

Technological organization in oral health in SUS: an archeology of national policy for oral health¹

Organização tecnológica do trabalho em saúde bucal no SUS: uma arqueologia da política nacional de saúde bucal

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Abstract

This article discusses the technological organization of care models for the oral health in the light of the National Oral Health Policy. The theoretical and methodological framework for this study was structured from a history of oral health policies in Brazil, seeking to understand the operative knowledge which guided practice in the field. The approach of health policies proceeded according to the theory of the work of M. Foucault *The Archaeology of Knowledge*. This was used to review normative SUS (Brazilian National Health System) documents and publications for the period 2000-2012. We sought to uncover, from the technological organization (analysis category) how such policies see the health needs of the population and what tools/ technologies are offered in oral health care. The SUS has sought to replace models of work organization that transform the practice of dental care (ineffective, low coverage, monopolistic, low resolution, poorly distributed geographically and socially), with models aimed at health promotion. The collection of articles on the current PNSB highlight a *modus operandi* in services underpinned by pragmatic dentistry, full of conflicts and contradictions. In order to transform NOHP guidelines into oral health practice with new technological arrangements in the labor process, other forms of bonding and commitment are desirable. It is necessary to rethink the technology of oral health care as a possibility with comprehensive care and its legitimacy as a component of health in a larger expression: quality of life.

Keywords: Oral Health; Public Policies; Brazilian National Health System; SUS; Health Care Models.

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Resumo

Este artigo discute a organização tecnológica dos modelos de atenção à saúde bucal à luz da Política Nacional de Saúde Bucal - PNSB. O referencial teórico-metodológico para este estudo estruturou-se em um histórico das políticas de saúde bucal no Brasil, buscando apreender o saber operante que norteou a prática neste campo. A abordagem das políticas de saúde procedeu-se sob teoria de M. Foucault na obra *Arqueologia do Saber*. Utilizou-se de revisão de documentos normativos do SUS e de publicações do período de 2000 a 2012. Procurou-se desvelar, a partir da organização tecnológica (categoria de análise) como tais políticas abordam as necessidades de saúde da população e quais ferramentas, instrumentos e tecnologias são oferecidas para o cuidado em saúde bucal. O SUS busca substituir modelos de organização do trabalho que transformem a prática de assistência odontológica (inefcaz, baixa cobertura, monopolista, baixa resolubilidade, mal distribuída geográfica e socialmente), por modelos voltados à promoção da saúde. O levantamento de artigos sobre a atual PNSB destacou nos serviços um *modus operandi* calcado na pragmática prática odontológica, plena de conflitos e contradições. Para que as diretrizes da PNSB transformem a prática em saúde bucal com novos arranjos tecnológicos no processo de trabalho, outras formas de vínculo e comprometimento devem ser almejadas. É necessário repensar a tecnologia do cuidado em saúde bucal como possibilidade da atenção com integralidade e de sua legitimação como um dos componentes da saúde em uma expressão ampliada: a da qualidade de vida.

Palavras-chave: Saúde Bucal; Políticas Públicas; Sistema Unificado de Saúde; Modelos de Atenção à Saúde.

Introduction

At this point in time of Brazilian health policies, there is wide debate on health care practice models, concerning whether they can truly correspond to Brazilian National Health System (SUS) doctrinal principles. When charting the history of these policies, many advances towards democracy and the right to health have been achieved and strengthened, especially through health care practices that seek to place the subject, the health-disease process and the social component of these processes as the protagonists in the organization of the country's health care system (Mattos, 2003; Alves, 2005; Pinheiro, 2008; Paim, 2009).

The process of constructing the SUS has been marked by drawing up and implementing legal and normative instruments aiming to rationalize the financing and management of state and municipal health systems, based on a proposed amplification of municipal political autonomy (decentralization), as the basis of the State political and administrative structure (Teixeira; Solla, 2005; Paim, 2009).

On the topic of a new way of organizing services, that is, a new health care model, Paim (2009) highlights comprehensiveness as the most neglected principle within the SUS ambit, as since the 1990s, the political emphasis has always been on financing and decentralization. In the view of that author, only through the expansion and political reorientation of the FHP/FHS will it be possible to resume discussion of comprehensiveness in the health care model, through incorporating proposals of territorialization, health surveillance, reception and building links.

