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'From Draft to Delivery': Dental Professionals as the Implementation Engine of India's Oral Health Policy: A Narrative Review.

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ABSTRACT :

Background Oral diseases are among the most prevalent non-communicable conditions in India, yet oral health has historically occupied a marginal place in national health policy. A national oral health policy was first drafted by the Indian Dental Association in 1986 and accepted in principle in 1995, but a stand-alone, notified policy still does not exist; the Draft National Oral Health Policy circulated in February 2021 remains unfinalised.1,2,20

Aim To describe the present architecture of India's oral health policy framework—global commitments, national policy instruments, the National Oral Health Programme (NOHP), primary-care integration through Ayushman Arogya Mandirs, convergent programmes and the new regulatory order under the National Dental Commission Act, 2023—and to define the operational roles of dental clinicians and dental institutions in implementing it.

Key content The framework is best understood as a six-tier cascade (global → national policy → national programme → state/district → primary care → community). Implementation is constrained by the absence of a notified policy, the lack of a formal NOHP evaluation, missing ring-fenced budgets, weak surveillance, an urban–rural workforce maldistribution and a persistent education-to-practice gap. A five-role model (provider, preventer, screener/gatekeeper, educator/trainer, researcher/advocate) is proposed to locate the contributions of clinicians at the chairside and of institutions at system scale.

ConclusionPolicy will not be implemented by the Ministry alone. With more than three lakh dentists and over 300 dental colleges, the profession is the de facto delivery system for oral health in India; aligning its everyday clinical, teaching and research activity with NOHP and WHO Global Oral Health Action Plan (GOHAP) targets is the most realistic route to universal oral health coverage by 2030.

Keywords: Oral health policy; National Oral Health Programme; Draft National Oral Health Policy 2021; GOHAP 2023–2030; Dental institutions; Policy implementation.

Learning objectives — at the end of this session the learner should be able to:
•Distinguish between a health policy, a programme, a strategy and an action plan, and apply the Walt–Gilson policy triangle to oral health.
•Trace the historical evolution of oral health policy in India from the Dentists Act, 1948 to the operationalisation of the National Dental Commission in 2026.
•Describe the goal, objectives, components, organisational structure and achievements of the National Oral Health Programme.
•Explain how oral health is integrated into comprehensive primary health care through Ayushman Arogya Mandirs and convergent national programmes.
•Critically appraise the gaps that impede implementation.
•Enumerate and justify the roles of dental clinicians (public, private, specialist) and dental institutions in implementing oral health policy.

Introduction

Why oral health needs a policy

Oral diseases—dental caries, periodontal disease, tooth loss, oral potentially malignant disorders (OPMD) and oral cancer, dental fluorosis, malocclusion, cleft lip and palate and orofacial trauma—share common risk factors with other non-communicable diseases (NCDs): sugar, tobacco, areca nut, alcohol and poor hygiene. In India, these conditions are widespread, largely preventable and disproportionately borne by rural, poor and elderly populations, while treatment is financed mainly out of pocket.17,20

A health policy is a formal statement of goals, priorities and the means of achieving them; it sets priorities and guides resource allocation.1 Without a policy, oral health competes poorly for budgets, data systems and workforce planning. A stand-alone policy also signals that oral health should be treated like any other serious health issue—precisely the stated intent of the 2021 draft.2

Workforce numbers illustrate the paradox. A 2026 narrative review reports about 3.7 lakh dentists in India, yet rural availability remains at roughly 1 dentist per 25,000 people.18 The problem is therefore not only the number of dentists but where they work, what they do and whether their work is organised around public-health goals—which is exactly where policy, clinicians and institutions meet.

Analytical lens: the policy triangle

The Walt–Gilson policy triangle analyses any policy through four interacting elements—context, content, actors and process.27 Applied here: the context is a high and rising burden with heavy out-of-pocket spending; the content is the draft policy, NOHP and the regulatory framework; the actors are MoHFW, states, the National Dental Commission, the Indian Dental Association, dental colleges, clinicians, industry and communities; and the process is the long, still-incomplete journey from drafting to notification. The rest of these notes follow this structure.

