

## **INTERIM REPORT 3**

# **Evidence-Based Oral Health Policy for Older People**

Protocol number: OHSRC00105

### **Report on Questionnaires Completed by and Interviews with Service Providers: General Dental Practitioners & Principal Dental Surgeons in the Public Dental Service**

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## Introduction

The aim of this project is to devise evidence-based recommendations for the development of an equitable, person-centred oral health policy for older people in Ireland; specifically, to develop policy recommendations for an available, accessible and acceptable oral health service for older people, which will increase the uptake of services and lead to improved oral health and well-being for this group.

The fifth objective of the study is to consult with public service dental surgeons, general dental practitioners and policy makers (civil servants) in relation to current practice and their views on challenges and opportunities in service provision for older patients. To address this objective, a survey of the key stakeholders involved in the organisation and delivery of oral health care services to older adults was conducted, using a combination of questionnaire and semi-structured interview methodologies. The first section of this Interim Report summarises the results of the questionnaire phase of the research; the second section considers the results of the interview phase.

The key stakeholders involved in the organisation and delivery of oral health care services to older people in Ireland are:

- the Department of Health and Children (DoHC),
- the Health Services Executive (HSE) Dental Service, and
- General Dental Practitioners (GDPs).

Since 1994, the DoHC has provided free basic dental services for Medical Card holders through the Dental Treatment Services Scheme (DTSS). Since 2001, everyone aged 70+ qualifies for a Medical Card, regardless of income. The DTSS provides emergency dental treatment (for the relief of pain), urgent denture repairs, and routine dental treatment through HSE clinics and private GDPs contracted to the HSE Panel. A number of more expensive treatments are not provided under the schemes, such as crowns, veneers, orthodontics and bridgework. Though there are variations between administrative regions of the HSE, routine dental treatment generally includes:

- |               |   |
|---------------|---|
| • examination | • removal/amputation of roots                   |
| • extractions | • root treatment (front 6 teeth top and bottom) |
| • fillings    | • x-rays  |
| • scaling     | • partial dentures                              |
| • polishing   | • full dentures                                 |

The Department of Social & Family Affairs Dental Treatment Benefit Scheme (DTBS) provides assistance towards the provision of dental treatment for employees who make Pay-Related Social Insurance (PRSI) contributions. Any person who has a certain number of PRSI contributions paid, either at age 60 or 66, retains the entitlement for life. The DTBS is operated by GDPs who have signed a contract with the Minister to operate the Scheme on behalf of the Department. The DTBS subsidises dental care, either fully or partially, for a limited range of treatments. An annual examination, diagnosis, and a mild scale and polish are free of charge to all qualified insured persons and their dependent spouse/partner. For other items of routine

treatment, such as extractions, fillings and the supply of acrylic dentures, the Department pays a set amount to the dentist in accordance with a fixed scale of charges; the remainder of the cost, if any, is paid by the patient. The DTBS also makes a fixed contribution towards the cost of certain other items of treatment, with the patient paying the balance due to the dentist.

Most GDPs in Ireland undertake private treatment of dental patients in addition to providing dental treatment through the state operated DTSS and DTBS. There are also a number of private practices which specialise in a specific type of treatment, e.g. prosthodontics, endodontics, restorative dentistry, periodontics, and oral surgery. For people who are not eligible for either of the state schemes, private dentistry is their only treatment option. In addition, a number of treatments are not provided under the state schemes, such as crowns, veneers, orthodontics and bridgework; patients wishing to have these treatments must pay a dentist privately for them. Some private dental treatments are eligible for tax relief.

To practice as a dentist in Ireland, one must be listed on the Register of Dentists maintained by the Dental Council of Ireland. However, being on the Register does not imply that one is a practicing dentist. As of November 2006, there were 2,416 dentists listed in the Register of Dentists. More than 200 of these dentists listed foreign addresses; about 180 would have been over 65 years and retired or close to retirement. A small number would be full-time academics, researchers or administrators who are not engaged in a dental practice. Though it is not possible to determine from the Register whether a dentist is involved in active practice in Ireland or not, the Register does provide an indicator of the maximum pool of dentists (including specialists) available to the population in Ireland.

## **1. Report on Questionnaires completed by General Dental Practitioners & Principal Dental Surgeons**

### **1.1. Methodology**

#### **1.1.1. Questionnaire Design**

The questionnaire was intended to focus on the current level of service provision for older people and the challenges facing services delivery to this group. It was decided at the outset to design two questionnaires – for GDPs and for HSE Principal Dental Surgeons (PDS) – to reflect the differing issues faced by private practitioners and the public dental service.

Both questionnaire designs were informed by a consideration of the results of the National Survey of Adult Oral Health 2000-2, the analysis of the DTSS utilisation patterns, the issues raised by the literature review, and the outcome of focus group discussions with older people. A semi-structured format was used to ensure information was gathered on certain key issues, while also allowing scope for respondents to elaborate on their answers and express their unique perspective on the topics of interest.

The GDP and PDS questionnaires are presented in full in Appendices A and B, respectively.

#### **1.1.2. Sampling Strategy**

A PDS questionnaire and SAE was posted to all 32 Principal Dental Surgeons. Follow-up emails were sent to non-respondents after 2 weeks.

It was intended to distribute GDP questionnaires similarly to a random sample of 5% of general dental practitioners on the Register of Dentists engaged in active practice within Ireland. As of 20 November 2006, there were 2416 dentists on the Register of Dentists maintained by the Dental Council of Ireland. The names of dentists with foreign addresses, dentists who qualified before 1964 (on the assumption that they would presently be over 65 years old and retired from active practice), and dentists who were also on the Register of Specialist Dentists were removed from the Register. The resulting list consisted of 1908 dentists of working age resident in Ireland - whether in active practice or not, and whether in general or public practice.

From this list, an initial random sample of 210 dentists was drawn. Efforts were made to verify that the randomly selected dentists were indeed general dental practitioners by checking their names and addresses against the Golden Pages directory of dentists, the Irish Dental Association find-a-dentist directory, and the Department of Social and Family Affairs PRSI scheme dentist list. If a dentist was not confirmed to be a general practitioner, a response slip with the statement “I am not a general dental practitioner” was included with the questionnaire and the dentist was asked to return this slip if indeed he/she was not a general dental practitioner.

The survey returns after 4 weeks revealed that only two out of every three respondents were general practitioners. Using this proportion as a guide, it was calculated that 67 respondents were required for the GDP questionnaire. A top-up random sample of 50 dentists was drawn. To improve the response rate, follow-up letters were also sent to the non-respondents of the initial sample.

## 1.2. Results

The results of both questionnaires were coded, entered onto computer and analysed using the SAS System.

### 1.2.1. Response Rate

Thirty one of the 32 Principal Dental Surgeons returned their completed questionnaire, a response rate of almost 97%.

One hundred and eleven of the 260 GDP questionnaires were returned, a response rate of 43%. Of those returned, 75 (68%) were completed by GDPs in active practice, while 36 (32%) indicated that they were not GDPs. Using the returned questionnaires as a guide to the proportion of general practitioners among the working-age resident dentists on the Register, the 75 completed questionnaires represent a sample slightly larger than the intended 5% of GDPs in active practice.

### 1.2.2. Demographic Characteristics

The respondents were asked to provide information regarding their gender, age, and number of years in private dental practice/public dental service in Ireland. The gender balance of both samples were similar; 61% of PDS and 66% of GDP respondents were male (4 GDPs did not provide this information).

With regard to age, the range reported by GDPs (24-65) was far greater than that reported by PDSs (35-63). Of the 72 GDPs who reported their age, 38% were aged 24-34, 30% were aged 35-44, 19% were aged 45-54, and 12% were aged 55-65. Of the 29 PDSs for whom there was age information, 31% were aged 35-44, 48% were aged 45-54 and 21% were aged 55-63. Among the GDPs sampled, over two-thirds were under 45 years of age; among the PDSs, over two-thirds were over 45 years of age.

