

Analysis of the strategic conduct of managers and professionals involved in oral cancer prevention and control

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Abstract: Health managers and professionals are the agents responsible for implementing public policies in health services. It is therefore essential to understand how they act in everyday practice. The aim of this study was to analyze the strategic conduct of managers and professionals involved in oral cancer prevention and control. We conducted a qualitative study based on 23 interviews with oral health managers and professionals in five municipalities in the Metropolitana I health region in the state of Rio de Janeiro and three interviews with members of the oral health technical team of the state health department. We performed a strategic conduct analysis drawing on Anthony Giddens' theory of structuration. The findings show that, sensitized by the representation of cancer in society, these agents act as potential facilitators of access to services, creating informal alternatives to more restrictive protocols. However, this mobilization only tends to occur in cases of suspected cancer, constituting an important contradiction. It is concluded that it is essential to improve access to primary care, enhance health promotion and cancer prevention actions, and promote continuing training to guarantee the right to early diagnosis and timely treatment of oral cancer.

► **Keywords:** Oral Neoplasms. Health Policy. Oral health services.

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Introduction

Oral cancer prevention and control actions carried out under Brazil's public health system, the *Sistema Único de Saúde* (SUS) or Unified Health System, are structured around guidelines set out in the National Oral Health Care Policy (PNSB) (BRASIL, 2004) and National Cancer Prevention and Control Policy (PNPCC) (BRASIL, 2017). Core areas include health promotion, disease prevention, early detection and timely treatment, and palliative care (BRASIL, 2017). Although the creation of these policies has resulted in the development of a more comprehensive normative framework and increased funding, the challenge of improving access to oral cancer diagnosis and treatment persists (LIMA; O'DWYER, 2020).

It is estimated that there were 15,190 new cases of oral cancer a year in Brazil between 2020 and 2022 (INCA, 2019). Although the condition is not among the five most common types of cancer, oral cancer has high rates of mortality and morbidity after treatment, as the site and size of lesions can strongly impair patient quality of life. Treatment can result in facial disfigurement, speech problems, difficulties chewing and swallowing, dysgeusia, and breathing problems (VIANA, 2014).

The leading risk factors for oral cancer are smoking and alcohol abuse. While the control of these factors is the best way to reduce disease incidence, the most effective way to decrease mortality and the negative impact of treatment on quality of life is early detection and timely treatment (MONTORO et al., 2008). Unfortunately, although lesions occur in the oral cavity, a site that is accessible to visual inspection and where early neoplastic changes are easily detectable, most diagnoses are delayed (GIGLIOTTI; MADATHIL; MAKHOUL, 2019).

From a normative perspective, the PNSB and PNPCC state that primary care services, more specifically oral health teams working in the Family Health Strategy (FHS), are responsible for detecting suspicious oral lesions and referring patients for diagnostic confirmation (BRASIL, 2004; 2017). Diagnosis is performed by specialized dental centers (CEOs), which, according to Ministerial Order 599, shall carry out the activities necessary for the diagnosis of oral diseases (BRASIL, 2006). After diagnosis, the patient is referred to an accredited cancer center, preferentially a High-complexity Cancer Care Center (CACON) or High-complexity Cancer Care Unit (UNACON), which provide radiotherapy services (BRASIL, 2019). During and after treatment, the patient remains affiliated with a primary care facility, using services on a routine basis.

However, it is known that idealized and regulated health system designs undergo transformations in practice. Despite “structural coercion” arising from the interplay of SUS rules and resources, agents involved in the health system subvert planned rationality, directly interfering in the health service regulation process. Thus, in practice, much more than the result of government actions, the day-to-day functioning of the SUS can be understood as the product of the actions of multiple actors (CECÍCLIO, 2012). It could be said that this process is characteristic of the hijacking of the system by private interests or the neglect that can lead to impoverished care. However, if we knew how to incorporate this process into management strategies, it could also operate at the service of “living work in action” and establishing a positive affectionate bond between health professionals and patients, resulting in a highly caring system (CECÍCLIO, 2012).