Historical evolution of oral health policy in India

Figure 2. Milestones in the evolution of oral health policy in India

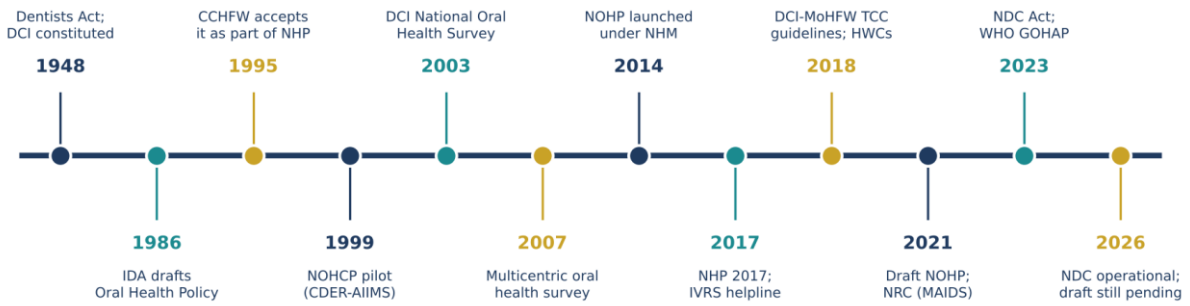


Table 2. Chronology of key milestones

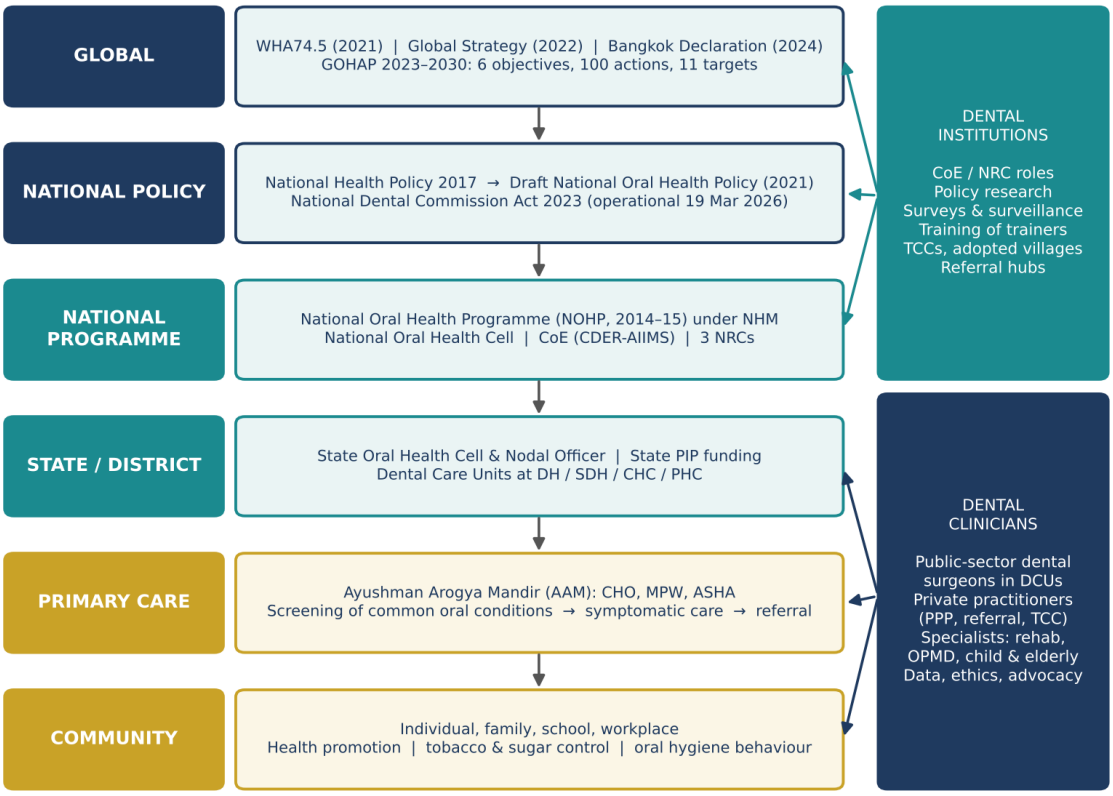
1948	Dentists Act; Dental Council of India (DCI)	Regulation of dental education and registration for 75 years
1984–86	National workshops on oral health targets; IDA drafts National Oral Health Policy (1986)	Profession-led agenda setting[1]
1995	Central Council of Health and Family Welfare accepts the oral health policy as an integral part of the National Health Policy	Acceptance in principle, not notification[1]
1999–2001	National Oral Health Care Programme pilot; implementation strategies published	First programme model, coordinated by CDER, AIIMS[26]
2002–03	National Oral Health Survey and Fluoride Mapping by DCI	Most recent completed nationwide survey cited in programme documents[3]
2007	Multicentric survey on burden of oral diseases (GoI–WHO)	Pathfinder-type data from seven states
2014–15	NOHP launched under the National Health Mission (NHM)	First nationally funded oral health programme[3,4]
2017	National Health Policy 2017; IVRS oral health helpline (20 March)	Primary-care framing; public information line[18]
2018	MoHFW–DCI operational guidelines for Tobacco Cessation Centres (TCCs) in dental colleges; Health & Wellness Centres	Dental institutions formally drawn into tobacco control[23]
2019	AIIMS–MoHFW nationwide oral health survey initiated	Baseline for the policy[25]
2021	Draft National Oral Health Policy circulated for public comment (22 Feb); NRC-OH-TC designated at MAIDS; WHA74.5 resolution	Policy content defined; resource-centre model[2,24]

