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Analysis of coverage of family health and oral health teams in Parana's health macroregions

Análise da cobertura das equipes de saúde da família e saúde bucal nas macrorregiões de saúde paranaenses

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ABSTRACT
This study aimed to analyze the coverage of the number of Family Health (eSF) and Oral Health (eSB) teams in the Health Macroregions (MS) in the state of Paraná, between 2007 and 2022. This was a longitudinal ecological study, using secondary data from Datasus: eSF, eSF with Oral Health in Modality I (ESFSB MI), and eSF with Oral Health in Modality II (ESFSB MII). Descriptive analyses and Pearson's correlation were applied. MS East had the highest number of eSF and ESFSB MI and MII. When correlating the number of eSF with ESFSB MI and ESFSB MII, the North and Northwest MS showed a very strong positive and strong positive correlation (r=0.91 and r=0.85), respectively. Thus, a direct and proportional relationship was found between the number of eSB linked to the Family Health Strategy in the MS in the state of Paraná, helping managers, workers, and researchers in planning and evaluation of public policies aimed at oral health in the Brazilian Unified Health System.

Keywords: Dentistry. National Health Strategies. Unified Health System.

RESUMO
O objetivo deste estudo é analisar a cobertura do número de equipes de Saúde da Família (eSF) e Saúde Bucal (eSB) nas Macrorregiões de Saúde (MS) do Paraná, entre 2007 e 2022. Trata-se de um estudo ecológico longitudinal, utilizando dados secundários do Datasus: eSF, eSF com Saúde Bucal modalidade I (ESFSB MI) e eSF com Saúde Bucal modalidade II (ESFSB MII). Foram realizadas análises descritivas e correlação de Pearson. A MS leste apresentou o maior número de eSF e ESFSB MI e MII. Ao correlacionar as variáveis número de eSF com ESFSB MI e ESFSB MII, as MS norte e noroeste apresentaram correlação positiva muito forte e positiva forte (r=0,91 e r=0,85), respectivamente. Assim, evidenciou-se relação direta e proporcional entre o número de eSB vinculadas à Estratégia Saúde da Família nas MS do Paraná, para auxiliar gestores, trabalhadores e pesquisadores no planejamento e avaliação de políticas públicas direcionadas à saúde bucal no Sistema Único de Saúde.

Palavras-chaves: Estratégia Saúde da Família. Odontologia. Sistema Único de Saúde.

INTRODUCTION

The creation of the Unified Health System (SUS) in 1988 provided Brazil with advances in health-related issues by establishing universality, integrality, and equity as principles[1]. For these principles to be achieved, it is important to overcome a major challenge, which is changing the care model, and shifting health care from a focus on curing diseases to preventing injuries and promoting health[2]. As a way of reorganizing the care model, the Family Health Program (PSF) was instituted in 1994, currently structured as the Family Health Strategy (ESF). For the Ministry of Health, the ESF is the main tool to strengthen and expand Primary Health Care (PHC) coverage in Brazil[3].

ESF has its specificities and the necessary items for the consolidation of the PHC, among them, the Family Health Team (eSF), whose attention is directed to the family and the interactions that occur between individuals and family members[4]. The professional gets to know the family members, expands their vision, and makes interventions to improve the quality of life of people who live together[5]. The eSF is composed of, at least, a general practitioner or a specialist in Family Health or Family and Community Health, a general practitioner or a specialist in Family Health, a nursing assistant or technician, and community health agents[3].

Through the publication of Ordinance 1,444 of 2000, which establishes financial incentives for the reorganization of oral health care, the oral health team (eSB) can be included in the ESF, and from that moment on, there is a great impetus for the expansion of actions in the field of dentistry across the country, by enabling the reorganization of oral health care[6]. Therefore, the inclusion of oral health actions in the ESF is an attempt to achieve comprehensive care, which is part of the health of families and communities[7]. The performance of the dental surgeon (DC) in the ESF must go beyond the limits of the mouth and not only limited to the professional-patient relationship, within the ESF, but the context is also broad (ranging from the service to the family) and, given this, bonding and welcoming attitudes are required to integrate the team, seek knowledge, punctual articulations and internal referrals, and the building of interventions together with other eSF professionals[4].

The presence of eSB in a multidisciplinary team provides interaction of different knowledge, and, in this way, interventions are produced that would not be carried out by any of the professionals alone[5]. The eSB can then be organized in the following ways: I – general dentist or specialist in Family Health, and oral health assistant (ASB); II – general dentist or specialist in Family Health, oral health technician, and oral health assistant[8]. Professionals in the dental area develop individual consultations in the office, at home, and in collective activities through health education groups, health promotion, and protection actions, recovery, prevention and control of oral cancer, inclusion of more complex procedures, and rehabilitation prosthetics in APS[4,9].