One of the main reasons that positive and significant change has been glimpsed in the reorganization of the Family Health Program (FHP) is that its institutional, political and social objectives and targets, place comprehensive care and caring for the family at the center of its activities (Pinheiro, 2001; Gomes; Pinheiro, 2005).

Thus, in the proposal of service organization, as a way of organizing practice, Pinheiro (2008) indicates the need to make previously vertical (Ministry of Health designed) programs more horizontal, overcoming the fragmentation of activities within

health care units in order to include and articulate programmed and spontaneous demand.

According to Alves (2005), assimilating comprehensiveness into organizing services and practices should be strongly founded on identifying the health problems the teams have to deal with based on the population being served. Comprehensiveness should counteract the fragmentary and reductionist approach of individuals. The professional view should be broad including the biopsychosocial subject, and should go beyond disease and obvious suffering, seeking to understand the more comprehensive needs of individuals.

The NOHP Brasil, (2004) defines the oral health directives in the Family Health Strategy from the perspective of creating flows of actions with more resolution, as well as covering activities to promote and protect health, recovery and rehabilitation. These directives propose to amplify and qualify primary care activities, recommended that, for this level of care, actions be developed to prevent and control mouth cancer, implementing and augmenting resolution in emergency care, implementing more complex procedures (such as pulpotomies and the clinical stage of implanting dentures), amplifying access through interventions organized according to care or according to living conditions.

In primary oral care, the aim of the NOHP has been to transform the approach to problems, contrasting with the hegemonic (dentistry) model that has, over the years, produced obstacles to comprehensive care of the patient/user, being based on a way of organizing work that distances the oral health care team from collective practices that could, in their basic - collective - function, respond to comprehensiveness (Botazzo, 2005).

According to Camargo Jr. (2003), in order to construct the health care model, it is important to understand that human suffering turns the subject into a patient seeking care and it is from this suffering that demand for health care services arise

Mattos (2003), based on the perspective of rights and the historical recovery of health policy formula-

tion in Brazil, reflects on the frequent separation between the dimensions of prevention and care, which often minimizes governmental discomfort with its failure to act to meet the needs of specific groups.

In oral health practice, in the same way that technicism and dependence on hard technologies (instruments and equipment), as covered by Merhy (1992, 1997)², have been shown to be sovereign, this is the model in practice, the response dentistry imposes for treating the object of their work: dental lesions, in a limited reading of the subjects' health problems.

On the topic of this historical concept of the object of dentistry, Botazzo (2000, 2008) also places and contextualizes it in the appearance, or birth, of Dentistry and uncovers how Dentistry separate from the medical profession appeared at the end of the 19th century with the political promise of restricting itself to treating teeth. In our understanding of dentistry as biopolitical, that is, social practice endowed with historicity, the product of the political action of specific individuals, the new profession explained what its political project would be and on what theory its practice was based, what would be the true work of dentists: "file, fill, extract and replace teeth" (Botazzo, 2008, p. 223).

These perceptions of dentistry endured for many years - and perhaps continue to populate the ideals of the profession and society - and resulted in oral health policies and practices averse to SUS doctrinal principles. Certainly, when faced with hierarchical and inflexible models in professional-patient relationship (the object of practice) contemplating the comprehensiveness of health care (regardless of the concept used for this principle) will be a challenge

NOHP – The national oral health policy, comprehensiveness, care

In the case of the National Oral Health Policy (NOHP), from 2004 onwards, on the topic of reorganizing Primary care (PC), local health care systems have attempted to reestablish work processes,

² Emerson Merhy conceived hard technology as the instrumental complex as a whole, encompassing all types of equipment for treating, examining and organizing information, whereas light-hard technologies would be well-structured professional knowledge, such as clinical and epidemiological knowledge and that of the other professionals who make up team, in the way they organize their part in the work process.

increasing participation of auxiliary staff (Oral Health Auxiliaries and Oral Health Technicians) in the team, aiming to address old oral health problems with other practice, demanding change and reformulations in the way work is conducted and organized, demanding other, complex, knowledge (Botazzo, 2008; Pezzato, 2009).

