The neglect of global oral health: symptoms and solutions
Benzian, H.

Citation for published version (APA):

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: http://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.
CHAPTER 3

Illegal oral care
– more than a legal issue

Abstract

Affordable, safe and appropriate oral care, including preventive services, is not available for large parts of the world’s population. In many low- and middle-income countries patients have to rely on a range of illegal oral care providers who are often socially accepted and part of the cultural context. Although filling a gap in service provision for poor populations, illegal provision of oral care is a serious public health problem, resulting in situations of low-quality care and risks for patients. It is a complex phenomenon going far beyond the legal context. It should be seen as a symptom of underlying health system and society deficits, ranging from lack of access to care and health inequities to problems of governance and law-enforcement. This paper analyses the problem based on the country case of Guyana, explores the public health, legal, professional, social, economical and ethical dimensions of the problem and proposes a differential view on illegal practice by grouping illegal oral care situations in four broad categories; each of them requiring different solutions to tackle underlying issues leading to the problem of illegal oral care.
Introduction
Affordable, safe and appropriate oral care, including preventive services, is not available for large parts of the world’s population. Disadvantaged communities in high-income countries suffer from access barriers impacting on their oral health status. Large segments of the population in low- and middle-income countries, mainly in rural areas and those with lower socio-economic status, are completely lacking access to formal oral health care provided by either private providers or public services. In such settings the informal sector may offer services through a range of care providers that are not legally recognised, but often socially accepted and part of the cultural context.

The illegal provision of oral care is a constant and increasing concern in many countries around the world. It can be considered a public health problem due to low quality of care and related health risks for patients. Just as an example, in Morocco it is estimated that there are three times more illegal providers than fully licensed dentists. Dental associations deplore the threats from illegal oral care, but scientific literature about the problem is very limited and the magnitude of the problem on a global scale unknown. In the context of global efforts for Health Systems Strengthening and improving patient safety the problem of illegal oral care merits a closer examination. This paper analyses the complex phenomenon based on the country case of Guyana and argues that illegal dental practice is more than just a legal problem. We propose a differential view on illegal practice by grouping illegal oral care situations in four broad categories; each of them requiring different solutions to tackle underlying issues in widespread illegal oral care.

What constitutes illegal dental practice?
According to a policy statement of the FDI World Dental Federation “only those with the specific education, training and qualifications, recognised in each country, can be entrusted with the practice of dentistry”. Consequently, practicing dentistry without fulfilling all of these conditions is considered illegal provision of oral care. Illegal practice includes offering oral care without appropriate licensing, training or quality standards. Specific national legislation usually details practice and licensing requirements. The Indian High-Court stated that “a person who does not have knowledge of a particular system of medicine but practises in that system is a quack and mere pretender to medical knowledge or skill”. Illegal care can refer to many different situations, such as street “doctors” without qualification, immigrant providers who failed to regularise their situation in the host country, therapies which are
not legally allowed under a specific jurisdiction (such as abortion or euthanasia), so called “alternative medicine” without proven health benefits, medical negligence and others. This paper, however, focuses on the provision of oral care by providers who have either no legal permission to practice or have no training to provide the services they pretend to offer. The terms “illegal dental practice” and “illegal oral care” are used interchangeably.

Many of the developed countries tackled the problem of illegal oral care between 1920 and 1980, mainly related to the provision of oral care by dental laboratory technicians (“denturists”)\(^{10-13}\). National dental associations in these countries were the driving forces behind addressing illegal practice, focussing on issues of professional competition and protectionism rather than on protection of patients\(^{14}\). Eventually, all high-income countries found viable solutions to the problem through the development of detailed professional and legislative regulation enforced by strong sanctions, penalties and other legal action. In some middle- and low-income countries the problem has been addressed as late as during the last decade of the 20\(^{th}\) century\(^{15}\), and it still persists in a number of countries with varying extent\(^{16,17}\).

The underlying causes of illegal oral care are complex and are related to the provider side, patient demand and a void in public service and policy. Some of these causes include, but are not limited to:

- The widening gap between need and available oral care services;
- Inappropriate workforce planning policies of governments coupled with an increasing liberalisation of health markets resulting in weak public systems;
- The high cost of available oral care services, making them unaffordable for populations living on a low income;
- Limited local service availability in a primary health context, often requiring significant travel and opportunity costs in a situation of pain or emergency;
- Weak or non-existent dental professional organisations, resulting in a regulation and enforcement void;
- A simplistic perception of the relationship between oral pain and a decayed or otherwise diseased tooth requiring little medical skills or knowledge to diagnose and relieve pain;
- The traditional focus of dental practice on technical interventions rather than on the medical aspects of oral care encouraging dental laymen to intervene.