If we are to improve oral cancer prevention and control actions and services, it is essential to understand the difference between normative prescriptions and practice to determine whether these prescriptions really serve the objectives of health services and if practices that step outside the parameters are adequate. The aim of this study was therefore to analyze the strategic conduct of health managers and professionals involved in oral cancer prevention and control actions and services.

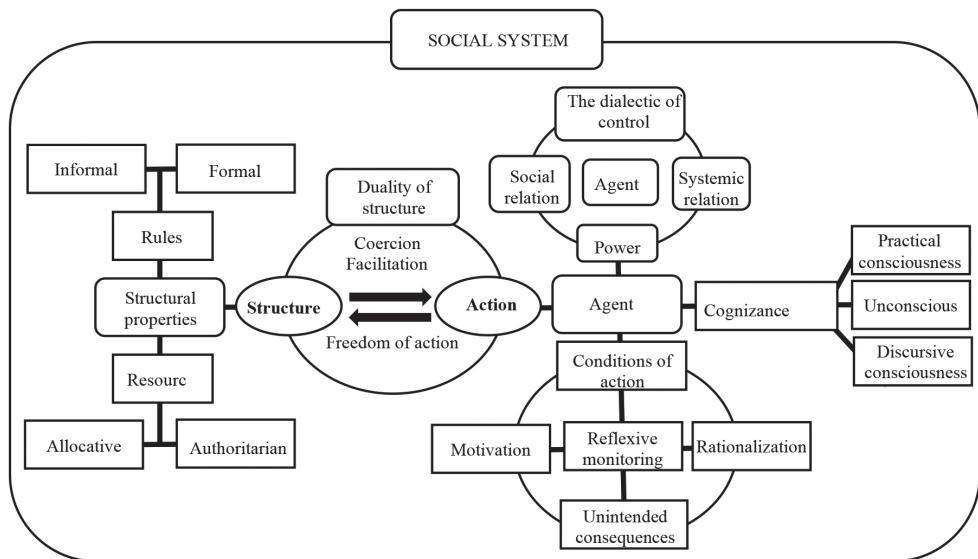
Methodology

We conducted a qualitative analytical study using “strategic conduct analysis” as outlined in Anthony Giddens’ (2003) theory of structuration, which has been employed as a theoretical resource for analyzing public health policies (O'DWYER, 2015). The theory of structuration (TS) is based on the concept of the “duality of structure”, where the structural properties of social systems are both medium and outcome of the practices they recursively organize (GIDDENS, 2003). We chose this theoretical framework as it provides the right tools and concepts to understand how formal prescribed structures in health systems determine, in part, the actions of the public agents involved, while at the same time being transformed and reconstructed daily by these same agents.

Far removed from any deterministic conception of society, this notion of the relationship between structure and action also suggests that social systems (including health systems) are not the creation of individual subjects. Rather it is an attempt to

comprehend the balance between the influence of society on the individual (coercive structure) and the freedom of individuals to act and influence society (freedom of action) (GIDDENS, 2003). Figure 1 presents a synthesis of the TS.

Figure 1. Synthesis of the theory of structuration



Source: the authors, based on Giddens (2003).

When it comes to the application of TS in research, Giddens (2003) distinguishes between two types of analyses: (1) institutional analysis; and (2) strategic conduct analysis. In institutional analysis, the researcher focuses on institutions as chronically reproduced rules and resources, suspending the skills and conscious awareness of actors (GIDDENS, 2003). In strategic conduct analysis, the focus is on the modes in which agents rely on structural properties to constitute social relations. Strategic conduct refers to the recognition of the cognizance and aptitude of agents in making intentional and skillful use of structural rules and resources in the production of their conduct. Hence, strategic conduct analysis concentrates on the mode in which agents reflexively monitor what they do and how actors draw upon rules and resources in the course of interaction (GIDDENS, 2003). It seeks to provide a hermeneutic elucidation of the interlacing of meanings, unveiling the reasons for action. This includes knowing what managers and professionals know (believe) about their actions

and express discursively (discursive consciousness), as well as what they do tacitly (practical consciousness) (GIDDENS, 2003). This differentiation between forms of consciousness in the TS is fundamental because, while the former refers generally to formal prescribed processes, the latter is more related to daily interactions.