From the perspective of this reshaping of health care, the NOHP Directives indicate a remodeling in Primary Care (PC) activities for the Family Health Strategy (FHS) and propose to create Dentistry Centers (DC) as a referral service for care of medium complexity (secondary).

In PC the actions of Oral health, individual or collective, involve: promoting health, preventing disease, diagnosis, treatment and rehabilitation in a progressive chain that aims to guarantee access to the necessary care and technology both to prevent and to treat disease (Barros; Botazzo, 2011).

This new model represents a proposal for a system of permanent epidemiological surveillance and information in order to monitor the impact of the actions, to evaluate and plan different strategies and/or adaptations resulting from the different socio-economic profiles of the Brazilian population.

By redefining the Family Health Strategy oral health directives and the model of care/practice, in the search for more resolute actions interventions organized according to care or to living conditions have been introduced (Junqueira; Frias; Zilbovicius, 2004).

We therefore deem the issue of health care highly relevant, understood to be a technology in health, light technology produced in living work, in the act, in a process of relationships, that is, at the point where the health worker and the user/patient meet. At this moment of talking and listening, complicity is created, as are relationships of connections, acceptance and responsibility is taken for the problem to be dealt with (Merhy, 1997).

This light relational technology could respond to the comprehensiveness we deem transformative in the processes of health care work.

On this topic, some authors (Pinheiro; Mattos, 2003; Gomes, 2004) state that in health care practices - and this is not exclusive to oral health - the biomedical model, fragmented and fragmentary in

its approach to problems, exclusionary, dichotomized between care and preventative actions, has been sovereign and institutes itself in both management structures and in day-to-day services of health care.

Be treating care as a technology for organizing work processes in oral health PC, it is necessary to explain comprehensiveness further, seeking to understand it in the broadest possible sense, so as to enable us to reflect on health care technologies established in oral health.

Machado et al. (2007) highlight comprehensiveness as a concept that enables subjects to be identified as a whole, even if this entirety cannot be reached, a principle that includes all possible dimensions that can intervene. Thus, comprehensive care would extrapolate the hierarchical and regionalized organizational structure of health care, it would prolong itself through the quality of individual and collective care, assuring health care system users, requiring commitment to continuous learning and to multi-professional practice.

Mattos (2001) emphasizes a view of comprehensiveness as a way of organizing services, always open to assimilating a need that was not included in the previous organization.

In this context, comprehensiveness emerges as a principle of ongoing organization of the work process in health care services, characterized by the also ongoing search to broaden the possibilities of understanding health needs in the population. An amplification that cannot take place without taking on the perspective of dialogue between different subjects and between their different ways of perceiving their health care service needs (Mattos, 2001).

In summary, be understanding comprehensiveness in caring for individuals, groups and for a collective, viewing the user as a historical, social and political subject, articulated to their family context, to the environment and to the society in which they find themselves, the role of education in health care is captured as an element that produces collective knowledge, which translates to individual autonomy and emancipation to "look after oneself", one's family and surroundings.

For the object of this study, we consider it important to take a new view of health care and the relationship with the care model. To do this, reflections

are made on care as a mode of interaction within and by health care practices today, defining the institutional field of health care practices to analyze configured technologies (Ayres, 2004).

With the emphasis placed on the individual - universalist character of care, what could be the health care system's response in organizing health care activities and services, formulating policy, doctor-patient relationships, services/population relationships, the relationships between the different professionals forming the health care teams, among other aspects, as has been dealt with in other studies (Schraiber; Nemes; Gonçalves, 2000; Pinheiro; Mattos, 2003; Czeresnia; Freitas, 2003), if, in developing discussions within the ambit of their technical and institutional configurations, constituted of a set of critical reflections on health technologies, we see the possibilities for interlocution, interdisciplinarity, multi-professionalism reduced?

Ayres (2004) points out, thought-provokingly: [...] science produces knowledge of diseases, technology transforms this knowledge into know-how and instruments for use in interventions, health care professionals apply this know-how and these instruments and produce health. We need to consider the opposite is also true: that the way in which we apply and construct technology and scientific knowledge determines limits to what we can view as health intervention needs. We also need to make it clear that not everything that is important to well-being can be immediately translated and operated as technical knowledge (Ayres, 2004, p. 84).

