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Letter to the Editor

Oral health inequities and COVID-19 in India: Time for nuanced radical action

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The coronavirus disease 2019 (COVID-19) pandemic has revealed deep-rooted global health inequities, with some populations bearing the brunt of the disease [1]. At the same time, the delivery of equitable oral healthcare services has been drastically impacted as a result of the severe disruption in healthcare amidst lockdowns, particularly in low- and middle-income countries, such as India where 65–68% of the population reside in rural areas [2]. Given the increasing burden of oral disease due to population growth and aging [3], and the fact that the COVID-19 virus does not differentiate between various socio-economic and ethnic groups, the pandemic is expected to further heighten the challenges that already exist in the distribution of oral health care facilities for underprivileged populations. In rural India, socio-cultural factors, such as inadequate or improper use of fluoride products and a lack of awareness regarding oral health and hygiene, further increase the risk of oral diseases [4].

According to the 'Commitment to Reducing Inequality' (CRI) Index report [5], the adverse situation in terms of Health Equity is highlighted by the fact that amongst the 158 countries evaluated, India ranks 121 in Health Coverage and 155 in Health Spending. While re-emphasising the commitments for the 2030 agenda for improving health as a central component of sustainable development [6], and considering oral health as an integral component of systemic health, the COVID-19 pandemic may serve as a golden opportunity for governments and the international community to set up a Health Inequities Task Force, implement/extend Universal Health Coverage for primary oral health, develop individualised specific oral health care pathways and identify essential drugs and diagnostics. Considering the fact that public policies have the power to enhance health, but, on the other hand, also exacerbate health disparities, a firmer and more resolute national and political advocacy is poised to play a pivotal role in tackling the dramatically increasing healthcare inequalities.

The current highly changing situation strongly underlines the need to urgently and decisively undertake the following radical preparedness measures [7]: (1) organise the national human resource planning system to ensure the equitable distribution of oral health care workers, including dental auxiliaries, in rural areas; (2) properly utilise the internship programme by sensitising and promoting awareness among dental graduates of their responsibilities towards society and providing future directions to policy makers for prioritising oral health; (3) strengthen dental education and public health systems; (4) improve oral health literacy; and (5) properly regulate private healthcare services.

Additional outreach initiatives include utilisation of smaller and compartmentalised portable dental units in isolated and inaccessible areas, adoption of a 'Dental safety net system' for underserved populations in remote areas, establishment of dental facilities at Primary Health Care Centres and government hospitals, community oral health programmes and promotion of dental insurance schemes for the general population.

As envisioned in the National Oral Health Programme, the existing situation also necessitates convergence of private sector interests and public sector goals. Utilisation and promotion of the Public Private Partnerships delivery model, involving private dental colleges, various dental associations and community based organisations, is required to target public expenditure towards health care, pooling of resources, optimisation of health manpower and reducing regional imbalances in health.

When considering the possible far-reaching adverse impact of exacerbated socioeconomic and ethnic inequalities on oral health inequalities, implementation strategies in dental care systems must be underpinned by adherence to delivery of stabilisation-centric, minimally invasive, prevention-focused, easily accessible and sustainable oral health care for vulnerable populations [8]. The proven beneficial effects of oxidative mouth-rinses in reducing COVID-19 viral loads in saliva demonstrates that they may be utilised for high-risk urban and rural poor populations residing in densely populated and crowded areas.

The time is ripe for considering COVID-19 as a 'syndemic' [9] rather than as a pandemic alone. This may play a vital role in the smooth integration of paradigm of value-based preventive oral healthcare strategies involving reduction in common risk factors, such as tobacco and alcohol use, promotion of healthy low-sugar diets, community water fluoridation, topical fluorides, and promotion of oral health in community settings with existing non-communicable disease prevention programmes in medical health care facilities.

With the COVID-19 contagion far from being over and given the

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possibility of post-pandemic resurgences as late as 2024 [10], safeguarding the workforce and populations also assumes even greater significance from a humanitarian point of view. Hence, the present pandemic needs to be taken as a wake-up call to proactively promote non-aerosolising procedures and utilise the concept of minimally invasive dentistry involving application of manual techniques, such as atraumatic restorative treatment or minimally invasive restorative management of active cavitated deep carious lesions [8]. Furthermore, strengthening of communication and surveillance, and monitoring systems and utilisation of teledentistry as an indispensable tool, may play a crucial role in taking on the current challenges in delivering unhindered dental care, while emerging from the pandemic.

References

[1] United Nations, The sustainable development goals report 2020. https://unstats.un.org/sdgs/report/2020/The-Sustainable-Development-Goals-Report-2020.pdf. (Accessed 24 October 2020).

[2] A. Kumar, K. Rajasekharan Nayar, S.F. Koya, COVID-19: challenges and its consequences for rural health care in India, Publ. Health Pract. 1 (2020) 100009, https://doi.org/10.1016/j.puhip.2020.100009.

[3] W. Marcenes, N.J. Kassebaum, E. Bernabé, et al., Global burden of oral conditions in 1990-2010: a systematic analysis, J. Dent. Res. 92 (2013) 592–597.

[4] A. Singh, B.M. Purohit, Addressing oral health disparities, inequity in access and workforce issues in a developing country, Int. Dent. J. 63 (2013) 225–229.

[5] M. Martin, M. Lawson, N. Abdo, D. Waddock, J. Walker, Fighting inequality in the time of COVID-19: the commitment to reducing inequality Index 2020, Published: 7th Oct, 2020, https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621061/rr-fighting-inequality-covid-19-cri-index-081020-en.pdf. (Accessed 24 October 2020).

[6] M.P. Kieny, H. Bekedam, D. Dovlo, et al., Strengthening health systems for universal health coverage and sustainable development, Bull. World Health Organ. 95 (2017) 537–539.

[7] V.C. Chandu, S. Pachava, V. Viswanath, A. Khanna, R. Kaur, Strategies for improving accessibility to oral health care services in rural India: an insight, Int. J. Oral. Health Med. Res. 4 (2017) 44–46.

[8] Z. Brian, J.A. Weintraub, Oral health and COVID-19: increasing the need for prevention and access, Prev. Chronic Dis. 17 (2020) E82, https://doi.org/10.5888/pcd17.200266. Erratum in: Prev Chronic Dis 2020 Aug 27;17:E93.

[9] R. Horton, Offline: COVID-19 is not a pandemic, Lancet 396 (2020) 874.

[10] S.M. Kissler, C. Tedijanto, E. Goldstein, Y.H. Grad, M. Lipsitch, Projecting the transmission dynamics of SARS-CoV-2 through the postpandemic period, Science 368 (2020) 860–868.

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