It is worth highlighting that, according to the TS, all individual agency is immersed in historically inherited social arrangements. It does not refer to people's intentions, but rather their capacity to act. Agents are unaware of the totalities of the conditions of human action and of the consequences of action (GIDDENS, 2003).

The study was undertaken in the Metropolitana I health region in Rio de Janeiro. We chose a health region as the study area because the organization of cancer diagnosis and treatment services in health regions is governed by the PNSB (BRASIL, 2004) and PNPCC (BRASIL, 2017). According to the Brazilian Institute of Geography and Statistics (IBGE – <https://cidades.ibge.gov.br>), this region harbors 55.17% of the state population. Overall primary oral health care coverage in the region is 22.12%, which is the lowest rate in the state. Rates in the municipalities that make up the region range from 6.90% to 63.81% (<https://emanagerab.saude.gov.br>). The region has 34 accredited CEOs, accounting for 41.46% of all centers in the state. Every municipality in the region has at least one CEO. The region has 18 accredited cancer centers (<http://cnes.datasus.gov.br>). Despite the fact that half of the state's accredited cancer centers are concentrated in the region, the current state cancer care plan recognizes that there is a shortfall of 11 centers (RIO DE JANEIRO, 2017).

We conducted 26 semi-structured interviews with oral health managers and professionals in five municipalities selected because they represent a range of contexts and population sizes: five interviews with municipal oral health coordinators; three interviews with members of the oral health technical team of the State of Rio de Janeiro Health Department (SES/RJ) to gain a deeper insight into the health region; and 18 interviews with oral health professionals (12 dental surgeons working in the FHS and six from CEOs). The latter were selected randomly using the data saturation method (FONTANELLA *et al.* 2011).

The interviews were conducted in 2019. The guiding questions were devised to collect information on the interviewee's professional background, everyday practice in the health service, the organization of specific oral cancer prevention and control actions, relations with other levels of care, and the diagnosis and treatment scheduling process. The interview process sought to explore the relationship between

oral cancer prevention and control actions and the prescriptions stated in the PNSB and PNPCC. Additional questions were asked based on direct observations during the interview, as recommended by the literature (YIN, 2016; GRAY, 2009).

The interviews were recorded and transcribed using NVivo®. The content of the interviews was organized by interviewee category (manager or professional) and municipality and inputted into the software to identify classification “nodes”. This process was performed independently by the authors, who reached a consensus for the final version of the article. Although the strategic conduct of managers and professionals is interrelated, the results and discussion section is structured according to interviewee category to simplify the organization of the themes.

The study protocol was approved by the research ethics committee (reference number CAAE 82201418.0.0000.5240) and all participants were aware of the study aims and procedures and signed an informed consent form. Each participant is identified using the acronym corresponding their role and a randomly selected number, as follows: municipal oral health coordinator (OHC), responsible for diagnosis (RD), family health (FH), and members of the oral health technical team (TT).

Results and Discussion

Strategic conduct of managers

Oral health coordinators play a pivotal role in the organization oral cancer diagnosis and treatment services. However, there is no doubt that the Ministry of Health, through the PNSB, has contributed towards the structuration of oral health care in these municipalities. In addition to technical guidance, federal funding has enabled the provision of dental care in primary and secondary health care services (KORNIS; MAIA; FORTUNA, 2011). A study of the period 2003-2017 shows that federal funding for oral health care increased up to 2012. Funding then fell in 2013, remaining stable thereafter up to 2016, followed by a slight drop in 2017, when it stood at R\$1,059,555,548.48 (ROSSI et al., 2018).

The findings show that local decision-making was driven by national criteria and guidelines, orienting the conduct of both municipal and state managers.

It was like a breath of fresh air when the policy started to be implemented. We used to have to work without any guidelines. When the policy provided funding for operational costs, it was all we were waiting for and need to be able to work with municipalities and so that the municipalities could begin to build their oral health services (TT1).

From a structuration theory perspective, the PNSB is viewed as a set of rules and resources that both enable and constrain the actions of agents. Before the PNSB, each manager built their own path. Today there is funding and the Ministry of Health adopts a formal discourse on what should and should not be done. On the one hand, this extends the possibilities for action open to municipal managers, structuring their actions. On the other, the standard funding criteria limit their freedom of action. In response to this situation, municipal coordinators have followed one of three paths.