The current problems in low- and middle-income countries differ greatly from those that high-income countries resolved decades ago. The complete neglect of oral health care in the conceptual and practical framework of Primary Health Care as proposed by the Alma Ata
declaration and the resulting failure to integrate oral health care in such systems in many countries equally led to the development of an informal, unlicensed and completely uncontrolled sector of oral care provision.

**Case study: Oral Health and Oral Health Professionals in Guyana**

The case study reports about the situation in Guyana in 2005 when the Ministry of Health called for expert support in the development of a code of practice for the dental profession as part of a broader strategy to improve patient safety in the context of the National Health Plan through addressing the growing problem of illegal oral care.

Guyana, a country with a population of 780,000 on the north-east coast of South America, ranks among the poorest of the Americas and is culturally and politically part of the Caribbean region. Delivery of health services in the public sector is based on a primary health care model with five levels ranging from health posts to the national referral and specialist hospitals. The referral system, while existing in theory, does not function well in practice. The private sector, including non-governmental organisations, is increasing in size and scope of its functions. One of the main factors affecting the delivery of health care are inadequate human resources at all levels of the system. Staff vacancy rates are in the range of 40 to 50% in most categories, due to migration. New cadres of workers have been introduced in the system but the attrition rate is high due to low public-sector wages.

The *Dental Registration Act* (1996) provided the basis for the establishment of a Dental Council in Guyana. However, the Council had no further applicable regulations or a code of practice; the only activity was to provide the minimal registration needs for the dental profession of the country. The National Dental Association has only very limited organisational capacities and resources.

The 33 residential dentists registered in the country are mainly working in public service (22 dentists) and in the affluent populated coastal regions; the hinterland is scarcely populated and basic dental services are not available in all districts. The dentist/population ratio is 1:36,900. The National Oral Health Strategy is based on a primary health care system with basic oral care delivered by therapists (“Dental Extenders”) and dentists available for referral in the higher levels of the treatment pyramid. There are about 150 illegal providers in Guyana, offering services ranging from emergency care and simple dentures to more complex restorative work.

In order to address the acute workforce shortage a dental school was opened in 2007 in
the capital Georgetown with international support. However, the school is short of academic and clinical teaching staff and operates still on a rather basic level.

Illegal oral care: a public health problem
As much as illegal dental practice contributes to alleviating the huge unmet treatment needs and access problems, it constitutes a major medical and public health problem that has not received much international attention so far. Firstly, the provision of care by untrained or insufficiently skilled personnel comes with serious risks to patient safety and infection control. District and reference hospitals in many developing countries see large numbers of patients with complications resulting from illegal providers, that very often lead to life-threatening conditions. Street side oral care is usually performed without any hygiene precautions, without disposable needles or instruments, and drugs are dispensed without proper medical assessment.

Illegal oral care: a legal problem
In Guyana, as in most other countries, the Dental Registration Act defines the practice of dentistry and stipulates who is allowed to practice dentistry. The Dental Council is requested to establish a Code of Practice regulating all aspects of professional practice, including licensing and re-licensing, continuing education, ethical practice, malpractice and disciplinary measures. This legal construction enables the Ministry of Health to control the profession “at arms length” while allowing the profession at the same time a degree of self-regulation that is key to many health professions, including the dental profession.

In 2005 the Guyana Dental Council had no professional code or other regulations for professional conduct, resulting in a regulatory void that favoured random decisions, corruption and a mushrooming informal sector. The Dental Registration Act only covered dentists, the allied professions were not included.

One of the main problems with regards to illegal practice lies in enforcing and controlling the existing regulations and in sanctioning those that do not comply. This requires a high degree of interaction between various bodies, namely the Dental Council, the Ministry of Health, the Ministry of Justice and other professional organisations. In a country like Guyana, where the rule of the law is not ensured in all aspects of public life or even impossible due to problems of access and geography, the enforcement of complex professional regulations remains a remote aspiration. Similar conditions are encountered in many African, Asian
and other Latin American countries. Dental professional organisations are usually keen on strict sanctioning, but need support from government administrations to enforce such sanctions. In the past governments have been reluctant to do so because the informal (but illegal) sector provides at least some kind of oral care where formal care would not exist otherwise. The ethical issues of that dilemma and the risks for patients are often ignored.

