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To

The Evaluator

Global Child Dental Fund

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Subject: COVER LETTER FOR ESSAY SUBMISSION

Respected sir

I am pleased to submit an article entitled **"Quality in Dental Practice"** by **Nishant** as a part of essay competition for dental students in India. This report contains extensive matter about quality in dental practice. We believe our work would appeal to the evaluators. This article has been written specifically for this competition and is not under consideration for publication anywhere. All authors have approved the manuscript and agree with its submission.

Please address all correspondence to undersigned. We look forward to hearing from you at your earliest convenience.

Regards:

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Quality in dental practice

The Indian healthcare industry is experiencing quick transformation owing to the increasing demand for quality healthcare. With the increased standard of living in India people are becoming health conscious, shaping a new market which is giving increasing importance to healthy teeth and dental cosmetics. The potential size of India's dental market is vast and as per the IDA, India is slated to become one of the largest single country markets for overseas dental products and materials. Currently, the Indian dental care services market is estimated at about US$ 600 million and dental equipment and appliances market is around US$ 90 million, with a yearly growth rate of 10%. As per the report of year 2010 published by Cygnus Business Consulting and Research, the Indian dental equipments industry is expected to reach US$ 116.43 million, the dental care services market to US$ 1.16 billion and oral care market to US$ 1.8 billion by 2014 (Agarwal, 2012). Unfortunately this is only side of the coin representing the flourishing Indian dental market and the other side represents the still grave rural and less privileged populations' front. Though great deals of funds have been raised and numerous acts and institutions formulated to up bring the health status of poor and needy ones and ensure equitable distribution of dental health care facilities. Moreover, the lack of tools to measure the quality of dental practice across the country place an additional hindrance to assess the value and volume of effective care delivered surpassing all inequalities of region and financial barriers.

STANDARDS OF DENTAL CARE AND TREATMENT

Dental services are delivered to masses at various levels in various modes:

Primary Care private dental services, including private treatments provided alongside Health Service treatments in mixed practices; and

Primary Care Health Service dental services, including those provided by the Community Dental Service. The term *Primary Care* refers to the local dental services available directly to patients, such as those services from High Street dentists and Health Centers. The term *Secondary Care* refers to hospital or specialist care, to which a patient may be referred from Primary Care. A standard has been set to achieve six important aims for quality improvement (Fish, 2009):

1. ***Safe*** — avoiding injuries to patients from the care that is intended to help them.

2. ***Effective*** — providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).

3. ***Patient-centered*** — providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

4. ***Timely*** — reducing waits and sometimes harmful delays for both those who receive and those who give care.

5. ***Efficient*** — avoiding waste, including waste of equipment, supplies, ideas, or energy.

6. *Equitable* — providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

These standards are to be adopted by all dentists in a Primary Care, whether Health Service or private setting. Their purpose is to ensure that masses receive consistently high quality care and treatment. The standards can be used to help consumers decide which dental service to choose.

The Quality Standards for Health and Social Care, have five key quality themes: (Entwistle et al., 2012)

- *Accessible, flexible and responsive services*: in choosing dental service, services before your appointment and visits.
- *Safe and effective care:* Assessing the needs of individual patients, the quality care and treatment provided Medical and other emergencies, Control of infection and care environment.

Effective communication and information

- *Promoting, protecting and improving health and social well being:* Ongoing care and attending to special needs of Children, young people and vulnerable adults.
- *Effective communication and information:* freedom to express and discuss the treatment options and confidentiality.
- *Corporate leadership and accountability* among the dental personnel.

MODES TO MEASURE QUALITY OF DENTAL CARE

As national expenditures on healthcare continue to rise, the need to accurately assess quality and efficiency of care has become more urgent. Studies have documented treatment reporting variations across providers, care settings and geographic regions. Measuring the quality of healthcare and using those measurements to promote improvements has been an agenda of concerns for health care administrators.

Many health organizations and government agencies are involved in the development and implementation of oral health measures (Mahal and Shah, 2006), (Guidebook, 2012)

Of note are:

- Agency for Healthcare Research and Quality
- Centers for Disease Control and Prevention,
- Centers for Medicare and Medicaid Services,
- Health Resources & Services Administration,
- Indian Health Service,
- Maternal and Child Health Bureau,
- National Committee on Quality Assurance,
- National Network for Oral Health Access, and,
- Veterans Administration.