The first is to follow federal guidelines and implement services as prescribed. While this may seem like the most logical path, it is also the most improbable, as the everyday reality of services is complex and widely variable, meaning that is difficult to base decisions on formal rationality.

The second path is to make adaptations to national policy at local level. The transformation of prescribed policy into real policy is understandable and happens on a daily basis. From Giddens' structurationist perspective, operating within these policy structures, agents end up molding and, in part, transforming them (OLIVEIRA; PEREIRA; FERREIRA, 2013). To obtain access to funding, managers accept the conditions imposed by the federal government, but as soon as the services are set up and funds begin to be transferred, they begin to make adaptations at local level.

In day-to-day management, when funding is allocated, [managers] use it in other ways. It's very common. [Managers] undertake a commitment and begin to receive funding and we monitor it, but they operate the service the way they want (AT3).

Adaptations mentioned by the interviewees include reducing the working hours of family health professionals, failure to provided certain mandatory specialized services in CEOs, and non-compliance with CEO production targets. The reason given by managers for the reduction in working hours was funding shortfalls, which mean that municipal governments are unable to complement funding to pay professionals to work full-time, and a reduction in the working hours of permanent staff assigned to the FHS. The reasons for the adaptations in the CEOs were funding shortfalls and shortage of specialists for certain specialized services, making it difficult to meet targets.

Program-based funding and the imposition of rules have become the dominant funding model. It is therefore taken for granted that municipal managers follow the

paths dictated by the federal government, albeit with adaptations, to access funding. When managers deliberately opt to take the third path, their own path, without resources from another federative entity, it creates a sense of surprise and distrust, casting doubt on the importance of the principle of administrative decentralization of the SUS and the independence of administrative spheres. This third path is also common, especially in primary care.

Irrespective of the paths taken by municipal managers, from a national perspective, it is undeniable that the PNSB has played a key role in structuring municipal services. Besides the direct influence of funding, the policy was used as a major marketing tool by the federal government during the first term of the Lula administration, in the form of the *Programa Brasil Sorridente* or “Smiling Brazil Program”. Being associated with this brand was important not only at federal level, but also to municipal managers, who saw in this initiative the possibility to expand their political capital (ROSSI, 2018; GARCIA, 2013).

The considerable increase in funding and political marketing associated with the PNSB elevated the status of the position of oral health coordinator, making it a coveted political appointment. Despite the upsides (for example, increased resources and occupational prestige), the fact that the post became a political appointment meant that it was often occupied by people who were technically unprepared to do the job. Further research is needed to determine whether this reality is specific to the study region or if it is an informal rule of thumb in the national system. The prevalence of political appointments leads to higher turnover rates and management capacities that fall way short of those needed to deal with the complexities of the sector, resulting in discontinuity, a constant cycle of starting over, and demotivation among staff (LORENZETTI *et al.*, 2014).

Strategic conduct of health professionals

The strategic conduct of health professionals directly influences oral cancer prevention and control actions, regardless of the service in which they work. The findings highlight a contradiction between the efforts expended by professionals in response to suspected oral cancer and professional negligence in the treatment of other problems.

The greater effort expended in response to suspected oral cancer is related mainly to the suffering caused by cancer and its treatment, as well as the proximity

to death. These elements, as objects of the dentist's work, mean that stomatology, a specialty that is more related to diagnosis, is set apart from other specialties in the dentistry field.

Dentists are very sensitive to cancer. Because it's the only thing that can really kill a career. When you say cancer, doors open (RD4).

The findings show that professionals seek to fast track work processes when there is suspicion of oral cancer, playing an active role in referral and scheduling process. It is acknowledged that early detection is the responsibility of dentists, irrespective of whether they perform the biopsy or refer the patient to a specialist (HADZIABDIC; SULEJMANAGICB; KURTOVIC-KOZARICC, 2017).

According to the interviewees, mobilization is anchored in a collective concern with cancer, meaning that it does not only affect dental surgeons, but also professionals from other areas, managers, and administrative staff.