2022–23	WHO Global Strategy (2022) and GOHAP 2023–2030; NDC Act notified (11 Aug 2023)	Global targets; new regulatory order[9,13]
2024	Bangkok Declaration on oral health	Political commitment to UHC for oral health[15]
2026	National Dental Commission operationalised (19 Mar 2026)	DCI replaced as apex regulator; draft policy still not finalised[12,20]

The present policy framework: a six-tier architecture

India does not have a single oral health policy document in force. What exists instead is a layered framework in which global commitments, the National Health Policy 2017, a draft oral health policy, a national programme, primary-care guidelines, convergent programmes and professional regulation operate together. Figure 1 maps these tiers and shows where clinicians and institutions plug in.

Figure 1. Architecture of India's oral health policy framework and entry points for dental professionals



1 Tier 1 — Global commitments

India is a signatory to the World Health Assembly resolution on oral health (WHA74.5, 2021), the Global Strategy on Oral Health (2022) and the Global Oral Health Action Plan (GOHAP) 2023–2030.13 GOHAP proposes 100 actions across six strategic objectives and 11 global targets for 2030, including two overarching targets: fully integrating oral health services into universal health coverage (UHC) and reducing the oral disease burden.13,14 Target B specifically calls for a 10% relative reduction in the combined prevalence of major oral diseases; GBD 2023 modelling suggests that global progress so far is modest and insufficient at the current pace.16

Table 3. Mapping WHO GOHAP strategic objectives to the Indian framework

1. Oral health governance	Draft NOHP 2021; NOHP cells; NDC Act	Participate in policy consultation; adhere to regulatory and ethical standards
2. Promotion & prevention	NOHP IEC; NTCP/COTPA; NPPCF; school health	Sugar and tobacco counselling, fluoride, sealants, community programmes
3. Health workforce	NDC Act (education standards, NExT); NOHP training	Competency-based education; train CHOs, MPWs, ASHAs
4. Oral health care	NOHP Dental Care Units; AAM package	Deliver essential care; build referral pathways; minimal-intervention dentistry

5. Information systems	Surveys (2003, 2007, 2019); proposed surveillance system	Standardised records, digital data, notification of OPMD/cancer
6. Research agendas	CoE, NRCs, NaRRIDS	Implementation research, programme evaluation, health technology assessment

