

A perspective from the developing world on the difficulties in providing adequate access to oral health

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Reprinted from: *International Collaboration in Dental Education: Facing the Challenge of Providing Adequate access to Oral Health Care. Meeting, Valley Forge, Pennsylvania 9-12 October 1994, pp. 37-44 (PHD, 2003; 10 (1), Pages 83-85)*

Access, a multi-dimensional determinant of utilization of health services, involves choices determined by social, economic and political realities arising from professional (provider) and client (recipient) needs at personal, family and community levels. All these take place in the national and global realm of demands competing for limited resources.

In this context, access to oral health services is one of many needs essential to an acceptable health status. Generally, health *per se* is of low priority in terms of overall needs. Among health needs, curative service is the priority with medical needs overshadowing those for dentistry. In addition, dental services in developing countries in greatest demand, e.g., pain relief, treatment of infections, and tooth extraction, are being provided by non-dental health workers.

Such a situation provides a dilemma for oral health services at all levels of access in developing countries. Therefore, in order to discuss difficulties of access, the context in which oral health services are deemed necessary must be discussed. This paper aims to examine oral health and its relationship to total needs in order to identify not only the difficulties, but their underlying causes and possible strategies for resolution.

Components of access

The purpose of accessing oral health services is to be able to determine the ability to use these services. Access involves four distinct components:

- the act of approaching or entering the service
- the state or condition of the service being approachable
- the right or privilege to approach, enter and make use of the service
- a way or means of approach or entry into the service.

Oral health services must be available before a sensible discussion of access can take place. In order for services to be available, there must be a need and a demand for these services and resources to provide such services. In this paper *need* refers to the professional definition of the problem and its prescribed solution, whereas *demand* is the problem identified and invested upon by a consumer in a bid for resolution. Need and demand may not coincide and thus initiate the difficulties of access.

Allocation of limited resources at personal, family and community levels entails choice. Therefore, each of the components of access raises several fundamental questions for individuals and families regarding availability, acceptability, affordability, and appropriateness. Questions relating to effectiveness, efficiency, efficacy and equity will be of interest at community and national levels. These parameters of resource allocation further complicate the consideration of access to oral health services.

Access issues in the Pacific

The issues of access to oral health services in the Pacific are not unique in the general context. The uniqueness is in the magnitude of addressing access among different populations and the contexts of the problems. Unlike Asia and Africa, Pacific populations are sparse and scattered over millions of square kilometers of a vast, unpredictable ocean. There are two to three jurisdictions at varying degrees of economic development, educational level, and health status, as well as religions and cultures of at least 1,000 languages. Nevertheless, over the years of interaction and a common heritage, unity in this diversity has evolved through the sharing of many common life concepts fundamental to all Pacific cultures. However, external influences, such as donor priorities, have complicated and corrupted the unity in diversity. Any analysis of oral health services must be viewed in this diversity and with each of the components of access to oral health services discussed below.

Approaching/entering (accessing) the service

In order to approach the service, there must be a demand and an acknowledged and available answer to the demand. In most Pacific countries oral health does get some resources to make services available. However, oral health is a low priority, so that utilization is almost entirely confined to clinical dental needs. Therefore, the act of approaching or entering the health services (i.e., accessing) must be stimulated with improved knowledge of the necessity of oral health, how services can contribute to better oral health status, and the allocation of resources to make appropriate services available. There must be motivation and incentive to approach services.

Means of approach/ entry

In addition to the motivation and incentive to access oral health services, means to act on this decision must be

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available. The means may also provide a "pushing effect" to enhance this decision making. For the Pacific, issues of distance, physical geography, weather, and other infrastructural deficiencies, such as availability and cost of transport, are prohibitive. The small, scattered populations provide special problems for the provision of equitable and efficient services. Infrastructural cost has been a major constraint in economic development of Pacific countries.

Approachability of services

This deals with the issues of acceptance and appropriateness of the service. The focus is on the socio-cultural distance between the service, providers and client, factors that change the equilibrium between the elements which include:

- *Service facility and equipment.* These may not be available or may be too frightening or too complex to be accessible, or the service may even seem to be physically impenetrable.
- *Client/cultural factor.* The service may be on socially inaccessible land, or the design of the facility may be culturally insensitive (e.g., resembling a totem).
- *Provider/staff factors.* This element relates to staff issues such as language, dress, manner, and sensitivities at the oral health service interface and at the decision making level. The latter is especially important to the development of appropriate policy, training, location of services, design of facilities and continuing support to oral health services. These are areas of much contention, but if addressed properly will provide a "pulling effect" on utilization of oral health services.
- *Right/privilege to use the service.* Once entry is made, clients must be able to use services offered, either through their own recognition of need or through encouragement. The important issues include target groups, opening times, waiting time, cost of use, translation, migrant services, and other restrictions like apartheid, visa requirements and non-smoking. These issues or service characteristics provide pulling effects on service utilization.

It is obvious that access to oral health services in the Pacific involves many issues in the social, economic, political and physical spheres. The dilemma to the Pacific is what takes precedence. Should society change to fit services or should services be changed to fit society? Historically, the former was the predominant approach, but in the last 20 years there have been deliberate moves towards the latter. This, of course, is not to advocate the noble savage, but to accept and plan change. The question is not whether to change or not, but which direction and how fast?