Regarding their number of years in general dental practice, 73% who provided this information were in practice in Ireland for less than 15 years; the remaining 27% were relatively evenly distributed with between 15 and 35+ years experience in this role. PDSs hold the most senior public dental service position within each HSE area; thus it is not surprising that 90% of PDSs had 15 or more years in the public dental service in Ireland behind them.

**Respondents by Number of Years in General Dental Practice (GDP) / Public Dental Service (PDS) in Ireland**

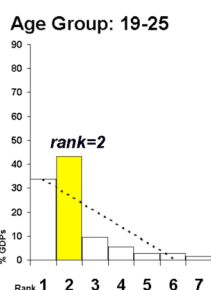
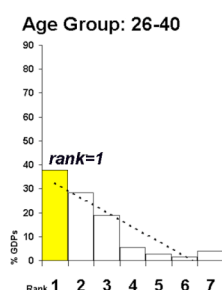
| Years        | GDP       |              | PDS       |              |
|--------------|-----------|--------------|-----------|--------------|
|              | N         | %            | N         | %            |
| <b>1-4</b>   | 15        | 20.5         |           |              |
| <b>5-9</b>   | 24        | 32.9         | 1         | 3.4          |
| <b>10-14</b> | 14        | 19.2         | 2         | 6.9          |
| <b>15-19</b> | 5         | 6.8          | 9         | 31.0         |
| <b>20-24</b> | 4         | 5.5          | 7         | 24.1         |
| <b>25-29</b> | 4         | 5.5          | 7         | 24.1         |
| <b>30-34</b> | 4         | 5.5          | 3         | 10.3         |
| <b>35+</b>   | 3         | 4.1          |           |              |
| <b>All</b>   | <b>73</b> | <b>100.0</b> | <b>29</b> | <b>100.0</b> |

### 1.2.3. GDP Dental Practice Characteristics

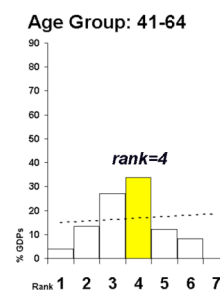
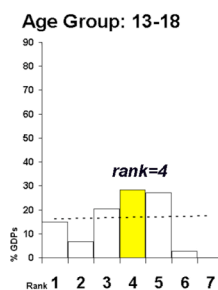
To ascertain dentists' attitudes towards treating older patients, the GDPs were asked to rank the age groups of patients aged 0-4 years, 5-12 years, 13-18 years, 19-25 years, 26-40 years, 41-64 years, and 65+ years in terms of their overall preference to treat. These age groups were scored from 1 (most favourite) to 7 (least favourite). The results are shown below.

## GDP Ranking of Age Groups by Overall Preference To Treat (1=Most Favourite, 7=Least Favourite)

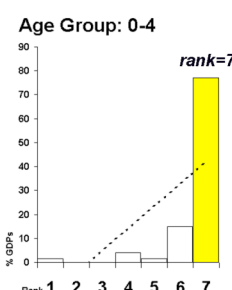
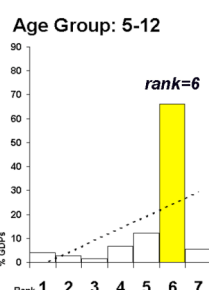
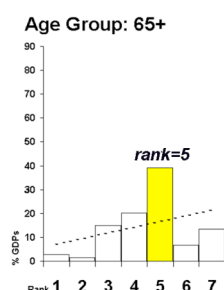
### High Preference (Rank 1-3)



### Neutral Preference (Rank 4)



### Low Preference (Rank 5-7)



n=74

The modal score for each age group (shaded column) gives its overall rank. For example, the first bar chart represents the frequency of each ranked preference for 26-40 year olds. The most commonly selected rank for this age group was rank 1 (most favourite). In fact the vast majority of dentists ranked this age group in the top three most favourite. Thus, the most preferred age groups to treat are younger adults aged 26-40 (modal rank=1) and 19-25 (modal rank=2). By an overwhelming consensus, the least preferred age groups to treat are young children aged 0-4 (modal rank=7) and 5-12 (modal rank=6): Ninety-two percent of GDPs agreed that the 0-4 age group and 72% that the 5-12 age group are their two least preferred age groups to treat.

**Distribution of GDPs by their Preference to Treat Older People Aged 65+**

| Rank                | N         | %            |
|---------------------|-----------|--------------|
| No rank given       | 1         | 1.4          |
| 1 = Most Favourite  | 2         | 2.7          |
| 2                   | 1         | 1.4          |
| 3                   | 11        | 14.9         |
| 4                   | 15        | 20.3         |
| 5                   | 29        | 39.2         |
| 6                   | 5         | 6.8          |
| 7 = Least Favourite | 10        | 13.5         |
| <b>All</b>          | <b>74</b> | <b>100.2</b> |

The greatest consensus among the 74 GDPs who responded places the 65+ group as the third least preferred age group to treat (modal rank=5). While only 14% indicated that the 65+ age group was their least favourite to treat, 80% of GDPs placed the 65+ group within their four least favourite groups to treat. In general, GDPs have a low preference for treating older people.



As of the last national census, 11% of the total population in Ireland are older people aged 65 years and over. If older people regularly visited the dentist for check-ups, one would expect that, on average, dentists would have at least the same proportion of older people among their patients. Visits to the dentist, however, are influenced by a host of economic, social, psychological and environmental factors. It is well documented that older people, particularly the edentulous, are not inclined to regularly attend for dental check-ups. The 2000-2 National Survey of Adult Oral Health reported that only 44% of dentate and 9% of edentulous adults aged 65+ visit the dentist every 2 years or more often.

When asked what proportion of their patients were older people, only about half (51%) of GDPs estimated 'more than 2 in every 20 patients' (i.e., more than 10%) of their patients were older people aged 65+. About one third (32%) reported a proportion of '1 or 2 in every 20 patients' (i.e., 5-10%) while 17% reported 'less than 1 in every 20 patients' (i.e., less than 5%). These estimations support previous findings of low levels of dental attendance by older people.

When asked if they would like to increase the number of older patients attending their practice, 61% of GDPs replied NO and 39% replied YES. This is in keeping with the finding that GDPs in general have a low preference for treating older people. As the table at right shows, there is a strong relationship between GDPs' willingness to increase the number of older patients attending their practice and their expressed preference to treat older people.

**GDPs by their willingness to increase the number of older patients attending their practice and their preference to treat older people**

| <i>Would you like to increase the number of older patients (65+) attending your practice?</i> |          |                  |                 |
|---|----------|------------------|-----------------|
|   | <b>n</b> | <b>Yes<br/>%</b> | <b>No<br/>%</b> |
| HIGH preference to treat older people   | 14       | 57.1             | 42.9            |
| NEUTRAL preference to treat older people  | 14       | 50.0             | 50.0            |
| LOW preference to treat older people  | 41       | 31.7             | 68.3            |

Roughly 27% of all adults in Ireland have medical cards, more than 52% have PRSI (social insurance) contributions which cover some of their dental treatment.<sup>1</sup> While a small number may have other forms of dental cover (e.g., armed forces schemes), most of the remaining adults have no cover and pay privately for their dental treatment. Eighty five per cent of the GDPs surveyed stated that they are listed on the DTSS register of dentists. Thirteen percent of the GDPs surveyed reported that the majority of their patients (all ages) were DTSS patients, 51% reported that half their patients were DTSS patients and 36% stated that the majority of their patients were non-DTSS patients. The DTSS is thus an important source of income for the majority of dental practitioners.

The GDPs were asked if, in their experience, their older patients aged 70+ were aware that they are entitled, irrespective of income, to a medical card and hence DTSS treatment. Eighty five per cent of respondents believed that 'most' of their older patients were aware of their entitlements, though 3% did report that 'few' or 'none' of their (mainly private) patients were aware.