Challenges for Measurement in Dentistry

There remain numerous challenges to develop and implement measurement in dentistry. These include:

- Few evidence-based guidelines
- Limited knowledge of outcomes
- Limited diagnostic data collection to establish oral health benchmarks
- Limited information systems for capturing and transmitting data from patient records
- Limited accessibility of claims data

Interviews and questionnaires have been utilized as a common way of collecting information regarding quality of care delivered (WHO, 2003). Although dentistry has recognized the need to adopt evidence based principles in the delivery of care, often they may be of limited value due to insufficient or inconclusive evidence. There are very few high-quality prospective clinical trials on oral health topics. There is limited knowledge of true oral health outcomes, which occurs in part because dentistry does not have a tradition of formally reporting specific diagnoses or associating such diagnoses with specific services, especially through the claims process. Ultimately, dentistry needs a cost-effective measurement system that can be easily implemented on a routine basis in small practices, measure factors under the control of the practitioner, and yield meaningful information that can be acted upon for improvement .the need to measure is rooted in the basic responsibility to assure that the public receives optimal benefits from available knowledge and effective care. Steeply rising costs

and inconsistent quality of medical care have culminated in the national priority to deliberately seek value from healthcare. To assure that we are providing the highest quality patient centered dental care, dentistry should be able to measure what works and what doesn't and make changes needed to improve health outcomes.

IMPROVEMENTS IN DENTAL PRACTICE SO FAR

- PARADIGM SHIFT ROM EXTRACTION TO PREVENTION .

  When structured preventive care was introduced, patients perceived the difference. This was true of patients in both practices, and for patients at all levels of risk of developing dental caries, that is, with healthy and less healthy mouths. Without preventive care, the existing vulnerability caused by a history of poor oral health was progressing to worsening oral health (Sbaraini et al., 2012). People were either unable to pay for care and living with pain, or were continuously paying for restorative work; although they were unhappy with this situation, they felt unable to address it.

- UPSURGE IN NUMBER OF DENTAL COLLEGES

  Formal dental hospitals and dental education which started in India as early as 1883 gained direction with the starting of the first autonomous dental college at Calcutta in 1920. Since then number of dental colleges has increased significantly in the past two decades. A recent report by the Comptroller and Auditor Genera [CAG] revealed the presence of 292

colleges, mostly in the private sector and concentrated in five states. 3 The number of dental students graduating has also increased significantly from 1370 in 1960 to over 26000 in the year 2000; the number is still increasing. (V, 2012)

- AWARENESS AMONGST MASSES.

  Patients transitioned from their initial state of being trapped in a situation of having degenerating teeth through a stage where they had achieved lifestyle changes and experienced reinforcing outcomes. Patients have gained new knowledge, developed new clinical relationships and established new practices. Patients value the dental care without drilling and filling" teeth and characterized dentists as\ either "old-school" or "new-school" based on the treatment options provided and the clinical relationship offered. Literature that suggests that patients' perceptions of the quality of dental care and the likelihood of them seeking care are related to their perceptions of dentists as caregivers. Several studies have described perceived characteristics of dentists that are likely to increase care-seeking or satisfaction with care, including communication skills, informing patients about treatment options, and dental teams' behavior during dental visits. (Sbaraini et al., 2012, Calnan et al., 1999)

- DENTAL CARE STATUS IN RURAL AREAS

Many social and environmental factors interact to determine the access, delivery and quality of dental health care. While the delivery of quality care

is important, access to oral health care is a more immediate concern for rural residents. Though many major steps have been taken by Indian dental association and impact of mobile dental services has been evident in improving rural health care services. But still the results are not remarkable or commendable. Official reports indicate that more than 52% of the dental colleges are concentrated in five states of the country and the dentist to population ratio in India in 2004 was 1:10,000 in urban areas and 1:250,000 in rural areas, which clearly indicates a skewed distribution of oral health care delivery system (Guay, 2004). When rural residents cannot access care, the delivery and quality of care becomes irrelevant. Rural populations can experience greater dental caries, poverty, smoking use, transportation barriers, and lower water fluoridation (Byron L, 2009). Adults in rural areas are more likely to have untreated dental decay, permanent loss of teeth and engage in smoking and tobacco use, increasing the likelihood of oral cancers, periodontal disease and dental caries and the volume of care being delivered is still meager.

HINDRANCES TO QUALITY DENTAL PRATICE (Ahuja NK, 2012)

The oral health care for a 1.1 billion population is one of the fore most challenges facing the dental health care delivery system in India.

- FALLING EDUCATION STANDARDS: There seems to be a disconnection between theory learned and its application. Obviously, the solution is to establish (Byron L, 2009)

    I. Provisions in the dental curriculum to include treatment planning seminars to encourage students to prepare ideal as well as alternative treatment plans and to improve analytical skills and logical reasoning.
    II. An environment conducive for problem based\learning [PBL] to improve knowledge, skills and attitude of the students and also prepare them for self-directed life-long\ learning
    III. Systems for periodic update of dental curriculum with emphasis on comprehensive treatment planning and to facilitate long term self-evaluation by students.

