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RESEARCH ARTICLE

UNIVERSAL ACCESS TO ORAL HEALTH: A SYSTEMATIC APPROACH TO MORAL IMAGINATION

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ABSTRACT

Oral health is an essential component of over-all health and quality of life of an individual as well as the community. Not much has been done at the government level to improve the oral health of the people which continues to be one of the areas of greatest health inequity in our society. Lack of access to care is a critical barrier to good oral health. The aim of the current literature review is to consider both the barriers and opportunities for policy development to redress the ongoing gaps access to oral health services and the consequential challenge to improve oral health outcomes. Reducing inequity in oral health between different socioeconomic-status groups has been stated as one of the principal global goals for oral health. Due to the limited public funding for oral health care, it is important to adopt an evidence-based approach for allocation of the available resources. Oral health promotion and disease prevention are essential to any strategies aimed at improving access to care. Dental educators also provide learning experiences for dental students that help them to develop the belief that universal access to oral health care is a social justice imperative that will compel them to provide care to unprivileged patients after they graduate.

INTRODUCTION

Oral health is an integral part of overall health. Therefore, oral health care is an essential component of comprehensive healthcare. Good oral health does not just happen; it is the result of both personal responsibility and professional care. Access to oral health care is essential to promoting and maintaining overall health care.[1]

Universal access to oral health care is a justifiable demand for a number of disparate but morally sound reasons.[2] The burden of oral diseases can be equally distributed among minorities and low income people with this population significantly more likely to report oral health problems.[3]A number of children and adults have limited access to dental services or do not utilize dental services. Inadequate funding of oral health services, resulting in the lack of dentist participation in these services, disparity in the demand for dental care, lack of dental service providers in certain areas and the current structure of the health care delivery system, contributes to this situation.[4]

Unlike general health, oral health has generally not been seen as the province of government responsibility – neither have dentists encouraged government intervention.[5] Issues surrounding access to oral health care services, models for delivering these services, and related workforce concerns are gathering increased attention.[6]

Although general health conditions frequently draw attention in health policy and health services discussions, oral health issues seldom rise to the top of the national health policy agenda. As a result, oral health concerns have persisted as a major, largely preventable, health problem across the life span.[1]Oral health continues to be one of the areas of greatest health inequity in our society.[7]

Lack of access to care is a critical barrier to good oral health. Access is hampered by a variety of social, cultural, economic structural and geographic factors.[1] Dental workforce such as dental hygienist, therapists, are trained to teach patients proper oral hygiene practices to provide a host of preventive dental services. Lack of access to this allied work force is a key predictor to poor oral health. This issue needs investigation that how well the current health system protects individual against the financial consequences of experiencing oral health problems and then utilizing oral healthcare.[8]

The aim of the current literature review is to consider both the barriers and opportunities for policy development to redress the ongoing gaps in access to oral health services and the consequential challenges to improve oral health outcomes.

Current Issues of Concern to General Health and Oral Health

The epidemiological profile has changed significantly, evolving from the preponderance of communicable diseases to a significant increase in non-communicable and chronic diseases. This advanced transition is associated with the ageing of the population, urbanisation, deterioration of the environment, and lifestyle factors. Notwithstanding good average health indicators, morbidity and mortality vary greatly across socio-economic groups and residency suggesting that programs and policies have not been effective in benefiting disadvantaged populations. This also reflects very low ranking of disadvantaged populations in terms of economic equality.[9]
An examination of issues of equity of access to health services in the context of setting targets to reduce poverty and inequalities in health raises the question of the extent to which health services influence health status and inequalities. Health is influenced by many factors including genetic endowment, early life experiences, material conditions such as income and housing, education, psycho-social factors such as social support networks, health-related behaviour and biological risk factors, and medical/dental care.[10]

The most serious challenges facing developing countries in South America, Africa, and Asia in their pursuit of optimal oral health. They include poor access to adequate care, lack of quality dental materials at an affordable price and insufficient investment in dental care.[11] The impact of poor access to oral health care services is even higher on special population like children. They depend entirely on their parents to utilize the health care services.