However, over time, estimates indicate an increase in the implementation of eSF and eSB in PHC in the macroregions that make up the state of Paraná, but little has been done to analyze the coverage of these data. In view of this, the Ministry of Health has used the SUS Department of Informatics (Datasus) to structure health information systems by integrating data and assisting in planning, management of health care levels, decision-making, strengthening administration, social control, and improvement of services offered[10,11]. Thus, the objective of this study was to analyze the coverage of the number of Family Health teams and Oral Health teams in the Health Macroregions in the state of Paraná, between 2007 and 2022.

METHODS

This was a longitudinal ecological study, using consolidated secondary data of public domain, from the East, North, West, and Northwest Health Macroregions (MS) of the state of Paraná, Brazil.

MS East covers the 1st, 2nd, 3rd, 4th, 5th, 6th, and 21st Health Regions of the State Health Secretariat of the state of Paraná (SESA/PR). MS North encompasses 16th, 17th, 18th, 19th and 22nd Health Regions. The MS West consists of the 7th, 8th, 9th, 10th, and 20th Health Districts. And MS Northwest includes the 11th, 12th, 13th, 14th, and 15th Health Regions of SESA/PR (SESA/PR: https://www.saude.pr.gov.br/Pagina/Regionais -de-Saude).

Data were collected by consultations with the National Registry of Health Establishments (CNES) - Health Teams, of the SUS Department of Informatics (Datasus: http://datasus.saude.gov.br), Ministry of Health of the following data: Family Health Team (eSF), eSF with Oral Health in Modality I (ESFSB MI), and eSF with Oral Health in Modality II (ESFSB MII), from April 2007 to March 2022.

The collected data were quantitatively treated, tabulated in an Excel® 16.0 spreadsheet, and analyzed. Descriptive statistics (mean, median, and standard deviation) were performed and Pearson's correlation was applied to check for associations between the numbers of Family Health and Oral Health modalities I and II implemented.

According to Resolution 510/2016 of the National Health Council, for the development of the study, approval by the Research Ethics Committee was not required, since the data are public domain.

RESULTS

The number of Family Health (eSF), eSF with Oral Health in Modality I (ESFSB MI), and eSF with Oral Health in Modality II (ESFSB MII) teams in the Health Macroregions (MS) in the state of Paraná are illustrated in Figure 1. This figure allows to compare the variation in the numbers of eSF, ESFSB MI, and ESFSB MII between the MS in the state. The number of

eSF, ESFSB MI, and ESFSB MII was higher in MS East, with 48,396, 48,679, and 26,130 teams, respectively, in the study period. On the other hand, MS West had lower values related to eSF and ESFSB MI, with 19,417 and 25,112, in that order. As well as MS North had 8,511 ESFSB MII.

