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Oral health indicators in the Interfederative Pacts of the Unified Health System: development in the 1998-2016 period

Indicadores de saúde bucal nos Pactos Interfederativos do Sistema Único de Saúde: evolução no período 1998-2016

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Resumo

Introdução: Nas últimas décadas, o Ministério da Saúde vem recomendando o uso de indicadores para a avaliação e a monitoração da atenção em saúde. Ao longo dos anos, instituiu pactos interfederativos que versam sobre indicadores de saúde, entre eles, os indicadores de saúde bucal, com o propósito de estimular gestores do sistema de saúde a incorporarem nas suas práticas o monitoramento e a avaliação das ações, bem como propiciar o acompanhamento do desempenho dos serviços. **Objetivo:** Analisar a evolução dos indicadores de saúde bucal presentes nos Pactos Interfederativos do Sistema Único de Saúde (SUS) no Brasil entre 1998 e 2016. **Material e método:** Pesquisa documental com base nas diretrizes governamentais editadas no período analisado. As variáveis estudadas foram as características das publicações e dos indicadores (denominação, método de cálculo, fonte e propósitos). **Resultado:** No período de 1998-2016, indicadores de saúde bucal foram propostos no pacto de indicadores da atenção básica (1998-2006), nos pactos pela saúde (2007-2011) e nas resoluções da comissão intergestores tripartite (2012, 2013 e 2016). Mudanças foram identificadas ao longo deste período, caracterizadas pela inclusão e exclusão de indicadores e por uma redução drástica no número de indicadores, culminado com a manutenção apenas da "Proporção de exodontias em relação aos procedimentos". **Conclusão:** Houve mudanças nos indicadores de saúde bucal no período analisado, caracterizadas por períodos de avanço e retrocesso, resultando em um único indicador em 2016, relacionado a ações mutiladoras.

Descritores: Indicadores de serviços; saúde bucal; gestão em saúde.

Abstract

Introduction: In recent decades, the Ministry of Health has been recommending the use of indicators for the assessment and monitoring of health care. Over the years, it has instituted interfederative pacts dealing with health indicators, including oral health indicators, with the purpose of encouraging health system managers to incorporate the monitoring and assessment of actions in their practice, as well as enabling the follow-up of the performance of services. **Objective:** To analyze the development of oral health indicators propounded in the interfederative pacts of the Unified Health System (SUS) in Brazil between 1998 and 2016. **Material and method:** Documentary research based on government guidelines issued during the analyzed period. The variables studied were the characteristics of publications and indicators (denomination, method of calculation, source and purposes). **Result:** In the period of 1998-2016, oral health indicators were proposed in the pact on primary care indicators (1998-2006), in the Pacts for Health (2007-2011), and in the resolutions of the tripartite intermanagerial committee (2012, 2013 and 2016). Changes were identified over this period, characterized by the inclusion and exclusion of indicators, and by a drastic reduction in the number of indicators, eventually leading to only one retained indicator: "Proportion of tooth extractions in relation to procedures." **Conclusion:** There were changes in oral health indicators over the analyzed period, characterized by periods of advancement and regression, eventually resulting in a single indicator related to mutilating actions (tooth extractions), effective in 2016.

Descriptors: Indicators of health services; oral health; health management.

INTRODUCTION

Health indicators are essential to health management and planning. They support the making of public policy and the setting of priorities to meet the needs of the population[1]. In the last decades, the Brazilian Ministry of Health instituted the interfederative pacts with the purpose of encouraging Unified Health System (SUS) managers to incorporate the monitoring and assessment of

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actions in their practice, as well as enabling the follow-up of the performance of services.

The pacts are designed to provide a tool for negotiation by the three federated entities, and set down the goals to be achieved and the previously recommended and agreed upon health indicators[2]. They contain a minimum list of indicators—including those for oral health management—to be adopted by municipalities and states, as well as the technical guidelines for calculating the indicators, and the deadlines and flows of the pact-building process at the national level[2].