2 Tier 2 — National policy instruments

(a) National Health Policy 2017

NHP 2017 frames health care around comprehensive primary health care and UHC. The 2021 draft oral health policy describes itself explicitly as an extension of the National Health Policy 2017, so oral health is meant to inherit NHP's architecture rather than run as a parallel system.2

(b) Draft National Oral Health Policy, 2021

Prepared by the NOHP Division of MoHFW and circulated on 22 February 2021 for public comment, the draft aims to provide a framework for prevention of oral diseases and promotion of oral health.2 Its salient features are:

- Guiding principles: equity, integration, community participation, gender, prevention and promotion, and research as the major tools for addressing the oral disease burden.2
- Time-bound objectives: establish baseline data on the national burden of oral diseases by 2025, and reduce mortality and morbidity from oral diseases by 2030.21
- Integration with relevant national health programmes (tobacco control, fluorosis, NCDs, child and adolescent health, elderly care).2
- Status (2026): still awaiting finalisation; commentators argue it needs stronger implementation mechanisms and action on high out-of-pocket expenditure.20

(c) National Dental Commission Act, 2023

The Act was notified on 11 August 2023 to regulate the dental profession, provide quality and affordable dental education and make high-quality oral health care accessible.10 After phased notification, the Commission was formally operationalised from 19 March 2026, replacing the DCI as the apex regulator.11,12 Points of policy relevance:

- Its stated objectives include prevention of oral diseases and promotion of oral health, and bringing awareness of oral health issues while facilitating implementation of updated government policies—an explicit statutory link between regulator and policy.9
- A National Exit Test (NExT) for dental graduates is to be introduced within three years; the Commission can regulate fees for half the seats in private dental colleges and deemed universities.11
- State Dental Councils are retained but restructured: heads are appointed by state governments and elected members are reduced from nine to four.11

3 Tier 3 — The National Oral Health Programme (NOHP)

NOHP was launched in 2014–15 under NHM to strengthen public health facilities for accessible, affordable and quality oral health care.4,18 Its goal is to improve the oral health status of the population across all age groups by reducing the oral disease burden through accessible, affordable, acceptable, appropriate and comprehensive oral health care.4

Objectives:3,4

1. Improve the determinants of oral health (healthy diet, oral hygiene) and reduce rural–urban disparity in access.
2. Reduce morbidity from oral diseases by strengthening services, initially at sub-district and district hospitals.
3. Integrate oral health promotion and preventive services with the general health system and other sectors, notably other national health programmes.
4. Promote public–private partnerships (PPPs) to achieve public health goals.

Table 4. Components of NOHP

NHM component (state level)	Dental Care Units (DCUs) at district hospitals or below: human resources (dental surgeon, dental hygienist, dental assistant, dental technician), equipment including dental chair and autoclave, consumables, training and IEC.[4]
Tertiary component (central level)	Prototype IEC material, training modules, national/regional training of nodal officers and state/district trainers, programme review.[4,18]
Centre of Excellence	Centre for Dental Education and Research (CDER), AIIMS, New Delhi.[4]
National Resource Centres	OPMD — Lady Hardinge Medical College, Delhi; Tobacco cessation & oral health — Maulana Azad Institute of Dental Sciences (MAIDS), Delhi; Oral health of children and elderly — PGIMER, Chandigarh.[4]
Research	National Referral & Research Institute for Higher Dental Studies (NaRRIDS) being established at AIIMS, Delhi.[4]
Public information	Toll-free IVRS oral health helpline 1800-11-2032 (since World Oral Health Day, 20 March 2017); e-DantSeva portal.[4,18]

Organisational structure. A National Oral Health Cell under the Deputy Director General (NCD), Dte.GHS, and a Joint Secretary in MoHFW oversees the programme; each state has a State Oral Health Cell led by a State Nodal Officer, with funding routed through flexi-pools in the State PIP.3

