Research Article

The Intersection of Dental Private and Public Health Practice in India - An Insight

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Abstract

For Dental Public Health, the patient is the entire community or population like school, neighborhood, city, state, or the nation, with a focus on vulnerable populations. Dental professionals must be educated to treat the entire community rather than concentrating on individual treatment and private practice. The utilization of resources should be maximized by making effective policies and programs to meet the needs of the community. Awareness must be increased among people so that they can take preventive measures rather than undergoing expensive treatments or extraction of teeth. Hence this article gives us an insight between the private and public dental practices in India.

Key Words – Public Dental Health, Private Dental Practice, Child Dental Treatment, Dental Prevention, Ayurveda.

Introduction

Oral health is fundamental to general health and well-being. A healthy mouth enables an individual to talk, eat, and socialize without experiencing active disease, discomfort, or embarrassment. Oral diseases present a major public health problem **(**1**).** About 90% of school children worldwide and most adults have experienced caries, with the disease being most prevalent in Asian and Latin American countries **(**2**).** These could be attributed to several factors that mainly lack oral health awareness and overconsumption of refined carbohydrates. Children who suffer from poor oral health are 12 times more likely to have restricted-activity days than those who do not **(**3**)** More than 50 million school hours are lost annually due to oral health problems, which affect children's performance at school and success in later life **(**4**).**

Dental disease has been widespread, recognizing a few barriers of class, ethnicity, or economic status. By the middle of the twentieth century, the acute manifestations of caries and advanced periodontitis left large numbers of persons with no options except extensive removal of teeth, restoration of the remaining teeth, and either fixed or removable prostheses. As the profession

emerged from the Second World War, it was equipped with the skills for extracting teeth and manufacturing a vast array of mechanical structures fabricated from a variety of materials.

The 1950s witnessed the rise of a much more focused approach to science in all of the health care. Through this movement, the profession began to understand the systemic causes of infection and disease, which led to a more scientific evaluation of existing treatments and new evidence-based approaches to prevention and therapy. Key among the preventive developments was the recognition of the efficacy of fluoride in preventing the onset of disease and the application of fluoride through water supplies as a population health strategy. Also contributing to prevention was the widespread information-sharing among dentists, dental hygienists, and educators about the causes of infection and the corresponding change in patterns of self-care and treatment in large parts of the population. New restorative techniques, coupled with the middle-class cultural expectation of the annual dental check-up and the disposable income to pay for these preventive and therapeutic services, led to improved oral health for many parts of the population **(**5**).**

Overall, the practice of dentistry has become a more lucrative and less time-consuming profession over the past decade. In comparison to physicians, dentists work more independently, have a higher rate of solo practice, and have greatly increased their earnings, in some cases surpassing the net income of physicians. Dentistry has remained a “cottage industry,” which has fought incorporation into larger systems of managed care and capitated payments that have permeated medical groups.

There is abundant evidence that a sizable segment of the population does not have access to dental care through the traditional private practice model **(**6**).** Yet there is a poorly defined and underdeveloped dental “safety net.” The result is that a growing number of people, many of them children, are unable to get regular dental care through the dental public health system or any other way.

Dental Public Health

Dental public health is a unique and challenging; American Dental Association-recognized specialty because the patient is the entire community or population, such as a school, neighborhood, city, state, or the nation, with a focus on vulnerable populations. Limited resources are maximized through prevention, policies, programs, and organized community

efforts to respond to great-unmet needs. Although dental public health professionals are few, millions of people every day have better oral health because of these professionals, who work on the local, state, and national level.

India is the second-largest country by population and seventh by area. Indian health care system is the most ancient and the Indian approach to health is enshrined in the concepts and principles of Ayurveda which means the 'science of life'. Ayurveda is one of the oldest systems of health care in the World. Ayurveda deals with both preventive and curative aspects of health. The public health system in India is a population-based normative approach is adopted for establishing hospitals and health centers, sub-center (SHC)– One for every 5000 (3000 in hilly/tribal areas) population. Primary Health Centre (PHC) – One for every 30000 population (20000 in difficult areas) with 4-6 indoor/observation beds. Community Health Centre (CHC) – One for every 80-120 thousand population with 30 beds. The norms are for government institutions and are for rural areas only. For urban areas, no norms have been defined. Nearly all government civil and district hospitals and most of the CHCs are located in the urban areas.

No information is available about the private health system.

