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ORIGINAL ARTICLE

CARE IN THE ORAL HEALTH CARE COMPLEX: WHAT DO THE PRACTICES REVEAL?

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ABSTRACT

Objective: analyzing the care practices of dental professionals in the Oral Health Care Network in the State of Paraná, Brazil. **Methodology:** this is a descriptive-exploratory study of a qualitative approach conducted with dentists in a health region. Data were collected in March and April 2019 through semi-structured interviews and submitted to discourse analysis. **Results:** it is emphasized that the organization of primary care through the Family Health Strategy (FHS), the qualification of queues, and the definition of the reference and counter-referral flow were fundamental for strengthening more integral care practices. However, the hegemony of curative practices and the repressed demand of the dental specialty center are limiting situations. **Final considerations:** even after undeniable advances with the insertion of oral health teams in the FHS and the National Oral Health Policy, this area is still permeated by uncertainties and sidelined by the organization of services from a network perspective, away from what is expected for effective comprehensive care. Therefore, thinking about care changes that promote the production of comprehensive care practices that overcome the curative perspective is still a challenge in dentistry.

Keywords: Dental Care. Health Knowledge, Attitudes and Practice. Health Integrality. Access to Health Services.

INTRODUCTION

Regarding oral health, Brazil is one of the few countries that offers universal access to actions related to this area. In several European countries, for example, despite the high prevalence of oral diseases, the coverage of public health systems is still low; it is up to the population to bear the costs and leaving those who are unable to afford their treatments by the private sector under conditions of vulnerability[1]. This reality has motivated efforts by several European countries to achieve the goal proposed by the global report on the state of oral health of the UN, which proposes universal coverage by the year 2030[2].

In Brazil, oral health gained space in the agenda of priorities of the SUS from the National Oral Health Policy (NOHP) and with the expansion and qualification of oral health teams in the Family Health Strategy (FHS)[3]. This strategy aims to replace curative, exclusionary, technical and biological care models, which are still very present in European countries[1], including in countries that have universal systems and treat health as a right[4]. Through its guidelines, the NOHP directs ways to overcome, with quality, the fragmentation of the health system through the proposal of a progressive care network, and seeks the integration of the different points of the Oral Health Care Network (OHCN), principles of care and integrality[3].

The model of care with conformation of oral health care networks proposes to ensure the change of hegemonic practices from the surgical-restorative model to a model that acts in an integral perspective of care. The OHCN, ordered by the principles of regionalization and hierarchization, requires the implementation and integration of several points of attention, which ensure access to different levels of complexity, and is considered a condition for raising oral health care to the level of comprehensive care[3].

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However, recent research points out that the fact that this network, at the federal level, has not been placed as one of the priority networks, but with a transversal insertion, makes it invisible to the specific demands of the area[5].

In the State of Paraná, OHCN was designated as the sixth priority network and as a public policy for the state in 2014, understanding that the model of organization of care in a fragmented way, which was in force at the time, was outmoded[6]. This model recommends that patients treated in primary health care (PHC) by the Oral Health Teams (OHT) of primary care who need specialized care have as reference the Dental Specialty Centers (DSC)[3].

The OHCN, as already mentioned, is structured to offer oral health care with a view to comprehensiveness[6]. Regarding comprehensiveness, this study adopts the conception that this constitutes characteristics that can be considered desirable in the health system, related to professionals and their practices, the organization of policies and their institutions. In this sense, the meanings of comprehensiveness of care are emphasized from three perspectives: professional practice, organization of services and constitution of policies[7].