Achievements. Since 2014–15, 9,587 dental care units have been supported partially or fully—593 at district hospitals, 1,083 at sub-district hospitals, 2,849 at CHCs, 5,113 at PHCs, 17 at AAMs and 27 mobile dental units.4 Other initiatives include TCCs in dental institutions, resource centres and pilot pit-and-fissure sealant programmes.18

4 Tiers 4–5 — State/district delivery and primary care (Ayushman Arogya Mandir)

Oral health is one of the expanded service packages of comprehensive primary health care delivered through Ayushman Arogya Mandirs (AAMs)—the erstwhile Health and Wellness Centres. As of 31 October 2025, 1,80,906 AAMs had been operationalised.8 Dedicated operational guidelines aim to strengthen integrated oral health care and complement NOHP.5 Roles are defined by level:

Table 5. Continuum of oral health care under the primary-care model

ASHA / MPW (family & community)	Identify oral hygiene practices and risk behaviours; raise awareness on oral hygiene, diet counselling, tobacco cessation and regular dental visits.[7]
Community Health Officer (AAM-SHC)	Early identification of common oral conditions (nine are listed in the training manual); symptomatic management of simple problems; referral of complicated cases; opportunistic screening and follow-up.[6,28]
Medical Officer (AAM-PHC)	Diagnosis, first-line management, oral cancer screening linked to NCD programme, referral to DCU.
Dental surgeon (PHC/CHC/SDH/DH DCU)	Comprehensive essential dental care, ART, preventive procedures, supportive supervision and training of primary-care team, referral to tertiary centres.
Dental college / tertiary centre	Specialist care, complex rehabilitation, oral cancer management, training and research.

5 Convergent programmes

Because oral diseases share risk factors with other NCDs, much of India's oral health 'policy' actually sits inside other programmes:5

- National Tobacco Control Programme (NTCP) and COTPA, 2003 — tobacco cessation in dental settings; MoHFW and DCI introduced TCC guidelines for dental colleges in 2018, and 302 tobacco cessation clinics had been set up by 2024.23
- National Programme for Prevention and Control of Fluorosis (NPPCF) — fluoride mapping, defluoridation, management of dental fluorosis.
- National Programme for Prevention and Control of NCDs (NP-NCD, formerly NPCDCS) — population-based screening for oral cancer at AAMs; periodontitis–diabetes linkage.
- Rashtriya Bal Swasthya Karyakram (RBSK) and school health — screening of children, including dental caries; cleft lip and palate management.
- National Programme for Health Care of the Elderly (NPHCE) — a natural platform for geriatric oral rehabilitation, including removable and implant prostheses.

6 Information systems and data

Credible national data are the weakest link. The 2002–03 DCI survey and the 2007 multicentric survey remain the main references; an AIIMS-led nationwide survey was launched in 2019 to provide the baseline for the policy, including early-childhood data and prosthetic treatment needs of the elderly.25 Authors at CDER, AIIMS have proposed a dedicated National Oral Health Surveillance System linked to the Integrated Disease Surveillance Programme.21

