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Research Article

ACCESS TO ORAL HEALTH CARE IN INDIA: OVERVIEW

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ABSTRACT

Major dental public health problems which affect physical as well as psychological well being include dental caries, periodontal disease and oral cancer. Social disparities in health and oral health outcomes as measured by education, occupation and income constitute one of the main challenges for Public health. The needs of population are increasing but there exist shortage of resources. Even the existing limited resources are not utilized by the population due to many barriers. There should be an increased awareness about maintaining good oral health among public. To create awareness, public or dental public health professionals should work together.

Keywords: Availability, Affordability, Oral Health Care, Accessibility.

INTRODUCTION

Good oral health is essential to good overall health. The largely preventable problem of poor oral health has widespread repercussions ranging from lost time at school and work to reduced quality of life and increased incidence of non-oral health problems. It is exacerbated by lack of access to quality care and disproportionately concentrated underserved people. Access to oral health care is essential to promoting and maintaining overall health and well-being. When individuals are able to access oral health care, they are more likely to receive basic preventive services and education on oral health behaviors. They are also more likely to have oral diseases detected in the earlier stages and obtain restorative care as needed. In contrast, lack of access to oral health care can result in delayed diagnosis, untreated oral diseases and conditions, compromised health status, and, occasionally, even death¹.

NEED FOR ORAL HEALTH CARE

Despite great achievements in oral health of populations globally, problems still remain in many communities all over the world - particularly among under-privileged groups in developed and developing countries. Dental caries and periodontal diseases have historically been considered the most important global oral health burdens. At present, the distribution and severity of oral diseases vary among different parts of the world and within the same country or region².

According to the WHO, the prevalent oral diseases are dental caries, periodontal diseases and edentulousness. Very little

oral health care services are provided, but oral healthcare seeking behavior is also very low, especially among the rural population.³

- In India Prevalence of dental caries is 40%-80% (very high in Northern states 85%-90%).
- Periodontal conditions usually increase with age and are found more in rural areas.
- Oral cancer and precancerous conditions are 3%-10% (highest being in Orissa 7%).(Shan N, WHO – Oral health survey 2004)

ORAL HEALTH CARE SYSTEM IN INDIA

Oral health care in India is delivered mainly by the following establishments:

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

India has approximately 289 dental colleges with around 25,000 graduates each year. Even with such a large work force, most of the people in India do not have access to basic oral health. Although, dental care is a part of primary health care in India, dental care services are available in very few states at the primary health care level. Patients are not covered under any type of insurance, and generally pay out of their pockets to get treatment from both public and private dentists. Utilization is the actual attendance by the members of the public at oral health care facilities to receive care. Majority of dental services in India is being provided by the private dental practitioners, followed by non-governmental organizations⁴.

Access to Oral Health Care Services (Access to Care)

The ability of an individual to obtain dental care, recognizing and addressing the unique barriers encountered by an individual seeking dental care, including the patient's perceived need for care, oral health literacy, dentist and dental team distribution, financial circumstances, special needs, transportation, location, language, cultural preferences and other factors influencing entry into the dental care system (Academy of General Dentistry).

Attaining good access to care requires three, discrete steps:

- Gaining entry into the health care system.
- Getting access to sites of care where patients can receive needed services.
- Finding providers who meet the needs of individual and with whom patients can develop a relationship based on mutual communication and trust⁵.

The demographics of India are remarkably diverse. India is the second most populous country in the world, with over 1.78 billion people. The 68.84% of population resides in the rural and 31.16% of in urban. The healthcare industry is experiencing a quick transformation owing to the increasing demand for quality healthcare. In India, Oral healthcare is an important aspect of the overall health of an individual. Indian dental care services market, constituted by dentists and dental ancillary services, was estimated to be US \$ 739 million in 2010 and is expected to reach US \$ 1302.5 by 2015 at a CAGR of 12 percent.

An estimated of 40-50 percent of Indian population has never visited a dentist. Moreover, nearly 70 percent of population is suffering from dental diseases. The dentist/population ratio in India, clearly indicates that there is a major rural and urban divide in the availability of dentists in India; It is 1: 10,000 in urban areas and 1: 250,000 in rural areas - a clear indication of the potential this dental industry holds⁶.

According to Lennon et al (1988), barriers to oral health care access are classified as follows;

Financial barriers: Low income can result in several disadvantages Family which is struggling financially has difficulty in paying fees, and also finding the money for bus fares. Self employed people might have to forego earnings to visit a dentist.

Physical barriers: Dentists can establish their practices wherever they like and this has led to an uneven distribution of services. Majority of practices are clustered in the more affluent areas, thus making a dental visit more difficult for those patients relying on public transport.