<sup>1</sup> Whelton, H., Crowley, E., O'Mullane, D., Woods, N., McGrath, C., Kelleher, V., Guiney, H., Byrtek, M., 2007a. *Oral Health of Irish Adults 2000 – 2002*. Dublin: Department of Health and Children. Retrieved from: [http://www.dohc.ie/publications/oral\\_health02.html](http://www.dohc.ie/publications/oral_health02.html)

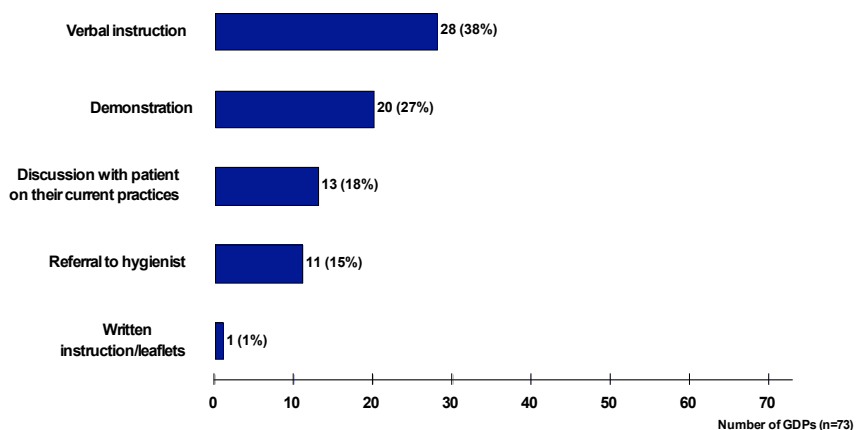
Sixty-eight GDPs responded to the question “Do you provide additional treatment not covered by the DTSS to your older DTSS patients (65+) which are paid for privately?” Nine per cent of GDPs did so ‘often’, with 41% doing so ‘sometimes’ and 35% doing so ‘rarely’; only 15% of GDPs stated that they ‘never’ provide additional treatment to older DTSS patients which are paid for privately. The finding that half of GDPs ‘often’ and ‘sometimes’ provide additional treatment to their older DTSS patients which must be paid for privately indicates that DTSS coverage may be inadequate to the needs of older people.

GDPs were also asked if they ever provide *pro-bono* (free of charge) treatment to older patients. While only 14% of GDPs stated that they provided pro-bono treatment to older people ‘often’, 55% do so ‘sometimes’ and 22% do so ‘rarely’; just 9% of GDPs ‘never’ provide pro-bono treatment to older people. The finding that more than two-thirds of GDPs ‘often’ and ‘sometimes’ provide treatment to older people for which they receive no payment raises questions: Are the recipients of pro-bono treatment mainly older people who have not reached 70 years and have no dental benefits? Or are dentists providing additional treatments to older people with DTSS benefits for which they are not being paid?

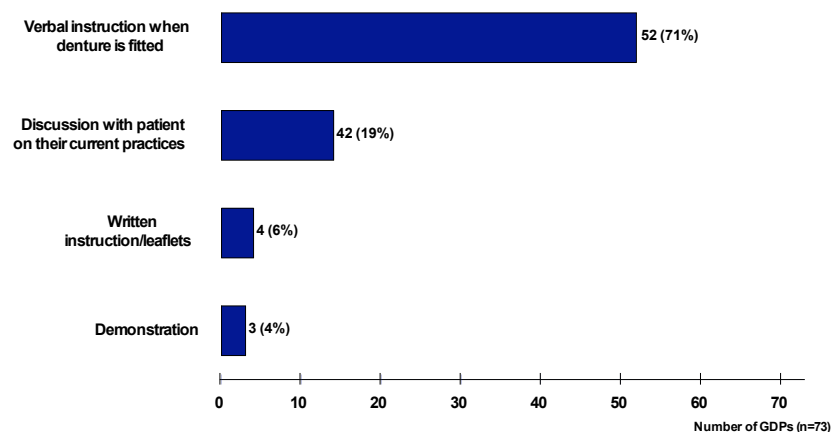
#### 1.2.4. GDP Oral Health Promotion Practices

GDPs were asked what their main method for promoting good oral health (and denture) care practices to their dentate and edentate (i.e., toothless) older patients. The charts at right show that ‘verbal instruction’ is the principal method used by GDPs with both their dentate and edentate older patients. For dentate patients, 38% of GDPs employed ‘verbal instruction’, followed closely by ‘demonstration’ (27%), ‘discussion with patient on their current practices’ (13%) and ‘referral to hygienists’ (15%) as their main method for promoting good oral health practices. For edentate patients, ‘verbal instruction when denture is fitted’ was the preferred method for the majority of respondents (70%), followed by ‘discussion with patient on their current practices’ (19%). Very few GDPs use ‘written instruction/leaflets’ as their primary method for promoting good oral health and denture care practices to their patients (1 GDP for dentate patients; 4 GDPs for edentate patients). Given that the supplementation of verbal information with written

Distribution of GDPs according to their Main Method for Promoting Good Oral Health Care Practices to their DENTATE Patients (65+)



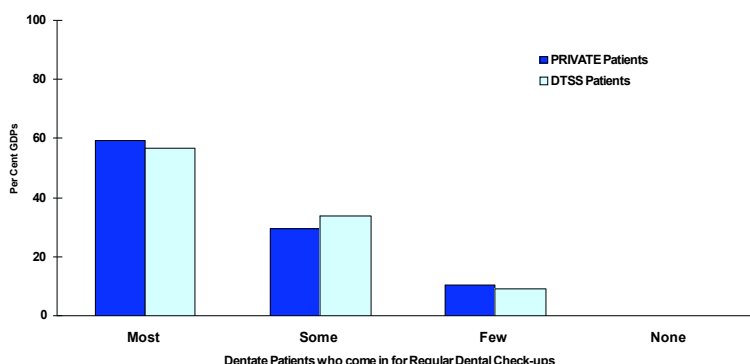
Distribution of GDPs according to their Main Method for Promoting Good Oral Health and Denture Care Practices to their EDENTATE Patients (65+)



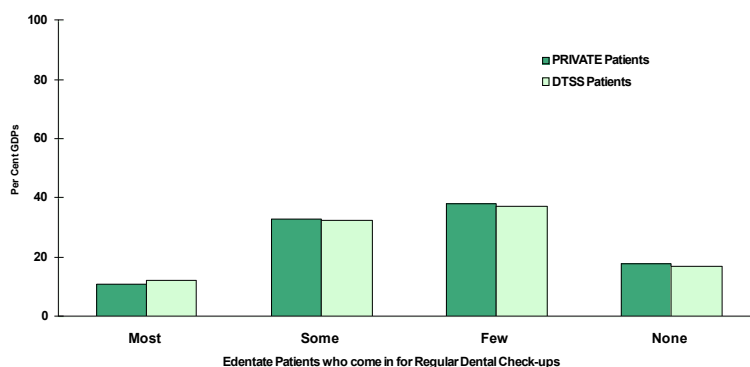
leaflets and a prompt to read the leaflet results in a greater increase in knowledge than verbal information alone, it would be worthwhile to provide dentists with well designed denture care instruction leaflets to give to their patients.

When asked if they issue recall or reminder letters to their older patients, 82% of GDPs reported doing so for their dentate patients, but only 51% do so for those who are edentate.