The receptionists develop a sensibility to certain signs. When a patient comes in looking very unwell or the lesion is large, they point it out. If somebody draws my attention to something more worrying, I see the patient on the same day. Outside the system, or, if there's a slot available on that day, the secretary schedules the appointment as if it was for that day. If not, I see the patient outside the system (RD6).

There is little concern with the refinement of cases referred for diagnosis by a specialist. Primary care professionals prefer to refer cases that may not really need referral than to run the risk of not referring a patient who does. A study conducted in a CEO in Santa Catarina found that 98% of patients referred for diagnosis had benign lesions at the time of the appointment (KNiest *et al.*, 2011).

Silly referrals happen, such as thinking that the parotid gland duct is a lesion. But I'd rather they sent me that than not send me something that is important. Too much is always better than too little (RD1).

The findings show that professionals make more effort when they suspect that a patient has a lesion than when a patient complains of pain. In cases of suspected cancer, professionals adopt forms of strategic conduct that they believe goes beyond their job functions, for example, calling a colleague, seeing a patient without an appointment, referring a patient without complying with system formalities, and taking the biopsy sample to a laboratory in another city and going back to get the result. This conduct is influenced by the practical consciousness of professionals. It is a socially constructed learning experience that leads to actions driven by alarm

over an extreme situation of having a patient with a hard-to-treat cancer whose diagnosis is normally delayed.

That happens only when the patient reports a lesion. When a patient seeks care without saying specifically what [the problem] is, it doesn't happen. If the patient arrives saying they want to make an appointment because they have a lesion or lump in their mouth, the guy thinks "*let me take a quick look here*", even on the impulse to refer. When [the patient] says it's toothache? [The dentist] does nothing, even when the patient is in pain (RD6).

This conduct is influenced by the representation of cancer in society. This representation is embedded in society's practical consciousness and revived the moment the cancer is suspected. The fact that the representation is embedded in society's practical consciousness means that professional delay in referral is harshly criticized by colleagues, who monitor, albeit tacitly, the behavior of others. This is what Giddens (2003) calls reflexive monitoring of action. Professionals place demands on themselves in relation to case urgency and expect others to do so as well. It is expected that professionals go beyond the limits imposed by the formal rules of the service, flows, and standards in order to meet the specific demands of each case. Care pathways and the rules set out by the PNSB and PNPCC are continually recreated by agents, just like the informalities of everyday work. Professionals who do not recreate these rules to meet the patient's needs are considered negligent.

Professional negligence in the identification of lesions can occur due to haste or oversight during patient assessment. While professional training emphasizes the importance of a comprehensive patient history (anamnesis) and thorough clinical assessment, heavy workloads and high stress levels mean that professionals seek to find quick solutions, focusing on immediate needs. Since oral mucosal lesions are rare and asymptomatic, professionals tend to focus on teeth and periodontal structures. Reports of lack of technical knowledge and skills and confidence in diagnosing lesions are common among FHS dentists (BARROS; CASOTTI; GOUVÊA, 2017). Lack of experience with this type of diagnosis, even among more experienced professionals, contributes to the failure to develop a careful eye for mucosal lesions.

Maybe training wasn't bad, he just didn't awaken an interest in the area and thinks [a case] will never pass through his hands. He does a wonderful filling, but the patient has the onset of a quiet little lesion. The dentist fails to see it because he doesn't have the habit of doing a sequential routine physical examination (RD5).

There is recognition of the importance of early detection of oral cancer. However, in contrast, there is no such concern about premalignant lesions such as leukoplakia and erythroplakia.

We referred a patient with a suspicious lesion and the stomatologist told her "*It's nothing, the guys there don't know anything*". What did we do? We scheduled the patient in another service, which did the biopsy. It was still leukoplakia, but isn't leukoplakia a premalignant lesion? What do you mean, it's nothing? (SF6)

In view of the lack of technical knowledge and skills among dental professionals, the SES/RJ included the need for training in early detection of oral cancer in the 2017 State Cancer Care Plan (RIO DE JANEIRO, 2017). While continuing training and professional development is essential to enhance practices, difficulties encountered by primary care professionals in identifying lesions mentioned in the interviews were more down to failure to acquire the habit of performing a thorough clinical examination than lack of knowledge of the characteristics of suspicious lesions. It is therefore essential that training occurs on a more regular basis so that professionals can incorporate screening into everyday practice. In addition, educational spaces should also serve to identify structural difficulties that extend beyond professional knowledge, because the reality of services means that professionals encounter difficulties putting technical knowledge into practice (SOUZA; SÁ; POPOV, 2016).