Implementation gaps: a critical appraisal

Table 6. Gaps in implementing India's oral health policy framework

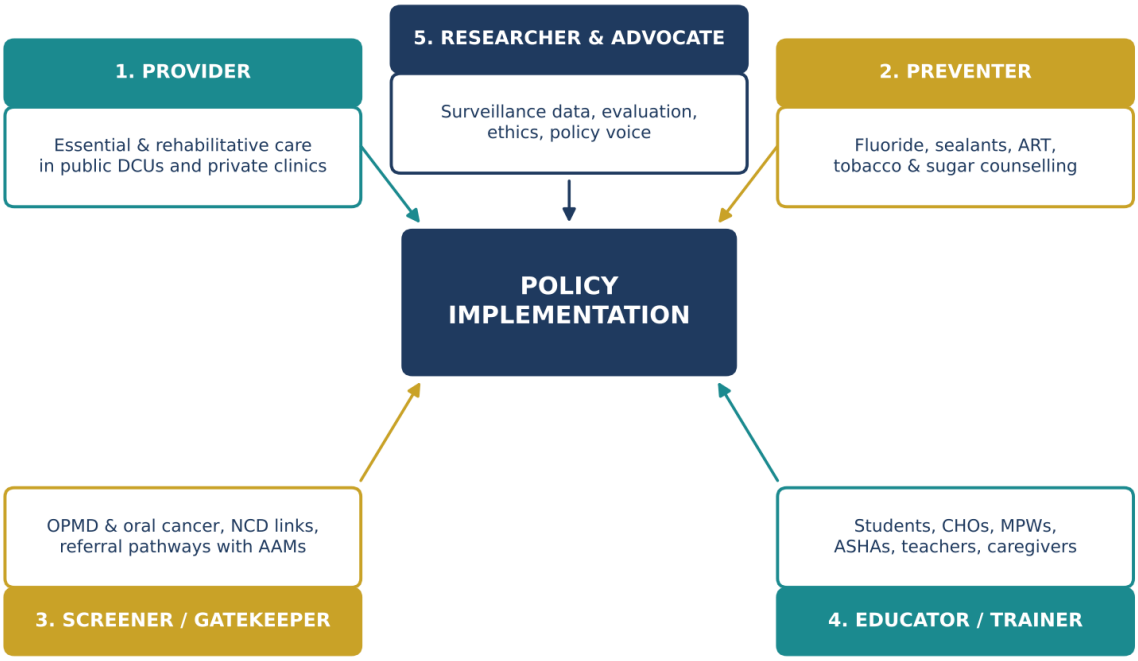
Policy	Draft policy of 2021 not finalised as of 2026[20]	No binding targets, accountability or budget lines
Evaluation	NOHP has not undergone a formal evaluation[19]	Achievements reported as inputs (units, chairs) rather than outcomes
Financing	No separate budget allocation for oral health in national or most state budgets; high out-of-pocket spending[17,20]	Inequitable access; catastrophic expenditure for prosthetic and implant care
Workforce	~3.7 lakh dentists but ~1:25,000 in rural areas[18]	Urban saturation, rural deprivation, underemployment of young graduates
Data	No regular national survey or surveillance[21]	Cannot set or monitor targets (e.g., the 2025 baseline objective)
Education–practice gap	83.7% of recent graduates had a TCC posting, but only 37.1% had further training; undergraduate exposure alone did not ensure routine counselling[22]	Policy mandates do not translate into chairside behaviour
Integration	Oral health weakly embedded in NCD, RBSK and elderly care packages; limited PPP operationalisation	Missed opportunities for common-risk-factor approach
Global trajectory	GBD 2023: progress toward GOHAP targets insufficient at current pace[16]	India risks missing 2030 targets

These gaps share a single theme: India has policy content but weak policy process. Recent national fora—such as the Oral Health India Summit, hosted by IIM Bangalore and the Institute of Public Health, Bengaluru, in July 2026—have framed the challenge explicitly as a move 'from policy to practice'.30 This is where the profession becomes decisive.

Role of dental clinicians in implementing the policy

Implementation science distinguishes policy makers from policy implementers. In dentistry, the implementers are overwhelmingly clinicians: most oral health care in India is delivered in private clinics, and public DCUs depend on the dental surgeons posted there. Their roles can be organised in the five-role model in Figure 3.

Figure 3. Five-role model of the dental professional in oral health policy implementation



Clinicians enact these roles at the chairside; institutions enact them at system scale.

1 Role 1 — Provider of essential and rehabilitative care

- Deliver the essential oral health care package at DCUs: emergency care; extractions; restorations, including atraumatic restorative treatment (ART); scaling; and referral.
- Adopt minimal-intervention dentistry and cost-effective materials to keep care within NOHP consumable budgets and to keep care affordable in private practice.
- Provide rehabilitation—particularly removable prostheses for the edentulous elderly—through state schemes and NPHCE-linked services; ensure follow-up and denture hygiene education.
- Maintain infection control, biomedical waste management and patient safety standards that the regulator now enforces through the Ethics and Dental Registration Board.9

2 Role 2 — Preventer and health promoter

- Make every patient contact a prevention contact: diet and sugar counselling, oral hygiene instruction, topical fluoride, pit-and-fissure sealants for children.
- Deliver brief tobacco-cessation advice (5A/5R) to every tobacco user and refer to TCCs or the national quitline; the reference manual from NRC-OH-TC provides the clinical protocol.23,24
- Participate in World Oral Health Day, school health and workplace campaigns using NOHP IEC material.

