Affordable & Accessible Oral Health Care

Dr. Vivek Singh[1], Dr. Anuradha P[2], Dr. Sahana S[3], Dr. Manu Narayan[4], Dr. Sugandha Agarwal[5], Dr. Shweta Singh[6]

PG Student[1], HOD & Professor[2], Reader[3,4], Senior Lecturer[5,6], Department of Public Health Dentistry, Babu Banarasi Das College of Dental Sciences, Lucknow

How to cite this Article: Singh V, P A, S S, Narayan M, Agarwal S, Singh S.Affordable & Accessible Oral Health Care.HTAJOCD.2019

Introduction

Globally, Oral health is an affair of interest & responsibility among adults and 90% school children but dental diseases is more prevalent than health. if health is seen affecting all segments of the population.[1] Compounding this problem is that an oral disease is the fourth most expensive disease to treat.[2] In the US alone, illnesses related to oral health result in 6.1 million days of bed disability, 12.7 million days of restricted activity, and 20.5 million workdays lost each year.[3]

Orodental diseases are blooming as a chief & primary public health problem in developing countries like India. Currently, in India, there are more than 267 dental schools, producing approximately 19000 dental graduates per year, and there are almost 3000 specialists available for providing dental care. In defiance of this, even the most elementary, crucial and unavoidable oral health education and simple interventions for pain relief and emergency care for acute infection and trauma is unaccessible to the vast majority of population, especially the rural and urban poor.[3] In addition, the recent growth in the economy and the advances in healthcare technology have widened the gap between the rich and the poor, exacerbating the inequity in access to oral health care in particular and health care in general. Despite the deleterious consequences of untreated oral pathology, inappropriate utilization of dental services remains a major problem.[4]

When people who can't incure or support dental care have a dental issue due to fewer allowances, they often go to the ER or their physician. Physicians often may prescribe analgesics and/or antibiotics to help manage the situation momentarily, but they are not qualified, experienced & knowledgeable enough to treat the underlying dental problem. The results from the study show that utilization of the dental service among adults attending outreach program was very low (28%). This is concordant with reports from China (20%) and Spain (34.3%).[5,6] In contrast, dental service utilization is high in developed countries, with figures of 75% in the US, 61% in the Danish adult population, 47% in the UK, 56% in Finland, and 43% in Singapore.

In dentistry, the notable improvements in oral health in order to make oral health care accessible and affordable. Over the past few decades reflect the sound science of the community-based prevention programs.[7] Successful strategies range from simple strategies that utilize preventive approach to more comprehensive strategies that involve multiple interventions. Some examples of community-based intervention include oral health education and community water fluoridation, which are the cornerstones of caries prevention in the United States.[8] Other intervention includes school mouth-rinse, provision of fluoride gel or varnish and school dental sealant program.[9,10]

Primary health care and dental insurance go a long way in rendering oral health accessible to all.

1. Little primary health
2. little insurance.

Admitting to the fact that, dental care is a part of primary health care in India, but very fewer states at the primary health care level are able to provide the mandatory and vital dental care services which is a matter of great concern. On the other hand as patients is not having any sort of insurance coverage or covered with a roof to support them, they largely or almost always end up paying their allowances by themselves from their very own pocket to receive or to get access to the required treatment from both public and private dentists.

Oral Health Care System In India

Oral health care in India is delivered mainly by the following establishments[11] -

***Government Organizations**

- Government Dental Colleges
- Government Medical Colleges and Dental Wing
- District Hospitals with Dental Unit
- Community Health Centers
- Primary Health Centers.

*** Non-governmental Organizations**

- Private Dental Colleges
- Private Medical Colleges with Dental Wing
- Corporate Hospitals with Dental Units.

*** Private Practitioners**

- Private dental practitioners
- Private dental hospitals
- Private medical hospitals with dental units.

***Indigenous Systems**

- Ayurveda
- Sidda
- Unani
- Homeopathy.

Majority of dental services in India is being provided by the private dental practitioners, followed by non-governmental organizations. Various nation-wide surveys have conducted to study the pattern of utilization of dental services by Indian population. The main objective behind these surveys was to evaluate the various factors that contributed towards utilization of dental services by the people residing in varied geographical regions of the country and factors predictive of this behavior.

Service Provided vs Service Accepted

Utilization is the actual attendance by the members of the public at oral health care facilities to receive the needful treatment. In regions where adequate dental manpower is available yet the utilization of oral health care services is low thereby widening the oral health differences across the social economic classes.[12]

Various factors like demographic, behavioral, socio-economic, cultural and epidemiogical, etc., contribute to people's decision to either forgo care or seek professional assistance for dental problems.