Some training is offered, but it's not very frequent. I think there could be an agreement to provide training over shorter periods, because the team changes, most staff only have a temporary contract. During the routine of day-to-day work, we tend to focus on other things and it goes very unnoticed. Yes, I confess that I may not have noticed lesions, it's not really my main focus (SF11).

Continuing education is fundamental, especially given the high rate of FHS staff turnover. Besides turnover, the lack of integration between CEO and FHS teams hampers the implementation of important processes that could better equip professionals and services. Building spaces that promote permanent dialogue between teams could enable knowledge and experience sharing.

It was our initiative, to get closer to the frontline. We had a totally wrong attitude. All I could see were the errors on the frontline. The only thing I did was question referral errors, without putting myself in their shoes. Now I see that they too have difficulties, just like me here. When you begin to cast aside certain things and put yourself in the shoes of the other, things improve (RD1).

Excessive team workloads are also a structural factor that hampers staff participation in training. This situation is no different to other settings where staff participation in educational activities is limited (PINHEIRO; AZAMBUJA; BONAMIGO, 2018). The lack of continuing education and low technical capacity of professionals, combined with excessive workloads and low primary care coverage, mean that many diagnoses of lesions are prompted by patients themselves, when condition is generally at a more advanced stage. The challenge facing professionals is to recognize early-stage lesions before the patient.

On the SUS, when we come across a patient, clinical experience means you can be certain about a lesion. You do the biopsy as a formality, it's just protocol. There is no merit in this diagnosis. Unfortunately early-stage lesions in their various forms go unnoticed (RD5).

Another form of strategic conduct essential to oral cancer diagnosis identified in the findings was professional-professional communication, which is particularly important in a health region where health facilities do not share patient records. With scarce and limited formal meetings, official communication between professionals is limited to referral and counter-referral forms, which focus on the patient's problem. This limitation means that informal means of communication, such as using digital technologies, become more important, helping to save time and reduce distances.

We discuss these cases in the dentist WhatsApp group. I have a case like that, and I'd like to do it that way. But we understand that even the managers are a bit constrained by a protocol that has to be respected (SF5).

Groups of professionals communicate constantly on a daily basis using cellphone messaging apps. This strategy has major potential for the promotion of early detection of oral cancer, given that this medium allows professionals to send photographs and videos. The use of cellphones can help the remote early detection of oral cancer by primary care professionals working in settings with limited resources. A study showed that photographs taken using a smartphone had a good level of agreement with those taken in-person, as well as good diagnostic accuracy (FONSECA *et al.*, 2018).

Communication with tertiary care is non-existent. Patient referral for treatment results in a practical break in the professional's connection with the care delivery process, preventing the construction of an effective health care system. Care is disintegrated and the role of primary and secondary care is reduced to "getting a treatment slot" in tertiary care (CASOTTI, 2019). The current management model restricts communication between levels of care.

Difficult, very bad, terrible to tell you the truth. I think that tertiary care needs to be closer. It's complex, as it's a unified system, but with different spheres governed by different people. They need to come together, because they depend on each other (RD1).

The informality of communication and processes can often be a facilitating factor for resolving specific problems, as it is not limited by restrictive rules. However, an unintended consequence of formality can be the maintenance of the problem situation. As Giddens (2003) highlights, since agents cannot identify all the consequences of their actions, they end up reproducing the conditions that make such actions possible.

It's detrimental when we accommodate ourselves with the system. For example, the personal nature of my first contact with the pathology lab and the establishment of informal [patient] flows happen because of lack of protocol. I found a way round it, but this continued for so long because people accommodate themselves. But it's detrimental. Some things go unnoticed (RD6).

These difficulties have resulted in professionals adopting different forms of conduct to ensure a rapid solution to the demands of suspected oral cancer patients. The formal scheduling process defined by macro-management does not adequately meet needs, resulting in informal micro-management that seeks to create solutions at local level to reduce wait times, as also found by Casotti (2019). The findings show that, despite formal structures, there is a constant inventive space in which agents can operate, reproducing and transforming practices and, consequently, health policy.