3 Role 3 — Screener and gatekeeper

- Conduct opportunistic screening for OPMD and oral cancer; use adjuncts such as toluidine blue where indicated; refer promptly to oncology services under NP-NCD.
- Recognise systemic links—diabetes, cardiovascular disease, pregnancy, HIV—and refer bidirectionally with medical officers at AAMs.
- Act as the referral node between the CHO/MPW at the AAM and tertiary dental colleges, closing the loop with documented feedback.

4 Role 4 — Educator and trainer

- Public-sector dental surgeons serve as district trainers for CHOs, MPWs and ASHAs under NOHP's cascade training model.3
- Private practitioners contribute through IDA branches, continuing dental education and community camps; this is the PPP avenue foreseen in NOHP guidelines.3

5 Role 5 — Researcher, data contributor and advocate

- Maintain standardised clinical records with ICD coding and link to digital health identifiers, so that routine practice data can feed national

surveillance.

- Contribute to practice-based research networks, national surveys and programme evaluation.
- Respond to public consultations (as invited for the 2021 draft) and advocate, individually and through professional bodies, for notification of the policy and a dedicated budget line.2
- Practise ethical, transparent pricing—reducing out-of-pocket burden is itself a policy objective.

6 Roles by practice setting and specialty

Table 7. Setting- and specialty-specific contributions of clinicians

Dental surgeon in NOHP DCU	Operate the DCU; deliver essential care; maintain NOHP reporting; train and supervise the AAM team; outreach through mobile dental units
General dental practitioner (private)	Prevention at every visit; tobacco cessation; OPMD screening and referral; PPP camps; data contribution; ethical fees
Prosthodontist	Geriatric rehabilitation (complete/removable/implant prostheses) aligned with NPHCE and state denture schemes; maxillofacial prostheses for oral cancer survivors and cleft patients; nutrition and quality-of-life outcomes; low-cost, durable prosthesis protocols for public programmes
Public health dentist	Surveys, surveillance, programme planning and evaluation; school and community programmes; health economics
Paediatric dentist	Early-childhood caries prevention, sealant programmes, RBSK linkage, NRC (children) activities
Oral medicine & radiology / oral pathology	OPMD screening, biopsy pathways, tobacco cessation clinics, NRC (OPMD) activities
Periodontist	Periodontitis–diabetes integration with NP-NCD; supportive periodontal care
Oral & maxillofacial surgeon	Trauma and oral cancer surgery; cleft care; referral hub roles
Orthodontist	Cleft and craniofacial team care; malocclusion screening in school programmes

Role of dental institutions in implementing the policy

Dental colleges are the profession's only institutions with simultaneous mandates for education, service, research and community engagement. India's network of over 300 colleges—many with satellite centres, adopted villages and TCCs—constitutes a ready-made implementation infrastructure that the public system has under-used. The NOHP guidelines explicitly envisage PPP with private dental colleges, dental associations and community organisations for awareness and service delivery.3

1 Education and workforce development (GOHAP SO-3)

- Embed public-health competencies, policy literacy, tobacco cessation and minimal-intervention dentistry in the competency-based curriculum; prepare graduates for NExT under the NDC framework.11
- Use community postings and the internship to provide structured service in AAMs, PHCs, and DCUs—turning a curricular requirement into policy implementation.
- Close the TCC education–practice gap by moving from passive postings to supervised counselling with assessed competencies.22
- Offer continuing dental education for public-sector dental surgeons and private practitioners on NOHP protocols.

