International Journal of Medical and Health Research
ISSN: 2454-9142
www.medicalsciencejournal.com
Volume 4; Issue 1; January 2018; Page No. 121-124

Comparative analysis of discrepancies in the Indian oral health care standard & the rest of the world along with the recommendations for improvement

Dr. Sakshi Goyal
Dentist, Rajasthan University of Health Sciences, Rajasthan, India

Abstract
Oral diseases and disorders are seen to be broader and extreme among migrants from low wage nations and exiles than medium or high salary have populace. Sporadic migrants speak to a particular gathering of the transient populace who are presented to higher health hazards due to a minimized living condition identified with outrageous restricted legitimate rights in the host nation. Health system ought to be sorted out to address the issues of whole populace of the country. Oral diseases are the most widely recognized of the interminable diseases, yet there are couples of productive dental care systems to adapt to these issues. There is a shortage in foundation and critical issue with the sufficiency of working offices. This can turn out to be a major obstacle in the arrangement of satisfactory oral health care to individuals with most noteworthy health-care needs. A lot of exertion is required to fit the oral health-care delivery system. In this paper we will find out about the oral health care standards in India and also worldwide and how these can be dealt with.

Keywords: oral diseases, health-care, dental care

1. Introduction
The profile of oral disease has changed particularly over the most recent 50 years. The effect of fluoride, the change from conventional diets to high sugar diets in developing economy countries, and the universality of liquor and tobacco have brought about a shifted picture of global oral health. The lion's shares of oral diseases are identified with ways of life and diminishing these for the most part incessant diseases depends much on evolving behavior. Improvements in behavior can and do happen, yet require duty and aptitude inside health promotion. Health promotion is a generally youthful science however is presently solidly acknowledged in general health. It is vital, however, to assess the adequacy of health promotion programs and the exploration of such assessments is, up 'til now, ineffectively created and reported.

1.1 Oral Problems
Oral problems are emerging as one of the main public health concerns in India. Oral problems are not only causing pain, agony, functional, and esthetic problems but also lead to loss of working man-hours. Hence, in the long run, they are bound to have a significant impact on our economy. In developing countries, there is a vast difference in oral health status between urban and rural populations, with enormous and widening disparities in access to quality care, predominantly in rural areas [1]. There are approximately 300 dental colleges in India, and annually 25,000 graduates pass out including 5000 specialists. Moreover, as per the latest statistics, there is concentration of only 10% of dentists where approximately 70% of the Indian population resides (rural areas) and 90% of concentration of dental professionals where only 30% of population resides (urban areas).

1.2 Attitude toward Oral Health
Peoples attitude is shaped by their convictions and the common conviction has been that dental treatment is unbearably painful, this has prompted individuals ignoring their oral health to a degree that when they eventually go to the dental clinic a portion of their teeth are invariably advised for extraction, which again as painful occasion reinforced this conviction and add to the general household reputation of dental treatment as painful which usually reason much for the individuals who bashful away from oral health both in rural and urban areas. This perception needs modification before any intervention. Inclusion of video-aids or demonstration regarding a matter would indeed help change this attitude although an exceptionally effective accomplishment on a large scale can eliminate this perception over an era.
Another factor is nearly traditional addiction of tobacco in Indian masses. Tobacco consumption, although harmful for systemic health, has many other ramifications in oral health. Initially, tobacco and tobacco items specifically harm the oral tissue; secondly, oral cavity is decreased secondarily to the pleasure of consumption and largely overlooked. This unhealthy attitude gradually develops to degree when the consumer totally overlooks his oral health. Thirdly, it turns into a habit, a habit both effective and prevalent. This has been passing from generation to generation. This variable of tobacco consumption is seen at each level, frame planning to execution of any intervention. Awareness and education are the only tools for masses at introduce. Although a top to bottom understanding of tobacco utilize and related behavioral factors would help in modification of the health-care program in advance [2].
Another factor is overlooked general awareness about the oral

health and its contribution to overall health and longevity. This has largely been made conceivable by continual non-availability of oral health benefits in their closeness and lack of elementary education in such matters. Contribution of oral health to systemic health is undeniable. This has to be reinforced into common mind by physicians and dentists. The scenario in which a patient reaches the clinic or nursing care in India is that of as a last option and not as a first reaction. This is for the most part because of the costly care as by the charge charges and costly medicine which usually surpass the paying capacity of the patient. Patient modest away from reaching at once for fear of money loss in interest and more often than not they wait for themselves to heal on their own. When they clearly realize that the disease is not going to heal on its own by other "Desi Nuskas" only then they find out a clinic in their nearest nearness and head to it with a dull face. This delay in proper care brings about added horribleness to the patient which in swing leads to added expenses and which again continue the endless loop of the perception that the treatment is costly. This attitude is more pronounced with dental health related behavior.

