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CRITICAL REVIEW

Oral Health: Work Process and Interdisciplinarity

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ABSTRACT

Objective: To contribute to the debate about tools that favor the organization of the health work process and its interface with interdisciplinary practices. **Material and Methods:** We opted for a textual construction based on more specific publications on the field of oral health care. **Results:** The matrix support is configured as a method of inter-professional activity in co-management that aims to favor the qualification of the health care network. From this perspective, it is an interdisciplinary practice capable of integrating two or more areas of knowledge for a better performance of the actors involved in a given organizational and decision-making process, whether in the clinical or health management scope. **Conclusion:** Matrix support is an essential tool for the practice of managing health services and amplifying interdisciplinary actions.

Keywords: Health Services; Oral Health; Patient Care Team.

Introduction

The aim of this text is to point out the need to consider the structuring of oral health care from a collective perspective, structuring itself with weaknesses and potentialities in an interdisciplinary work process through matrix support.

In the 20th century, Brazil underwent major changes in its demographic and epidemiological profile. In 1950, approximately 64% of the population lived in rural areas and 50 years later, in 2000, this percentage was reduced to 19%. The work habitat also underwent changes; before, the greatest concentration of workers was in the countryside, later it became a closed environment, the large industries. These changes led to a large disorderly growth of cities, thus creating a new scenario for health practices. However, this growth of cities did not necessarily imply an improvement in the population's living conditions. A significant portion of society lives in poverty, which is characterized as the main risk factor and vulnerability to situations of health carelessness [1].

The 1980s and 1990s were characterized as a period of significant change in the way of conceiving and organizing health services in Brazil; however, some strategic areas need faster development to strengthen the qualification process of the health care system, adapting to the provisions of the Brazilian Constitution and Federal Laws No. 8080/90 and No. 8142/90, as the guarantee of universal access to all health technologies in their entirety. Advances are needed in health information and informatics, planning, monitoring, control, and evaluation, with the production of management technologies compatible with the rationality that underlies the structure being implemented, the Unified Health System [2].

Considering the positive and negative aspects of this urbanization, the author Eugênio Vilaça, in his book "The Health Care Networks", reveals the negative effect on the process of worsening chronic conditions of the effective marketing strategies of products harmful to health, especially those from the cigarette, alcohol and industrialized food industries. This movement ends up putting pressure on health services, suffocating them, especially poor populations living on the outskirts of large urban centers. A positive aspect was the social tension for the state to start developing public policies to face this reality. SUS is also a product of this social tension [3].

The Brazilian Unified Health System (SUS) aims to provide more democratic access to health actions and services; this system is guided by the principles of integrality, universality, and equity [4]. In the context of oral health, SUS brought to Brazilian Dentistry the challenge of reformulating its practices so that the SUS principles are ensured.

Despite the important changes that took place in the last three decades of the 20th century, until 1998, 12.5% of the urban population and 32% of the rural population had never received any type of dental treatment. However, the fact that other users had already gone to the dentist, does not mean that they were met in their health needs [5].

Oral diseases are a public health problem on a worldwide scale, impacting people's health and quality of life, with children, the elderly, and groups living in poverty being the most affected, which is a challenge to be faced [6].

In 2004, the National Oral Health Policy (PNSB) was launched, the starting point of an extensive process of debates and construction of strategies that proposed a reorientation of the care model, supported by an adaptation of the work system of Oral Health Teams (ESB) to encompass health promotion and protection actions. ESB, together with other sectors of society, must participate in the construction of health awareness in a political and social movement that transcends the technical dimension of Dentistry to rationally expand access

to comprehensive oral health care, where the lines of care (child, adolescent, adult and elderly) have flows centered on reception, information, care, and safe referral so that they result in resolute actions [2,7].

The priority actions within the organization of the oral health services network, based on PNSB, were the expansion of ESB in the Family Health Strategy (ESF), which evolved from 4,271 (ESB) in 2002 to approximately 27,283 (ESB) until August 2019; creation of the secondary network of specialized care through Dental Specialty Centers (CEO) and Regional Dental Prosthesis Laboratories (LRPD), which together total 2,803, of which 1,033 are CEOs in all regions of the country in 2019 [8].