The complete lack of malpractice insurance in the illegal sector is another reason in favour of formal oral care; yet this may only be realistic and a viable argument in countries where law and health care systems are developed enough to provide this type of patient protection effectively.

**Illegal oral care: the social dimension**

Who constitutes an illegal provider of oral care? The case of Guyana shows that there is no simple answer to this question. The distinction between traditional practice and quackery is often difficult and sensitive. Sometimes, the business of providing oral care is inherited within the family and is closely related to practicing traditional medicine with high social esteem. On the other hand, there are dental laboratory technicians providing oral care, even beyond fitting dentures. There are also trained auxiliaries opening private practices. From the legal point of view a clearly illegal practice; however, such providers are often the only person capable of simple pain relief for people in rural areas or for those who cannot afford other services. Often the patients lack trust in public services which may be poorly equipped and staffed so that they choose to go to a private – and often illegal provider - who has a better “reputation” in the patient’s eye. Usually the public is not aware about the problem and the legality of different providers of oral care; not to mention the inherent health risks when using the services of unskilled and unlicensed providers.

**Illegal oral care: an economical problem**

Illegal providers usually work in the informal sector of economies and do not pay taxes or other levies. Furthermore, the out-of-pocket payments of patients are not subject to any regulation so that overcharging for low-quality care is frequent. Patients have little options in case of dispute. Payments to illegal providers remain in the informal sector and are undermining the public health care system.
Illegal oral care: a professional problem

The provision of oral health care by illegal providers constitutes a major professional problem for dentists and their organisations. Similar to the example of Guyana, Dental Councils and Dental Associations in many countries are weak and suffer from very limited resources due to small numbers of dental professionals or due to lack of recognition by their medical colleagues and politics. This significantly limits their capacity to be effective regulators as intended by most dental acts or legislation. Even if illegal situations are recognised and the need to address them is acknowledged, the organisational strength and/or the political support to enforce sanctions is missing in many cases.

This situation is complicated by the need to delegate tasks to allied professions within the health care system in order to address the huge unmet treatment needs and to meet the ethical obligation of providing oral care for all. This delegation requires a self-confident profession with an organisational capacity to regulate, control and train all involved cadres effectively. The fear of many dental professional organisations to allow delegation of certain tasks in the context of the delivery of basic oral care or prevention is often motivated by a perceived or real risk of illegal practice through overstepping of competencies by less trained allied professionals.

The situation in Guyana shows that it is possible, but challenging, to establish oral health care within a primary health care system on the basis of different levels of professionals. While the majority of lower-level oral health workers adhere to their scope and roles, others choose to overstep their capacities or to leave the system entirely by working without license.

Illegal oral care: an ethical problem

Last, but not least, considerations about access to care and illegal oral care face an inevitable ethical dilemma: are bad, or even hazardous services better than no services? If an illegal provider is the only one available or affordable in an emergency situation, should the patient be discouraged to seek their help? From a medical point of view any treatment involving a health risk is unacceptable, but for a suffering patient the reasoning is a different one and need for pain relief may override all other concerns.
Simplification for solutions: Types of illegal dental practice

Illegal dental practice generally is a symptom of broader failures of the health system and society at large. Since the phenomenon is complex and has many different forms, it is helpful to distinguish and standardise different illegal care situations.

Illegality can occur

- a) On the basis of lacking proper registration and licensing with the relevant regulatory bodies of a country;
- b) Because of lack of necessary training and professional education; or,
- c) A combination of both.

Based on these criteria there are at least four main types of illegality (see figure 1, page 53):
Type 1: Providers not formally trained for the provision of oral care and not registered in any way
This group of illegal providers (often called “quacks”) is probably the most dangerous for patients – they work without any formal training and control, with simple instruments, lacking proper infection control and are usually not capable of handling any kind of dental/medical complication. Treatment is generally performed without safe and effective anaesthesia. Sometimes they work in a simple cabinet like setting, but in many places they are offering their services on markets or other outdoor locations. Fees for service are freely negotiated. This group also comprises dental laboratory technicians providing clinical care if they have neither been trained for this nor are registered for clinical practice.

