Academic Leadership: The Online Journal

Volume 9
Issue 2 *Spring 2011*

Article 13

4-1-2011

Dental Public Health! A Mistaken Identity

A. Singh

Bharathi Purohit

Academic Leadership Journal

Dental Public Health! A Mistaken Identity

The dental public health field has been expanding in scope & complexity with more emphasis being placed on the total dental care delivery system and its impact on oral health status.

A broadly accepted definition of “dental public health” has been given by Downer 1994: “The science and art of preventing oral disease, promoting oral health and improving quality of life through the organized efforts of society” (Downer et al,1994). A broader definition was made ten years later as follows: “The science and art of preventing oral disease, promoting oral health and improving quality of life through the organized efforts and informed choices of society, organizations, public and private, communities and individuals” (Pine & Harris 2007).

The purpose of an oral health care system is to influence the population’s way of life so that oral health is promoted or maintained and oral disease prevented; and to promote adequate treatment to those members of the population affected by oral disease so that disease is arrested at an early stage and loss of function is prevented. These functions apply whether the service is in a developing or developed country.

Dental public health in Indian scenario

At the very basis of the system of oral health care are the goals and objectives-the purposes and expected outcomes of care. Some countries have neither clearly articulated oral health objectives nor a well defined system of care; others have oral health objectives that appear to have developed independently of the organization of care, with a system that is unresponsive to those objectives; yet others have clearly stated objectives and system designed to respond to those objectives, both of which are outdated. Often uncoordinated programmes and appearances of ambivalence about oral health care as a social good result when there is no clearly articulated policy (Andersen et al, 1995).

Master of Dental Surgery or MDS is a post graduate program offered by dental schools in India. The minimum qualification for the program is Bachelor of Dental Surgery (BDS). A five-year dental education leads to the B.D.S. degreein India, including one year of compulsory internship. Dental Council of India (DCI) is the regulatory body for these courses (Dental Council of India, Government of India).

In India, Public health dentistry is also known as Community dentistry. Apart from few, most of the schools in India do not understand what community dentistry is about. It is taken as means of increasing number of patients to dental schools. It is seen as an advertisement agency for the schools. These schools have developed, for various reasons, an attitude that patients to be treated in specialized departments. Role of Community dentist (MDS in Public health dentistry) is of a referring body.

Dental camps are organized to create awareness in the public so that the dental disease can be prevented and treated. Dental camps are helpful in providing dental health care to the poor, needy and rural population. Specialists (MDS in Public health dentistry) attend these programs along with BDS (dental graduates), but instead of providing preventive and treatment services, only referrals are made to the dental schools.

Oral health policy was drafted by Dental Council of India (DCI) way back in 1985. National oral health policy (1985) recommends public health dentists to be appointed at primary and community health centers. Till present the policy has not be implemented (National oral health policy, 1985).

Dental public health as practiced in other diverse cultures

European countries

In UK, National Health Service (NHS) dentistry has produced one of the most cost efficient delivery systems in the world. Administration and delivery of health care service is divided into those that purchase health care and those that provide care. General practitioners (84%), hospital (9%) and Community Dental Service (6%) provide dental care. The Community Dental Service (CDS) forms a 'safety net' treatment service for those who are unable or unwilling to access care within the general dental service. These services are managed by dentists with training in public health. In addition to this role, the CDS monitors the oral health needs of the population through screening of children in schools and regular epidemiological surveys. In addition, the CDS has a health promotion role and provides referral service principally for general anesthesia and orthodontics (Daly, 2002).

The community based dentist in UK has the following functions:

1. Manager: Leader of primary oral health care team; monitor and control the oral health subsystem, organize/coordinate preventive, treatment and treatment services; help data analysis research and information dissemination; help plan supervise and evaluate oral health activities.
2. Agent of Socioeconomic development: Development of community participation in oral health; participate in community meetings and development activities; liaison with public, politicians and other sectors, participate in intersetcoral projects.
3. Dental officer: Complex treatment of patients; promotion of oral health at community, family and individual level.
4. Educator: Continuing education of colleagues; training of lower level oral health workers; oral health education of families and communities.

The essence of welfare state is a government protected minimum standard of income, nutrition, health, housing, and education, assured to every citizen as a right, not charity. However the definition by Wilensky provides no indication of how far the government protection should go in terms of level of protection and in terms of equality (Wilensky, 1975).