A World Health Survey (WHS) was conducted in India in 2003 and successfully implemented in six states namely, Assam, Karnataka, Maharashtra, Rajasthan, Uttar Pradesh and West Bengal, which comprised about 47% of the country's population.Overall, 28% of respondents reported oral health problems in India. West Bengal (42%) has the highest proportion of respondents with oral health problems. Respondents treated for oral health problems ranges between 21% and 28%, except West Bengal.[13]

Of those who were diagnosed with oral health problems, 51% have been treated. The percent of respondents treated for oral health problems is highest in Karnataka (72%) and lowest in Assam (26%). Prevalence of oral health problems is higher among females than in males. However, the percentage who received treatment for oral health problems do not vary much by sexes. A higher percentage of urban and higher income quintile respondents received treatment for oral health problems.[13]

Barriers to oral health care in India

There are several barriers to oral healthcare in India, identified by Singh et al[6] as:

(i) A lack of acknowledgement of the importance of oral health among the population, which perceives it as independent from and secondary to general health
(ii) No access for many to an oral health provider due to geographic distance
(iii) Dental treatment is unaffordable for many
(iv) Quality of dental treatment is varied.

Strategies for Improving Accessibility to Oral Health Care Services

Before proposing strategies to improve access to dental services, the actual meaning of "access to care" must first be comprehended. The current concept of "access to dental care" reaches far beyond its traditional meaning. The traditional meaning of access to dental services has changed over years, from just the adequacy of the workforce to a cascade of factors which are patient based. Some of the patient-based factors that determine the access to dental services are perceived need for care, cultural preferences, and language. So, when speaking of access to dental care today, both the availability of care and the willingness of the patient to seek care have to be considered. The connotation of access has changed from supply side of dental care alone, to the demand for dental care as well.[14,15] In essence, it is a supply-demand consideration.

1. Oral Health Workforce:

WHO recommends dentist to population

ratio for developing countries 1:7,500, while a developing country like India lags far behind this number.[16] A demand-based calculation of dental manpower needs in India suggests that one dentist would suffice for every 13,239 people, and this number rises to 18,738 people when the assessment was made based on effective demand.[17] However, these projections do not consider the geographical distribution of the services. The solution for improving oral health status of improving the rural Indian populace does not lie in increasing the absolute number of dentists available but in ensuring equitable distribution of the existing dental manpower, since it is the services but not the manpower that people want.

2. Strengthening Public Health System:

Indian expenditure on health care was just 4.2% of its GDP, of which public health spending is mere 1.2%. This is nominal when compared to China and the Unites States where the public spending on health care was 3% and 8.3% of GDP respectively.[18] The Dental Council of India drafted an oral health policy in 1985 recommending dentists to be recruited to PHCs (Primary Health Centers) and CHCs (Community Health Centers). It is unfortunate that the policy has not been implemented till date, and oral health has not been finding place in public health policies so long for now.[19] Strengthening the public health systems is very essential in tackling shortage of dental manpower and poor oral health status in rural India.

3. Strengthening Dental Education in India:

There were no private dental colleges in India before 1966. These numbers changed drastically by 2014, and 86% of dental colleges in India today are under the ownership of private sector but they are evenly distributed geographically. While welcoming the growth of dental education in India, emphasis must also be placed on the uniform distribution of dental colleges, quality of education being provided, and the values, social responsibilities that are being instilled in the students. An audit conducted on 82 dental colleges between 2006 and 2011 revealed that 13 of these colleges were granted permission in spite of negative recommendations of the Dental Council of India (DCI). So, poor management prevails in the country. Accreditation of dental schools must be made mandatory by the DCI, and this must be an ongoing, cyclic process.[20]

4. Community Oral Health Programs :

Community participation is a major key to a lucrative & fruitful community oral health programs which can be accomplished by headlining & promoting the importance and magnitude of oral health needs in a community, understanding the feasibility and acceptance of interventions, creating trust among people.[21] Legitimate and routine oral health education sessions in communities could modify & reshape the patient-based factors for instance, perceived need for care, knowledge and attitude towards dental care, conduct relating to individual and community health. Oral health education administered at schools, especially in rural areas where dental myths are more common, not only improves the oral health status of the children but also gives direction in maintaining the future generations towards better oral care.

5. Public Private Partnerships:

Universal health care must be made efficiently accessible and feasible to the entire Indian populace by fostering public private partnerships. However, the governments should take necessary care in involving only non-profit private partners, as for profit private sector encouragement in the provision of health care services would further deteriorate the already weak public health systems in India.