Therefore, from a discussion of the NOHP, we seek to browse documents indicating the technological organization for practical production in oral health in a historical period - mid-twentieth century to the present day - and what new arrangements, new knowledge and learning have been incorporated into public oral health practice over time.

From this perspective, we seek to find discursive regularities, objects of knowledge; we seek to discover how to produce the discourse of a given period how the production of statements of an era was formed, or what materiality - statements expressed by health policy - we could highlight.

The main reflection that we set for ourselves was to reveal the technological organization, knowledge and practices that make up oral health practice from the new model proposed by the NOHP.

Methodological procedures

This article is part of the theoretical elaboration of the PhD thesis: "Organização tecnológica do trabalho em saúde bucal no SUS: uma arqueologia da política nacional de saúde bucal - Technological organization of labor in oral health in the SUS: an archeology of the national oral health policy", which was structured methodologically, to study oral health policies and the technological organization of work in the SUS, in a history of policies and their care models in Brazil. We go on to approach the content of the policies from the perspective of M. Foucault's theoretical constructs in his work *Arqueologia do Saber* (1997).

According to Machado (2006), in this work Michel Foucault sought to explain his categories of analysis and the new direction of his theoretical project, taking an interest in the actual discourse, delivered, existing as materiality and defining an archaeological method based on its objects: discourse, statement and knowledge. In order to establish regularity, Foucault investigated what makes a discourse a unit. In this context, he examines four hypotheses of units (the object, type of statement, the concept, the subject / theories).

Thus, we tried to perceive, in the documents on health policy, the possible materiality of statements on oral health. Sometimes with the materiality in dentistry, sometimes in health promotion and a change of statements - such as institutional role - was found and subtly highlighted.

It is the way in which contents of the documents is grasped which characterizes the research, as the objects of research, by themselves, do not explain anything. The researcher should interpret them, synthesize information, uncover trends and, as far as possible, make inferences.

Regarding the theme of the texts and official documents consulted, the issue of technological organization of work was the converging point of oral health policies, now she is putting it as a means,

or as a guideline for model of care in specific public policy. It is this issue, inseparable from the central category, which became the object of research during the course of this research.

Thus, we seek to trace routes concerning how the new organization of technology (based on promoting health and organized according to care needs) can constitute change in the model, as it will be introduced into an unfinished process, under construction, a model in which dental technique (fragmentation) coexists and the prospect of comprehensive health care, subjects with autonomy and health promotion and surveillance practices.

Result and discussion

Among certain reflections lies the understanding that dentistry, historically - as can be seen in the characteristics of the oral health care model from the 1950s to the 2000s - has been a specific form of policy, reproducing dentistry techniques without criticism in the public sector. This historical *modus operandi* of oral health policy, strongly founded in dental practice, with all its baggage of biologicism, its shortcomings in meeting public sector demand, has perversely led public services to exclude the majority of the population from the benefits and technologies of care (Botazzo, 2008).

Eight years later (using experiences relating to the current NOHP up to 2012 as references), cases in different parts of Brazil and with geographic, demographic, political and economic peculiarities have shown a gap between the purpose of the policy and the day-to-day practice of the services, as we shall see in the articles highlighted in the following paragraphs.

Returning to the survey of articles organized in this study, experiences of the new model of oral health care have not found much space in the technological organization for oral health care.

Soares et al. (2011) conducted a study to evaluate care provided by the Oral Health Team (OHT) in the FHS, analyzing the conduct of oral health practice in several Brazilian municipalities that had adopted the FHP, seeking to discover how the new arrangement of technological organization of work had occurred in oral health.

The authors highlight that, overall, the survey enabled a need to be identified, in principle, reorienting established routines as, in the great majority of municipalities studied, OHS activities in the FHS were not carried out satisfactorily when the parameters of the directives contained in the official documents were used and, overall, the municipalities had not fully carried out oral health activities as recommended by the Ministry of Health. The predominant characteristics are those of the traditional care model, indicating that the financial incentive did not appear to be sufficient to promote the desired changes (Soares et al., 2011).