Equity of Access to Health Services

Oral disease affect every community and it is the responsibility of local public health agencies (LPHAs) to assess the oral health needs of the communities they serve and to develop policies and programs to help ensure that those needs are met.[12]The definition suggested of equity in relation to health care is based upon:[10]

- Equal access to available care for equal need
- Equal utilisation for equal need
- Equal quality of care for all

Reducing inequity in oral health between different socioeconomic-status groups has been stated as one of the principal global goals for oral health. In addition, the development of equitable oral health system which improves oral health outcomes and responds to people's legitimate demands with a fairness in finance, is addressed to be one of the main strategic implications for the WHO oral health program.[8]

Health disparities, including oral health disparities, and their relation to socio-demographic characteristics, are now a major focus of public health.[13]

Oral health services transition coincides with the general trend in health services reform. In several Western industrialized countries, oral health services are made available to the population which comprises of preventive and curative services and are based on either private or public systems. Meanwhile, people in deprived communities, certain ethnic minorities, homeless people, homebound or disabled individuals and the elderly are not sufficiently covered by oral health care. With privatisation, growing number of people cannot afford private dental care. The demand for radical treatment services has increased particularly for low-income groups.[14]

In developing countries, oral health services are mostly offered from regional or central hospitals of urban centres and little, if any, priority is given to preventive or restorative dental care. Many countries in Africa, Asia and Latin-America have a shortage of oral healthcare personnel and by and large the capacity of the systems is limited to pain relief or emergency care.[14]

Determinants of Oral Health Inequality

Some of the determinants of oral health inequalities are:[15]

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.

The National Health Strategy – Shaping a Healthier Future is underpinned by three principles, one of which is equity. As defined in the National Health Strategy the principle of equity means that services are accessible on the basis of need rather than on geographical location or ability to pay.[10]

The Strategy elaborates on the principle as follows:[10]

"The achievement of equitable health services has a number of dimensions. Access to health care should be determined by actual need for services rather than ability to pay or geographic location. Formal entitlement to services is not enough; those needing services must have them available within a reasonable period. Furthermore, the pursuit of equity must extend beyond the question of access to treatment and care, and must examine variations in the health status of different groups in society and how these might be addressed."

The Strategy also states that achieving equity in the health care system will involve not only ensuring fairness, but also being seen to be fair and that important steps to ensure greater equity are:[10]

- Implementing uniform rules for eligibility and charges for services across the country
- Measures to reduce waiting-times for those availing of public services
- Giving special attention to certain disadvantaged groups

The American Association for Community Dental Programs (AACDP) developed *A Model Framework for Community Oral Health Programs* (the *Framework*), a policy document describing the integration of oral health into the 10 essential public health services.[12]

The *Framework* provides a context in which to consider the relationship between oral health activities, public health responsibilities, and desired outcomes and describes how oral health can be promoted within the context of the 10 essential public health services to improve a community's overall health status. To accomplish their goals, LPHAs must strive to meet the *Competencies for Dental Public Health.* They must also

work toward complying with accepted standards and guidelines that address *Healthy People 2010* oral health objectives.[12]

Social Differences in Dental Health

At every age, lower socioeconomic individuals are more than twice as likely to have untreated dental caries compared to higher income counterparts. People with dental care needs suffer disproportionately from periodontal disease and edentulism have more untreated dental caries, poorer oral hygiene and receive less care than general population.[1]

Despite major improvements in oral health for the population as a whole, oral health disparities exist for many racial and ethnic groups, by socioeconomic status, gender, age and geographic location. The economic factors that often relate to poor oral health include access to health services and an individual's ability to get and keep dental insurance.[1]