Despite these numbers, it is worth mentioning that the coverage of oral health teams in primary care is only 53% when considering DSCs, which represents a proportion of one DSC for every 217,596 inhabitants, with a higher concentration in the Northeastern and Southeastern regions. Therefore, it is necessary to expand all these services [9].

About 12% of the population has an exclusively dental private plan, with an increase from 2.6 million in 2000 to 24.3 million in 2018 in the number of users, and there is coexistence between the public and private systems in terms of their regulation and tax subsidies that favor the private sector [10].

About the Network and Care

Having a set of services quantitatively implemented does not mean having a consolidated care network:

> "*The organization and structuring of new care models demand challenges in several dimensions of health systems. Among these, the need to reorder health work processes stands out, which increasingly requires the articulation of various knowledge and professions in the face of complex contemporary health problems*" [11].

This movement can take place from the organization of local systems into Lines of Care, in this case, the Line of Care in Oral Health (LCSB), which must be supported by an oral health care network, being essential to articulate actions and services from the perspective of acting based on the health needs of the population, as the line of care presupposes products, clients and quality of care, being fed by resources/inputs that express the technologies to be consumed during the user assistance process, functioning in a systemic form and operating several services in an articulated way. A lively work process is conducted by management for the care of its users [12-15].

For the pursuit of health promotion, prevention, and control of oral diseases, based on a management model articulated with other governmental areas and civil society, an Oral Health Care Network must be structured to allow users greater quality, efficiency, and effectiveness of public dental services. Changing the concept of health care, done in a punctual and isolated way, to that of health care in which the "caregiver" sense is strengthened is necessary and urgent.

Matrix Support, Training, and Interdisciplinarity

Interdisciplinarity is the ability to integrate two or more areas of knowledge for a better performance of those involved. As human knowledge through the traditional model makes its fragmentation increasingly visible, it is necessary to take advantage of the different dimensions and possibilities when including this multidisciplinary strategy in health care since health care encompasses the individual and his/her integrality regarding the health-disease process [16].

Concerning interdisciplinary practices, an important element for health care management, it is noteworthy that this is a methodology for work management and organizational arrangement. As a working method, it is a set of concepts about how to develop inter-professional work in co-management and in a shared way. As an organizational arrangement, it is characterized as a structural place based on which the support function is performed [17,18].

In the international scenario, the discussion is centered on the exchange of knowledge among professionals and on shared care, especially in the care of chronic diseases, as observed in experiences from Canada [19] and the United Kingdom [20]. An analysis showed that the counterparts in the international literature for interprofessional work correspond to collaborative care and shared care. Although evidence is still limited, the main factors that enhance collaborative care in other countries are communication between professionals, the existence of agile information technologies, and the organizational structure of the health system [17,18].

It is noteworthy that a work process with collectively planned actions favors the implementation of a health care model coherent with the population's health situation, basing it on principles of sharing knowledge, establishing a link between the various actors in the health network and surveillance, in addition to the search for the comprehensiveness of health actions [21].

However, we are faced with the paradigm of health care as a caring perspective, but limited by the daily conflicts of alienated and technocratic practices, being neglected in several managerial scopes. The lack of communication among healthcare professionals is an obstacle to the care of the population's health. The turnover of professionals, often produced by the absence of job and career plans, poor working conditions, and low wages, also favors health carelessness, as it disrupts the bonding relationships between them and users, which is a fundamental aspect of healthcare production, in addition to favoring the poor distribution of professionals, concentrating them in large urban centers. A study that compared oral health in Brazil and the United Kingdom revealed that, in these two universal health systems, newly trained professionals tend to consider the public sector as a temporary job to gain experience before working in the private sector, also being a factor of high turnover and reflection of low empathy with health care [22,23].

Interdisciplinarity manages to establish an exchange of knowledge among professionals to better establish a relationship between the health-disease process of the population in a given location [16]. In the context of the management of secondary oral health services, it is important to emphasize that it is difficult to have full-time professionals to monitor and develop support practices in health services. The study by Lucena et al. [24], who evaluated conditions associated with the planning activity in CEOs throughout Brazil and who also identified the manager profile, showed that 50% of services were managed by managers who also accumulated clinical activity. This same study showed that of all CEOs in the country that were evaluated by the National Program for Improving Access and Quality of Dental Specialty Centers (PMAQ-CEO), only 33.3% of managers had additional training in collective health or public management.