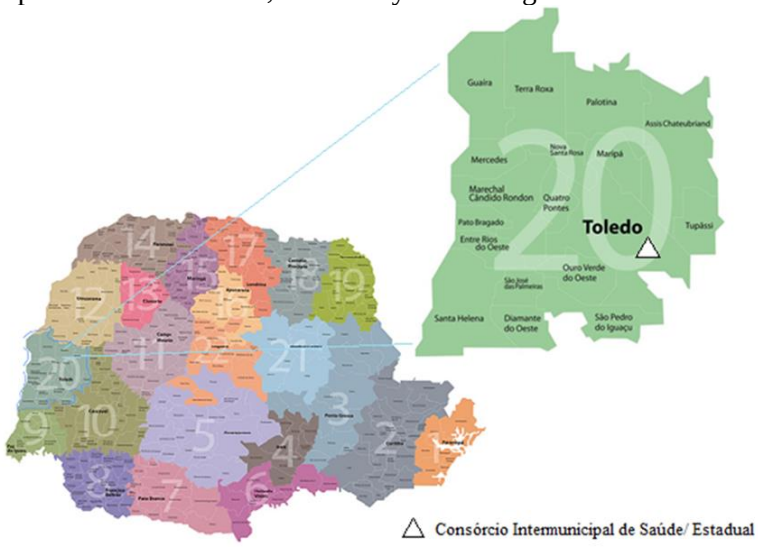
That is, despite the fact that, from the point of view of the constitution of policies, Brazil has universal coverage for oral health[1] and the state of Paraná insert the OHCN as a priority network[6], still the professional practices, focus of the present study, may also interfere with the comprehensiveness of the network[7]. Effective care coordination needs to incorporate the perspectives of health profesionals in the conduction of the system, and to promote the intertwining of connections between the actors of the primary and specialized care teams[8].

The lack of professional technical quality in the provision of care, the inefficient use of existing resources, services with traces of fragmentation and the mismatch between the supply and the needs of the population produce obstacles to the functionality of the network. That said, it becomes relevant to carry out studies that identify, through a critical analysis, gaps, challenges and opportunities for improvement of professional practice as a fundamental element for the construction of a network that aims to promote integral care. Therefore, the objective of this study is to analyze the care practices of dental professionals in the Oral Health Care Network in the State of Paraná, Brazil.

METHODOLOGY

This is a descriptive-exploratory study with a qualitative approach, conducted in the 20th Regional of Health of the State of Paraná, Brazil. In this health region, the Center for Dental Specialties (CDS) is implemented in the city of Toledo, linked to the intermunicipal health consortium, as illustrated in Figure 1. This is a reference for specialized dental care for the primary care (PC) teams of the 18 municipalities and a population base of 398,323 inhabitants. All municipalities provide actions and oral health services in primary care, and outline a minimum of integration between the other levels of care.

Figure 1. Political Map of the State of Paraná, Division by Macro-Regions.



For the analysis, 14 dental surgeons were interviewed, nine of them working in the PHC and five in the CDS. The PHC professionals were selected from those municipalities indicated by the Section of Primary Health Care (SPHC) of the 20th RS, being inserted in the process of tutoring qualification of primary health care, implemented by the State Health Department (SHD) in 2014. According to SHD, these municipalities have satisfactory compliance with oral health items related to risk stratification, improved access and continuous development of planning, negotiation and contracting actions, among other actions listed in SHS Resolution N 741/2018.

In the CDS, five randomly selected dentists were interviewed, one professional per dental specialty offered (dental prosthesis, endodontic, bucomaxilofacial surgery, periodontics and special patients).

Data were obtained from March and April 2019 by the main researcher, dentist-surgeon linked to the health consortium, through recorded interviews, previously scheduled via telephone contact, and performed in the workplace of professionals and had an average of 30 minutes of duration. The interviews were guided by a semi-structured script physically appropriate and used by the researcher, containing questions related to oral health care practices and the organization of services in the OHCN. These were transcribed in full and submitted to discourse analysis, and subsequently the audios were deleted.

The interviews were analyzed according to ideographic technique - individual and nomotetic – general[9]. First ideographic analysis was performed by floating reading of discourses and then units of meaning (UM) were selected, words or phrases that have meaning in the perspective of the phenomenon studied. Then, we performed the interpretation of the UM and the convergence of the UM within the speech of each interviewee. Finally, the nomotetic analysis was performed, re-reading the UM and identifying the convergences and divergences present enabling the construction of the categories of analysis. The meanings obtained through the units of meaning identified in order to interpret oral health care practices were analyzed.