In Nordic countries all children aged 0-18 (Denmark), 0-18 (Norway) and 0-19 (Sweden) are provided free systematic preventive services and comprehensive treatment by the public dental services. In Norway and Sweden new groups of priority, i.e. disadvantaged, handicapped and institutionalized old

age people were included as target groups of public dental services. The adult population of Nordic countries demands oral health care primarily from private practitioners. In Sweden, Finland and Norway the public service is dimensioned to provide services to the adult population on demand, particularly in districts particularly in districts where there is no or low availability of private practitioners (Rossow and Holst, 1991; Vigild, 1992).

Compared to development of welfare legislation in other European countries, following elements can be said to be typical for the Nordic model: a greater government involvement in both financing and delivery of services; a high proportion of public employment in education and in health and social services; policies and services are universal and no selective; the eligibility is based on rights related to citizenship and to a small extent earned by employment and other merit; the political aims are to a larger extent a redistribution of wealth.

In Netherlands National Health Insurance (NHI) includes only preventive treatments (checkups, oral hygiene instruction and scaling). Young patients up to 19 years of age still have the right to full dental care. Adults have to pay for dental care not covered by the public health system or to arrange privately a supplementary insurance.Public health dentist provide complete range of services to children and preventive treatment to adults under NHI (Pine and Harris, 2007).

Latin America

Health care, including oral health is closely related to social and economic situation of each country. All Latin countries have some sort of organized health care system. Its offer and delivery can be grouped into public and private sectors. 70% of Latin American population relies on public services which employ 25% of dentists. In spite of this, public services are poorly structured, offer limited services and usually their population coverage is low (Pan American Health Organization, 1994).

The trends are not encouraging. The present unequal system of mainly private practice is directed to a minority of population. There is no sign of changes in model of high production of dentists for facing high prevalence of diseases. Increasing difficulties in finding jobs may lead to lower demand for places in dental school. Organized oral health promotion, including prevention has had a nominal role to date.

In future, public sector which tries to cover low income population may remain to close to what it is today in Latin countries. Largely this is due to the model adopted by majority of governments in region, implementing privatization and trying to reduce state participation in the economy.

Brazil

A classic study of Nadanovsky & Sheiham (1995) showed only 3% of reduction of cavity levels in 12 year-old-children with access to the oral care, while the same study showed 65% of reduction caused by macro social factors, including the public health politics.

In Brazil, the DMFT (level of teeth lost, with restorations and with cavities) index fell from 6.65 in 1986 to 2.79 in 2003, representing a reduction of 58%. In the same period, the level of children with zero DMFT increased from 3.7% to 31.1% (Narvai et al 2006). With this text, it is clear that Brazil has much to do, especially to modify the model of dental treatment, based on restorations and surgery, for a model of health promotion, and this factor is the dependence of the policies of the public health system as

inclusion. “Oral health care strategy” has been included in the Family Health Program (December, 2000), which has deployed 18,480 staff to promote health care for poor families in more than 4,000 cities in Brazil (Brasil et al 2009). Number of dentists in Brazil reached nearly 220,000 and most of them (70,000) are employed by the federal government in the public health system (Brasil et al 2002).

United States

In United States of America Public health dentists practice at the local, state and federal levels as well as in academic environments. The four major areas of public oral health are: health policy, program management and administration; research; oral health promotion and disease prevention; and delivery systems. Policy work includes such dissimilar concerns as developing dental programs for low-income communities and making recommendations for the state dental practice act. It is not just dentistry for the poor, although provision of care to persons who do not fit the private practice mode is part of it (Burt and Eklund, 2005)

People’s Republic of China

During Mao Tse- tung’s era in the People’s Republic of China, policy guidelines were observed in the implementation of an oral health programme through provision of services such as fillings, extractions and stainless steel crowns to range of workers, peasants and soldiers using the counterpart of barefoot doctors, dental health workers.

Until recently, all health care workers in China were government employees and there was no private sector. At present, majority (over 80%) of health care personnel work in various health care facilities set up by government. In rural areas public health dentist work in a out patient clinic at village level. Small general hospitals are set up at township level while larger general and some specialist hospitals are set up at country level. A corresponding structure is established in urban areas. Public health dentists provide the range of preventive and treatment services to the community. Complicated treatments are referred to specialist hospitals (Hillier and Shen, 1996).

Policy issues in Indian context

Ultimate responsibility for the performance of a country’s health system lies with government. Public health dentistry in India has become a moral science, both for students and faculty. The problem being faced is of mistaken identity or an identity crisis. The meaning of words public, health and dentistry all seems lost.