Emotional barriers:

Dentistry has the reputation of being painful and it seems that some people are reluctant to visit a dentist because they expect to experience pain. Smith and Sheiham's (1980) study of elderly people showed that people who would have liked to receive treatment had not tried to obtain it because they felt they were 'too old', while many who were in pain who did not want to 'waste the dentist's time'. These feelings of low personal worth and that dental care is not 'worth it' may be important barriers for many elderly people.

The problems to access the health service described under following dimensions are Availability, Accessibility, Accommodation, Affordability and Acceptability (A's)

Availability: Most of dentist practice in urban and metropolitans cities. This paradox describes the *Inverse care law* where availability of good medical/dental or social care tends to vary inversely with the need of the population served to the extent that health care becomes a commodity just like sparkling wine. That is rich people gets lots of it and poor people don't get any of it.

Accessibility: Accessibility of services depends on two factors: 1) Location: How far you have to travel to the nearest dental practice? 2) Spatial direction: Whether a person can physically access the premises.

Accommodation: Accommodation refers to the way services are organized in relation to the client's needs and the patient's perception of their appropriateness.

Affordability: Payment for dental treatment can act as a barrier to people using dental services. Some people are bothered about both Direct and Indirect costs spent after visiting a dentist.

Acceptability: Users and providers of health services have expectations about how services should be delivered and received. These expectations are not always shared. Barriers could arise from both providers side as well as from the recipient side or the patient.⁷

The factors that contribute to problems with access to oral health care are numerous and complex. The **Federation Dentaire Internationale (FDI)** suggested that three separate category of barrier should be considered.

- **The first of these related specifically to the individual** and included: 'lack of perceived need, anxiety and fear, financial considerations and lack of access'
- **The second category related to the dental profession.** They included: 'inappropriate manpower resources, uneven geographical distribution, training inappropriate to changing needs and demands and insufficient sensitivity to patient's attitudes and needs'.
- **The third and final category of barrier related to society:** 'insufficient public support of attitudes conducive to health, inadequate oral health care facilities, inadequate oral health manpower planning and insufficient support for research'.⁸

Groups or vulnerable people face challenges to access the care

- 1) Poor and the working poor: Socioeconomic status is the strongest determinant of dental care use and expenditure. In a systematic review conducted by Costa SM et al in the year 2012, a total of 41 studies were included to check for the influence of socio economic status on dental caries. It was concluded that dental caries was higher among people with low socioeconomic status
- 2) Poor inner-city residents: Poor families are concentrated in inner-city neighborhoods They are beneficiaries of inadequately funded public assistance programs
- 3) Rural area residents: Dentists are significantly under represented within rural areas, especially in smaller and more isolated locations
- 4) Mobility-restricted people: People who cannot travel to dental care treatment facility because they are homebound or are residents of nursing homes or other assisted living settings must have dental personnel provide dental care to them where they reside. There are a variety of barriers to access for this group, including lack of facilities, insufficient reimbursement, complicated administration, poor daily support from caregivers and lack of experience among dental personnel.
- 5) Culturally isolated groups: Various ethnic groups, particularly newcomers to the states, often find that their language, political status and/or all cultural values may be barriers to receiving dental care.
- 6) Uninsured: People with limited financial resources may give dental care a lower priority than other expenses that they perceive to be more urgent.
- 7) People with special needs: Limited access because of complicated physical, medical, social or psychological conditions. (Pregnant mothers, very young children and older adults)
- 8) Prisoners: Limited financial resources and difficulty in recruiting dentists to work in that system are major barriers to provide care.
- 9) Victims of natural disasters: As dental services require stable source of electricity and water, even small disaster limits dentists' ability to provide care. Common needs in such cases include treating orofacial fractures, extractions, denture adjustments or replacements, temporary fillings.
- 10) Recent immigrants: Lack of knowledge of health care system, limited knowledge of language, cultural beliefs and fear associated with their legal status.
- 11) Unemployed: Families having limited income and who have lost dental benefits because of unemployment may find that their access to dental care is interrupted⁹.

MAJOR CHALLENGES FOR ACCESS ORAL HEALTH CARE IN INDIA ARE

- **Geographic Imbalance:** The number of colleges has increased to meet the demands of the society, but has there been a uniform growth of these colleges across the country and more over many colleges are to be found in cities and many times in one city more than two colleges are there. This show inequitable distribution.
- **Dentist-Population Ratio**