2 Service delivery and referral (GOHAP SO-4)

- Function as tertiary referral hubs for districts: complex rehabilitation, oral cancer, cleft, special-care and geriatric dentistry.
- Run satellite centres, mobile dental vans and adopted villages; for example, GDCH Nagpur has adopted 10 tribal villages for screening, basic treatment and specialist-led tobacco cessation with follow-up.29
- Operate Tobacco Cessation Centres to standard guidelines and report utilisation.23
- Develop hub-and-spoke tele-dentistry links with AAMs and PHCs.

3 Capacity building for the primary-care team

- Serve as state and regional training centres for CHOs, MPWs, ASHAs and medical officers using MoHFW training manuals.6,7
- National Resource Centres model this role: NRC-OH-TC at MAIDS provides technical support, e-learning, operational guidelines and IEC for tobacco cessation, with a target of increasing utilisation by at least 5% per facility.24

4 Research, surveillance and evaluation (GOHAP SO-5, SO-6)

- Generate the baseline data the draft policy requires: district and state epidemiological surveys using WHO methods; CDER and AIIMS have led national survey design.25
- Conduct the first formal NOHP evaluations, implementation research, cost-effectiveness studies and health technology assessment of

preventive and prosthetic interventions.19

- Host sentinel sites for an oral health surveillance system and maintain hospital-based oral cancer registries.21

5 Policy advocacy and technical support (GOHAP SO-1)

- Provide technical expertise to State Oral Health Cells and the National Oral Health Cell; contribute to drafting state oral health policies and PIPs.
- Translate research into policy briefs; engage with the National Dental Commission on standards that reward community engagement.

6 Government vs private dental institutions

Table 8. Complementary roles of government and private dental institutions

Policy linkage	Directly within state health/medical education departments; natural partners of State Oral Health Cells	Linked through PPP, MoUs and regulatory requirements
Service role	State-level referral centres serving low-income patients at minimal cost	Large outpatient volumes; satellite clinics; camps
Specific opportunity	Host state training centres and surveillance sentinel sites; co-locate NOHP specialist services	Adopt PHCs/AAMs under MoUs; contribute faculty to district training; subsidised treatment days
Accountability	Public reporting to state government	NDC standards; fee regulation for 50% of seats[11]

The way forward

1. Notify the National Oral Health Policy with a costed implementation framework, measurable targets aligned to GOHAP and a ring-fenced budget line.
2. Institutionalise surveillance: a periodic national survey and a routine information system that capture public- and private-sector data.
3. Evaluate NOHP independently, shifting from input indicators to coverage, outcome and equity indicators.
4. Formalise a PPP between NOHP and dental colleges through standard MoUs, with each college adopting a defined catchment of AAMs/PHCs.
5. Correct workforce maldistribution through rural service incentives, public-sector posts at the CHC/PHC level, and the use of mid-level providers (dental hygienists).
6. Integrate oral health into financing schemes to reduce out-of-pocket expenditure, prioritising the elderly, children and the poor.
7. Align education with policy under the NDC by assessing public health competencies, implementing compulsory community service, and adopting outcome-based TCC training.
8. Common-risk-factor approach: coordinate with fiscal measures on tobacco, alcohol and sugar-sweetened beverages.

Conclusion

- India has no notified oral health policy; the Draft National Oral Health Policy (Feb 2021) is an extension of NHP 2017 and remains unfinalised.
- NOHP (2014–15, under NHM) has an NHM component (DCUs with manpower, equipment, consumables) and a tertiary component; 9,587 DCUs have been supported.
- CoE: CDER, AIIMS. NRCs: OPMD (LHMC), tobacco cessation (MAIDS), children and elderly (PGIMER). NaRRIDS at AIIMS for research.
- Primary care: oral health is a service package of Ayushman Arogya Mandirs, with defined roles for ASHA/MPW, CHO and MO.
- The NDC Act, 2023, operational since 19 March 2026, includes oral disease prevention and facilitating policy implementation among its objectives.
- WHO GOHAP 2023–2030: 6 strategic objectives, 100 actions, 11 targets; overarching targets are UHC for oral health and burden reduction.
- Clinicians implement policy as providers, preventers, screeners, educators and researcher-advocates; institutions do so through education, referral services, training, research and advocacy.

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