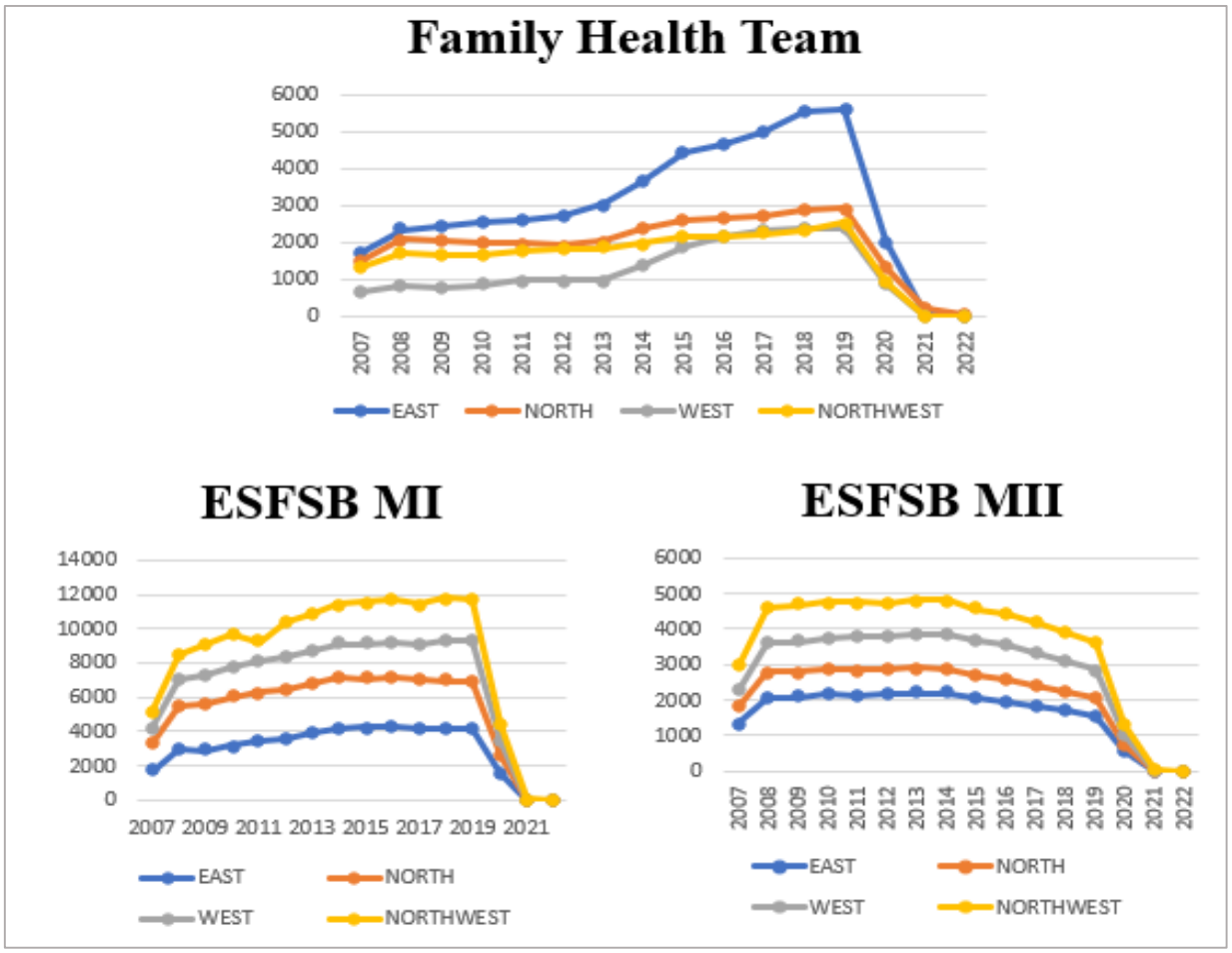

Figure 1. Variation in the number of Family Health (eSF), eSF with Oral Health in Modality I (ESFSB MI), and eSF with Oral Health in Modality II (ESFSB MII) teams in the East, North, West, and Northwest Macroregions (Paraná, Brazil, 2007- 2022).
Source: SUS Department of Informatics (Datasus; http://datasus.saude.gov.br).

MS West showed the highest mean values in the number of Family Health teams, ESFSB MI (Table 1), and ESFSB MII (Table 2).

Table 1. Descriptive statistics and correlation between the number of Family Health teams (eSF), ESF with Oral Health in Modality I (ESFSB MI) in the East, North, West and Northwest Health Macroregions (MS) (Paraná, Brazil, 2007- 2022).

	eSF			**ESFSB MI**			
	Mean	Median	Standard deviation	Mean	Median	Standard deviation	Correlation (r)
East	3,025	2,664	1,709	3,042	3,546	1,466	0.90
North	1,959	2,052	847	2,276	2,810	1,023	0.91
West	1,214	976	782	1,570	1,873	737	0.82
Northwest	1,631	1,790	742	2,258	2,119	2,250	0.40
Total	**7,829**	**7,373**	**3,995**	**9,146**	**10,670**	**4,676**	**0.69**

Source: SUS Department of Informatics (Datasus; http://datasus.saude.gov.br).

Table 2. Descriptive statistics and correlation between the number of Family Health teams (eSF), ESF with Oral Health in Modality II (ESFSB MII) in the East, North, West, and Northwest Health Macroregions (MS) (Paraná, Brazil, 2007- 2022)

	eSF			**ESFSB MII**			
	Mean	Median	Standard deviation	Mean	Median	Standard deviation	Correlation (r)
East	3,025	2,664	1,709	1,633	2,010	765	0.61
North	1,959	2,052	847	532	641	250	0.77
West	1,214	976	782	725	848	338	0.66
Northwest	1,631	1,790	742	746	883	339	0.85
Total	**7,829**	**7,373**	**3,995**	**3,636**	**4,502**	**1,679**	**0.71**

Source: SUS Department of Informatics (Datasus; http://datasus.saude.gov.br).