There has also been considerably increased investment in the public hospital system on which those in lower socio-economic groups are dependent and to which the whole population has access (with modest charges for non-medical card holders).[1]

Due to the limited public funding for oral health care, it is important to adopt an evidence-based approach for allocation of the available resources. That is, gathering detailed evidence on the dynamics of inequalities among subgroups is essential for decision making purposes.[13]

Oral Health Personnel

The issue of oral health personnel - which categories of personnel need to be educated, their duties and the numbers of each - has for many years been of great concern. The importance of this matter really has become evident in a number of countries where the production of dentists appears irrelevant to the oral health needs and demands. The problem of production of inappropriate types and numbers of oral health professionals is still being faced by some countries. It has been reported, particularly in countries where over-production exists, that duties which traditionally have been performed by assisting personnel are now being carried out by the dentists themselves. In those countries, the introduction of ancillary personnel has been delayed.[14]

The changing pattern of oral disease and socio-demographic factors imply that adjustment of existing oral health manpower structures are needed for several developed countries. In developing countries, the challenge is to stimulate training programmes for types of personnel which would match the oral health needs and the infrastructure of the country.[14]

Barriers to Oral Health

Barriers to oral health care include illiteracy, financial constraints, cultural perceptions, lack of awareness, inequitable distribution of dental manpower and inaccessibility to services as seen in most parts of many countries. For example dental coverage is correlated to access to and utilization of oral health care. One recent report found that individuals who lacked dental insurance were about 2/3rd less likely than people with private insurance to have had a dental visit with in last year. (16.1% compared to 50.9%).

To ensure those in need receive care; attention must focus on variety of barriers that limit access to oral health care.[15]

Knowledge and values

Those in need of oral health care lack knowledge about prevention of oral diseases and awareness of their clinical need.[15]

Accessibility issues

Many in need do not have access to oral health provider within their vicinity due to geographic disparity.[15]

Affordability issue

Many underserved groups cannot secure and afford dental treatment.[15]

Systemic barriers within oral care delivery systems

Unequal distribution of oral health services with majority of dentist being located being in urban areas and very few of dentists practice in rural area Where the majority of population resides.[15]

Patient problems

There exists a fear of dental treatment among majority of Indian population which refrains them from seeking dental treatment. 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.[15]

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.[15]

Primary Health Care: Can This Be A Solution

Primary healthcare is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health.[16]

As the National Health Strategy *Shaping a Healthier Future* states "health promotion provides the obvious starting point for any refocusing of the health services towards improving health status and the quality of life." This entails a multi-sectorial approach since many of the factors which affect health lie outside the direct remit of the health sector per se.[10]

Evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary healthcare helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians/dentists/surgeons, a relationship with a source of primary care, or the receipt of important features of it.[17]

CONCLUSION

Dental educators also provide learning experiences for dental students that help them to develop the belief that universal access to oral health care is a social justice imperative that will

compel them to provide care to unprivileged patients after they graduate.[18]

Oral health promotion and disease prevention are essential to any strategies aimed at improving access to care. Realizing this vision will require numerous coordinated and sustained actions with special attention to the distinct and underserved populations. This will require flexibility and ingenuity among leaders at the federal state local and community levels acting in concert with oral health and oral health care professionals.
The following recommendations are:

- This article calls in to sharp focus the challenges that, million people faces in accessing oral health care. Government should provide a road map for the important and necessary next steps to improve access to oral health care, reduce oral health disparities to improve oral health of the nation's vulnerable and underserved populations.
- Creating optimal laws and regulations to maximize access to oral health care; Improving dental education and training, reduce financial and administrative barriers; Regulation of allied dental providers; Government, federal agencies, private foundations should support oral health research to evaluation of new methods to technologies for delivery of oral health care to the populations, measure of access, quality to outcomes, payment and regulatory systems.
- For children, various programs to encourage oral health screenings by paediatrician and dental professional and provide wider access to school based sealants services can provides important benefits.

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