In the coding process, dental surgeons were assigned the initial DS. The PHC professionals received the numerical sequence from 1 to 9 (DS1 to DS9), and the CDS from 10 to 14 (DS10 to DS14), according to the order of the interviews.

The ethical aspects were strictly obeyed according to Resolution 466/12 that regulates research involving human beings. The project was submitted and approved by the Research Ethics Committee of the institution in which the researchers are linked, with opinion number 3.120.681/2019 and CAAE 04165518.2.0000.5231.

RESULTS

The study participants were 14 dental surgeons working at points of oral health care of the single health system, at the levels of primary and specialized care. Among the nine PHC professionals, seven are female and among them, six have specialization in family health. Among the CDS professionals, four female and all have expertise in their areas of expertise (dental prosthesis, endodontics, bucomaxilofacial surgery, periodontics and special patients). The age group of professionals is concentrated from 30 to 49, with different times of performance in the points of attention, ranging from 1 to 12 years of operation.

From the analysis process, subcategories articulated to the category of oral health care emerged, more precise and more specific in relation to the research object, which will be described below.

Care practices in PHC and CDS

In the scope of care practices in the PHC, knowledge of the attribution of each level of care of the OHCN and the qualification of queues for referral to the CDS were essential to enable comprehensive care.

It is noted in the speeches of the professionals of the PHC that they recognize their role as a level of ordering assistance.

> The team provides primary care and what needs to be referred; we refer to the CDS, and inform them that they can return to PHC as often as necessary. (SD1)

In general, the teams of PC act in the triage motivating the referral to specialized attention, and maintaining control over the users who are referenced and against referenced by the CDS.

> We can follow this patient every 6 months, and I can schedule a return, so there are patients who are already back in the office just for a review and he does not have a new problem. (SD6)

Some efficient strategies such as qualification of the queue prior to referral to the CDS also contribute to comprehensive care. This process consists in the identification of users, so that the one that most needs is attended more quickly, and that those who do not have clinical indication for the performance of specialized procedure are removed from this queue, or referred to the correct specialty. This favors timely treatment and optimization of the reference, reducing inappropriate demand at specialized levels and also contributing to an equitable care.

Successful experiences have been recorded in the prioritization of patient care against referrals by the CDS for the completion of treatment in a timely manner, favoring the process of maintaining the longitudinality of care.

> The patient comes back with the counter-reference, came from the endododonty, so we fit as an urgency, I do not leave 2, 3 months in the queue, to drop the dressing and contaminate the tooth. (SD8)

> The organization of services and the challenges imposed on care practices

On the other hand, professionals report the main challenges faced daily in PHC for the promotion of comprehensive care. We highlight the difficulty in promoting changes in the work process, which occurs, in part, due to the insufficient number of professionals, the low qualification and the overload of functions in this level of care.

> Going out to do prevention is very difficult, we are "drying ice", and it is a lot of demand for so little time. (SD3)

> So we spent a long time with few professionals, stopped prevention activities, education in school, everything was stopped. Now we are having this function of healing what was not prevented, and still trying to prevent what gives, and this reflects in the queues. (SD1)

In addition, there is recognition of technical limitations and insecurity in attending some cases and performing dental procedures in the PHC, especially in more complex patients.

> "The special patient of poly pharmacy with various diseases, sometimes we end up doing the procedures, but with fear, with insecurity". (SD2)

The structure of the unit and the limited availability of materials and inputs appropriate to the work of the dentist also compromise the services.

> "Because we see that many municipalities do not have much instrumental, has no material, this makes things a bit arduous. The dentist, suddenly, does not want to risk, and does not have the support there in the municipality if something happens". (SD10)

In addition, the teams also report that they constantly face tensions between spontaneous and scheduled demand. The latter is succumbed under the pressure of demand for immediate care, and this does not correspond to the ideal of completeness.