In general, both the indicators and the factors that may influence their use in public service practice are still rather unknown, despite the availability of a great deal of information regarding their importance and purpose. In a previous study, the following difficulties and limitations in the use of health indicators were pointed out by managers: slowness, lack of integration of health systems, and lack of training for managers on how to operate the system[3].

Contributing to this state of affairs is the lack of a theoretical background enabling the description and systematic assessment of the various indicators for oral health management, published in the governmental guidelines for the different health services in Brazil, as well as the unavailability of data needed to calculate these indicators and information about their source.

This issue has been little addressed in the field of oral health. Bordin, Fardel[4] analyzed the temporal evolution of oral health indicators from 2008 to 2010 in the databases of the Informatics Department of SUS (DATASUS), and pointed out that, ever since the government guidelines were instituted to steer the pact-building process and provide a list of indicators to be agreed on by managers, the proposals put forth for oral health indicators have been meager.

Bearing these aspects in mind, it is important to evaluate the importance given to oral health in this process of pact building and monitoring of health indicators. Over the years, the use of indicators has made it possible to analyze the quantity and quality of the oral health services provided, and determine whether they are appropriate and enough to meet the existing demand. The indicators also show if the actions planned should be improved and changed, and determine the level of compliance of these actions to SUS principles, among other information.

It is important that the indicators proposed in the Interfederative Pacts be well known in their historical perspective, so that federated entities may be guided in the national process of goal setting and health management planning. Therefore, the aim of this study was to analyze the development of oral health indicators propounded in the interfederative pacts between 1998 and 2016 in Brazil.

MATERIAL AND METHOD

The study was set up as a documentary research, based on the government guidelines of the Interfederative Pacts issued between 1998 and 2016. This period was chosen because 1998 marked the beginning of the series of pacts proposed by the Ministry of Health.

Table 1. Characteristics of the interfederative pacts issued in Brazil in the 1998-2016 period

TYPE OF DOCUMENT	DENOMINATION	NUMBER	YEAR/EFFECTIVE FOR[1]
MINISTERIAL ORDINANCE	Pact on Primary Care Indicators of 1998	GM/MS[2] Ordinance No. 3925 (November 13, 1998)	1999
	Pact on Primary Care Indicators of 2000	GM/MS Ordinance No. 779 (July 14, 2000)	2000
	Pact on Primary Care Indicators of 2001	GM/MS Ordinance No. 723 (May 10, 2001)	2001
	Pact on Primary Care Indicators of 2002	GM/MS Ordinance No. 1121 (June 17, 2002)	2002
	Pact on Primary Care Indicators of 2003	GM/MS Ordinance No. 456 (April 16, 2003)	2003
	Pact on Primary Care Indicators of 2004	GM/MS Ordinance No. 2394 (December 19, 2003)	2004
	Pact on Primary Care Indicators of 2005	GM/MS Ordinance No. 21 (January 5, 2005)	2005
	Pact on Primary Care Indicators of 2006	GM/MS Ordinance No. 493 (March 10, 2006)	2006
	Pact for Health of 2007	GM/MS Ordinance No. 91 (January 10, 2007)	2007
	Pact for Health of 2008	GM/MS Ordinance No. 325 (February 21, 2008)	2008
	Pact for Health of 2009	GM/MS Ordinance No. 48 (January 12, 2009)	2009
	Pact for Health of 2011	GM/MS Ordinance No. 3840 (December 7, 2010)	2011
RESOLUTION	Transition from the Pact for Health to the COAP[3] - 2012	CIT[4] Resolution No. 04 (July 19, 2012)	2012
	COAP 2013 to 2015	CIT Resolution No. 5 (June 19, 2013)	2013-2015
	COAP 2016	CIT Resolution No. 2 (August 16, 2016)	2016

SOURCE: Ministry of Health[5-19]. [1]Effective for - Corresponds to the period during which the indicators were effective. In general, the Interfederative Pacts were issued in the same year in which the indicators were effective, except for Ordinances No. 3925/1998 and No. 2394/2003, in which the indicators were published in advance for the following year, i.e. for 1999 and 2004, respectively. [2]GM/MS - Ministerial Office of the Ministry of Health. [3]COAP - Organizational Contract of Public Healthcare Action. [4]Tripartite Intermanagerial Committee.