Limitations to this study include the study region, which has its own specific characteristics, meaning that the interpretations are specific to the reality of this setting. However, we discussed the relationship between everyday practice in the health region and national policies, drawing on other studies, thereby minimizing these limitations. Moreover, we sought to focus the analysis on conduct at a micro-political level due to the interpretive framework employed. Further research is needed to explore the collective conduct of agents that drive transformations at the macro-political level.

Box 1 presents a synthesis of the strategic conduct of managers and professionals involved in oral cancer prevention and control.

Box 1. Strategic conduct of managers and professionals involved in oral cancer prevention and control

Agent	Facilitating strategies	Restrictive strategies
Managers	Adherence to federal norms. Acquisition of political capital.	Non-compliance with federal norms. Reduction of working hours of professionals and specialists. Non-compliance with CEO production targets. Management turnover
Professionals	Efforts expended in response to suspected oral cancer. Tolerance with uncertain referrals. Dialogue between different types of professionals. Informal communication. Local solutions.	Negligence in lesion identification. Lack of technical knowledge and skills. Staff turnover. Distance from tertiary care.

Source: the authors.

Final considerations

This study provides important insights into how the strategic conduct of managers and professionals influences everyday oral cancer prevention and control actions. The findings show that the structuration brought about by the PNSB and PNPCC restricts the freedom of action of this group. On the other hand, these policies have been transformed on a daily basis by these agents in different institutional spaces within the SUS. This duality of the structure of these policies concurs directly with Giddens' structuration theory, used as an analytical framework for this study.

On the one hand, these agents, sensitized by the representation of cancer in society, are mobilized as potential facilitators of access, creating informal alternatives to more restrictive protocols. On the other, there is an important contradiction between the level of effort expended by managers and professionals in response to suspected oral cancer and negligence in the treatment of other problems. Part of this negligence is the result of lack of experience in the area, poor primary oral health care coverage, and heavy workloads, which means that each team is responsible for an excessive number of patients. In light of this situation, the reconfiguration of work processes, placing greater emphasis on health promotion and cancer prevention, together with

improvements in and the systematization of stomatology, are important measures that should be taken to promote the early diagnosis of oral cancer.

The findings reveal that it is essential to improve access to primary care to create structural conditions of action and invest in continuing training for professionals and managers to ensure that constant attention is paid to patients' needs. Without these measures, it will be difficult to achieve the desired levels of early diagnosis and timely treatment of oral cancer and guarantee the right to health.¹

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Note

¹ F. L. T. de Lima: study conception and design, data collection and analysis, and drafting of the article. G. O'Dwyer: study design, data analysis, and drafting and final revision of the article.

Resumo

Análise das condutas estratégicas de gestores e profissionais para a prevenção e o controle do câncer bucal

Gestores e profissionais de saúde são os agentes responsáveis pela implementação das políticas públicas nos serviços de saúde, sendo de fundamental importância compreender as formas como agem no cotidiano. O objetivo desta pesquisa é analisar as condutas estratégicas de gestores e profissionais que intervêm na prevenção e no controle do câncer bucal. Trata-se de pesquisa qualitativa, realizada por meio de 23 entrevistas com gestores e profissionais de cinco municípios da região de saúde Metropolitana I do Rio de Janeiro e três entrevistas com o corpo técnico estadual. Realizou-se a análise da conduta estratégica prevista na Teoria da Estruturação de Giddens. Verificou-se que esses agentes, sensibilizados pelas representações do câncer na sociedade, se mobilizam como potenciais agentes facilitadores do acesso e criam alternativas informais aos protocolos mais restritores. No entanto, essa mobilização não costuma ocorrer no período anterior à suspeita do câncer, constituindo uma contradição importante. Destacou-se a importância da ampliação da atenção primária e do aperfeiçoamento das ações de promoção da saúde, prevenção do câncer e educação permanente para garantia do direito ao acesso ao diagnóstico e tratamento precoce do câncer bucal.

► **Palavras-chave:** Neoplasias Bucais. Política de Saúde. Serviços de saúde bucal.

