



## ORAL HEALTH INEQUALITY AND BARRIERS TO ORAL HEALTH CARE IN INDIA

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### ABSTRACT:

Oral health is an important integral part of general health of an individual. In developing countries like India, Oral health care services have always been a challenge due to inaffordability, inaccessibility and lack of utilization by the general community Oral health care services are expensive at corporate and private levels and cheap in medical and dental institutions where they are provided by trainees under good supervision. However, because of wide geographical variations and unequal distribution of oral health care providers with majority being in urban areas, it is mostly difficult for the rural population to easily access these services. Besides, ignorance about significance of oral health, lack of perceived needs, economic constraints, cultural and psychological barriers are few other constraints to utilisation of these services by the masses. Though a fair proportion of urban Indians have recognised the importance of oral health care, a vast majority of rural population still lacks an insight to this core area. Measures such as proper Oral Health Insurances, Governmental implementation awareness programs and introduction of oral health policies could help overcome these barriers. Every dental surgeon should contribute to bring about this behavioural change among Indian population.

**KEY WORDS:** Oral health, inequality, oral health care, barrier

### INTRODUCTION

Dentistry has evolved through society's attempt to meet the demands made by those suffering from dental pain from the ravages that dental disease has made to their functional ability to appearance. Dentistry is considered by society as service delivered from one person to another. The pattern is characterised by treatment of established lesion and the repair of damage rather than its prevention. The condition is aggravated by general orientation towards the requirements of those sections of the community capable of meeting the economic implications rather than those best able to benefit by it. An individual may have dental needs as determined by health care professionals but fail to seek services because he/she either does not perceive reason for the same or lacks sufficient resources as time, money or transportation to receive treatment.<sup>[1]</sup> Alternatively, individuals may demand services such as routine cosmetic services from health professionals which are motivated by concerns that do not meet generally accepted criteria for medical necessity.<sup>[2]</sup>

### INEQUALITY

It has been described as health differences which are avoidable, unnecessary, unjust and

unfair.<sup>[3]</sup> Inequalities have been observed between groups in a region and between geographic regions in the same country. It has even been described in every type of social and political system worldwide. There has been an oral health inequality associated with social class and place of residence. A high prevalence of dental caries has been found to be associated with low socioeconomic status. This variation in oral health has been found to exhibit national, regional and district variation.<sup>[4]</sup>

### DETERMINANTS OF ORAL HEALTH INEQUALITY<sup>[2]</sup>

1. Natural, genetic or biological variation.
2. Oral health damaging behaviour if freely chosen. Eg. Smoking.
3. Transient oral health advantage when one group is first to adopt a health promoting behaviour which then becomes widespread.
4. Oral health damaging behaviour where choice of lifestyle is severely restricted.
5. Exposure to unhealthy, stressful living and working conditions.
6. Inadequate access to essential health services.
7. Natural selection or oral health related social mobility where there is a tendency for sick people to move down the social scale.

8. Taboo practiced at rural and tribal population.  
**COMMON PROBLEMS WITH ORAL HEALTH CARE DELIVERY** (Plamping, 1988)<sup>[5]</sup>

1. Insufficient resources
2. Insufficient emphasis on prevention and public health
3. Unclear goals.
4. Inadequate organisation and management
  - Poor planning
  - Administration not unified
  - Little emphasis on evaluation
5. Inequality of distribution of services regionally
6. Failure in manpower planning and use of auxiliaries.
7. Inequitable access for people in certain localities and those with disabilities and elderly.
8. Method of payment of dentist not promoting high professional standards.
9. Lack of public accountancy and public involvement
10. Dental training not oriented to health service goals (attachment to a medical rather than a social model of health)
11. Dental research not sufficiently oriented to health care needs and prevention.
12. Unclear strategies for implementing policies.
13. Access problems.

