

**LETTER TO THE EDITOR**

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In our country, oral pathologies are a group of diseases with high prevalence. They also have a high burden of disease and cost of treatment, with a relevant impact on the quality of life. Similarly, it has been described that Chileans consider these important conditions as a health need. This scenario sets oral diseases as a public health problem in Chile due to their epidemiology, social demand and high cost. Additionally, from a more collective point of view, it is possible to mention another aspect that positions them as relevant problems in public health: their inequitable distribution among the population. Based on this, it is possible to say that the context of oral diseases in Chile better resembles the reality of underdeveloped countries than that of the developed countries which Chile is often compared with for other social and sanitary issues.

In Chile, public policies have been developed for tackling oral health problems, mostly in the health system. With the exception of fluoride in drinking water, the solutions offered for oral health problems have insistently based on reinforcing and increasing care benefits. This may show that the rationale for solving oral health problems may have its foundation on sanitary approaches with an eminently biomedical model of care. The arising question then is: What determines the inequity in the distribution of oral pathologies among the Chilean population? Is it mainly related to the access to dental care? What is the reason that makes us consider that increasing access to dental care is the main intervention to tackle inequity in oral health? Probably, one of the aspects that explain this logic is embedded in what and how we do research.

Epidemiological researching in dentistry has shown a great interest in studying harm reduction practices in order to be an active agent in lowering the prevalence of oral diseases and increasing control over them¹. Special emphasis has been placed on the study of the individual risk factors, over the risks or conditions at the population level, which are the ones that finally establish individual

What role does the social and political context play in people's oral health?

risks distribution². Thus, our focus is usually, for example, in identifying acceptable biofilm levels for good oral health, how to decrease caries risk in patients, which are risk factors for oral diseases, how to decrease caries risk in patients, and even what behaviors relate to better oral health status. However, these research lines continue to guide us to view oral health from an individual perspective, minimizing the importance of the social and political context that influences the inequitable distribution of those individual risk factors in the Chilean population. This is the point where dentistry, from a collective and public health perspective, finds an opportunity to intervene oral health problems at a population level.

From a health policy point of view, it is possible to observe that the focus on the reduction of individual harm practices is usually promoted by different [interest] groups with the purpose to divert the potential attention from the collective risk factors affecting the health of an entire population¹. The case of oral health in Chile is not an exception. There has been special emphasis on clinical practice from undergraduate training in dentistry, which has led us to believe that the main tool of intervention we have is the dental clinic. However, the clinical measures are insufficient to solve a problem that demands relieving social and political aspects in order to intervene collective risk factors, which are ultimately the cause of inequities in oral health³.

If we analyze oral health and the explanations for its distributions in the population from an individual perspective only, we may hinder the necessary reflection on the causality of its high prevalence in specific population groups³. At the same time, this reinforces the notion of individual responsibility and self-determination in oral health, which at a population level, becomes a barrier to notice the determinants involved in positioning individuals in contexts that allow them to achieve better oral health states, that are unattainable for others^{4,5}.



Public health research in dentistry coincide in the emphasis that has been given to risk, which explains why most of it has traditionally studied epidemiological questions about individual risks or clinical epidemiology, with the aim to describe how many individuals become ill and what the risk factors in these individuals are, instead of wondering why populations have a certain dental health profile or why certain oral health problems are prevalent in certain populations⁶. Even at the time of measuring the inequity gap in oral health, the tendency is to study individual risks to explain these differences. Many studies refer to social determinants of health as attributes of the individual, which again directs the attention to individual risk factors. Because of this, it is recommended to pay attention to the processes of social determination over the determinant itself, since this allows us to understand that oral health status of individuals involves a historical and collective development, associated with social and political contexts.

The study of the social and political context influencing oral health states has gained considerable interest at present. It is possible to find data on social inequities and determinants in health in scientific journals of clinical tradition. However, in spite of this good initial indicator, most of them perpetuate the approach to individual attributes. It may seem logical to keep our attention mainly on sanitary strategies, since known research supports these decisions due to the effectiveness of these actions on reducing the average of the diseases at the co-

llective level. This is what has happened at the national level, because the strategies of oral health implemented have been effective for decreasing the average of dental caries in some age groups. This is a positive result, but it is insufficient to tackle inequities in oral health. This may be associated to the fact that research in dentistry has prioritized this approach of analysis, assuming a result that is independent from the distribution pattern of population risks in health, which makes it impossible to explain why caries levels are more prevalent in certain populations and not just on certain individuals⁶. Therefore, the strategies arising from these investigations do not resolve the inequity issue in the distribution, since health interventions do not have the same results in all individuals of a population.

Therefore, oral health does not only depend on individual and “free” choices of people; but, above all, on the multiple conditions and social positions that shape the way we live, relate, work and get sick in each group or sector of society. The need to investigate with a perspective on the social determination of inequities in oral health in Chile, which goes beyond clinical care, is a responsibility that we are able to consider and we must assume if we want to contribute to reduce health inequity in our country from a dentistry point of view.

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