The context of oral health services in the Pacific

In developing countries, there are many competing demands for very limited resources. Priority needs and demands are for food, shelter, security and protection from life-threatening matters. Oral health is not perceived as one of these priorities. Therefore, oral health services are the last to be addressed when all else has been satisfied. Oral health problems are perceived either as non-fatal or the least life-threatening. The problems of caries,

periodontal disease, edentulousness, and malocclusion are not priority health problems. Cleft lip, cleft palate and injuries to the face or mouth are urgent and may be life-threatening, but are uncommon. Moreover, these conditions, including manifestations of systemic diseases and oral cancer,

can be dealt with adequately by others in the medical profession. In addition, symptoms of pain and aesthetics are shared with other medical conditions. The lack of uniqueness of these symptoms does very little to stimulate demand for oral health services. Consequently, in spite of the very high prevalence and incidence of caries and periodontal disease, these do not exert a burden on the health services comparable to major diseases like malaria, NCD, diarrheal disease, or acute respiratory disease.

Another factor that threatens access is the move to professionalize oral health workers. This grew out of the emphasis on professional development and holistic care which has enhanced the growth of oral health services. The creation of a professional power base may have enhanced the status of the health provider, but has alienated consumers. In exchange for professional autonomy and supremacy, oral health workers may have distanced themselves from community needs through a growing access to and intimacy with elite bureaucrats, increasing wealth, higher education, and exclusive professional values. The adoption of the theory of focal sepsis in the early twentieth century, without scientific foundation, is an example of how the dental profession used its special position to enhance its claims for professional recognition.

The classification of natural states and social problems as dental ones, i.e., low grade malocclusion or teeth discoloration, helped to expand professional influence. The perpetuation of the client sick-role further consolidates control, e.g., six-monthly dental visits. All these decrease access.

Simplifying and demystifying oral health services will improve access, overcome professional barriers and enhance availability through the use of auxiliary workers, self-help techniques and more affordable services. Demystifying oral health services will also attract communities to learn more about services and what they

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can or cannot provide. This will improve acceptability, choices and utilization of these services.

There are several factors that work against access. The training and socialization processes of dentists shape them to reflect the values and treatment philosophy of the institutions in which they trained and may not derive their motivations for service from the community. The patterning of Pacific institutions has exacerbated this trend. The emphasis of restorative, curative and aesthetic dentistry does little to address the underlying problems. Even when health services are free, issues in communication and the costs and availability of transportation contribute to the problem of access because health clinics are situated in urban areas. The travel time may increase the cost of the visit beyond its perceived value. This is especially so if cheaper and more accessible alternatives are available such as traditional healers or other health workers.

Access to oral health care implies continuous and organized supply of care that is geographically, financially, culturally and functionally within easy reach of the community. Care has to be appropriate and adequate in quality and quantity to meet the needs and demands of the community, the service has to be provided by methods acceptable to and appropriate for it.

Many have argued that the emphasis of oral health services must shift from their current clinical focus to preventive and promotional activities. This will enhance demystifying oral health and widening the human resource base at a more affordable cost and better coverage. The main dental problems of caries and periodontal disease have been repeatedly shown to be amenable to public health approaches, for example, fluoride use, less sugar in the diet and tooth brushing. Together with appropriate structural policies, these can easily alleviate most dental problems.

Training programs in developing countries are addressing this very approach. Inasmuch as training is a socialization process, the emphasis on preventive and community-based approaches will improve need assessment. Together with a strong health education program, the need

and demands and services offered should eventually coincide. The recognition and respect of these training programs by credible institutions and individuals will enhance regional utilization. Recognition can be attained through registration of the program in developed countries; ease of access of graduates to postgraduate training programs; appropriate students from developed countries, among them Australian aborigines, New Zealand Maoris, and indigenous groups; and the use of graduates as regional consultants.

The integration of dental care with general health care has strong advocates. Such an approach will enhance the status of oral health care and the availability of services. The linking of oral health to fatal life events and priority areas, for example, economic progress and income earning, will enhance the value accorded to dental health and the subsequent opportunity cost of neglect or delay in seeking care for dental diseases.

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By the same token, the linkage of the dental profession to the medical profession and other priority health professionals will also elevate the objective. This can be achieved through sharing of common training courses such as public

health and social sciences, or in shared tasks of routine screening of systemic - diseases through oral manifestations, and the use of simple diagnostic skills, for example, blood pressure measurements. Perhaps dentistry should become a superspecialty of medical practice incorporating oral and maxillofacial surgery as well as dentistry.

The merging of dentistry and medicine can only provide quality and affordable service. The decrease in the number of personnel and facilities alone is an attractive option for small Pacific islands. The subsequent streamlining of service will improve efficiency and decrease bureaucracy. There are many merits in the merger to warrant at least piloting and prevent another futile exercise in futurology.

Reference

Available from the author and source for this article

Dentist, n. A prestidigitator who, putting metal into your mouth, pulls coins out of your pocket
(Ambrose Bierce in The Devil's Dictionary)