Botazzo (1999), discussing primary health care units and what he calls internal (here, among other, can be found caring for the users) and external (causal factors or those associated with health risks to the population) processes, uncovers a duplication in health care practice: medical-care functions and interventions concerning risk factors, identified by epidemiology. The author highlights the disjunction in this process: if the policies indicate an “active thing” such as an intervention, then we are faced with a practical activity that goes beyond the environment of clinical intervention. But can the health care professional manage to carry out extramural activities for other principles than medicalization (to a certain extent inevitable in health care services, according to the author) for the set of social relationships surrounding him?

From discussing technological organization in the SUS to its particular relationship with oral health, in the NOHP (Brasil, 2004) we can highlight some questions that remain unanswered. As has already been said by Roncalli (2000) and Botazzo (2005), an extremely critical point is the possibility of establishing a model based on the SUS ideals. Although the former author considers that epidemiology, as an area of knowledge in terms of scientific and technological output in Brazil could be an essential tool (as it would bring oral health care models closer to the SUS ideals of universality, comprehensiveness and equity, encouraging discussion on the bio-psycho-social determinants of oral disease), we highlight the contributions made by Ayres (2002) as a counterpoint to the strong epidemiological focus of the current NOHP.

Looking at the topic in-depth, Ayres (2002) questions the contributions epidemiology can make to a positive concept of health. The theory is that the paradigm of risk places epidemiology in a paradoxical situation:

[...] none of the other bio-medical sciences has such methodological liberty to take health as a positive object of knowledge as epidemiology and, at the same time, few have such restricted epistemological possibilities of validating this knowledge (Ayres, 2002, p.29).

The relevance of epidemiological indices as benchmarks of technological arrangements for health care in formatting the models of care, occupy an ideal for collective actions that, in a sense, come to support and organize much of its practice, even clinical practice.

Through the concept of vulnerability Ayres (2002), has sought to promote dialogue between epidemiology and other disciplines, so that epidemiology and health promotion can effectively dialogue. In describing discourse of risk with its high degree of formalization, the author points out that in this approach to promoting health or even care models, what matters is not what escaped the risk, but that which somehow does not concern it, was not among the requirements / regulatory, propositional or expressive conditions that complied to it and may have an effect on health.

Despite the clear proposal to change the model of oral healthcare that the NOHP brings, what we see today is the maintenance of models of practice focused on organizational strategies already overcome, still very grounded in techno-biologist knowledge, even in the guise of health promotion that has been much more within the field of preventing diseases and health problems (especially those related to tooth decay) than health promotion.

We return to talk about the nodes that connect oral health practice to the old models.

By emphasizing that the technological organization for oral health care in the day-to-day work of the health care services remains centered around models based on bio-medical patterns, dependent on hard or light-hard technology, strongly guided

by etiopathogenic knowledge of tooth decay, we perceive the so-called controllist practice of collective activities (such as supervised brushing and educational talks), justified in this operational mode as Health Promotion which, in our view, is strongly associated with action to prevent disease.

Another point underlined in several studies (Santos et al., 2007; Pezzato, 2009; Soares et al., 2011) as critical for new oral health practices is professional training that remains centered on the mercantile, specialist “doing”, little directed towards an imperatively technical (in the sense of techno-science) dentistry. Training that has not considered solidarity or the human dimension of health care practice, nor discussed the subjective involvement of the professional in the live production of health care.

The anticipated reorganization of oral health care has perhaps refined and expanded the way of doing things and knowledge in dentistry by seeking its field of action in addressing family / community, but it is still in search of the teeth, the caries, the injury that this practice is based.

The regularity that we found when working with oral health policies, both at the federal and municipal level throughout the 1980s, 1990s and 2000s has been to produce health care to control the most prevalent diseases, both for the individual and collective approach, in order to meet oral health needs through the epidemiology bias (reducing morbidity) (Botazzo et al., 2008).

By approaching dentistry as biopolitics, we must emphasize what dental work and work in oral health consists of, as for dentistry, the instruments and techniques (as in the academic training and also in graduate school) are the means of achieving the health product - a restoration, a dental crown, a denture ... - are the source and the object of operating knowledge.

