IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 14, Issue 2 Ver. IV (Feb. 2015), PP 13-16
www.iosrjournals.org

Dental Safety Net: To Reach the Underserved

Dr. Abdul Salam T.A[1], Dr. Rekha P. Shenoy[2], Dr. Ganesh Shenoy Panchmal[3]
[1] *(Post Graduate Student, First and Corresponding Author)*
[2,3,] *(Reader, Senior Professor and Head of Department)*
[1,2,3,] *(Department of Public Health Dentistry, Yenepoya Dental College / Yenepoya University, India)*

Abstract: *Huge differences exist in oral health status of population groups in India. This is mainly attributed to differences in socioeconomic status. In India, health care is mostly provided by the private sector and in part by the public sector. Treatment for oral diseases is expensive and therefore, many patients are unable to receive any care. Dental safety net is defined as "the facilities, providers, and payment programs that supplement dental care specifically for underserved populations". Dental safety net providers are public and private non-profit organisations that provide comprehensive oral health care to children, adults and elderly. Examples of dental safety nets are rural safety net (targeting rural populations) and informal safety net (clinics, private physicians, traditional healers, etc.).In India, the formation and inclusion of dental safety net in public health services may significantly reduce oral health differences and meet the characteristics of primary care services.*
Keywords: *Dental safety net, Informal safety net, Public and private non-profit organisations, Rural safety net, Underserved population*

I. Introduction

Oral health is a critical but overlooked component of overall health and well-being among children and adults. Activities in school, work and home can be restricted due to Diseases of Dental origin and can significantly diminish the quality of life of children as well as adults, especially people with low-income or uninsured. Also there is increasing evidence of interrelationship between oral infections and other health problems, such as low birth weight babies, and heart disease, lung disease, diabetes and stroke among adults [1].
Health of a population depends on -
1. Health care delivery system
2. Socio-demographic profile of the population
a). Socio-economic status
b). Literacy rate
c). Health indicators

In India health care is provided mainly by private sectors and in part by the public sector. Even with the impressive advances in both dental technology and the scientific understanding of oral diseases, and with sufficient Dental manpower [2], significant disparities remain in both the rates of dental disease and access to dental care between groups and among subgroups of the population. This is because the poor and marginalized form a majority of the population in developing countries. This underserved population is typically defined by low income, has poor oral status and most times are unable to afford basic and emergency health care services [3, 4]. This is mainly due to fact that the only mechanism of payment for dental care is Private Fee- for- service, the major disadvantage of which is that many patients are unable to receive any care, especially children and adults who live below the poverty threshold [1]. Thus socio economic factors play a major role in use of health care services.

II. Dental Practices In India

Barring quackery, we have a range of dental services from single unit setups to the most modern multi-chaired exotic clinics, (including dental spas) in cities and metros which constitute urban areas. Whereas in rural areas the condition is different. Although huge unmet treatment needs exist, striking inequality in the delivery system and absence of an adequate community-oriented prevention system is further aggravating this problem in rural India.

National oral health policy drafted by Dental Council of India (DCI) in 1985 recommended dentist be appointed at primary and community health centres, but to date has not been implemented.

In India only 15 – 20% of people are able to get dental services through national health insurance scheme. In India expenditure spend on the annual per capita public health is not more than Rs.200.8 thus; availability and quality of public health care services have been reached below desirable standards majority of people spending money from their pocket. Because of expensive nature of dental treatment oral health care

seeking behaviour is very low in India and thus People visit dentists rarely and that too only during the episodes of pain.

In the last financial year only 6% of the total GDP was allocated to health-related expenditures in India, whereas other Southeast Asian countries with smaller population allocate nearly the same amount or more for health related activities [5, 6].

Thus there is a need for alternative policy or supplementation of oral health care delivery systems through inclusion of organizations such as public and private non-profit organizations like the dental safety net in India.