The Modern System of Medicine is regulated by the Medical Council of India (MCI), and Dental Council of India (DCI). Whereas the alternative systems recognised by Government of India are regulated by the Department of AYUSH (an acronym for Ayurveda, Yoga, Unani, Siddha & Homeopathy) under the Ministry of Health, Government of India. PHCs are non-existent in most places, due to poor pay and scarcity of resources. Patients generally prefer private health clinics. According to National Family Health Survey-3, the private medical sector remains the primary source of health care for 70% of households in urban areas and 63% of households in rural areas **(**7**)**. Reliance on public and private health care sector varies significantly between states. Several reasons are cited for relying on private rather than public sector; the main reason at the national level is poor quality of care in the public sector, with more than 57% of households pointing to this as the reason for a preference for private health care. Other major reasons are distance of the public sector facility, long wait times, and inconvenient hours of operation.

Public health dental workers are responsible for planning, developing, implementing, and evaluating programs to promote and maintain the oral health of the public. Functioning at the federal, state, and local levels, these public health workers are defined officially only by their training in dentistry or dental health. Additional public health staff may work on dental public health issues but under a different official title.

Around 400 dentists (in 2002) work for the Indian Health Service, and 258 are serving in the National Health Service Corps **(**8**)** Community health centers (CHCs), serving 8.6 million people, including 2.8 million Medicaid beneficiaries, were only able to provide 1.2 million patients with preventive and basic dental care in 1998, less than 13 percent of the total clientele **(**9**).**

Dentists actively fought any Medicare dental benefit when the program was created in the late 1960s. Unless this lack of coverage changes, baby boomers soon reaching retirement age will be faced with no systematic way to finance their dental care (**Figure** 1).

Age Structure

- 0-5 Years : 10.3%
- 0-14 Years : 30.8%
- 15-64 Years : 64.3%
- 65 + years : 4.9%

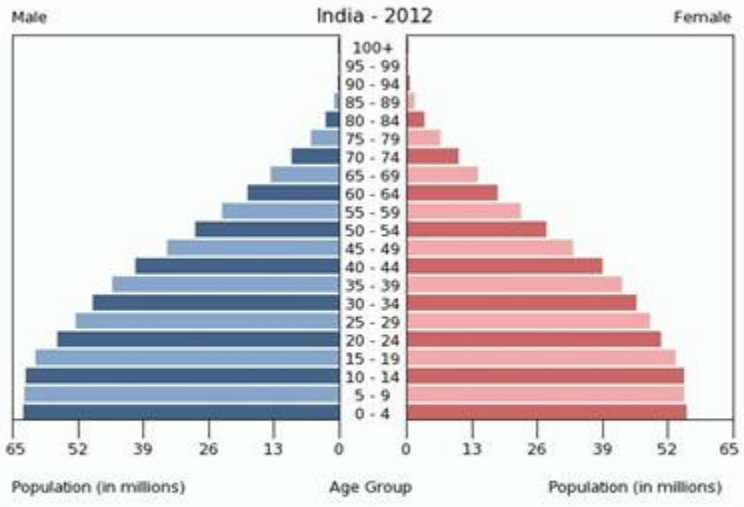

Figure 1 - Population Pyramid

Current Crisis of Care

While some dentists volunteer their time to help the underserved, the lack of dentists participating in Medicaid continues to be a major access barrier for many low-income populations **(**10**)**.

Underserved groups include people who are low-income or indigent; live in rural communities; are racial or ethnic minorities, non–English speaking, children, or elderly; and are developmentally disabled or have major medical problems. This population faces sizable barriers to care, and all are at a notable disadvantage with poor health outcomes. Socioeconomic status tends to be the most important indicator for use of services and health outcomes, regardless of race and gender, while people with dental insurance have a higher likelihood of visiting a dentist than do those without **(**11**).**

This is attributable to the current practice model of dentistry, which is structured to serve insured patients or patients who have the disposable income to pay for services out of pocket, in areas served by dental providers. Moreover, dental education trains new providers leaving little room for developing a different type of practitioner that might appropriately address unmet needs. There is limited public financing for oral health care services outside of private dental offices. The dental safety net is small compared with the medical safety net, and many safety-net providers are underfinanced, understaffed, and overburdened **(**12**).**

The lack of incentive, the limited supply of dentists, and the lack of alternatives for delivery and financing of care mean that much of the population with the greatest and fastest-growing set of needs will continue to be underserved by the traditional system of private practice.