The health problem that is before the dentist directs the gaze, and the neurological connections, towards the technological arsenal with which they could respond to the person requesting their talent and refined technique. This seemed to us to one of the nodes in the organizational model of oral health care model, as the problem and working in oral health originates in another dimension (the collective) than dentistry. From oral health, other actors such

as ancillary staff and the figure of the patient, i.e. user emerge.

The ideology of dentistry may be strongly tied to the nodes that link oral health practice to dental content, both in technique and in prescription.

By linking a way of thinking about health that is guided by such nuances, we can see it emerge from the conceptual confusion between prevention and health promotion that we mentioned a short time ago. It is the preventative ideology that has bound dentistry concepts of oral diseases (with great emphasis on caries) for decades and for which dogmas and approaches have been developed that appear to echo ad infinitum: situations that perpetuate themselves forever or without limit, or repeat themselves indefinitely. It has been this way for the new model of oral health care with provisions and recommendations for monitoring it.

We should point out the power relations that are established and would be reshaped within a new model, because the proposition of new forms of organizing health practices, also for oral health, tends to change the balance of power exercised in that practice and to transform the subjects' world views, supporting a change in power relations through the potential for realizing new collective practices driven by this new conception of the world (Giovanella, 1990).

In our view, our interpretation and reading of the NOHP does not find other possibilities for falling ill apart from diet, hygiene habits or epidemiological risk.

By understanding that a new model of oral health practice should aspire to comprehensive health care, we return to the discussion of technological organization, situating this guiding strand of policy as a possible way of reorganizing practice directed towards new relationships between the subjects. Where, then, would be the qualified listening to patients' suffering to go beyond diagnosing signs and symptoms, noticing the subjectivities produced in the condition of being ill?

The comprehensiveness proposed by the NOHP is that which aims to respond to a wider range of conditions than the user could possibly demand, but it still does not appear to have conceptual or even practical proximity to the quality of care, as in the

NOHP, comprehensiveness means better integration between the different levels of complexity, or as a response and technology for a wider cast of oral diseases. Likewise, comprehensive care has been treated as a chimera, as a bureaucratic organization of care is sought, with hierarchized flows in which the comprehensiveness of the current model of practice resides.

In the NOHP discourse, we did not perceive any other discussion on the possible approaches to oral health problems (gingivitis, periodontitis, xerostomia, halitosis, tooth loss, joint pain, dental crowding etc.) that was not: improved brushing, controlling cariogenic diet or correcting harmful habits. This undetailed type of comprehensiveness, little developed and with little depth is far from integral health care and, to a certain extent, contributes to concealing and covering a significant contingent of oral health diseases which we could easily call *neglected*.

In our view, should also affect work practices through new knowledge and practice which, in turn, require new cognitive and cultural patterns. New patterns that will rejoin knowledge and practice that have traditionally been understood and organized dichotomously, for example, Clinical *versus* Public Health, as Souza discusses in his 2004 publication.

As our discussion approaches the thesis by Fernandes (2007), we realize that by understanding our subjects' day-to-day experience, by identifying the limits and efforts made to be healthy in daily life, we can direct our thinking, putting ourselves in the position of human beings in the middle of a learning movement, sharing experiences and possibilities of constructions in outlining the limits of daily life. In this way, a relativist sensitivity may promote meetings with their singular and intense way of living, being alert to its diverse expressions may direct the work with a freedom of view, preserving the flexibility and imperfections of the singular way of living, approaching the multi-dimensionality of day-to-day life as a path to learning the meaning of the others way of life, their interactions, pleasures and dislikes, outlined by each individuals rhythm of life.

Health care practice cannot be limited to protocols or prescriptions but should be understood as a field of possibilities that may direct new ways of working and of caring for health, valuing the day-

-to-day life and other discourses. Understanding the day-to-day as a form of reflecting on various aspects concerning the rhythm and way of living, which may be limiting in the process of human life, but recovers the potential for outlining these limits, would lead to understanding health care as the premise for knowing how the people at whom the treatment project is aimed live, interact in their environment and look after themselves and others, identifying their difficulties and their efforts. In this way, we health care professionals can help them to act so as to meet their own needs and wants, recovering their strengths to meet their day-to-day limits.