PC professionals are constantly reported to feel:

> “[...] drowned in the curative part (SD3)

> "The actions are imposed by spontaneous demand, because the population that seeks the services is still for curative procedures". (SD1)

On the other hand, it is observed that the model of organization of PC through family health and oral health teams is a characteristic that changes the work process of professionals, making the care more integral, as highlighted in the report:

> Our reality is different from the reality of other municipalities, which I see in the meetings that they complain a lot. For each office we have an oral health technician. And actually, I don’t have a lot of repressed demand. (SD6)

The implementation of oral health teams organized through the FHS also contributes to the reversal of the perspective of curative dentistry for collective dentistry in the municipalities studied. And, although with limitations, due to the low coverage, it has offered a more comprehensive service.

> "In the units of the strategy they have a more

> defined population, they can work more, and they can have this different view of the patient, a greater view of the human being". (SD9)

However, the conduct of each dentist is also influenced by the academic training of these professionals.

> "My vision is an older school, and nowadays you will talk to the dental student, it's all different, professionals no longer have the same patience for collective actions". (SD6)

In the context of care practices in the CDS, the reference and counter-referral instruments are well defined, the care directed also to the families of users and the search for efficiency and problem resolution indicate practices that approach comprehensiveness.

Care at the CDS is closely related to the care provided at the PHC, and well-defined reference and counter-reference instruments enable the integration of services.

> I am here every day, I see that the patient is referred from the PHC, we do what we have to do {in the CDS}, then we return to the PHC for them to finish the treatment, or refer to other specialties. I think it {counter-reference} happens in practice. (SD11)

> It is very valid when the patient comes, when he brings the counter-referral we know what was done, what happened, what he was really guided. (SD2)

This study identified an organized counter-reference system. Individuals who attended PC were referred to specialized services, and later were against referral to PC after performing specialized procedures.

The CDS's professionals also identified that the counter-reference instrument is important to direct PC's performance.

> "When you send the counter-reference with the guidelines for cleaning, taking care of the patient, guiding the patient, it works". (SD13) And in a way, specialized care professionals report being "assuming some responsibilities that are of primary care". (SD10)

Specialized care also reports offering oral health care to users and families:

> I do orientation for the mothers of special patients, because often the family also ends up being a special family, in fact they are a special family. Many of them are illiterate, are people who cannot understand what the child has, so I always guide brushing, I teach how to do [...]. And in this particular case, I'm going to send a letter to the social worker, and to the school, so they can follow him, and he's going to have to come here every 4 months. (SD12)

Finally, the search for efficiency and resolution appears constantly in the speeches of the CDS's professionals, because

> "It has to be solved, it is in the hands of the specialist, it is our role, the resolution" (SD14)

> "What we can supply here we always try to be efficient". (SD10)

So that there is a flow also within the CDS between the specialties, this is important,

> "Because it's not just our specialty, we have to see the patient as a whole, and I think this works well here". (SD11)

Other related factors, such as the repressed demand of the CDS, also compromise the integrality of oral health care.

> We find several patients with the indication for more than a year, so a problem that was small, may have become something bigger, so if I need a complementary examination, it comes after 4/5 months, if it was an urgent thing, the care is lost. (SD14)

The largest repressed demand has been reported mainly in the specialties of dental prosthesis, endodontics and pediatric dentistry. The first has the largest repressed demand, with a waiting time of approximately three years.

> "Our list is made up of a thousand or so prosthetic patients; we are calling the patient of 2016". (SD9)

Another aspect that increases the repressed demand according to the participants is the fact that some users

> "[...] before they only went to private practice, now they use the SUS network". (SD6)

The achievement of access to such services for the population is extremely important, as it enables the continuity of dental treatments.