Measures to address this type of illegal practice:
• Enforcing existing regulations;
• Strengthening administration, governance and civil society awareness;
• Providing all communities with appropriate oral health services offering emergency oral care on the basis of primary health care principles;
• Educating the public about the available system of oral health care services and the risks of using unlicensed, untrained providers.

Special case: Traditional medicine practitioners:
From a legal and professional point of view traditional healers are part of the group defined above, although their role and function in many traditional communities is associated with highest social esteem and respect. For many populations and communities, traditional medicine may be the only available and affordable therapy for pain relief. Exploring the relation between traditional medicine and professional dentistry is not part of this paper; however, more research of this aspect is needed to explore the complex cultural, social and economical interactions and dependencies between communities, traditional medicine and oral health professionals.
Type 2: Providers with health-related training (but not in dentistry) and not registered to provide oral care

A community health worker, a family nurse, a pharmacy assistant or even a physician may be facing patients with oral health problems and he or she may be the only health worker available. In such circumstances it may be necessary to drain an abscess or to extract a loose tooth in order to alleviate suffering. Such simple treatment is usually performed in health care settings. Strictly speaking this is illegal oral care (although some national legislations allow physicians to perform such basic oral care); however, it should be seen as an immediate response to unmet community needs. The associated risks for patients seeking or receiving such treatments are considerably lower than those related to treatment of providers mentioned in group one. It is quite likely that more complicated cases will be referred to specialist care. However, there are also situations where health workers provide such basic oral care on a continuous basis, maybe even to earn an additional income.

Measures to address this type of illegal practice:

• Providing all communities with appropriate oral health services offering emergency oral care on the basis of primary health care principles;
• Educating the public about the available system of oral health care services and the risks of using unlicensed, untrained providers;
• Ensuring that all health personnel in the public system is appropriately supervised, trained and remunerated;
• For remote communities with no specially trained oral health professional a skills-based education of health workers can be considered, including basic skills for emergency oral care;
• Development of laws and regulation allowing for legal provision of oral care by medical health workers in the context of delegation after appropriate training and education.
Type 3: Providers with (basic) oral health care training practicing unlicensed and thus illegal
There are situations where health workers with basic training in providing oral care, such as community oral health workers, dental therapists or dental hygienists, may choose to practice independently without being licensed to do so. Usually they will do so for financial reasons, perhaps because of low income in the public system where they would typically be employed. While practising “outside” of the system and thus illegal, they may keep their original scope of practice or overstep their original therapeutic boundaries. This group also includes professionals who have received training and practice outside of their country of training, but their training is either not recognised or they failed to regularise their situation in their current country of residence. Unfortunately, this group also includes expatriate volunteering dentists and dental students working with non-governmental organisations (NGO) in resource-poor countries; although providing needed oral care they are often bypassing or ignoring local authorities and registration rules24,25.

Measures addressing this type of illegal practice are:

- Ensuring that all health personnel in the public system is appropriately supervised, trained and remunerated;
- Providing career paths and opportunities for personal and professional development;
- Including all members of the dental team in professional legislation, submitting them to a common framework of rights, responsibilities and sanctions;
- Making licensing regulations transparent and ensuring a consistent process, thus facilitating the legalisation of previously unregistered providers;
- Offering additional qualification and training incentives to allow informal providers entry into the formal system;
- Ensuring that NGOs employing expatriate dentists and dental students comply with local professional registration rules.
Type 4: Providers with basic oral health care training, registered to provide aspects of oral care, but overstepping their responsibilities

This group includes members of the dental team with lower levels of training and restricted scope of practice, performing interventions that they are not educated for or legally allowed to do. This is a typical situation within the dental team resulting from lack of supervision, training, or other control. Overstepping responsibilities may occur involuntarily due to the nature of a specific case or by overestimating the own capacities. If providing care beyond of the scope of their job or training they are providing illegal care, whether in an emergency situation or as an additional income to their regular salary.

Measures to address this type of illegal practice:

- Proper training, supervision and continuous control;
- Re-motivation of professionals; and
- All measures mentioned under type 3.

Discussion

The analysis of the oral health workforce situation in Guyana shows that illegal provision of oral care is a complex ethical, professional, social, economical, legal and public health problem. There are different forms and levels of illegality based on two basic facts: Has the provider received approved and appropriate training to provide oral care? Is the provider legally allowed through registration and licensing to provide the services offered? The classification into four main groups of illegal practice is an attempt to differentiate the realities of illegal practice and at the same time to simplify the various situations based on these two key criteria.