GDPs according to how many of their DENTATE patients come in for regular (every 2 years or more often) dental check-ups



GDPs according to how many of their EDENTATE patients come in for regular (every 2 years or more often) dental check-ups



GDPs were asked how often their older private patients and their older DTSS patients come in for regular (every 2 years or more often) dental check-ups. Their responses (charts at left) indicate that the attendance patterns of private patients are very similar to those of DTSS patients. However, as expected, there is a marked disparity between the attendance patterns of dentate patients compared to edentate (toothless) patients: Close to 60% of GDPs reported that 'Most' of their dentate (private and DTSS) patients attend for regular check-ups compared to just over 10% of GDPs reporting 'Most' for their toothless (private and DTSS) patients. While no GDP reported 'None' for their dentate patients, almost one fifth of GDPs (18% private, 17% DTSS) reported that 'None' of their toothless patients came in for regular check-ups.

In your opinion, how often should edentate patients be encouraged to attend for a check-up?

|               | N         | %            |
|---------------|-----------|--------------|
| Every year    | 30        | 40.5         |
| Every 2 years | 29        | 39.2         |
| Every 3 years | 7         | 9.5          |
| Every 4 years | 2         | 2.7          |
| Every 5 years | 4         | 5.4          |
| Other: _____  | 2         | 2.7          |
| <b>All</b>    | <b>74</b> | <b>100.0</b> |

The GDPs were also asked how often they think edentate patients should be encouraged to attend for a check-up. Forty per cent stated that they should attend for check-up 'every year', with a further 39% responding 'every 2 years'. Five per cent of GDPs felt that 'every 5 years' was an adequate check-up interval for their edentate patients.

Finally, the GDPs were asked how the majority of new older patients present at their practice. As in the medical profession, recruitment of patients by dentists is tightly regulated in Ireland. It is not surprising, therefore, that for 85% of GDPs 'word-of-mouth' is the source of most of their new older patients. Another 8% reported that 'patients just walk in'. Less than 6% reported that older patients found them through the 'DTSS listing' or through a 'phone book/business listing'. Only 1 respondent had a majority of older patients coming in as a result of 'referrals from medical GPs'.

### 1.2.5. GDP Domiciliary Care

Domiciliary dental care is an important service for older people, particularly those who are unable (by virtue of their age, health or other circumstances) to transport themselves to a dental clinic. The GDPs were asked if they engaged in the domiciliary dental treatment of older people in residential care (e.g., extended care unit, welfare home, hospital, nursing home)<sup>2</sup>, older people at day care centres and older people in their own

**Percent of GDPs who provide Domiciliary Care according to Location and Basis of Care (n=74)**

|  | <b>Routine basis</b> | <b>Emergency basis</b> |
|--|----------------------|------------------------|
| <b>residential care units (extended care unit, welfare home, hospital, nursing home)</b> | 4.1%                 | 36.5%                  |
| <b>day care centres</b>  | 0.0%                 | 18.9%                  |
| <b>patients' own homes</b>   | 4.1%                 | 29.7%                  |

homes; and if such care was provided on a routine basis or an emergency basis. Only 3 GDPs (4%) provided domiciliary care to older people on a routine basis (in residential care units and in patients' own homes). On an emergency basis, however, 36% did provide domiciliary care to older people in residential care, 19% to older people in day care centres and 30% in patients' own homes.

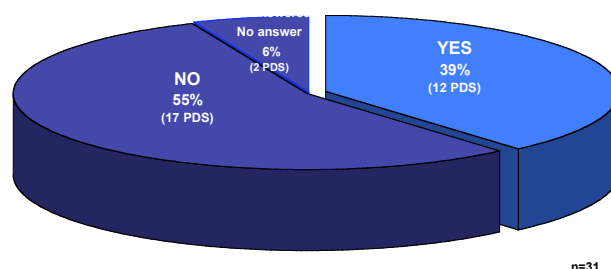
### 1.2.6. PDS HSE- Dental Service

The remit of the HSE Dental Service is to provide dental care to children under 16 and children attending primary school, to medical card holders and to EU residents for emergency treatment. Dental services are provided directly by HSE-salaried public service dentists, or through private sector GDPs with a DTSS contract. The HSE-salaried dental service prioritises the primary care of children, and relies heavily on DTSS-contracted GDPs to service adult medical card holders. It should be noted that since 1<sup>st</sup> July 2001, every person aged 70 years or more, regardless of income, is eligible for a medical card.

The PDSs were asked if the treatment of older people forms part of their annual service plan for HSE-salaried dentists. Of the 31 PDS surveyed, only 39% (12) responded 'YES'.

Those respondents who replied positively were then asked to briefly describe the treatments provided. Eight respondents mentioned domiciliary visits, mainly to residential care units. A similar number

**Does the treatment of older people (65+) form part of your annual service plan for HSE-salaried dentists?**



mentioned clinic-based treatment to adults (all ages), particularly those who are unable to access care from GDPs via the DTSS, mainly during after-hours/evening sessions. Four respondents mentioned the care of older people under their 'Special Needs' remit. Three respondents mentioned the screening of older people in residential units.

Despite not specifically targeting the treatment of older people in their annual service plan, 55% of PDSs reported that HSE-salaried dentists in their respective areas provide clinic-based treatment to older people on a routine basis, and 94% on an emergency basis.

<sup>2</sup> Long-term care facilities comprise: HSE extended care units, HSE welfare homes, voluntary homes/hospitals for older people, voluntary welfare homes, private nursing homes (Long-Stay Activity Statistics 2005, Department of Health and Children).

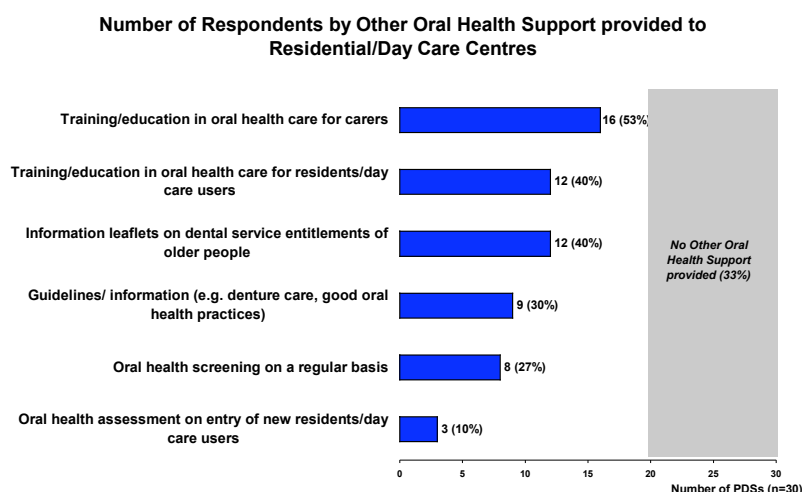
Similarly to GDPs, the PDSs were asked if they or any of the HSE-salaried dentists in their service engage in the domiciliary treatment of older people in residential care (extended care unit, welfare home, hospital, nursing home), older people in day care centres and older people in their own homes; and whether such care was provided on a routine basis or an emergency basis.

**Percent of HSE dental service areas that provide Domiciliary Care according to Location and Basis of Care (n=31)**

|  | <b>Routine basis</b> | <b>Emergency basis</b> |
|--|----------------------|------------------------|
| <b>residential care units (extended care unit, welfare home, hospital, nursing home)</b> | 41.9%                | 96.8%                  |
| <b>day care centres</b>  | 25.8%                | 67.7%                  |
| <b>patients' own homes</b>   | 16.1%                | 93.5%                  |

Less than half of the 31 PDSs surveyed reported their HSE-salaried service provide domiciliary dental care to older people on a routine basis (42% in residential care units, 26% in day care centres, 16% in patients' own homes). Domiciliary care on an emergency basis, however, was reported by 97% of PDSs for older people in residential care, 68% for older people in day care centres, and 94% for older people in their own homes.