Indeed, even after getting a professional opinion of the disease and formulation of standard treatment plan most patient ask for medicines and intend to escape with the issue after eating medicines, which is not usually the case with dental treatment. As dental treatment essentially involve some work either in the type of scaling or cavity preparation. The treatment even asks for patient time which is usually depicted as the period of worry in his universes. This add as far as anyone is concerned that longer treatment time, increased patient clinic time and different appointment to the clinic apart from cost frame the actual treatment are other factors, which make individuals timid away from dental care.

1.3 Role of oral health in human physical and psychological well-being

According to WHO definition of health" Health is a state of finish physical, mental and social well-being and not simply the absence of disease or infirmity." Oral health as an essential part of general health plays a pivotal part in human physical and psychological well-being. Known as the craniofacial unpredictable, oral health means more than healthy teeth and includes "being free of chronic or facial pain, oral and pharyngeal cancer, and oral soft tissue lesion, birth deformity, for example, congenital fissure and palate and scores of other diseases and disorders that affect oral dental and craniofacial tissues". Great oral health is not only a key component in providing our body with essential supplement but also has influence on social mobility, mental self portrait and regard, and discourse. Interaction between oral health and general health continues lifelong. A mouth as a "window" to the human body may give indications of general health disorders [3]. For instance: as a first symptom of some infectious diseases, for example, HIV, oral manifestation of Syphilis; blood disorders may manifest in pale and bleeding gums; aphthous stomatitis may be linked to systemic conditions, for example, gastrointestinal disease, Bechet disorder, auto-inflammatory disorders; changes in the thickness of the (bone loss) of the lower jaw may be an early indicator of skeletal osteoporosis; changes in tooth appearance may be an indication of eating disorders, for example, bulimia and anorexia. Saliva as a part of oral environment may indicate the nearness of various mixes in the body, for example, alcohol, nicotine, hormones, drugs, environmental toxins and so forward. Oral health conditions may have an impact on overall health similarly as systemic conditions may incite diseases in the oral cavity. Poor oral health is associated with number of adverse medical conditions.

2. Oral health diseases standard in India

Oral diseases affect both the young and the old. A portion of the common diseases are dental caries, periodontal diseases, malocclusion, sub-mucosal fibrosis, oral cancer and so forth. Congenital fissure and congenital fissure also continue to affect the population. Oral lesions are also common with patients with HIV/AIDS and other debilitating systemic conditions. Two large scale Oral Health Surveys have been conducted in the past (I) National Oral Health Survey and Fluoride Mapping by Dental Council of India in 2003 and (ii) Oral Health in India: Report of multi-driven oral health overview by MoHFW in collaboration with Dental Department AIIMS in 2007.These two surveys indicate the prevalence of some oral diseases and conditions in the nation. Problems related to the teeth and mouth makes youngsters restless and having challenges in concentration at school, restricted profitability of adults at work and at home causing millions of school and working hours to be lost throughout each year. Poor and disadvantaged population in both developed and developing countries draws particular attention in regards to poor oral health. The weight of oral diseases among this population is higher [4].

3. Oral Health Diseases Standard Worldwide

Oral diseases are considered a major public health issue. Regardless of great achievements in the treatment and prevention of oral diseases in several countries, dental caries and periodontal diseases belong to one of the most common and widespread pathologies among population in the high-income countries and the growing quantities of oral diseases in many low-and center income countries is marked. The seriousness of dental caries is distributed contrastingly between the countries around the world, but also within the nation in various regions. Such assorted variety of dental caries distribution relates to distinct risk factors across the countries and within. It relates to socioeconomic conditions and ways of life of the population but also environmental exposures and prioritization of preventive dental care treatment. According to a fact sheet of WHO from 20012 nearly 100% of adults worldwide have experienced dental caries. Serious periodontal disease, which can bring about tooth loss, is found in 15-20% of moderately aged (35-44 years) adults. 30 % of individuals aged 65-74 have no natural teeth. Other oral health diseases and conditions which contribute to the overall picture of major global oral health problems are: oral mucosal lesions, tooth loss, HIV/AIDS-related oral disease, oropharyngeal cancers, orodental trauma, developmental disorders, fluorosis of teeth, and dental erosion. In industrialized countries the main focal point of dental care administrations is coordinated to preventive and restorative dental care [5]. In developing countries, on the other

hand, there is nearly nothing if any attention to this area. Many countries in Africa, Asia, and Latin America have inadequate number of dental care professional (the ratio of dentist to population constitute 1:150 000 in developing countries compared to 1:2000 in most industrialized countries) and the capacity of dental care administrations is generally limited to crisis dental care and pain relief [6].

