prevalence that increases to 33.4% in adults over 65 years of age, with a higher prevalence in women, in the rural population, and the population with less than eight years of education.[29]

In Brazil, in 1998, the National Household Sample Survey (PNAD) was carried out and it was found that 18.7% of the Brazilian population had never been to the dentist. In some states, this figure reached 38% of the population,[30] representing 32 million people who had never been to the dentist in their entire life. This impacting data was mobilized to identify the need for a look at dentistry in the SUS.

Conclusion

The inclusion of oral health and dentistry in health system is fundamental for ensuring quality and easy access to health services. Political interest is an important factor in highlighting the importance of this issue in health systems. In the countries studied, conducting national epidemiological studies opened the biggest window of opportunity to serve as a basis for the development and improvement of policies and programs. Also, the role of the academy as an actor that highlights the importance of oral health in health systems when approaching management has allowed this issue to be addressed by management.

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