    - LACK OF RESEARCH IN DENTAL SET-UP: Under graduate level dental programs in India has very little scope for research activity. The reasons range from lack of funds to lack of research mentors. The BDS curriculum also lacks formal training in research methodology. Moreover, the problem being faced in research centre is the absence of original research and duplicacy of results leading to pooling up of fake data.

    - INCOMPETENT FACULTY: Recent reports indicate that shortage of teaching faculties in some dental colleges ranged from 8-97percent. Most of the faculties despite having completed a postgraduate program [MDS],

lack research training and are ill equipped to guide students in research. Similarly, very few dental colleges have the facility for evaluation of staff, by the students, and in those few colleges where such system exists there is little control over biased opinions.

- PRESERVING ETHICS IN DENTAL PRACTICE: Despite the existence of a code of Medical and Dental ethics, unethical practices are in plenty. There is hardly a mechanism to advise and correct those who are deviating from normal ethical practices. The problem seems to be arising from lack of awareness coupled with an official mechanism incapable of enforcing ethical practice. Formal training on medical and dental ethics and medical jurisprudence is lacking in our undergraduate curriculum.

- LACK OF EMPLOYMENTS AND FINANCIAL SECURITY AMONGST PRACTITIONERS: Dental colleges are mushrooming, the number of under graduate seats in the existing colleges is being increased, the number of dental graduates is increasing in leaps and bounds, but there hardly seems to be any serious thinking regarding the future and profitable employability of a dental graduate. The pay packet of a senior lecturer in a private dental college in some metropolitan cities of the country is in fact less than that of a skilled laborer.

- LACK OF GOVERNMENT FUNDED DENTAL AIDS AND RECOMMENDED DENTAL HEALTH INSURANCES: The strategies employed by government to improve oral health status fail to take upon a wholesome approach and target each and every individual irrespective of age, gender and socio economic status. The oral diseases are rampant and affect every sector of people due to lenience at the part of government practitioners, lack of funds and perseverance, the deliverance of health care is inefficient. The government and private sectors still don't consider the oral heath under the health insurance schemes, thus making it an unattended sector.
- SKEWED MANPOWER DISTRIBUTION: The manpower in dental care sector in India is near to adequate but the problem lies in its skewed distribution. There are many states viz: Orissa, Jammu and Kashmir, North eastern territorial states that due to various geographical and political barriers represent high inadequacy in dental health sector. On the other hand, in the states like Maharashtra, Punjab and Haryana, dentists are facing crisis to find jobs and struggle to establish due to ever-growing saturations and competitions. The skewed distribution also put additional physical stress on dentists in overburdened areas and mental stress.

A THOUGHT FOR IMPROVEMENT

Amendments are needed at every front to ensure deliverance of quality care. Funds are needed to be raised in this respect especially to reach to rural areas. More manpower aiming at equal distribution of services needs to be recruited. Providing quality to masses by means of providing quality life to dentists. That becomes a moral responsibility of administration to deal with underemployment, the gravest of all problems, at this scenario. Opening of new government colleges and putting a check on distribution of private colleges is another area where government considerations are may work for betterment. The timely inspections of educational and infrastructural facilities being provided by colleges is essential, as the quality of dentists being produced by the institutions govern the quality of care delivered. The major problem being encountered is the rising number of oral cancers and other oral diseases numbers despite of all efforts put forth till date. The reason behind is failure to diagnose the oral ailments at an earlier stages. It demands special thought to introduce diagnostic tools and equip dental personnel to make prompt diagnosis (WHO, 2003) and carry out preventive regimes to deal with such rampant oral disasters. The quality of dental care is not only determined by the number of restorations carried out or extractions done, but incorporating the right lifestyle and habits to ensure good oral health is sole aim of dentist and number of healthy individuals are indicative of quality of dental practice. The primordial and primary levels of prevention are equally important as secondary and tertiary levels. A lot has been done and a lot is still needed to be done. To produce able dentists imbibing ethics, skill,

armamentarium, funds, perseverance, knowledge and hospitability is the responsibility of dental associations and faculty members. It is also essential to maintain a routine regulatory check on dental clinics and hospitals, be it private or government aided. If properly synchronized strategies harboring all the needs of both the consumers and dental personnel are implemented the day is not far off when every dentist will be delivering a quality dental care and every individual will be a recipient of the same.

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