The interfederative pacts were analyzed for publication characteristics (document type, denomination, document number, issuing year or publication year) and oral health indicator characteristics (denomination, method of calculation, data gathering source and purposes).

Documentary research to gather data was carried out by one of the study researchers, using the Ministry of Health website as its source. The following descriptors and similar key words were used in the document search strategy for the study: indicators and oral health. In addition, new searches were performed in said source according to the references found.

The research was not submitted to a research ethics committee, because the documents analyzed were available on a public domain website.

RESULT

The government guidelines set forth in the Interfederative Pacts presenting oral health indicators from 1998 to 2016 were issued in the form of ordinances by the Ministerial Office ("Gabinete Ministerial", GM) of the Ministry of Health ("Ministério da Saúde", MS) and Resolutions of the Tripartite Intermanagerial Committee ("Comissão Intergestores Tripartite," CIT) (Table 1). Oral health indicators were found in the Pact on Primary Care Indicators (1998-2006), in the Pacts for Health (2007-2011), and in the Organizational Contract of Public Healthcare Action (COAP), mentioned in the CIT Resolutions of 2012, 2013 and 2016.

In general, the guidelines were issued annually, and the indicators remained in effect for the same year in which they were published, except for Ordinances No. 3925/1998[5] and No. 2394/2003[6], in which the indicators were published in advance for the following year, i.e., 1999 and 2004, respectively. The same situation occurred with the COAP indicators for the years of 2014 and 2015, published in Resolution No. 5 (June 19, 2013)[7], which defined the same indicators for the 2013-2015 triennium.

Ordinance No. 2669 (November 3, 2009)[20] was issued in 2009, and defined the indicators for the 2010 Pact for Health, but they did not concern oral health.

Oral Health as Addressed in the Pact on Primary Care Indicators

An analysis of the oral health indicators set out in the historical series of the Pacts of Primary Care Indicators, effective for the period between 1999 and 2006 (Table 2), reveals that five indicators were proposed[5] since its institution, as of the issuing of Ordinance No. 3925 in 1998. Changes made over time were characterized by the replacement, expansion, and later exclusion of the vast majority of the indicators proposed initially.

The Pact on Primary Care Indicators published in 1998, when Ordinance GM/MS No. 3925 (November 13, 1998) was issued, is

Table 2. Oral health indicators of the pact on primary care indicators for the 1999-2006 period

ORAL HEALTH INDICATORS	Pact on Primary Care Indicators							
	1999	2000	2001	2002	2003	2004	2005	2006
Coverage of preventive dental procedures in the population aged 0 to 14 years.	X	X	X					
Coverage of first dental consultation				X	X	X	X	X
Ratio of community dental procedures to the population aged 0-14 years				X	X	X	X	
Proportion of tooth extractions in relation to individual basic actions				X	X	X	X	
Coverage of the "supervised toothbrushing" community action								X
Average of individual basic dental procedures								X
Proportion of specialized dental procedures in relation to individual dental actions								X

SOURCE: GM/MS Ordinance Nos. 3925/1998[5], 779/2000[8], 723/2001[9], 1121/2002[10], 456/2003[11], 2394/2004[6], 21/2005[12] and 493/2006[13].