> "The CDS is considered an important complement to follow up on treatment, and without him specialized care would not happen, and would increase extractions, and tooth loss". (SD2)

DISCUSSION

Brazil is the only country in the world to propose a universal health system with the aim of ensuring care at all levels of health care. The NOHP provided a significant increase in jobs in the network of dental services and the insertion of the oral health team, even if late, in all the activities and actions of the FHS, constituted an undeniable advance10. In comparison, European countries, for example, have low coverage of public systems, leaving a portion of the population without financial resources to pay for treatments in the private sector, under conditions of great vulnerability[1].

In this model, PC professionals must act in the ordering of the oral health care network, in the coordination of health care, in the accountability of users and in the creation of a bond with the community, motivating referral[6,11], and favoring the shared care provided in the expanded clinic[12]. Thus, the fragmentation present in care should be deconstructed, so that health professionals can act from the perspective of integral care[4,10,13,14].

However, there are reports of difficulties on the part of PC professionals in performing all activities relevant to them, such as home visits, prevention actions and health promotion. For a long time, the established priority for dental care was marked by needs considered more urgent, actions of a curative nature[15], restricted to basic outpatient clinical care with care actions centered on the disease and on the user's momentary complain[16], in the production of procedures aimed at meeting productivity points[4,14] to the detriment of preventive activities and collective actions[6,8,10,12,13].

Ensuring the largest number of professionals, among other aspects, may represent more access to the service and contribute to overcoming this reality, in addition to avoiding excess demand and a drop in the quality of the services rendered[10,16]. It is also important to have adequate structure and materials and inputs essential to the work of dentists[13]. Recent studies show that the lack of material resources, dental supplies, and inadequate infrastructure constitute a weakness in oral health work, sometimes taxing oral health as costly and difficult to maintenance[4].

The lack of a PC team or one that does not fulfill its role effectively, either by the insufficient number of professionals, the difficulty of operating the various actions, or the high number of demands, impairs the coordination of care by basic care[8]. The absence of timely care appears in long queues and late references. These difficulties reflect dependence and increased repressed demand for the specialty, sometimes generating inappropriate demand[18].

One of the meanings of comprehensiveness is based on the need to combat fragmented and reductionist practices of exclusively biological dimensions, to the detriment of psychological and social considerations[7]. The production of care should be seen in a systemic and integrated way, with direction brought in the expanded concept of health and health promotion[4]. We start from the care as an attitude of zeal, care, responsibility and affective involvement towards the other, in the accomplishment of health actions aiming at the relief of a suffering or at the reach of a good be always mediated by knowledge specifically focused on this finality[14], which begin with the organization of the work process in the basic network, adding to actions at other levels of care[3]. However, such placements become challenging considering that the practices of oral health professionals, historically, are based on individual, curative and fragmented clinical care[10,13].

The reproduction of the hospital-centered model in general is linked to the profile of university education of the professional, considered traditional, segmented, uncritical and poorly reflexive[15]. There is an eminent need to qualify human resources in collective oral health guided by the professional training processes for SUS[4]. For it is essential to overcome the effects of teaching dentistry, still curative and individualistic, which is not guided by the epidemiological, social, cultural and economic situation of the population[19].

Pioneering work carried out in Brazil addressed the influence of professional training in the work processes developed OHT, and found that the predominant model of oral health care in the country are OHT (81%) and that, despite only 34% (4,272) of professionals with training in family health, there was a significant

association between this training and better performance in work processes more appropriate to the SUS premises of access, teamwork, comprehensiveness and longitudinality[19].

In addition, the organization of the network from a resolutive and expanded PC can contribute to reducing the demand for specialized services. Otherwise, it may contribute to the transformation of PHC's spontaneous demand in demand referenced to specialized care services[3]. In fact, some studies indicate a large proportion of typical PC procedures being performed in the CDS[17].

The effective functioning of CDS also depends on an appropriate PC/CDS interface. This interface is very dependent on the agreement of flow of references and counter-references and the organization of the care network[8,11,12,16,20]. Thus, authors argue that OHCN has all the elements to constitute a priority network, with points of attention and logistical support and diagnosis. Thus, it is necessary to situate the oral health management space beyond primary care in order to strengthen the network. Integrating PC into other levels of care is still a challenge for the Brazilian health system in shaping health care networks[3,8].