Pearson Correlation analysis indicated correlations between eSF and ESFSB MI (Figure 2), eSF and ESFSB MII (Figure 3), with a very strong positive correlation between eSF and ESFSB MI (r=0.91) in MS North, and a strong positive correlation between eSF and ESFSB MII (r=0.85) in MS Northwest.

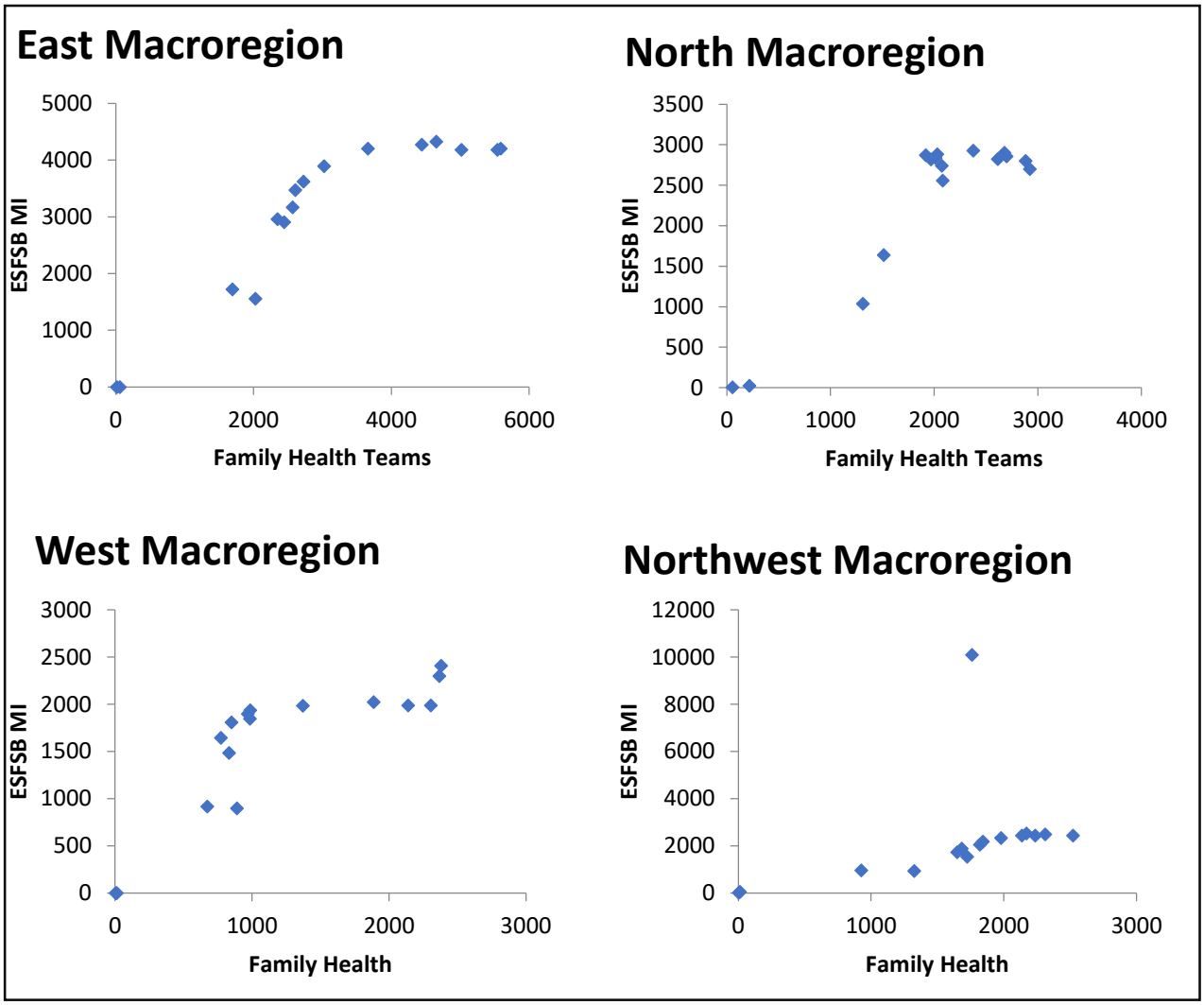

Figure 2. Correlation between the number of Family Health Teams (eSF) and ESF with Oral Health in Modality I (ESFSB MI) (Paraná, Brazil, 2007-2022).