Table 3. Development of oral health indicators of the pact for health in the 2007-2011 period

ORAL HEALTH INDICATORS	PACT FOR HEALTH			
	2007	2008	2009	2011
Coverage of first dental consultation	X	X	X	
Coverage of the "supervised toothbrushing" community action	X	X*	X*	X*
Average of individual basic dental procedures	X			
Estimated population coverage by the Oral Health Teams of the Family Health Strategy				X

SOURCE: Ordinances GM/MS Nos. 91/2007[14], 325/2008[15], 48/2009[16] and 3840/2010[17].*Indicator advocated by the Primary Care Pact of 2006, titled Coverage of the Community Action of Supervised Toothbrushing. In 2008, it was renamed Community Annual Average of Supervised Toothbrushing. In 2011, with the issuing of Ordinance No. 3840/2010, this indicator began to be recorded as average of the community action of supervised toothbrushing.

particularly noteworthy, since this was the starting point of the series of these pacts[5]. This Pact defined an oral health indicator to be followed up by primary care managers for the year 1999, namely the "Coverage of preventive dental procedures in the population aged 0 to 14 years," which was maintained until 2001[5,8,9]. The method for calculating this indicator involved different dimensions, and the individual and community procedures were discriminated in the different age groups for the purpose of calculation[5]. This indicator was replaced by three new indicators in 2002[5,10-12], two of which remained in place until 2005[12], and one, until 2006[13].

An analysis of the pacts revealed that the "Coverage of community procedures" indicator underwent two changes over the time period considered, regarding its denomination and method of calculation. As of year 2000, the community and individual procedures, as well as the different age groups, were no longer discriminated for the purpose of calculation. In 2002, this indicator was renamed "Ratio of community dental procedures to the population aged 0-14 years"[10].

GM/MS Ordinance No. 779 of July 17, 2000, referring to the Pact on Primary Care Indicators of 2000, stated that the "Concentration of preventive dental procedures in the population aged 0 to 14 years" indicator would reflect the degree of reach of the actions taken to prevent dental illnesses in the defined population[8]. The ordinance also stated that this indicator could be used to support the planning, management and evaluation of oral health policies and actions[8].

One of the modifications implemented in the pact-building process of the indicators was made in 2002. Ordinance No. 1121 (July 17, 2002) provided that the indicators of the Primary Care Pact were to be denominated according to the type of aggreement established, as follows: core indicators, compulsory agreement indicators, and complementary indicators (optional agreement)[10].

In the 2002 pact, two indicators were considered as core indicators: "Coverage of first dental consultation" and "Ratio of community dental procedures to the population aged 0 to 14 years." The "Proportion of tooth extractions in relation to individual basic dental actions"[10] was a complementary indicator.

The same indicators of the 2002 pact were maintained for the 2003-2005 period[6,11,12]. In 2006, three more indicators were added[14]; moreover, this year corresponds to a phase of greater progress in the evolution of the indicators, with the reinstatement of the indicator of preventive measures and the inclusion of new and important indicators related to basic and specialized care procedures (Table 2).

Oral Health Indicators: Starting from the Pact for Health to the Organizational Contract of Public Healthcare Action (COAP)

The series of Pacts on Primary Care Indicators ended in 2006 with the publication of the Pact for Health, signed by the three levels of administration. This edition of the pact established new forms of relationship and negotiation among SUS managers, comprising three components: The Pact for Life, The Pact in Defense of SUS and The Pact for Management.

Regulation of the Pact for Health involved implementing operational guidelines for the SUS management process, and for the transition and monitoring of the Pacts for Life and Management, thereby unifying the processes of agreement regarding indicators and targets. However, the complete unification of these processes occurred only in 2007[14]. In the time period between 2007 and 2011 (Table 3), changes were made to the oral health indicators, with the exception of 2010[14-17], at which time new indicators were incorporated, and others were excluded.