Therefore, by identifying users who were referred to specialized services and later against referred to PC at the end of the visits, it is confirmed what determines the structuring of OHCN[8,20]. Comprehensiveness in oral health can be verified in the report of completion by the user of basic dental treatment before or concomitant to specialized treatment. These patients are more successful in continuing the process of oral health care[18]. On the other hand, studies elect the deficiency of first contact access as an aggravating factor in longitudinality, since accessibility is fundamental in the regular provision of services[16,21]. In addition, failure to prioritize returns and completed treatments results in low resolution of oral problems, since there is no follow-up of cases or the formation of links between professionals and users[22].

In the medium complexity dimension of care, the implementation of CDS can be a relevant strategy for the organization of services and practices of integrality in dentistry[17,20]. When a professional, in front of a patient, whether in primary or specialized care, takes the opportunity to assess risk factors for diseases other than those involved in concrete suffering, and seeks to understand the set of needs for actions and services that he presents, would be the greatest mark of one of the senses of integrality[7].

However, a study carried out in the Brazilian capitals highlights a reality of coverage of CDS that is lower than expected. These factors in practice have a high waiting time to consult and/or reschedule returns. The expansion of oral health actions in PC increased the demand for specialized treatment, and CDS are not able to absorb it contentious[12]. Dental prosthesis and endodontics appear as a greater repressed demand in studies that evaluate the performance of CDS[18], which corroborates the result of this study.

It is observed that, in the early 2000s, there was a great leap in quality and quantity of service in the CDS. A study reveals a 4% increase in PC services and in specialized services, these percentages exceed 200% between 2001 and 2015; in the "access and coverage" block, it was possible to verify the increase in population coverage from 9% to 43% in Brazil[19]. Currently, the same pace of growth and reach is not observed for the population that does not have the resources to move to large cities for specialized service[12], also configuring itself as an access limiter[8].

And because it is a service of the secondary level of care, the CDS require a greater incorporation of equipment, inputs and dental materials, as well as professionals more specialized in certain oral health problems. These characteristics contribute to the resolution of specialized care[18].

The starting point for change is to assume the expanded concept and health promotion in the reorientation of the model with adherence to the FHS[4,14]. The potentialities evidenced in the studies were the insertion of OHT in the FHS, considered as a success, a gain for public health, since it facilitates the population's access to oral health actions and services[22]. In this direction, it is necessary that the NOHP becomes a state policy, in order to consolidate the model of health care based on the defense of life, social determinants, and that oral health is understood as a social right for the entire population, within

a universal, public and quality system[4].

However, restlessness is installed in the face of changes in the National Policy and Financing of Primary Care, which induces other arrangements of teams other than family health, which exempts state and, above all, municipal managers from developing oral health actions. It is therefore open to the possibility of a municipality organizing its public health system with great weaknesses in the field of oral health.

The study's limitations are the absence of the user's perspective on the oral health care network, as well as the interface with high complexity. Therefore, we suggest new studies that aim to analyze the care also on these perspectives, considering, above all, the changes in the organization and financing of PC.

FINAL CONSIDERATIONS

The oral health professionals of PC recognize their role in the coordination of care and as the ordering of OHCN, but report difficulties and challenges for the promotion of comprehensive care, and reversal of the persistent curative model in oral health practices, obstacle imposed by curative dentistry, still hegemonic. A situation historically based on the late insertion of oral health care in the FHS.

Professional practices and the organization of services can interfere in the integrality of a system, because services with traces of fragmentation generate difficulties in accessing health actions and timely care. Therefore, the initiatives indicated in this study, such as the articulation of oral health care through the FHS, the qualification of queues for adequate referral and counter-referral, are good strategies for improving care flows. These initiatives also reduce the demand for more complex curative procedures, and consequently the repressed demand for specialized care.

The medium complexity stands out for the search for efficiency and resolution, however, it presents great repressed demand, and suffers overload of referrals due to the fragility of the organization of PC, which also generates inappropriate demand at specialized levels.