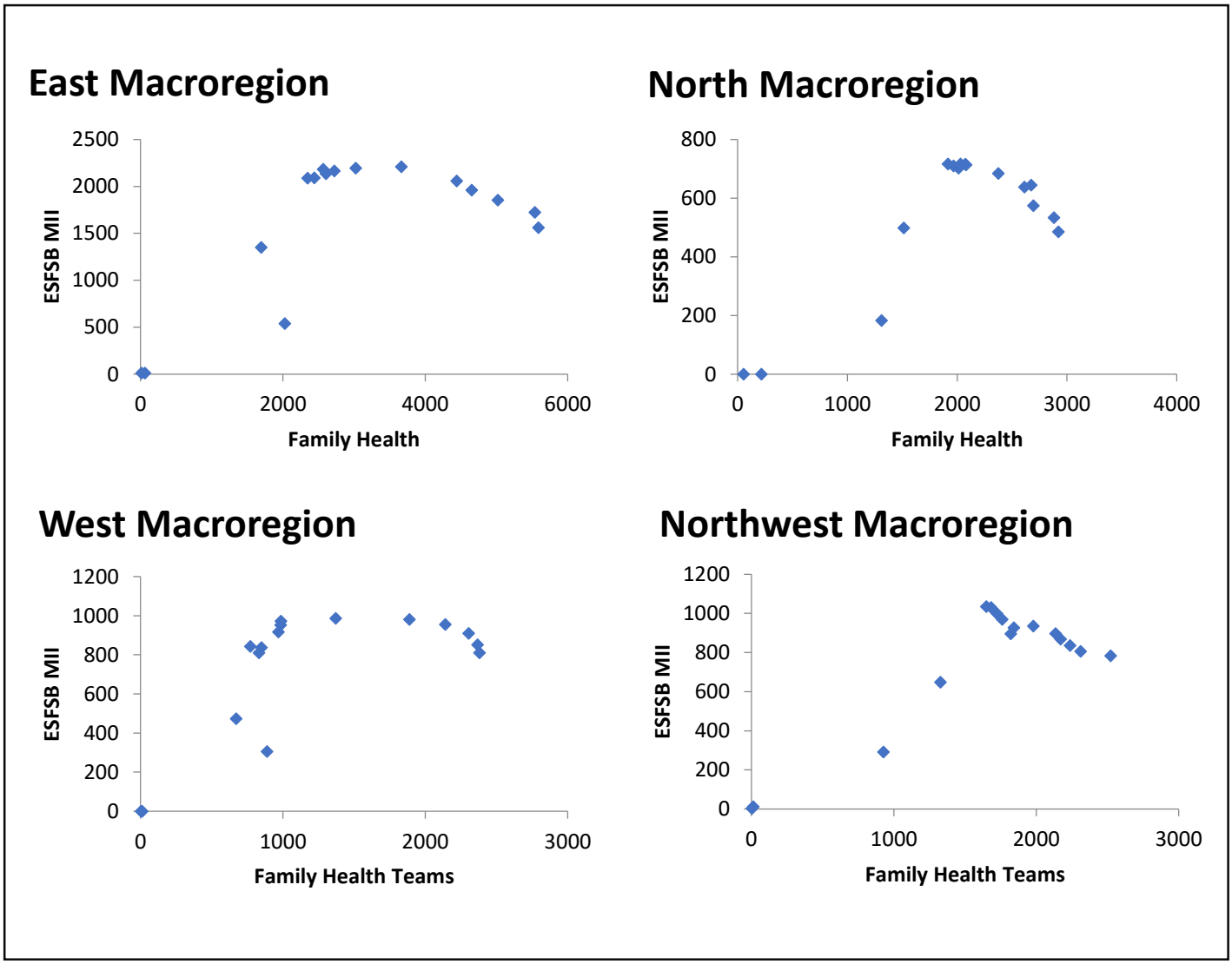

Figure 3. Pearson correlation between the number of Family Health teams (eSF) and ESF with Oral Health in Modality II (ESFSB MII) (Paraná, Brazil, 2007-2022).

DISCUSSION

The insertion of Oral Health teams (eSB) into the Family Health Strategy (ESF) represents the possibility of creating spaces for practices and relationships to be built for the reorientation of the work process, and the very performance of oral health within the scope of health services[12]. Therefore, analyzing the coverage of Family Health (eSF and eSB teams) helps to strengthen oral health care as a public policy and promotes its expansion, qualification, and visibility[13].