In 2009, Ordinance No. 2669 (November 3, 2009) was issued with the list of Pact for Health indicators for the 2010-2011 biennium, in the various priority areas; however, oral health indicators for 2010[20] were not included in this list. Only at the end of that year, with the issuing of Ordinance No. 3840 (December 12, 2010), was oral health included in the monitoring and assessment of the Pact for Health; this ordinance established the guidelines, instructions and

Table 4. Evolution of oral health indicators of the Organizational Contract of Public Healthcare Action (COAP) in the 2012-2016 period

ORAL HEALTH INDICATORS	PACT FOR HEALTH / COAP	COAP				
	2012	2012	2013	2014	2015	2016
Coverage of the "supervised toothbrushing" community action	X	X				
Average of individual basic dental procedures			X	X	X	
Estimated population coverage by the Oral Health Teams of the Family Health Strategy	X	X	X	X	X	
Proportion of tooth extractions in relation to procedures		X	X	X	X	X
Number of municipalities with workers in the process of professional technical training according to PROFAPS guidelines[1] and service needs of the health region		X				
Proportion of residents of basic area medical residency programs (medical clinic, pediatrics, obstetrics-gynecology, geriatrics), multiprofessional, oral health, and pharmaceutical care residency programs working in Primary care services in the region		X				

SOURCE: CIT Resolution No. 4/12[18]; CIT Resolution No. 5/13[7], and CIT Resolution No. 2/16[19]. [1]Program for the Training of High-School Level Health Professionals.

deadlines for the 2011 target adjustment process[17]. The following indicators were established to follow up the basic care strengthening actions: "Population coverage by the Oral Health Teams of the Family Health Strategy" and "Average community action of supervised toothbrushing"[17].

A proposal for a new pact was made in June 2011, when Decree No. 7508 (June 28, 2011) was issued[21]. This decree defined new criteria, pact-building tools, and action-monitoring tools to be used by the federated entities, through the COAP. The publication of Ordinance No. 1580/12 released managers from the obligation of complying with the Pact for Health or signing the Term of Management Commitment ("Termo de Compromisso de Gestão"), and established the COAP as the appropriate federative tool to formalize interfederative relationships[22,23].

The two oral health indicators used in the transition from the Pact for Health to COAP in 2012 (Table 4) aimed at guaranteeing equitable and timely access of the population to quality services[23].

While awaiting the finalization of the pact reorientation process, CIT Resolution No. 04 (July 19, 2012) was published in August 2012. It provided for the tripartite agreement on the rules regarding sanitary responsibilities within the SUS for the purpose of making the transition from the operational processes of the Pact for Health to the COAP system[18]. This resolution contained the guidelines, objectives, targets and indicators for 2012.

In 2012, the Ministry of Health published a manual with the targets and indicators making up the COAP, and added a set of different indicators to the list for that year[23]. The indicators of the Pact for Health were maintained, and two new and different indicators were incorporated addressing oral health, related to Healthcare Work Management and Education Program (Table 4).

Resolution No. 5/2013 defined three oral health indicators for the 2013-2015 triennium (Table 4). Although this resolution reduced the number of indicators in comparison to 2012, it maintained important indicators for the monitoring of actions. However, the issuing of Resolution No. 2/2016 in 2016 excluded all previously proposed indicators, and retained only one: "Proportion of tooth extractions in relation to procedures"[19].

DISCUSSION

An analysis of the development of the oral health indicators set forth in the Interfederative Pacts issued over the years (1998 to 2016) reveals a decrease in these indicators, and the keeping of only one indicator as of 2016. This result shows how important it is to encourage the incorporation of different oral health indicators, include indicators that enable monitoring, and highlight the relevance of oral health in the pact-building and follow-up processes.

The analysis of the evolution of the Pacts on Primary Care Indicators (1998-2006) showed that the proposal of a single indicator from 1999 to 2001 ("Coverage of preventive dental procedures in the population aged 0 to 14 years") represented a situation in which little emphasis was placed on the monitoring of the oral health actions conducted and the dental services provided. This situation coincides with the period of exclusionary practices, which persisted for a long time in the country, where public dental care was provided to school children on a priority and scheduled basis, whereas, care was provided to the rest of the population according to spontaneous demand.