- **Lacking Dental Auxiliaries:** In all the countries Dentist is the responsible individual, directly or indirectly overseeing or coordinating contributions from related personnel. Dental therapists, school dental nurse, expanded duty auxiliaries and dental assistant exist in over 50 countries and work under the supervision of the dentist which allow them to provide specific services. Incorporation of auxiliaries increases the number of patients to whom dentist can provide dental treatment. In 1990 there were 3,000 registered hygienists and 5,000 lab technicians. i.e. 1 hygienist for 7 dentists where as the ratio should be 1:1. There were no registered dental nurses or chair side assistants and denturists. With the result that there has been no increase in the efficiency of overburdened dentists.
 - **Inadequate Workforce in Rural Areas:** The quality and functionality of a health care delivery system depend on the availability of dental personnel and infrastructure to provide needed services. Rural communities generally have fewer dentist, specialists, and other health care workforce, and the small population size and scale makes the loss or shortage of a single health provider likely to have far-reaching impacts
 - **Immigration and Migration of the Dental Workforce:** With increasing awareness amongst the urban population and the stiff competition that graduates face in cities, there has been an increase in the number of aspirants for postgraduate courses. Since the number of seats in various postgraduate courses is very few in proportion to the large number of graduates each year, many of the new graduates immigrate to other countries to fulfill their aspirations. Another reason for an increase in this immigration is the monetary benefits that the dentists get in most of the developed countries, especially the United States, United Kingdom, Canada, Australia, and New Zealand. These are the main four countries that receive the greatest immigration from India. Out of the 63 percent of dentists in New Zealand who are from overseas, for example, 15 percent are Indians.
 - **Lack of adequate research facilities:** Is also one of the reasons for a small percentage of immigration. The facilities in the developed countries are more advanced, easily accessible, and promising as compared to those available in India or any other Southeast Asian nation. Those aspiring to rise in research and academics prefer to go abroad.
 - 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 planners¹⁰.
- Health care access is measured in several ways, including:**
- Structural measures of the presence or absence of specific resources that facilitate health care, such as having health insurance or a usual source of care.
 - Assessments by patients of how easily they are able to gain access to health care.

- Utilization measures of the ultimate outcome of good access to care⁵. (i.e., the successful receipt of needed services)

Regardless of the group that is targeted for promoting increased access to dental care or specific problems being experienced by that group, any program developed to enhance access to care must address adequately three essential elements which are demand for dental care, dental workforce and economic environment¹¹.

Strategies for Reducing Barriers to Dental Care

- Developing a comprehensive oral health education component for public schools' health curriculums, in addition to providing editorial and consultative services to primary and secondary school textbook publishers.
- Providing oral health exams for 1-year-olds to help facilitate early screenings and implement oral health recommendations for children and their mothers.
- Offering multi-factorial interventions and educational programs to parents of young children, including public media and information provided at hospitals and other health care points of care
- Providing information to dentists and their dental teams on cultural diversity concerns, which will help dental professionals reduce or eliminate communication barriers and help enhance patients' understanding of treatment and treatment options;
- Working with community leaders to break down cultural barriers;
- Providing oral health information in multiple languages through multiple community channels.
- Providing tax credits to dentists who establish and operate dental practices that serves vulnerable populations;
- Offering scholarships to dental students in exchange for commitments to serve vulnerable populations;
- Support the re-establishment and expansion of school-based/ linked programs for low-income children, focusing first on prevention and oral health literacy, with a long-term goal of comprehensive care
- Establishing a system for surveillance and oral health reporting
- Encouraging private and public collaboration (Private public partnership Public sector: Provision of tax incentives to encourage private sector investment in health care capacity. Private sector: Planning, designing and development of health care facilities in whole or specialty wise.)
- Encourage and support dental professionals to obtain advanced degrees in public health (Dental public health leaders are needed to plan and implement programs, and advocate for the oral health)
- Teledentistry (Technology now exists to support distance collaboration between dentists and allied dental health professionals working in community settings, such as schools and long-term care facilities. Electronic collaborations are frequently used in medicine, but have been slow to be adopted in dentistry. However, they hold potential to bring more patients into the dental delivery system.)

- Dental health insurance can also bring about dental health care awareness percolating at the grass root levels. It would serve as a good motivation to the people to regularly visit the dentist and this in turn serves as an effective preventive measure

CONCLUSION

Dental disease is a serious public health problem with universal distribution and affecting all age groups. However, despite this universal distribution, only a few seek dental care. Thus a wide gap is created between the actual dental needs of the population and the demand for dental care which is quite understandable from the cited literature. In India, people encounter various obstacles in utilization of dental services. These barriers can be removed by motivating people and making them aware about the oral health problems that remove anxiety and fear so that they develop positive attitude towards dental treatment. There is a need for reasonably priced, rural oral health centers to make dental care available to rural strata of the population. Unmet treatment needs of the people belonging to lower class should be addressed during conduction of dental programs. Poor oral health care access significantly affects the oral health of the public. Strategies or methods to improve oral health access would ultimately improve the oral health status of population at large. Strategies involved in improving oral health care access should not only be realistic and applicable for a particular population based on its needs but also sustainable. There should be a collaboration between various departments with dentistry for achieving good oral health. All the possible barriers which prevent providers or recipients from achieving good oral health should be tackled. Improving access is a team work and if we work together there would be a sure success.

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