PDSs were then asked if their HSE-salaried service provide any other oral health support to residential/day care centres; 20 (67%) responded 'YES' and 10 (33%) responded 'NO'. Those who responded positively were asked to tick from a given list of interventions all that applied to their service. Sixteen services (53%) engage in 'training/education in oral health care for carers'; 12 services (40%) provide 'training/education in



oral health care for residents/day care users' and 'information leaflets on dental service entitlements of older people'. Nine services (30%) provide 'guidelines/ information (e.g. denture care, good oral health practices)', 8 services (27%) provide 'oral health screening on a regular basis'. However, just 3 services (10%) provide 'oral health assessment on entry of new residents/day care users'.

Finally, the PDSs were asked if their HSE-salaried service provide screening facilities to older people for oral health problems (such as oral cancer or pre-malignant lesions). Only one Principal Dental Surgeon reported that this important service is provided within his/her HSE-service area and that screening for oral health problems is carried out in clinics, residential care units and day care centres.

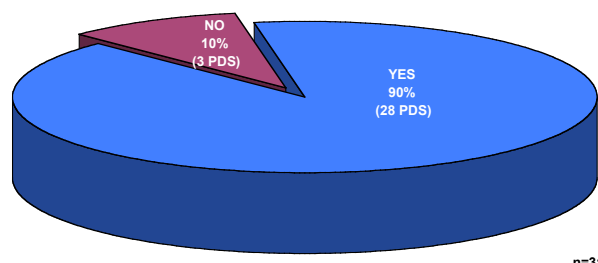
### 1.2.7. Perceptions relating to Service Provision for Older People

#### Role of the HSE-Salaried Dental Service

Twenty-eight (90%) of the 31 PDSs surveyed perceived a role for the HSE-Salaried Public Dental Service in the provision of dental care to older people. The various elements of this role (as described by 23 PDSs) include:

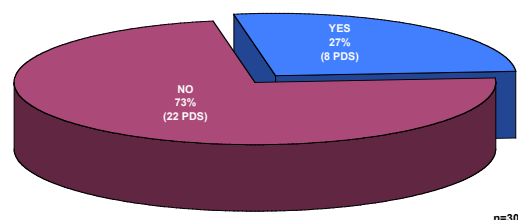
- Care for older medical card holders unable to access care with GDPs via the DTSS or who require specialised treatment (10 PDSs)
  - Routine service
  - Evening DTSS sessions
  - Domiciliary service
  - Creation of Elderly Care posts and team (hygienists, nurses, oral health promoters)
- Care for older patients in institutions (7 PDSs)
  - Routine care to older people in long-stay institutions (maintained by the HSE)
  - Care on a domiciliary care to patients in residential/day care centres
  - Hygienist-led care under supervision of a senior dentist
  - Screening
  - Provision of dentures
- Care for those with special needs unable to attend GDPs via the DTSS (5 PDSs)
  - Clinic-based care for wheelchair patients who require additional facilities such as wheelchair lifts which would be uneconomical for GDPs to maintain
  - Domiciliary visits to frail/highly dependent older people
- Training/education of carers and the elderly in oral health & oral hygiene (4 PDSs)
- Screening for oral health problems such as oral cancer (4 PDSs)
- Domiciliary services (4 PDSs)
- Oral health promotion/Public health approach (with support from hygienists) (2 PDSs)
- Specialist expertise in denture provision (1 PDS)

Do you perceive a role for the HSE-Salaried Public Dental Service in the provision of dental care to older people (65+)?



The consensus among the respondent PDSs appears to be that the delivery of treatment for the mainstream of older people should remain with GDPs. The roles perceived for the HSE-salaried dental service with regards older people relate to the provision of care for medical card holders unable to access the services of GDPs via the DTSS, care for those with special needs and care for those in institutions. Screening for oral health problems, provision of domiciliary services and oral health promotion were also perceived to be roles that should be assumed by the HSE-salaried dental service.

In your opinion, should the present priority of the HSE-Salaried Public Dental Service be shifted towards providing more care for older people (65+)?



Only 8 PDSs (27%) were of the opinion that the present priority of the HSE-Salaried Public Dental Service should be shifted towards providing more care for older people; a hefty 73% of respondents were opposed to shifting the present priority of the HSE-salaried service, which centres on the care of children, towards more care for older people.

## Barriers to Care

GDPs were asked to tick from a given list all the main barriers, if any, they encounter in the provision of dental treatment to older people. They were then asked to indicate which among these barriers were for them the first, second and third most important. The table below summarises the responses of GDPs according to all main barriers cited, and according to barriers cited with the rank of first, second or third most important. Fifteen per cent of the 74 GDPs who replied to this question stated that they encountered 'no barriers' in the provision of treatment to older people; 85% of GDPs identified a wide range of barriers.

What are the main barriers you encounter in the provision of treatment to older people (65+)? (Tick all that apply)

|  | Number and % of GDPs citing as main barrier |              | Number and % of GDPs citing as first, second or third most important barrier |              |
|--|---|--------------|--|--------------|
|  | N   | %            | N  | %            |
| <b>No barriers</b>   | 11  | 14.9         |  |              |
| <b>DTSS fee levels are not adequate</b>  | 47  | 63.5         | 45   | 72.6         |
| <b>DTSS range of services is not adequate</b>  | 41  | 55.4         | 36   | 58.1         |
| <b>Medical complications of older people</b>   | 38  | 51.4         | 31   | 50.0         |
| <b>Older people don't come in for check-ups/treatment</b>  | 16  | 21.6         | 11   | 17.7         |
| <b>Time-consuming/difficult to treat older people</b>  | 22  | 29.7         | 10   | 16.1         |
| <b>Treatment outcomes not as successful as in younger age groups</b>                                       | 17  | 23.0         | 10   | 16.1         |
| <b>Surgery not set-up for patients with disabilities (e.g., not wheelchair accessible)</b>                 | 19  | 25.7         | 10   | 16.1         |
| <b>No staff to help or staff not trained in lifting older people who use wheelchairs onto dental chair</b> | 11  | 14.9         | 5  | 8.1          |
| <b>Inadequate training in the care of older people</b>   | 8   | 10.8         | 4  | 6.5          |
| <b>Older people are more demanding</b>   | 3   | 4.1          | 2  | 3.2          |
| <b>Older people not aware that their medical card entitles them to dental care</b>                         | 3   | 4.1          | 2  | 3.2          |
| <b>Personal dislike for treating older people</b>  | 1   | 1.4          | 1  | 1.6          |
| <b>Older people have a fear of dental treatment</b>  | 7   | 9.5          | 1  | 1.6          |
| <b>Other (please specify):</b>   | 4   | 5.4          |  |              |
| <i>older people don't always want protracted treatment</i>   |   |              | 1  | 1.6          |
| <i>older people decline necessary treatment a lot</i>  |   |              | 1  | 1.6          |
| <i>inadequate training + personal dislike in providing dentures for edentate patients</i>                  |   |              |  |              |
| <b>Total Respondents</b>   | <b>74</b>                                   | <b>100.0</b> | <b>62</b>  | <b>100.0</b> |

Among the 62 GDPs who provided rankings, there was majority consensus that 'DTSS fee levels are not adequate' (73%), 'DTSS range of services is not adequate' (58%), and 'medical complications of older people' (50%) are the three most important barriers the private sector encounters in the dental treatment of older people.

A similar procedure was used with the PDSs to assess the main barriers to HSE service provision, either through the Public Dental Service or the DTSS, to older people. The table below summarises the views of PDSs according to all main barriers cited, and according to barriers cited with the rank of first, second or third most important. Just one PDS stated that they encounter 'no barriers' in the provision of treatment to older people. Among the 30 PDSs who cited barriers, 83% agree that 'inadequate manpower' is among the three most important barriers to HSE-service provision. This was followed by 'time-consuming/difficult to treat older people' (33%), medical complications of older people (30%), and 'inadequate training of clinicians in the care of older people' (27%).