Conclusion

* Accessibility of services depends upon Location, how far you have to travel to the nearest dental practice and Spatial direction, whether a person can physically access the premises.
* Afford ability of dental treatment can act as a hindrance to people who are seeking for dental services. Some people are bothered about both Direct and Indirect costs spent after visiting a dentist.
* Various models can be employed to make health care accessible and cost effective. Integration of oral health programs into the existing national health programs avoids duplicity in resources and allows the ease of implementation.
* School dental health programs should be given due consideration and contemplated upon. Thus, should be seriously implemented by the policy makers as India constitutes 40% of the child population.
* Promoting fluoride use, both systemic and topical will reduce the economic burden of the population as it is easily available and scientifically proven.
* Public private sector collaboration will ensure equitable distribution of dental manpower, thus ensuring oral health for all.

Activist and humanitarian Martin Luther King Jr. told the Medical Committee for Human Rights in 1966: 'Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.' This remark is apt for the status of oral healthcare in a country with such a vast population and cultural diversity as India. Oral diseases are highly prevalent and affect general health and there is an urgent need to combat them by rendering affordable and accessible health care.

References

1. Petersen PE, Yamamoto T. Improving the oral health of older people:The approach of the WHO Global oral health programme.Community Dent Oral Epidemiol, 2005Apr;33(2):81-92.
2. Glick, M., Monteiro Da Silva, O., Seeberger, G. K., Xu, T., Pucca, G., Williams, D. M., Séverin, T. (2012). FDI Vision 2020: Shaping the future of oral health. International Dental Journal, 62(6), 278–291.
3. Kadaluru UG, Kempraj VM, Muddaiah P. Utilization of oral health care services among adults attending community outreach programs. Indian J Dent Res 2012;23:841-2.
4. Nanda Kishor KM. Public health implications of oral health -inequity in India. J Adv Dent Res 2010;I:OnlineISSN (22294120).
5. Pizzaro V, Ferrer M. The utilization of dental care services according to health insurance coverage in Catalonia Spain. Community Dent Oral Epidemiology 2009; 37:78-84.
6. Brown LJ, Lazar V. Dental care utilization: How saturated is the patient market? J Am Dent Assoc 1999; 130:573-80.
7. Ismail, A. I., & Bader, J. D. (2004). Evidence-based dentistry in clinical practice. Journal of the American Dental Association (1939), 135(1), 78–83.
8. Beltran-Aguilar, E. D., Barker, L. K., Canto, M. T., Dye, B. A., Gooch, B. F., Griffin, S. O., … Wu, T. (2005). Surveillance for dental caries, dental sealants, tooth retention, edentulism, and enamel fluorosis - United States, 1988-1994 and 1999-2002. Journal of the Canadian Dental Association, 54(3), 1-43.
9. Al-Jundi, S. H., Hammad, M., & Alwaeli, H. (2006). The efficacy of a school-based caries preventive program: A 4-year study. International Journal of Dental Hygiene, 4(1), 30– 34.
10. Gold, J. (2013). Fluoride varnish with community-based oral health promotion may reduce surface-level caries risk in preschool children. Journal of Evidence-Based Dental Practice. 13(2), 55-57.
11. Gambhir RS, Brar P, Singh G, Sofat A, Kakar H.Utilization of dental care: An Indian outlook. J NatSci Biol Med. 2013 Jul;4(2):292-297
12. Katherine H, M Practicum Access to Affordable Oral Health Care in Waterloo Region. A report for the Waterloo Region Oral Health Coalition Kitchener Downtown. Community Health Centre 2017;1-23
13. Toor RS, Jindal R. Dental insurance! Are we ready? Indian J Dent Res. 2011;22:144–7. [PubMed]
14. Marya C.M Textbook Of Public Health Dentistry 1st edition jaypee publication 2011; 240-241
15. Ganesh. M School dental health programme: a potential untapped yet. The journal of Ahmadabad dental college and hospital 2010; 1(1):22-28.
16. World Health Organization. (2012). Oral health fact sheet. Retrieved from http://www.who.int/mediacentre/factsheets/fs318/en/
17. Guay AH. Access to dental care: solving the problemfor underserved populations. J Am Dent Assoc. 2004Nov;135(11):1599-605;
18. Khemka S, Baliga S, Thosar N. Approaches to improve access to dental care services. Int DentMed J Adv Res 2015; 1:1-4.
19. Kothia N.R, B. Simha Vikram, P. Srinivas assessment of the status of National oral health policy in India. International Journal health policy management 2015Sep; 4(9):575-581.
20. Singh A, Purohit B. Targeting poor health: Improving oral health for the poor and the underserved. Int Aff and Glob Strategy. 2012;3:1–6.
21. Rajasekharan.S,Martens.C.L,Cauwels.R.E.G.C, Verbeeck,R.M.H Biodentine™ Material characteristics and clinical applications: A review of the literature, European Archives of Paediatric Dentistry June 2014;15(3):147-158