III. Dental Safety Net

Dental safety nets are public and private non-profit organizations which provide comprehensive oral health care to all age groups. It has been variously defined as the providers, facilities and payment programs that support dental care specifically for "underserved populations" [7].

3.1 To whom and how Dental safety net?

Dental safety nets serve a wide range of patient population, which includes low-income migrant workers, inner city and rural poor, the homeless, the uninsured and underinsured. Among these patients many of them are also chronically ill and require coordinated disease management. In addition to those disadvantaged by income, the underserved also includes those whose physical health, age, behavioural, social, language, or geographical conditions limit their access to or acceptance by majority of dentist in private practice [7]. In short dental safety net is the composite of all places, programs and providers that deliver dental services to people deprived from the predominant private dental delivery system.

Dental Safety nets usually are community-based and are influenced in large part by economic and other characteristics of the communities. Some safety net providers are operated by hospitals or community groups, others by dentist or local governments. Some rely on donations of time and effort by dentist, nurses and other providers, while others rely on discounted payment for caregivers. Some are a mixture of both. To sum up, they are organized according to their particular patient population and financing.

The local variations in patient mix, financing and workforce may result in a poorly coordinated and fragmented system of safety nets.

Thus, while Dental safety nets provide essential health services to individuals who otherwise would lack access to care, this system also results in common problems such as inadequate access to specialty services, interruption in care, and long time waiting periods for patients. Despite these strains, the same fragmented local forces that create a patchwork system also open up opportunities for innovation that are highly attuned to a specific community's need. A microscopic view at different safety nets across nations reveals some examples that provide adequate and integrated care. In this case, adequacy means that the providers actively screens and enrols eligible patients, assigns them to a primary care, and provides a reasonably comprehensive range of health care services, including essential medications, referrals to specialist, management of chronic diseases and admit to hospitals. Through integration of such care, these adequate safety nets can also rein in health care costs [8, 9].

3.2 Dental Safety Net Capacity

Dental practitioner, hygienists and assistants constitute a team and provide a quality oral health care. An adequate workforce and sufficient treatment space are critical to ensuring access to care [10].

3.3 Services offered

All dental safety net providers offer preventive and diagnostic services, including oral examination and x-rays, and also perform basic restorative care (fillings) and uncomplicated extractions. Dental services also are delivered by dental safety net providers in a variety of locations through mobile programs (Molar Express and Wisdom Tooth), school-based and community-based dental programs. Locations for these programs include elementary schools, Head Start/Early Head Start programs and nursing homes [10].

3.4 Financing of Dental Safety Net Providers

Safety net dental center budgets are typically derived from a combination of patient fees and reimbursements; federal, state, local and foundation grants; and parent organization support. Most of dental safety providers are completely supported through state funds [10, 11].

3.5 Challenges Facing Dental Safety Net Providers

Most Dental safety net organizations reported they were unable to meet all of their patient's oral health needs because they faced a variety of barriers such as the lack of Dental specialists willing to accept referrals for Dental safety net patients inadequate reimbursement rates, limited type / scope of dental services, insufficient funding, insufficient space and insufficient staff. Additional barriers cited included limited hours of operation, limited language capacity among staff, insufficient equipment, poor patient attendance rates, the large uninsured population that the safety net serves, and the limited number of general dentists in private practice willing to treat underserved populations [10].

3.6 Policy alternatives

Addressing consequential oral health inequities and safety net inadequacies will require multifactorial approaches and will therefore require the concerted and cooperative efforts of policymakers from across domains of government, the profession of health, education, research, social service, and the dental industry. Without question, the single best approach is to dramatically reduce need and demand for conventional dental treatment by preventing and controlling disease, thereby attaining better health at lower costs. To accomplish this, effective biological and behavioural interventions need to be further developed by behaviourists, scientist health educators, social workers, and health professionals; promoted by governmental payment, workforce, and reporting policies; and institutionalized for the next generation of caregivers through changes in curricula and experiential education.