Even with the undeniable advances achieved after the insertion of the oral health team in the FHS and the NOHP and in the current scenario, oral health is still permeated by uncertainties and sidelined in discussions regarding the organization of services in the network perspective. Therefore, thinking about care changes so that comprehensive care practices are produced, not only focused on the curative perspective and strictly technical quality, is still a challenge in dentistry.

Finally, it is observed that there is a gap between the predicted and the reality in the various levels of care so that comprehensive oral health care is effective. It implies the need to review practices that can optimize vacancies and expand access, enabling the expansion of adequate care in a timely manner. It is also essential to defend the prioritization and strengthening of OHCN in municipal, state and national instances.

O CUIDADO NA REDE DE ATENÇÃO À SAÚDE BUCAL: O QUE AS PRÁTICAS REVELAM?

RESUMO

Objetivo: analisar as práticas de cuidado dos profissionais de odontologia na Rede de Atenção à Saúde Bucal no estado do Paraná, Brasil. **Metodologia:** trata-se de um estudo descritivo-exploratório, de abordagem qualitativa, realizado com cirurgiões-dentistas de uma região de saúde. Os dados foram coletados em março e abril de 2019, por meio de entrevistas semiestruturadas e submetidas à análise de discurso. **Resultados:** destaca-se que a organização da atenção básica por meio da Estratégia de Saúde da Família (ESF), a qualificação das filas, e a definição do fluxo de referência e contrarreferência foram fundamentais para o fortalecimento de práticas de cuidado mais integrais. No entanto, a hegemonia de práticas curativas e a demanda reprimida do centro de especialidades odontológicas são situações limitantes. **Considerações finais:** mesmo após inegáveis avanços com a inserção de equipes de saúde bucal na ESF e da Política Nacional de Saúde Bucal, esta área ainda é permeada de indefinições e posta à margem da organização dos serviços na perspectiva de rede, distanciando-se do previsto para um cuidado integral efetivo. Portanto, pensar mudanças assistenciais que promovam a produção de práticas de cuidado integrais que superem a perspectiva curativa ainda se constitui desafio na odontologia.

Palavras-chave: Assistência Odontológica; Conhecimentos, Atitudes e Prática em Saúde; Integralidade em Saúde; Acesso aos Serviços de Saúde.

EL CUIDADO EN LA RED DE ATENCIÓN A LA SALUD BUCAL: ¿QUÉ REVELAN LAS PRÁCTICAS?

RESUMEN

Objetivo: analizar las prácticas de cuidado de los profesionales de odontología en la Red de Atención a la Salud Bucal en el estado de Paraná, Brasil. **Metodología**: se trata de un estudio descriptivo-exploratorio, de abordaje cualitativo, realizado con cirujanos-dentistas de una región de salud. Los datos fueron recolectados en marzo y abril de 2019, por medio de entrevistas semiestructuradas y sometidos al análisis de discurso. **Resultados**: se destaca que la organización de la atención básica por medio de la Estrategia Salud de la Familia (ESF), la calificación de las filas, y la definición del flujo de referencia y contrarreferencia fueron fundamentales para el fortalecimiento de prácticas de cuidado más integrales. Sin embargo, la hegemonía de prácticas curativas y la demanda reprimida del centro de especialidades odontológicas son situaciones limitantes. **Consideraciones finales**: incluso después de innegables avances con la inserción de equipos de salud bucal en la ESF y de la Política Nacional de Salud Bucal, esta área aún es permeada de indefiniciones y aislada de la organización de los servicios en la perspectiva de red, alejándose de lo previsto para un cuidado integral efectivo. Por lo tanto, pensar cambios asistenciales que promuevan la producción de prácticas de cuidado integrales que superen la perspectiva curativa aún se constituye desafío en la odontología.

Palabras clave Atención Odontológica. Conocimientos. Actitudes y Práctica en Salud. Integralidad en Salud. Acceso a los Servicios de Salud.

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