4. Recommendations for the Improvement of Oral Health

Before proposing strategies to enhance access to dental administrations, the actual meaning of 'access to care' should first be appreciated. The present concept of 'access to dental care' reaches far beyond its traditional meaning. The traditional meaning of access to dental administrations has changed over years, from simply the adequacy of the workforce to a cascade of factors which are patient based. A portion of the patient based factors that determine the access to dental administrations are perceived requirement for care, cultural inclinations, and language. Thus, when speaking of access to dental care today, both the availability of care and the willingness of the patient to look for care have to be considered.

- **Oral Health Workforce:** There has been a substantial increase in the quantity of dentists throughout the last decade with 1, 17,825 dentists presently working in the nation. In spite of the fact that this number is less when figured according to the WHO prescribed dentist to population ratio for developing countries (1:7,500), there is neither a change in the accessibility to oral health care for rural population nor does the graduating dentists find it easy to make due in the profession [7]. The reasons for this phenomenon are both the lack of perceived oral health needs among public, especially in rural areas, together with the non-availability of oral health care administrations.
- **Strengthening Public Health System:** India is facing formidable challenges in health sector as with many other low-income and center income countries, Indian consumption on health care was only 4.2% of its GDP, of which public health spending is insignificant 1.2%, This is nominal when compared to China and the Unites States where the public spending on health care was 3% and 8.3% of GDP separately. There is no particular separate allocation of assets for oral health in Indian spending plan. There are no dental professionals in the administration decision making bodies and this is the reason why dentistry continues to be helpless before medical professionals who usually take a lion's share of the sanctioned amount for their own profession [8]. Along these lines, there is a critical requirement for dental health planners with relevant qualifications and training in public health dentistry.
- **Strengthening Dental Education in India:** There were no private dental colleges in India before 1966, these numbers changed drastically by 2014, and 86% of dental colleges in India today are under the responsibility for sector, There also has been a substantial rise in the quantity of dental colleges in the course of the last couple of decades, but the distribution has not been uniform and is in accordance with the phrase "insufficient here and too many there". While welcoming the development of dental education in India, emphasis should also be placed on the uniform distribution of dental colleges, quality of education being given, and the values, social responsibilities that are being instilled in the understudies.
- **Dental Safety Net Systems:** The most common or rather the almost selective mechanism of dental care payment in a large portion of the developing countries, including India, is the private expense for benefit. This limits access to poor and marginalized population as they are unable to afford these health care services [9]. The "Dental safety net system" is defined in various ways as the facilities, suppliers, and payment programs that help dental care specifically for "underserved populations".
- **Dental Homes:** Dental home fills in as a locus for preventive oral health supervision, building the requisite foundation for good oral health early throughout everyday life. Be that as it may, in context of lack of awareness on the importance of oral health, it is difficult to establish dental homes in rural India and worldwide.
- **Community Oral Health Programs:** Community oral health programs contrast from individual care in that they center primarily around population, including those persons who don't or cannot access care. Community participation is a major key to effective community oral health programs. Highlighting the importance and magnitude of oral health needs in a community, understanding the feasibility and acceptance of interventions, creating trust among individuals are conceivable only with community participation [10].
- **Public Private Partnerships**: Universal health care must be made available to the whole Indian populace by fostering public private partnerships. Notwithstanding, the legislatures should take necessary care in involving only non-profit private partners, as revenue driven private sector encouragement in the provision of health care services would further deteriorate the already weak public health systems in India. Change in the distal determinants of health like social, economic, and political disparities through thorough partnerships could profit in improving the overall health status of the nation, rather than focusing on proximal determinants through solitary, vertical programs