We emphasize the relevance of what the daily lives of human beings signify, since the ways of living can indicate ways of caring, contributing to their being healthy, which manifest themselves in the body, in the soul and in the mouth. It is necessary to recognize and analyze the effects of dental practice on the body of the subject and take what is of value from dentistry - that of restoring lost dignity through restorative dental treatment, which can resolve cases of pain, dysfunction disharmonies, misfits - but it is not limited to these. We have to expand the search for care of oral health practices that take the mouth as a life affirming place (Souza, 2004).

To achieve this, other forms of connection and commitment should be prioritized. These depend on understanding the healthcare work process and using relational devices (reception, bonding) and instituting devices (autonomy, belonging, empowerment) with a view to treating health problems but primarily to overcoming the dichotomy (here lies the dentistry bias) between oral health and other elements associated with health care, realizing that oral health conditions are not determined by each subject, but are the sum of several factors (housing, sanitation, employment, access to health services, ways of living), that generate health conditions/disease.

Final considerations

Historically, Oral Health has been confused with Dentistry, as it is characterized by being centered around proceedings as Dentistry takes the mouth as a fragmented organ, destitute of a body and, by using

data as the basis for planning activities, prioritizes the epidemiology of the two most prevalent diseases - tooth decay and periodontal disease -, failing to consider other oral diseases, or even the subjectivity produced by the condition of falling ill, as a source of information for organizing clinical care.

We emphasize that the mold of a task force, oral health activities, seated in the motto of health surveillance and irrigated by epidemiological information, return to eradicating dental caries in relapsing form, over the years and health policies, reinforcing our interpretation that epidemiological basis and bio-medical technology again, or permanently, acquire the concreteness that supports public oral health practice. Thus, the NOHP indicates and guides health actions focused on reducing rates of epidemiological diseases and proposes a technological model to achieve this, often with (epidemiological!) success, but in the possibilities for intervention, protection and social support that could build or consolidate individual autonomy, they do not explicitly emerge as practice or policy.

For NOHP guidelines to be effectively transformed into oral health practice and promote new technological arrangements in the labor process, other forms of bonding and commitment would need to be sovereign in the relationship between the subject actors. There is a clear need to improve training of professionals towards professional practice inconsonance with the basis of the Family Health Strategy and also to producing care, of Becoming, sensitive to the day-to-day of those for whom the therapeutic project is designed. We therefore emphasize that another possible node is the distance that the technician (dentist) produces in relation to his product. Of the health practices we have examined, the product is the recovery of damages using materials and techniques without the subject, neither the one who provides nor the one who receives the result/technical product, emerging as social and political subjects.

In addition, the primary issue of the bond that a reorganization of the care model assumes, must be worked from the perspective of subjectivity in dental clinical practice, often alienated by the essentially and historically programmatic bias of health policies. Subjectivity overlaps when it actually places

the subject of clinical action (the patient) at the center of the work.

The professional-patient relationship has shown that the bond is constructed at each meeting, each treatment negotiation, resulting in frank dialogue, in responsibilities being assumed and in resolving the complaints, as "... it is the understanding of health as a state of imbalance, socially and subjectively determined (...), of the reassigning of the mouth's social functions (...) that will establish another position" (Barros; Botazzo, 2011 p. 4347).

We understand that new approaches to care, directed toward the subject and not the disease, even if initially strange, end up producing some effects for a denaturalization of day-to-day oral health services in the SUS.

On the edges of utopia, if the health professional could get to know what is lacking for the other, what their life project is, what he has beyond what is imprinted in his mouth, x the therapeutic project might make more sense. Not that we want to take away all the credit of oral health in the SUS , constructing and with collective action of a social nature - such as the fluoridation of drinking water - but the proposed new looks and new discourse on the condition of being ill, on projects of life, health and the oral experiences of each patient, could be a transformation in health practices. This would be liberating for both patient and health professional, as it would make room for other professional, personal and institutional projects.

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Authors' contributions

Pires edited the article based on the doctoral thesis *Organização tecnológica do trabalho em saúde bucal no SUS: uma arqueologia da política nacional de saúde bucal* on which the article is based. Botazzo directed the thesis and participated in editing and revising the article.

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