#### **ORAL HEALTH CARE IN INDIA**

India is a developing country with a population of 1.21 billion. 70% of the Indian population resides in rural areas with little health care facilities and the major share of health facilities is taken up by the urban 30% population. Even in urban areas, the urban poor is a neglected lot in terms of health and oral health. Thus, there exists a huge oral health inequality among the masses in rural population.<sup>[6]</sup>

#### **BARRIERS TO ORAL HEALTH CARE IN INDIA**

To ensure those in need receive care, attention must focus on variety of barriers that limit access to oral health care.<sup>[6,7]</sup>

##### **A.) KNOWLEDGE AND VALUES**

Those in need of oral health care lack knowledge about prevention of oral diseases and awareness of their clinical need. The general public often does not appreciate importance of oral health, perceives it as independent from and secondary to general health. Many public policy makers do not understand or value oral health as part of general health care, thereby marginalising oral health to a policy of lower priority.

##### **B.) ACCESSIBILITY ISSUES**

Many in need do not have access to a oral health provider within their vicinity due to geographic disparity. Much of the oral health workforce is unprepared to render culturally competent care to diverse population, to people with complex medical and psychological conditions or

developmental and other disabilities to the very young and the aged to tribal or rural areas.

##### **C.) AFFORDABILITY ISSUES**

Many underserved groups cannot secure and afford dental treatment. Because of their economic status, some underserved are unable to pay for oral health care services. Dental insurance is universally non-existent in India.

##### **D.) SYSTEMIC BARRIERS WITHIN ORAL HEALTH CARE DELIVERY SYSTEMS**

A large number of systemic barriers exist within the oral health care delivery system of India. There is unequal distribution of health services with majority of dentists being located in urban areas and few of the dentists practice in rural areas where the majority of Indian population resides. There is a huge shortage of dentists in government services and the majority of health care services is provided by private practitioners and dental institution by trainees which raises the cost of quality oral health care services and hence becoming unaffordable to the majority of Indian rural masses. Even if whatever very small or negligible proportion of dentists are posted at government centres, there is a lack of infrastructure at Primary Health Centres and Community Health Centres which again becomes a major hindrance. The training of dental graduates is also not planned well with inadequate organisation and management, poor or no planning and minimal exposure to Indian rural masses. Administration of oral health care services at government level or decision making body is centralised with nobody taking up the responsibility for any health problems. There is no or little evaluation of health programmes. Also, there is a lack of research on oral health care delivery system as well as utilisation. There is a non-availability of oral health records, statistics, dental treatment audit of that particular area served.

##### **E.) PATIENT PROBLEMS**

There exists a fear of dental treatment among majority of Indian population which refrains them from seeking dental treatment. Reception and waiting room procedures are often time-consuming. Also, fear from white coat and bright lights, clinical smell, feeling vulnerable, lack of perceived need for routine dental check up, high cost of dental treatment, time off from work and taboos/ misconceptions related to dentistry are a major hindrance to patient's acceptance of oral health care.

##### **F.) QUALITY OF DENTAL WORKFORCE**

Another important challenge is to produce a high-quality workforce for future generations. Due to widespread commercialization of colleges, dental education has become a

business, and the ethical core of the profession has declined. With passing time there has been a gradual decline in the moral values of the workforce, with the majority of the workforce concentrating on making money. Care for the patient has taken a back seat. Various reasons have been cited as to why the workforce should have its own code of ethics such as the unprecedented growth in some specialties, the mushrooming of continuing education courses, and the maintenance of their standards. Also, well-qualified and high caliber students should be encouraged to enter the profession. Many of the students entering the dental schools have taken admission simply because they wanted a dental education or an alternate to medicine, not unlike the dentists who preceded them.<sup>[6]</sup>

The unprecedented mass of students entering the dental schools over the years represents a bulge in the enrollment trends. And when they begin to graduate, they find the world of dentistry moving at an increasingly competitive clip. The world is changing at enormous speed. The workforce should be able to keep pace with the fast-changing society so that it is not left behind in its service and is able to cope with the desires of the society. The goal of the workforce should be based on a commitment to prevention. Health education and the development of an effective health care system with proper communication are a must.<sup>[7]</sup>

#### **STRATEGIES TO SOLVE UTILISATION ISSUES**

1. Strengthening of oral health care delivery systems.
2. Assessing the oral health care needs and demands of the population.
3. Proper planning and setting realistic oral health goals.
4. Provision of adequate payment for health professionals.
5. Optimal use of auxiliary staff and health education
6. Use of mobile dental care office/unit and regular dental camps.
7. Change in the mindset of dental to assume professionals and social responsibility.
8. Proper development and utilisation of resources.