Alternative Organizational Structures

A variety of strategies have been explored to provide some level of improved access to dental care for underserved populations **(**13**)**. One of the keys to improving access to care is making dental services visible, affordable, and convenient for underserved populations. On the supply side, public dental clinics, whether freestanding or integrated into larger medical clinics, represent the closest alternative to private practice. Dental vans and mobile dental services have become a popular solution for delivering services to rural communities or schools. Increasingly, school-based or -linked services organize care at easily accessible sites and emphasize preventive care

and screening. Teledentistry enables dentists in remote clinics to communicate with specialists in urban centers, to provide better diagnosis and referral **(**14**)**.

Dental Care for Children

Dental care has been systematically organized to improve dental health attitudes among children and the young **(**15**)**. Studies have shown that appropriate oral health education can help to cultivate healthy oral health practice **(**16**)**. Schools may be the only place for children, who are at the highest risk of dental disease, to gain access to oral health services. As children spend much time in school, teachers can assist with dental health education programs **(**17**)**. In parallel with the changing oral disease pattern, there have been significant improvements in oral health awareness, dental knowledge and attitudes of children and parents **(**18,19,20**)**.

However comprehensive preventive programs for oral health care are still lacking, so more dental education is needed to improve oral health standards among the children.

Oral health education programs could be included in the school curriculum for the children to emphasize a positive attitude toward oral health. To positively influence and improve oral hygiene practices among children. Community dental health carnivals, costumed characters and oral health booths and children's dental health shows could be arranged. Dental professionals should seize the opportunity to educate the public and children to enhance awareness among children and impart a positive attitude toward oral health.

Dental Care for Elderly

The elderly should receive special consideration in terms of their oral health care needs since they:

1) may have unique problems accessing the health care delivery system;

2) experience different patterns and prevalence rates of oral diseases;

3) may have characteristics that affect the amount and types of dental treatment and the method by which it is performed.

Older adults are maintaining their natural teeth into their later years, and epidemiologic trends suggest the increasing need for dental services by older adults. Yet dental utilization rates are lower for older adults than for younger age groups, and barriers to care include the cost of dental care, the lack of perceived need for care, transportation problems, and fear. Oral diseases and impairments are most commonly experienced by those segments of society least able to obtain dental care. Economically and socially disadvantaged older adults and the physically impaired are more likely to experience tooth loss and edentulism, untreated dental decay and periodontal diseases. Additional research is needed to accurately characterize the oral health status and needs of the growing number of homebound and institutionalized elders. This will be of growing importance with the emergence of the vast array of home health care services available to older adults, and the changing emphasis on home care often seen as the preferred and lower-cost alternative to nursing home care **(**21**)**.

The monitoring of oral health could be incorporated into a chronic care model and be offered in systemic primary care carried out by family physicians **(**22**)**. This would be beneficial to Medicare recipients who have no dental coverage. Although access to care for underserved populations is on the policy screen, the important issues associated with dental care for the elderly have yet to catch policymakers' attention.

RDHs, with their occupational growth and focus on preventive care, maybe oral health professionals best poised to address issues of access. However, RDHs are restricted in most states from practicing without a dentist's supervision. The growing shortage of dentists in many areas limits hygienists' ability to provide preventive care where it is needed most. The low priority of dental public health within public funding mechanisms has also restricted full-scale prevention activities in schools and health care facilities. While many benefits from fluoridated water, only those who can afford regular dental care receive the benefits of regular, comprehensive preventive care.

This apparent signal of market equilibrium is misleading. There is "abundant evidence that a sizable segment of the population does not have access" to private care, while the dental safety net is "poorly defined and underdeveloped." Dentists' participation in Medicaid is not robust; community health centers and public health facilities have scant dental capabilities, and Medicare offers no dental coverage. "Radical steps" will be needed to correct "a growing disconnect between the dominant pattern of practice…and the oral health needs of the nation," including new practice settings for dental care, integration of oral and primary health care, and expanded scope of practice for hygienists and other allied professions.

Emerging concerns for the nation's oral health include access to care for low-income and underserved minority groups, oral diseases related to tobacco use, chronic facial pain, craniofacial birth defects and trauma, and the emergent health needs of an aging population that will need services in new locations and new forms **(**23**)**.

Conclusion

Meeting the challenges of reducing disparities in oral health care will require fundamental redefinitions of how dental practice is organized, financed, and provided. Finally, the education of dental professionals must focus on community health and well-being, in addition to individual treatment and private practice.

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