**In your opinion, what are the main barriers to the provision of treatment, either through the Public Dental Service or the DTSS, to older people (65+)? (Tick all that apply)**

|  | Number and % of PDSs citing as main barrier |              | Number and % of PDSs citing as first, second or third most important barrier |              |
|--|---|--------------|--|--------------|
|  | N   | %            | N  | %            |
| <b>No barriers</b>   | 1   | 3.2          |  |              |
| <b>Inadequate manpower</b>   | 25  | 80.6         | 25   | 83.3         |
| <b>Time-consuming/difficult to treat older people</b>  | 15  | 48.4         | 10   | 33.3         |
| <b>Medical complications of older people</b>   | 14  | 45.2         | 9  | 30.0         |
| <b>Inadequate training of clinicians in the care of older people</b>                                       | 18  | 58.1         | 8  | 26.7         |
| <b>DTSS fee levels are not adequate</b>  | 17  | 54.8         | 6  | 20.0         |
| <b>Older people not aware that their medical card entitles them to dental care</b>                         | 12  | 38.7         | 5  | 16.7         |
| <b>Clinics not set-up for patients with disabilities (e.g., not wheelchair accessible)</b>                 | 12  | 38.7         | 5  | 16.7         |
| <b>Lack of specialist equipment (e.g., domiciliary kits, mobile dental units)</b>                          | 10  | 32.3         | 4  | 13.3         |
| <b>Older people don't come in for check-ups/treatment</b>  | 9   | 29.0         | 4  | 13.3         |
| <b>Negative attitudes towards treating older people on part of clinicians</b>                              | 6   | 19.4         | 4  | 13.3         |
| <b>DTSS range of services is not adequate</b>  | 11  | 35.5         | 3  | 10.0         |
| <b>Treatment outcomes not as successful as in younger age groups</b>                                       | 4   | 12.9         | 1  | 3.3          |
| <b>Access problems to day care centres/ residential centres</b>  | 4   | 12.9         | 1  | 3.3          |
| <b>No staff to help or staff not trained in lifting older people who use wheelchairs onto dental chair</b> | 4   | 12.9         |  |              |
| <b>Older people have a fear of dental treatment</b>  | 2   | 6.5          |  |              |
| <b>Older people are more demanding</b>   | 0   | 0.0          |  |              |
| <b>Other (please specify):</b>   | 4   | 12.9         |  |              |
| <i>Older people may feel no need to access dental care routinely</i>                                       |   |              | 1  | 3.3          |
| <i>Transport of residential/housebound elderly to dental surgery</i>                                       |   |              | 1  | 3.3          |
| <i>Inadequate funding of HSE services for elderly</i>  |   |              | 1  | 3.3          |
| <i>Older people not a priority in the dental service</i>   |   |              |  |              |
| <b>Total Respondents</b>   | <b>31</b>                                   | <b>100.0</b> | <b>30</b>  | <b>100.0</b> |



It is interesting that while 73% of GDPS identified 'DTSS fee levels are not adequate' as among their top three most important barriers, only 20% of PDSs agree with them. 'Medical complications of older people' scores the third highest consensus among both GDPs (50%) and PDSs (30%) that cited their first, second and third most important barriers.

### Improving Oral Health Services for Older People

The GDPs and PDSs were asked identical questions regarding what they would suggest to improve oral health services to older people. The suggestions made by the GDPs and PDSs to improve oral health services to older people logically target the barriers to treatment provision they had identified. The table below presents the distribution of GDPs and PDSs in accordance with their first, second or third most important suggestions.

What would you suggest to improve oral health services to older people (65+)? (Tick all that apply)

|  | Number and % of<br>GDPs citing as<br>first, second or<br>third most<br>important<br>improvement |              | Number and % of<br>PDSs citing as<br>first, second or<br>third most<br>important<br>improvement |              |
|--|---|--------------|---|--------------|
|  | N   | %            | N   | %            |
| <b>Expand HSE-Salaried Public Dental Service to cater for older people</b>   | 28  | 38.4 (3)     | 18  | 58.1 (2)     |
| <b>Increase number of DTSS-registered dentists</b>   | 4   | 5.5          | 1   | 3.2          |
| <b>DTSS financial support/incentives for domiciliary care</b>  | 20  | 27.4 (5)     | 10  | 32.3 (3)     |
| <b>Improve the range of services covered by DTSS</b>   | 29  | 39.7 (2)     | 3   | 9.7          |
| <b>Improve DTSS fee levels</b>   | 38  | 52.1 (1)     | 8   | 25.8 (5)     |
| <b>Improve undergraduate training on the oral health care of older people</b>  | 6   | 8.2          | 6   | 19.4         |
| <b>Create a course specialisation on the dental treatment of older people</b>  | 8   | 11.0         | 9   | 29.0 (4)     |
| <b>Provide training to carers on the oral health care of older people</b>  | 20  | 27.4 (5)     | 19  | 61.3 (1)     |
| <b>Advertise need for regular dental visits (including edentulous elderly)</b>   | 22  | 30.1 (4)     | 4   | 12.9         |
| <b>Make DTSS information readily available (e.g., in doctors' surgeries)</b>   | 10  | 13.7         | 2   | 6.5          |
| <b>Increase oral health care awareness among health care workers</b>   | 14  | 19.2         | 6   | 19.4         |
| <b>Include basic oral health questions to determine if a dental referral is required as part of routine medical check-up by GPs / Public Health Nurses</b> | 13  | 17.8         | 3   | 9.7          |
| <b>Dental visits to day care centres</b>   | 3   | 4.1          | 3   | 9.7          |
| <b>Other (please specify):</b>   |   |              |   |              |
| <i>Create specialist post in gerodontology in salaried HSE service</i>   |   |              | 1   | 3.2          |
| <b>Total Respondents</b>   | <b>73</b>   | <b>100.0</b> | <b>31</b>   | <b>100.0</b> |

The greatest consensus among GDPs as to their top three most important improvements are 'improve DTSS fee levels' (52%), 'improve the range of services covered by the DTSS' (40%) and 'expand the HSE-Salaried Public Dental Service to cater for older people' (38%). This is followed by 'advertise need for regular dental visits (including edentulous elderly)' (30%) and, in joint fifth place, 'DTSS financial support/incentives for domiciliary care' (27%) and 'provide training to carers on the oral health care of older people' (27%).

Among the PDSs, there is majority consensus that to 'provide training to carers on the oral health care of older people' (61%) and to 'expand HSE-Salaried Public Dental Service to cater for older people' (58%) are among their three most important suggestions to improve services. Just under one third agree that 'DTSS financial support/incentives for domiciliary care' (32%) is important, followed by 'create a course specialisation on the dental treatment of older people' (29%). The suggestion to 'improve DTSS fee levels' is cited as being within the top three most important by only 26% of PDSs compared to 52% of GDPs, while the suggestion to 'provide training to carers on the oral health care of older people' is supported by 61% of PDSs compared to only 27% of GDPs.