The reason for these problems is that dental schools are being run for monetary gains. The management running these schools is not concerned with the health of the community. They require public health dentist because it is a post graduate subject for which admissions are taken each year on basis of huge amount of capitation fees. The government has not included oral health in public health politics, a change that could have led to improvement in the differences in health status of urban and rural population. It would have also brought down the dissatisfaction among the dental community by new jobs being created.

Dental camps in most part of India do little benefit to the people. They are being conducted for gaining publicity, such as for newspaper publications or for promoting dental schools. Therefore with time,

number of patients attending these camps drops drastically, as they are aware that treatment is not being provided and only referrals are made.

Who is to be blamed? Who is responsible for these misconceptions? It is the managements running these schools and the dentists working in such schools. School children, elderly, socially disadvantaged, rural and poor population require dental treatment, which if provided at dental camp settings, mobile unit or other health care settings will reduce disparities in oral health between deprived and non deprived communities and improve overall oral health of the community.

Public health dentistry is not just a paper which undergraduates and postgraduates have to clear to obtain the degree. It is much beyond that. It is dentistry for the entire community and nation.

Conclusion

To improve the picture in present scenario, MDS in Public health dentistry have to take a lead. The government and the management running the dental schools must understand the duties, function and role of a public health dentist. Apart from dental check up camps, dental treatment camp should also be conducted; the treatment being provided at the camp or health care settings. Dental schools and the management needs to understand what public health dentistry is, and what it stands for. The government too must include oral health in family welfare programs as in countries like Brazil and China or can follow the NHS as in UK or NHI as in Netherlands.

Such outlook makes international support to national initiatives in public health tremendously important. Population strategies need to be implemented, in order to reverse the negative trends prevailing today. India is a developing country; we cannot afford to waste skills of our specialists (MDS in public health dentistry) and dental graduates. We have to reach to the people and practice what we are. We have to do public health dentistry.

References

Andersen R, Marcus M, and Mashshigan M (1995) A comparative system perspective on oral health promotion and disease prevention. In: Oral health promotion: Socio-dental sciences in Action. Munksgaard International Publishers, Copenhagen.

Brasil, Conselho Federal de Odontologia. Pesquisa Perfil Atual e Tendências do Cirurgião-Dentista Brasileiro, CES-MEC e CFO, 2009. http://cfo.org.br.

Brasil, Ministério da Educação. Diretrizes Curriculares Nacionais do Curso de Graduação em Odontologia. Resolução CNE/CES 3, de 19 de fevereiro de 2002. http://portal.mec.gov.br/index.php.

Burt BA, Eklund SA (2005). Dentistry, Dental Practice and the Community. 6th ed. Elsevier Saunders, USA.

Daly B et al (2002) Essential dental public health1st ed. Oxford university press, New Delhi, India.

Dental Council of India, Government of India. Available from: http://www.dciindia.org

Downer MC, Gelbier S, Gibbons DE, Gallagher JE (1994). Introduction to dental public health. London:

FDI World Dental Press, 1994.

Hillier S, Shen J. Health care systems in transition: People's Republic of China. Part I: An overview of China's care system. J Public Health Med 1996; 18: 258-265.

Nadanovsky P; Sheiham A. Relative contribution of dental services to the changes in caries levels of 12-year-old children in 18 industrialized countries in the 1970s and early 1980s. Community Dent Oral Epidemiol. 1995; 23(6): 331-9.
Narvai PC, Frazão P, Roncalli AG, Antunes JLF. Cárie dentária no Brasil: declínio, iniqüidade e exclusão social. Rev Panam Salud Publica.2006;19(6):385 -93.

National oral health policy: Prepared by core committee, appointed by Ministry of Health and Family Welfare, 1985

Pine C, Harris R (2007). Community oral health. Quintessence Publishing Co. Ltd, London 2007.

Pan American Health Organization (1994). Regional oral health strategy for the 1990s.

Rossow I and Holst D (1991) Legislation and reality in public dental services in Norway: dental health services for children and adolescents in 1975 and 1985. Journal of Public Health Dentistry 51:152 -157

Vigild M. (1992) Oral health progrrames for elderly in Scandinavia. International Dental Journal 42: 323-329.

Wilensky H, (1975). The welfare state and equality. University of California Press, Los Angeles, CA.