Among the Paraná macroregions, the East Health Macroregion showed the highest number of eSF and ESFSB in Modalities I and II, and when correlating the number of eSF and ESFSB MI and ESFSB MII, the North and Northwest Health Macroregions, showed a very

strong positive correlation, and a strong positive correlation (r=0.91 and r=0.85), respectively. The number of health teams in these macroregions stood out, probably due to financial incentives provided by the Ministry of Health, qualified management that believes that the inclusion of health into the ESF can improve the oral health of the population and the possibility of reorganizing actions in oral health based on health promotion, prevention and recovery[14,15]. Investments from the National Oral Health Policy (PNSB) allowed for an expansion of approximately 500% in the number of eSB, which allowed the expansion of 4,261 eSB in 2002, more than 25,000 in 2017, and 31,821 in 2021, resulting in a coverage of approximately 40% of the Brazilian population[16].

Although progress has been made with the PNSB, the political and economic scenario in Brazil has been transformed in recent years. Since 2017, with the update of the National Primary Care Policy, non-mandatory oral health in the ESF, and 2020, with the onset of the COVID-19 pandemic, access to Primary Health Care (PHC) was weakened, and the risk of possible setbacks can be seen[16,17]. With the pandemic, there were recommendations for social isolation and the cancellation of routine activities, which affected the organization of PHC services[18]. In addition, investments in public health have become insufficient, and access has been impaired, as well as the lack of professionals, inputs, and adequate structure for care[19].

The insufficient number of eSB points to a difficulty in the quality of oral health implementation in the ESF and in enhancing the effectiveness of the system as a whole[20,21]. The relationship between the teams, oral health, and family health was initially determined in the ratio of one eSB to two eSF, implemented or under implementation, where each eSB should serve an average of 6,900 inhabitants[22]. Since the year 2000, there has been a significant growth in eSB throughout Brazil[23]. As of Ordinance GM/MS 673, of June 3, 2003, it was established that as many eSBs could be implemented as there are eSFs in operation in the municipalities, provided they did not exceed the existing number of eSFs and considered the logic of organization of the APS[24].

In this study, a gradual increase in the implementation of eSB, ESFSB MI, and ESFSB MII in the Health Macroregions in the state of Paraná was found in the period from 2017 to 2019. These results corroborate Siqueira et al. (2021)[11], who showed an increase in the number of eSB in the state of Paraná, however, coverage by eSB is still low, demonstrating great potential for expansion to be developed in the state. In the period from 2020 to 2022, there was a drop in values, possibly due to the COVID-19 pandemic. During the pandemic, investments in medical health were certainly preferred over oral health, since the first half of 2020 was the period in which the number of eSBs in the ESF fell[25].

The eSB linked to an ESF, whether in modalities I or II, make up the vast majority of dental care in PHC[25]. Adherence to the ESF has been prioritized by some states and is desired,

given the change in the care model, in addition to the incorporation of eSB associated with increased use of the Dental service in SUS. Municipalities with greater coverage by ESFSB MI and ESFSB MII have better oral health indicators and greater chances of increasing the use of dental services[26]. According to Lucena et al. (2020)[27], although the number of eSB in Brazil increased between 2017 and 2019, in the Northeast and Southeast regions of Brazil, there was an increase in the number of municipalities that reduced the number of eSB in the ESF. In the South region, the impact may be more significant, as this region has low oral health coverage (36.2%), second only to the Southeast region (27.2%). This phenomenon may represent a reduction in users' access to oral health services, with consequent impacts on health conditions and quality of life[28]. Therefore, the reduction in the number of eSB in the country is a problem that can increase health inequalities, and reduce the access by those who most need dental services from the perspective of SUS.

Regarding the limitations of the study, this was based on secondary data provided by Datasus, from the Ministry of Health, which is liable to present misleading information.

CONCLUSION

Our results showed that the number of Family Health teams and Oral Health teams in Modalities I and II was higher in the Eastern Paraná Health Macroregion. By correlating the number of Family Health teams and Oral Health teams in Modalities I and II, a direct and proportional relationship was evidenced. In other words, the North Health Macroregion presented, between the variables Family Health teams and Oral Health teams in Modality I, a very strong positive correlation. And in the Northwest Health Macroregion, it showed, between the variables Family Health teams and Oral Health teams in Modality II, a strong positive correlation.

Thus, resources and investments must be allocated to Primary Health Care so that Family Health and Oral Health teams can increase, expanding the offer of health services and health professionals, especially in areas with poor access. Thus, our findings contribute to helping researchers and managers in the planning and evaluation of public policies aimed at oral health in the Unified Health System.

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