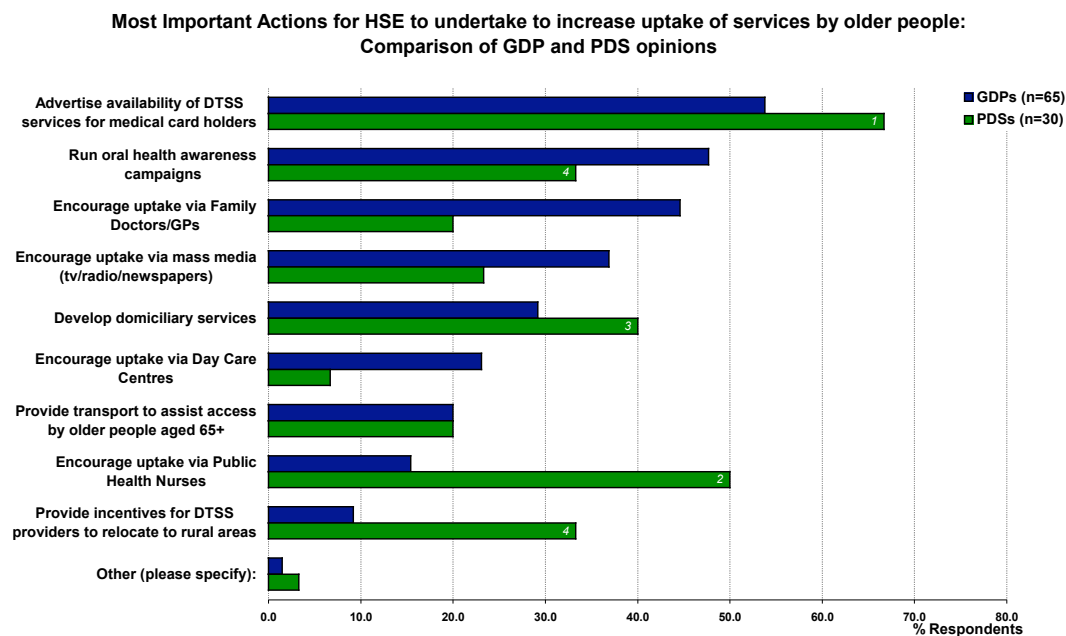
### Increasing uptake of dental services by older people

Finally, both the GDPs and PDSs were asked identical questions regarding what actions, in their opinions, the HSE should undertake to increase the uptake of dental services by older people. Once again the respondents were asked first to tick all of a list of suggested improvements that they agreed with. Subsequently, they were asked to identify the three responses they regarded as most important. The following table shows the distribution of GDP and PDS respondents according to which actions they regarded as most important for the HSE to undertake to increase the uptake of dental services by older people.

**In your opinion, what actions should the HSE undertake to increase the uptake of dental services by older people (65+)? (Tick all that apply)**

|  | Number and % of<br>GDPs citing as first,<br>second or third<br>most important<br>action |              | Number and % of<br>PDSs citing as first,<br>second or third<br>most important<br>action |              |
|--|---|--------------|---|--------------|
|  | N   | %            | N   | %            |
| <b>Advertise availability of DTSS services for medical card holders</b>  | 35  | 53.8 (1)     | 20  | 66.7 (1)     |
| <b>Provide incentives for DTSS providers to relocate to rural areas</b>  | 6   | 9.2          | 10  | 33.3 (4)     |
| <b>Provide transport to assist access by older people aged 65+</b>   | 13  | 20.0         | 6   | 20.0         |
| <b>Run oral health awareness campaigns</b>   | 31  | 47.7 (2)     | 10  | 33.3 (4)     |
| <b>Encourage uptake via Public Health Nurses</b>   | 10  | 15.4         | 15  | 50.0 (2)     |
| <b>Encourage uptake via Day Care Centres</b>   | 15  | 23.1         | 2   | 6.7          |
| <b>Encourage uptake via Family Doctors/GPs</b>   | 29  | 44.6 (3)     | 6   | 20.0         |
| <b>Encourage uptake via mass media (tv/radio/newspapers)</b>   | 24  | 36.9 (4)     | 7   | 23.3         |
| <b>Develop domiciliary services</b>  | 19  | 29.2 (5)     | 12  | 40.0 (3)     |
| <b>Other (please specify):</b>   |   |              |   |              |
| <i>Ensure private dentists fulfill their contractual obligations to provide appropriate care to older people</i> |   |              | 1   | 3.3          |
| <i>HSE to improve fees &amp; services covered</i>  | 1   | 1.5          |   |              |
| <b>Total Respondents</b>   | <b>65</b>   | <b>100.0</b> | <b>30</b>   | <b>100.0</b> |

'Advertise availability of DTSS services for medical card holders' is recommended as a priority action by 54% of GDPs and 68% of PDSs. GDPs also regarded running oral health awareness campaigns (48%) and encouraging uptake via family doctors/GPs (45%) and via mass media (37%) as important actions the HSE should undertake. Among PDSs, the most important actions for increasing uptake by older people are to 'encourage uptake via Public Health Nurses' (50%), 'develop domiciliary services' (40%) and, jointly in fourth place, 'provide incentives for DTSS providers to relocate to rural areas' (33%) and 'run oral health awareness campaigns' (33%).



### 1.3. Discussion of Implications for Interviews of Service Providers

When examining the supply of oral health services to older people, a salient factor is the blanket eligibility for a medical card, and hence DTSS benefits, for those aged 70 and over. Though they may not avail of their entitlements, everyone aged 70 and over has access to dental services via the DTSS. For older people who have not yet reached the turnkey age of 70, access to dental services is dependent upon whether they possess a (means-tested) medical card, whether they have dental insurance cover (e.g., PRSI, VHI Dental), and whether they are able to pay for private dental services themselves.

Payment considerations aside, older people's access to care is also dependent upon their ability to avail of services in a clinic-based setting or whether their only treatment option is domiciliary care.

The primary providers of dental services to older people are private sector dentists: 85% of GDPs are on the DTSS register. The HSE-Salaried Public Dental Service serve as the 'fallback' provider – they are responsible for ensuring care to those older people who are entitled to DTSS services but cannot access care from GDPs.

While services are thus 'available' for older people, the questionnaire results reveal that, on the one hand, GDPs as a whole have a low preference for treating older people, and that on the other hand, service provision to older people is not a priority for the HSE-salaried service:

- 14% of GDPs rank older people as their least preferred age group to treat; overall, GDPs rank older people aged 65+ as their third least favourite age group to treat, above only children aged 0-4 (least favourite) and children aged 5-12 (second least favourite);
- 61% of GDPs do not want to increase the number of older patients attending their practice.
- Only 12 out of 31 PDSs (39%) surveyed reported that the treatment of older people forms part of their annual service plans;
- Only 8 PDSs (27%) were of the opinion that the present priority of the HSE-Salaried Public Dental Service should be shifted towards providing more care for older people.

Private-sector GDPs must necessarily operate their practices along economic principles. It is not surprising, therefore, that the most important barrier to providing care for older people - most of whom have DTSS cover - encountered by the majority of GDPs relates to the DTSS fees. 'DTSS fee levels are not adequate' was cited by 73% of respondent GDPs as being among their top three most important barriers; 'DTSS range of services are not adequate' was cited by 58%. Among the respondent GDPs, 50% 'often' or 'sometimes' provide additional treatment to their older DTSS patients which must be paid for privately, and 69% 'often' or 'sometimes' provide pro-bono (free of charge) treatment to older people.

From the point of view of PDSs, the single most important barrier to providing care to older people, either through the Public Dental Service or the DTSS, is 'inadequate manpower' (cited by 83% of respondent PDSs). (Note: It is likely that the recent decision by the Irish Dental Association to withdraw their support for the DTSS will further aggravate the manpower problems already being encountered by the HSE Public Dental Service.) 'Medical complications of older people' was also among the top three most important barriers for 50% of GDPs and 30% of PDSs.

The perceptions of GDPs and PDSs on how to improve oral health service to older people reflect their main concerns. The most important recommendation for the majority of GDPs was to 'improve DTSS fee levels' (52%); for the majority of PDSs, the most important recommendations were 'provide training to carers on the oral health care of older people' (61%) and 'expand HSE-Salaried Public Dental Service to cater for older people' (58%). Expanding the HSE-salaried service to cater for older people was also recommended by 38% of GDPs.

Though 90% of PDSs feel that the HSE-salaried service does have a role to play in the care of older people, the consensus among them seems to be that the delivery of treatment for the mainstream of older people should remain with GDPs and that the present priority of the HSE-salaried service (which is focused on the care of children) should not be shifted towards providing more care for older people.

The majority of GDPs and PDSs both agree that the most important action the HSE should undertake to increase the uptake of dental services by older people is 'advertise availability of DTSS services for medical card holders' (54% GDPs, 67% PDSs). Other priority recommendations for the HSE Dental Service included running oral health awareness campaigns, encouraging uptake via public health nurses, via family doctors/GPs, via mass media (TV/radio/newspapers) and develop domiciliary services.