Reality, however, may be much more complex. A practitioner may work fully trained and licensed as a community dental therapist in a public clinic in the morning, while providing illegal services in the same setting in the afternoon after official duty hours. Combinations and overlaps between the different types outlined are possible and quite likely. Since this is the first time such a classification has ever been attempted there may also be other practice situations that have not been considered when defining the types of illegality.
The judgement whether to condemn illegal practice or to welcome a contribution to emergency care is complex: there are risks for patients with all four types of illegal practice, but some seem less harmful than others. From an ethical point of view there is also a difference whether illegal practice occurs in an emergency situation or whether it is performed routinely to increase income.
Tackling illegal practice as a public health problem requires a multisectorial approach in order to address the complexity of issues and situations. All types of illegal practice outlined in the model require a set of different measures to address them, since the underlying issues and motivations for illegal practice are different in each of the typical scenarios. The overall requirement and starting point, however, is an existing and functioning legal framework defining the professions active in providing oral care, as well as their roles and responsibilities. Only if this prerequisite is fulfilled it is possible to reduce or eliminate illegal practice. On the other hand, even with an existing legal framework it may be difficult to control illegal practice if the professional associations involved and/or the state are not able or willing to take an active role in this matter. Again, functioning codes of practice including professional jurisdiction are necessary in addition to national government legislation to control the informal sector of illegal practice.

An other important element of reducing illegal practice is a functioning public health service, providing training, career paths, quality control and supervision for all health workers. This is of course a problem that lies outside of the limited scope of dentistry and needs to be addressed in the wider societal context and the renewed focus on Health Systems Strengthening. The introduction of Social Health Insurance schemes, also covering basic oral care, may be an opportunity to address illegal practice through inclusion of formal providers. However, equity and access issues need to be carefully considered if the intention of reducing demand for health care in the informal sector is to be reached.
Guyana’s strategy to tackle illegal dental practice

The Ministry of Health and the professional association decided to develop a comprehensive strategy to address the issue of illegal oral care. The starting point was a renewed and strengthened legislation with the key aim of improving quality of care for all citizens. A revised Dental Registration Act proposed to the Ministry made provision to clearly define all professions related to oral care, making a more exact definition of illegal practice easier. The plan also included scaling-up of the existing workforce, a clear definition of roles and responsibilities of involved professions, a Health Facilities Act setting minimum standards for clinical settings, including infection control, and a framework of sanctions in case of non-compliance, among others. On the incentive side training for all related professions was offered, with the clear aim of integrating as many providers as possible into the formal sector by providing career paths, personal development and social acceptance. Joint action with the physicians and pharmacists in the areas of continuing professional development and mandatory relicensing, created positive synergies and a momentum towards change. Furthermore, a dental school was established in the capital Georgetown, as well as an additional 20 public dental clinics were opened throughout the country in order to improve the population’s access to formal care. It is expected that the increase of registered dentist numbers will contribute to mitigating the issue of illegal providers.

Conclusions

Illegal provision of oral care is a serious public health problem in many low- and middle-income countries, resulting in situations of low-quality care and risks for patients seeking help. It is a complex problem that goes far beyond the legal context that the terminology suggests. It should be seen as a symptom of underlying health system and society deficits, ranging from lack of access to care and health inequities to problems of governance and law-enforcement.

It is surprising that only little research into the medical, social, economic and legal aspects of the phenomenon has been undertaken. Efforts to address the problem have usually focussed on legal interventions and strengthened regulations, with varying success. We suggest a more differentiated approach, which is clear in its direction, but more embracing and inclusive than confrontational. The aim should be to integrate formerly illegal providers into the formal system by offering incentives, training and opportunities. The case of Guyana has shown that this strategy is more likely to be successful. National professional associations
are key stakeholders in this process. They need to find a pragmatic approach that covers the ethical imperative of providing the best possible oral care to all, allowing as much delegation and team work as possible and realistic. They also need to protect professional interests while contributing to a higher public good – access to safe, affordable and appropriate oral care. In this context, international organisations and development partners have an important role in providing guidance and templates that facilitate the necessary intersectorial and interprofessional collaboration to tackle the problem.
References


