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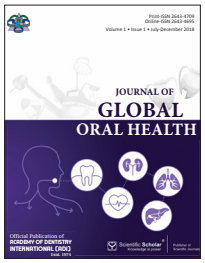

Editorial

Access to oral health-care and inequalities

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Access to health-care deserves to be basic right to every human. All humans irrespective of any factor deserve an equal opportunity for a reasonably long, healthy, and productive life. However, in real-world situations, the health access remains different between nations, regions, and even at subregional levels. Quite recently, the Global Burden of Diseases study group published the health-care access inequalities in the world, using sociodemographic index (SDI) as a comparing parameter in the time period of 1990–2017. This SDI is a novel, combined indicator of measures of income, education, and fertility. The study proceeded to identify wide disparities among nations and even in specific regions within countries. They also observed a uniform trend of relatively smaller burden in countries that are traditionally held as wealthy. Lifestyle disorders such as, high blood pressure, high body mass index, diet, and high fasting plasma glucose are significant risk factors. Furthermore, the use of illicit drugs, use of tobacco, and alcohol use disorders were also significantly related to health-care access inequalities. Their findings can be extrapolated to design pertinent research studies to identify the root causes of such disparities and develop evidence-based solutions to improve health and health equity.[1]

This is very interesting and pertinent to relate to oral health-care access. It is common knowledge that oral health-care access remains distributed in a skewed fashion since the 16th century.[2] India and Southeast Asia top such a list.[3] While there could be a huge list of factors that could prevent the oral health-care access inequalities, there are no studies in literature that has systematically and periodically assessed the inequalities. Such a study on a global or a regional study would help the policy-makers to find the list of diseases and conditions that predispose to poor oral health as well as remain as a crucial factor that influences the oral health-care access. Influence of non-communicable diseases on this would be an added factor that needs to be studied. When such lists of factors are collected with evidence of involvement, it would be easier for the policy-makers to design solutions.

It is the need of the hour for the oral health-care fraternity to accept, identify, and quantify the presence of oral health-care inequalities and the factors that cause them. It would be needed to provide oral health and systemic health to all.

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