This scenario makes us reflect on the importance of the need to qualify healthcare management processes with training focused on service management. The management of oral health services cannot be a functional palliative for the dentist. Therefore, matrix support as a tool for the re-signification of interdisciplinary practices in the health care scope can be present and strong in the scope of management as a structural arrangement to break with the weaknesses of traditional health training strongly focused on clinical activity. Such weaknesses may suggest implications for work within the scope of ESB care in primary care since this tool

aims to expand interventions towards the expanded clinic, overcome the logic of referrals that fragments care, and enhance integration between different specialties and professions [17,18].

The establishment of methods to facilitate this flow is essential to provide comprehensive care; however, in all health areas, the methods used remain insufficient, especially at the municipal level [25]. A study evaluated the referral flow of users who access services provided by Dental Specialty Centers (CEO) implemented in medium-sized cities in the Southeastern region of Brazil and found that there are weaknesses in referrals in the form filling incompleteness regarding legibility. The authors suggest that the adoption of standardized medical records prepared to simplify form filling is of great importance for the improvement of communication between the different levels of care. Matrix support becomes a favorable tool for this need [26].

Another study that sought to identify the challenges for Matrix Support with NASF, from the point of view of health workers, identified a set of obstacles regarding the implementation of the matrix support, ranging from the scarcity of professionals with favorable training areas (consider that is a new activity within the scope of SUS) to the work precariousness, which increases the turnover of actors in the service network. However, the authors point out that such obstacles can be essentially recognized as of a political nature and that their overcoming depends on the valorization of health workers and the resumption of the Health Reform principles [27].

This isolated training of health professionals and little articulated with the principles of SUS must necessarily be rethought; as it does not include the Matrix Support guidelines, it is insufficient for professionals to act as managers who exercise supportive practices and does not emphasize the importance of democratizing interprofessional relationships through the institution of co-management spaces [28,29].

Health education in Brazil still adopts a disciplinary teaching model, with biological sciences as the main source of knowledge. At best, it trains competent technicians, but it rarely commits to public policies and social changes necessary to promote adequate health conditions [30].

It is essential to connect the in-service training policy with the Matrix Support guidelines, in addition to rethinking academic training itself. Some studies have pointed out that this practice is still incipient or, in many cases, not even adopted, which impairs and demobilizes changes in the work process, allowing the coexistence of care and co-responsibility fragmentation [31-33].

Concluding Remarks

Matrix support is an essential tool for the practice of managing health services and amplifying interdisciplinary actions. In the case of this study, with emphasis on the field of collective oral health, the idea was to contribute to the possibilities of qualifying the work process in a solidary and communicative way in the search to broaden the view and the desire to expand the population's access to services and improve their quality. However, the matrix support in health services must be carried out in a systematic way, with a view to favoring the establishment of oral health care networks.

Factors linked to the profile of oral health professionals and service managers need to be a field of investigation and critical analysis as a way to build institutional possibilities both in the field of academic training and in the scope of management, with interdisciplinarity being a cross-sectional guideline that can be cause and consequence for a work process capable of providing care for the entire population.

Finally, it should be emphasized that matrix support, as a possibility of qualifying the collective oral health care work process, is a management innovation of paramount importance since it promotes a reorganization of health services through new organizational arrangements, which can become a good possibility

for reflection on this tool since in the scope of oral health, there are still few studies that deal with matrix support practices by health workers. This gap indicates the need for broader and more analytical research efforts.

Authors' Contributions

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RPTV	https://orcid.org/0000-0002-5358-1967	Writing - Original Draft.
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DGS	https://orcid.org/0000-0002-7605-9530	Writing - Original Draft.

All authors declare that they contributed to critical review of intellectual content and approval of the final version to be published.

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Conflict of Interest

The authors declare no conflicts of interest.

Data Availability

The data used to support the findings of this study can be made available upon request to the corresponding author.

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