The success of utilisation of oral health care services lies in team work and intersectoral coordination. This can be achieved through coordination between the public and the private sector with governmental Support (Public Private Partnership).<sup>[8,9,10,11]</sup>

#### **DENTAL INSTITUTIONS**

Adoption of an area/ village or schools / special centres like old age homes, orphanages etc. by the dental institutions within its geographical area. Satellite centres can be initialised in

remote and underprivileged areas to provide oral health care services to the people of those areas at free or subsidised rates. Utilisation of mobile dental van to reach far and remote places. Utilisation of dental workforce-interns for oral health awareness, preventive programmes along with their exposure to community oriented approach. Health workers at PHC, school teachers can be utilised to impart oral health education.<sup>[11,12]</sup>

#### **PROFESSIONAL BODIES**

DCI should take an initiative by introducing competency based, community oriented training in internship.<sup>[13]</sup> IDA, Local NGO's, Corporate companies should work towards investing a particular share towards oral health.<sup>[12]</sup>

#### **GOVERNMENT:**

Utilise the services of fresh graduates on contract basis for rural areas. Establishment of dental clinics or upgradation of infrastructure for oral health at PHC level is required. There has been no oral health policy in India though drafts have been formulated but not implemented. Hence, there is an urgent need of a national oral health policy and separate budget allocation for oral health. Attempts should be directed towards funding for research on cheaper and quality materials to be used in field. Reduce taxes on toothpastes and dental materials to make it more affordable to the public and the dentist so as to cut down the cost factor. Also, local manufacturing of these products should be encouraged to provide both employment and to reduce the costs of these products. Oral health should be integrated into general health so that it becomes more acceptable to the community.<sup>[7,14,15,16]</sup>

#### **CONCLUSION:**

Numerous challenges exist for expanding oral health care in India. The biggest challenge is the need for dental health planners with relevant qualifications and training in public health dentistry. There is a serious lack of authentic and valid data for assessment of community demands, as well as the lack of an organized system for monitoring oral health care services need to guide planners. Human resource planning and utilization should be based on the aim for sustained development along with a system of monitoring and evaluation of programs.

Since there are no dentists in government decision-making bodies, dentistry is at the mercy of medical professionals who usually take for their own profession the major share in the meager amounts sanctioned by the government. Health education and the development of an effective health care system with proper communication are a must.

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Oral health inequalities. Oral diseases disproportionately affect the poor and socially-disadvantaged members of society. There is a very strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases.<sup>9</sup> This association exists from early childhood to older age, and across populations in high-, middle- and low-income countries. Twice-daily tooth brushing with fluoride-containing toothpaste (1000 to 1500 ppm) should be encouraged. Access to oral health services. Unequal distribution of oral health professionals and a lack of appropriate health facilities in most countries means that access to primary oral health services is often low. Reduce inequalities in both oral and general health. Definitions. Oral health problems tend to be more prevalent among people who are socially or economically disadvantaged. Understand the cultural, environmental and economic barriers to good oral health. This includes: - links between poor oral health and socioeconomic deprivation - the fact that some people may not think it is important to go to the dentist on a regular basis - the fact that some parents or carers may not realise that it is important to keep children's primary teeth healthy - being aware that people may need help to use the dental service

1. Apply oral health core clinical competencies within primary care practices to increase oral health care access for safety net populations in the United States.
2. Develop infrastructure that is interoperable, accessible across clinical settings, and enhances adoption of the oral health core clinical competencies. The defined, essential elements of the oral health core clinical competencies should be used to inform decision-making and measure health outcomes.
3. Modify payment policies to efficiently address costs of implementing oral health competencies and provide incentives to health care...