4.1 National Oral Health Policy in India

Oral health policy in India, formulated way back, is a bleak picture even today. In 1984, national workshops were organized in Bombay on oral health targets for India and in the year 1986, oral health policy was conscripted by Indian Dental Association (IDA). Based on the recommendation of IDA, 2 more national workshops were organized; one at Delhi in 1991 and the other at Mysore after 3 years, through the input of these 2 workshops, national oral health policy has been developed by Dental Council of India (DCI). It is the same time when World Health Organization (WHO) had offered importance to dental health by selecting the theme "Oral Health for Healthy life" for global health for the year 1994. In continuum of this, the center council appointed by Ministry of Health and Family Welfare, GoI accepted in principle national oral health policy as a component of NHP

and moved a 10 point resolution in its fourth conference in the year 1995. After 3 years, National Oral Health Care Program (NOHCP), an undertaking of Directorate General of Health Services (DGHS) and Ministry of Health and Family Welfare was initiated and launched on a pilot basis. Later the Department of Oral and Maxillofacial Surgery, All India Institute of Medical Sciences (AIIMS) was given the charge to execute it. NOHCP, initiated as a "Pilot Project" in 5 states (Delhi, Punjab, Maharashtra, Kerala, and North Eastern states), during the time spent achieving the goals of national oral health policy. Single district from each above-mentioned were chosen to trial the strategies generated through 2 national and 4 regional workshops held in collaboration with AIIMS, New Delhi, in various areas of the nation. The strategies of this program include oral health education with information, education and communication (IEC) materials by involving health workers, school children, teachers and mass media, formulation of basic package on rural healthcare, man power and infrastructure advancement, portable dental clinic services for rural individuals, public health as well as research monitoring. The task was looked into by the National Institute of Health and Family Welfare in 2004.

5. Conclusion

There are many yet unexplored convictions and convictions in Indian subconscious, which should be worked in a multipronged strategy. Despite the fact that, India is progressing as at no other time in oral health, a sharp understanding of societal aspects can certainly would be useful for both oral health planners and implementers especially in rural areas. A change in the public eye outlook and attitude is moderate, which requires persistent endeavors and continuous education and active participation of society in its own oral health is of paramount importance. There are a ton of barriers for equitable access to oral health care in India that have to be addressed. We need a strong public health system before ensuring equitable access for the natives of this nation. The profession of dentistry is as yet striving to establish its own particular character in certain parts of the nation and the world. With situated endeavors by governments and policy makers, we couldn't only observe a change in oral health status of the rural populace but also guarantee the graduating dentists a secured career, since there is a humungous oral health require in rural India which unfortunately is not being realized. Indoctrination of administration attitude among dental understudies must be adopted by all the dental institutions to make them discern that it is the responsibility of each oral health care professional to make India and the world grin.

6. References

1. Rani M, Bonu S, Jha P, Nguyen SN, Jamjoum L. Tobacco use in India: Prevalence and predictors of smoking and chewing in a national cross sectional household survey. Tob Control. 2003; 12:e4.
2. Grewal N, Kaur M. Status of oral health awareness in Indian children as compared to Western children: A thought provoking situation (a pilot study) J Indian Soc Pedod Prev Dent. 2007; 25:15-9.
3. Dolan RW, Vaughan CW, Fuleihan N. Symptoms in early head and neck cancer: An inadequate indicator. Otolaryngol Head Neck Surg. 1998; 119:463-7.
4. Ahuja NK, Parmar R. Demographics and current scenario with respect to dentists, dental institutions and dental practices in India. Indian J Dent Sci. 2011; 3:8-11.
5. Vaidya AD, Devasagayam TP. Current status of herbal drugs in India: An overview. J Clin Biochem Nutr. 2007; 41:1-11.
6. Sarojini N, Amit Sengupta. Realizing the right to health care a policy brief, Jan Swasthya Abhiyan, 2014.
7. Chandrashekar Janakiram, Rajeev B Rudrappa, Farheen Taha, Venkatachalam Ramanarayanan, Harikiran G Akalgud, Sushi Kadanakuppe. Equity in oral health care in India. A review on health system analysis. Economic and Political Weekly. 2017; 52(9):83-89.
8. Ashish K. Jaiswal, Pachava Srinivas, Sanikommu Suresh. Dental manpower in India: Changing trends since 1920. International Dental Journal 2014; 64(4):213-8.
9. Sankalp Yadav, Gautam Rawal. The current status of dental graduates in India. Pan African Medical Journal 2016; 23:22.
10. Albert H. Guay. Access to dental care solving the problem for underserved populations. Journal of American Dental Association. 2004; 135(11):1599-1605.