Only as of 2002 were new indicators incorporated to monitor health actions. Thereafter, oral health gained relevance in the monitoring process, with the inclusion of indicators related to the coverage of dental services and the assessment of the care actions related to mutilating (tooth extractions) and individual basic procedures (restorative and preventive).

In the period between 1999 and 2003, the Pact on Primary Care Indicators was progressively signed by the federation entities and municipalities, and the pact-building process underwent important changes regarding its performance and indicators for assessment[24]. However, in the field of oral health, the changes in indicators occurred only in 2002. Although the indicators in this year were designated as core and as complementary indicators, the latter were intended to be monitored by managers, albeit optional[24].

Between 2003 and 2006, the pacts were established by specific ordinances, and, with the exception of 2006, the set of oral health indicators remained unchanged. It is also noteworthy that, despite implementation of the National Oral Health Policy in 2004[25], no new indicators were proposed for the 2004 and 2005 pacts, demonstrating that oral health still required efforts, discussions and pact-building efforts to advance through the appropriate proposals to assess the basic care provided. In 2006, virtually all indicators were replaced; however, the denomination, calculation formula or purpose of those that remained effective up to that time were modified. Nevertheless, the evaluation of service coverage, and preventive and restorative actions was maintained.

The goal persued by the Ministry of Health in drafting a proposal to develop management pacts between the three federated entities[2] was to guide SUS municipal managers in the process of evaluation and monitoring of Primary Care. Nevertheless, it was observed that the indicators proposed in 2006 in the field of oral health were insufficient.

The indicators of the Pact for Health in place during 2007-2011 represented a promising proposal for evaluating services in the field of oral health, and included an assessment not only of the impact of actions carried out by the services in this area, but also of the population's level of access to the services offered. However, there was an interruption in the propounding of oral health indicators in the Pact for Health for 2010, and the indicators and targets for 2011 were presented only at the end of 2010.

Following the transition period, COAP 2012 innovated by including indicators related to the process of permanent education of health professionals, with the purpose of contributing toward adequate training, allocation, qualification and valuation of SUS professionals, in addition to promoting the democratization of labor relations[18]. In the 2013-2015 triennium, several indicators were proposed. However, contrary to expectations, there was a gradual decrease in the number of oral health indicators. In 2016, the only indicator proposed for the monitoring of actions in this area was the "Proportion of tooth extractions in relation to procedures," similar to the "Proportion of tooth extractions in relation to individual

basic actions," which was part of the list of indicators of the Primary Care Pact in the 2002 to 2006 period.

Thus, despite the potential contribution expected from the indicators set forth in the COAP, there was a drastic reduction in the number of indicators for the oral health area. This situation is similar to that experienced at the beginning of the Interfederative Pacts, when only one indicator was used for this area. Therefore, it is recommended that dialogues be established with the participation of players from different areas (management, social control, and academia, among others) to identify and establish a list of indicators covering aspects inherent to the monitoring and planning of actions in the field of oral health.

Over time, ministerial ordinances were found to reassert the role of interfederative pacts as legal instruments for monitoring and assessing health actions and services related to basic care. However, in the oral health area, these instruments were inconsistent in terms of the proposed indicators, inasmuch as they maintained a single indicator in certain periods, and incorporated new ones in others. This situation points to the need for selecting appropriate indicators to allow systematization of the monitoring and an assessment of actions, thus promoting effective management of oral healthcare within the SUS.

CONCLUSION

In conclusion, there were changes in the oral health indicators between 1998 and 2016, characterized by periods of advancement and regression, and eventually leading to only one indicator retained in 2016 related to mutilating actions.

The findings of this study highlighted the trajectory of the indicators recommended for oral health management, and identified gaps that may negatively influence the decision making and public policies required to meet the needs of the population.

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CONFLICTS OF INTERESTS

The authors declare no conflicts of interest.

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