The nation's long-established and new dental schools need to view themselves as having a primary responsibility to care for the underserved while balancing their educational and research missions. The new dental schools need to explicitly reference responsibility of care for the underserved in their mission statements and incorporate community-based learning as core elements of their curricular design. For example, College of Dental Medicine, Western University of Health Science, America describes its mission as training dentists "who will fulfil their professional obligation to improve the oral health of all age groups of society, especially those with underserved". In India Private Dentist constitute the overwhelming majority oral health care delivery capacity, any attempt to reduce disparities must find ways to significantly increase private dentist's participation. In the short term, this can be accomplished through efforts ranging from providing outreach programme to private practitioners, organizing care facilitation at the community level, contracting between health care centers and private dentists, organising continuing education of dentists in care of special populations, and conducting local and state level care programs. In the long term, safety net improvements will require active engagement of future dental professionals. This can result from changes in how students are selected, trained, licensed, and recognized and rewarded [1].

From our point of view developing countries like India with sufficient dental manpower resources urgently need to include dental safety net in public health services. These safety nets should target population from low socio economic status, children and other dependent groups. Dentists have to be employed by the state or central governments from the manpower resources available. Related dental health professionals also may contribute meaningfully to the Dental safety net. Emergency and basic oral health care services need to be provided at these public health centers with provision of preventive care at the core. The next step could be setting up of health centers where such care can be provided. These centers should be located preferably within the reach of such population, specifically in underserved areas such as rural areas.

IV. Conclusion

Ultimate responsibility for the health of its citizen lies with the government. The government specifically in developing countries needs to focus on the health of its population irrespective of their ability to pay. Inclusion of oral health in public health policies in India lead to improvement in the oral health status of urban and rural populations. Local efforts may also be needed to engage more private practitioners in care of the underserved. The formation and inclusion of dental safety net in public health services may significantly reduce the oral health differences between the low and high socio economic classes and thereby improve the oral health status of citizens in India.

References

[1]. Singh A and Purohit B, Targeting poor health: Improving oral health for the Poor and the underserved, International Affairs and Global Strategy, 3, 2012, 1-7.
[2]. Sivapathasundharam B, Dental education in India, Indian J Dent Res, 18(3):2007; 93.
[3]. Guay AH, Access to dental Care: the triad of essential factors in access-to-care Programs, J Am Dent Assoc, Jun; 135(6), 2004, 779-85.
[4]. Bailit H, Beazoglou T, Demby N, Mcfarland J, Robinson P and Weaver R, Dental safety net: current capacity and potential for expansion. J Am Dent Assoc Jun; 137(6), 2006, 807-15.
[5]. Ahuja NK and Renu P, Demographics & Current Scenario with Respect to Dentists, Dental Institutions & Dental Practices in India. Indian Journal of Dental Sciences, June; 3(2), 2011, 8-11.
[6]. National Oral Health Policy: Prepared By Core Committee, Appointed By Ministry Of Health And Family Welfare, 1985.

[7]. Kwon S, Medicaid: a dental safety net in tough times. J Indiana Dent Assoc, 88.2009, 6.
[8]. Edelstein BL, Dental and interdisciplinary workforce Approaches to oral health care for vulnerable and special needs populations. Rockville; 2005: Advisory Committee on Training in Primary Care Medicine and Dentistry, Health Resources and Services Administration, US Department of Health and Human Services.

[9]. Byck G, Cooksey JA and Russinof HJ, Wisconsin Dentists and Medicaid: Who Participates?. Abstr acad Health Serv Res Health Policy meet, 19,2002,13.
[10]. Okunseri C, Bajorunaite R, Abena A, Self K , Lacopino AM and Flores G, Racial / ethnic disparities in the acceptance of Medicaid patients in dental practices, J Public Health Dent Summer, 68(3), 2008,149-53.
[11]. Beckwith J, Kislak R, Leonard L and Junhi OH, The dental safety net in Rhode island 2011;1-20.