With regards uptake of services by older people, GDPs report no difference in attendance for regular check-ups between private patients and DTSS patients. However, GDPs report a marked difference in attendance for regular dental check-ups between dentate and edentulous (toothless) patients. Linked to this, while 82% of GDPs will issue reminder letters to their older dentate patients, only 51% do so for their older edentulous patients, despite the fact that 80% of GDPs feel that their edentate patients should be encouraged to attend for check-up at least every 2 years. Almost one fifth of GDPs reported that 'None' of their toothless patients came in for regular check-ups.

With regards domiciliary services, domiciliary care to older people on a regular basis is rare among GDPs and is provided by less than half of the HSE service areas, mainly to residential care units. On an emergency basis, domiciliary care is provided by almost all HSE service areas (97% in residential care units, 94% in patients own homes, 68% in day care centres) but by less than 40% of GDPs (36% in residential care units, 30% in patients' own homes, 19% in day care centres).

The main issues with regards dental service provision for older people brought up by the GDPs and PDSs and their differing perspectives on the challenges and opportunities for service providers were further explored via individual interviews of GDPs and PDSs. The next section of this report presents the results of the individual interviews with service providers.

## **2. Report on Interviews with General Dental Practitioners & Principal Dental Surgeons**

### **2.1. Methodology**

#### **2.1.1. Interview Schedule Design**

This section of the Interim Report documents the results of the interview phase of the consultation with key stakeholders involved in the organisation and delivery of oral healthcare services to older people. Similar to the questionnaire, the interview schedule was intended to focus on current practices in dental service provision for older people and the challenges and opportunities facing the services delivering dental care to this group. Specifically, the interview schedule was designed to further explore the themes raised in relation to these issues during the questionnaire phase. To address the differing perspectives of private dental practitioners and the public dental service on the topics raised by the GDP and PDS questionnaires, it was decided to design two semi-structured interview schedules – one each for GDPs and PDSs.

Both interview schedule designs were informed by a consideration of the questionnaire results from both stakeholder groups (see above). In addition, the Principal Investigator facilitated a roundtable discussion with the investigating team and representatives of the HSE-salaried service and GDPs to tease out which of the many issues raised by the questionnaires merited inclusion in the interviews. The use of a semi-structured interview format ensured that while information was gathered on these key issues, the respondents also had scope to elaborate on their answers and express their personal views on the subject matter. The resulting draft interview schedules were piloted and modified appropriately prior to the commencement of fieldwork.

The GDP and PDS interview schedules are presented in full in the Appendix.

#### **2.1.2. Sampling Strategy**

Twenty eight GDPs and twenty four PDSs who returned the questionnaire indicated that they were willing to participate in a follow-up telephone interview. It was attempted to arrange interview appointments with all of these individuals.

#### **2.1.3. Interview Procedure**

The GDP interviews were conducted during one working week, at a time convenient for each dentist, as established by a prior telephone call; the PDS interviews were similarly conducted during the following week.

All of the interviews were conducted by a single interviewer, the second author, to control for, if not eliminate, interviewer effects resulting from the interaction of the interviewer's and interviewee's personal characteristics. It was also hoped that the interviewer's social science, rather than dental, background would reduce the likelihood of researcher effects due to expectations regarding the research outcome, or prior experience of the organisation and delivery of oral healthcare services to older people.

While the prospect of socially desirable responding by the dentists cannot be ruled out, they were instructed to respond as honestly as possible, their anonymity was guaranteed, and their right to withdraw was clearly explained to them. Subject to participant consent, the interviews were recorded via a loudspeaker telephone and digital voice recorder, and transcribed in full to eliminate bias in the reporting process. Where consent was not given, note-taking was used by the interviewer to record the participant's responses.

## **2.2. Results**

### **2.2.1. Response Rate**

Twenty six of the GDPs who returned the questionnaire indicated that they were willing to participate in a follow-up telephone interview. When the interviewer attempted to arrange interview appointments with these dentists, two were on holidays, three did not return repeated phone calls, and no contact could be established with three GDPs. Thus eighteen GDP interviews were conducted and transcribed.

Twenty four of the respondents to the PDS questionnaire signalled that they were willing to participate in a follow-up telephone interview. Four of the PDSs did not return repeated phone calls and no contact could be established with two PDSs. Thus eighteen PDS interviews were conducted and transcribed.

### **2.2.2. Content Analysis of Interview Transcripts**

The interpretative framework for the data was based upon the topics of questions in the interview schedules. As a basis for content analysis, a coding scheme was developed whereby each question in the schedule was given a code number. The content of the transcripts was then categorised according to these questions, with the relevant responses being systematically allocated one or more code numbers corresponding to one or more of the specific questions in the schedule, as appropriate.

Subsequently, each sentence, or group of sentences, from the transcripts was copied and pasted into the schedule format under one or more of the questions to which it was an appropriate response, and then marked with a label denoting the interview it derived from. Finally, the collected responses to each individual question were analysed, and the responses for topics common to the two interview schedules compared. The presentation of the results below is thematic, while still broadly reflecting the sequence of the questions in the two schedules.

### **2.2.3. DTSS Entitlements and Fees**

The first set of questions for the GDPs concerned the economics of providing dental care to older people, focusing in particular on their views regarding the DTSS entitlement and fees. To create a context for the initial question, the interviewer noted that universal eligibility for the medical card begins at 70 years of age, whereas most older people retire at age 65. The GDPs were then asked if they thought that, in general, 65-69 year olds without a medical card are prepared to pay for an adequate quality of care to ensure good oral health and function.

The responses to this question fell evenly into three broad categories: those who agreed unreservedly; those who agreed, but qualified their response in some way; and those who did not agree. Six of the interviewees agreed that 65-69 year olds without a medical card are prepared to pay for an adequate quality of care to ensure good oral health and function. A second group of interviewees were less decisive in their replies. Two GDPs indicated that, while their 65-69 year old patients are prepared to pay for treatment that is immediately necessary, they tend to put off non-urgent treatment until they get the medical card. Other interviewees thought that those with partial cover via the PRSI [DTBS] scheme were more likely to pay than those with no cover and that possessing the financial resources to pay was an important factor in influencing the decision



to pay for dental treatment. The priority individual patients give to their oral health, and their attitude toward dentistry in terms of a preventive or pain management approach, were also noted as factors which influence the decision to pay. Finally, a third group of six GDPs stated that they thought 65-69 year olds without a medical card were not prepared to pay for an adequate quality of care to ensure good oral health and function. All of these respondents cited financial reasons for this decision.

Pursuing the DTSS theme further, the GDPs were first reminded that the medical card covers some, but not all, possible treatments, and subsequently asked if they thought older people's medical card entitlements provide an adequate quality of care to ensure good oral health and function. Exactly half of the interviewees responded positively, and half negatively, to this question. Those GDPs who believed that the medical card entitlements were adequate cited the levels of oral health experienced by the current cohort of seventy-plus year olds. Those who gave a reason for thinking that the DTSS entitlements are not adequate stated that the range of treatments covered by the scheme is no longer sufficiently comprehensive, particularly if treatment plans are relatively demanding; e.g., crowns and root canal treatments are not covered on back teeth, and treatment for gum (periodontal) disease, common among older people, is limited. In addition, two of the interviewees who responded in the affirmative, and one who thought the medical card entitlements were inadequate, stated that the fees paid to dentists for performing DTSS-funded treatment are not commensurate with the time and effort involved. This theme will be explored further below.

The nine GDPs who responded negatively to the question above, stating that older people's medical card entitlements do not provide an adequate quality of care to ensure good oral health and function, were then asked if they find that older medical card holders are prepared to pay for any extra care they require. Two GDPs stated, quite correctly, that under the DTSS rules, dentists are not permitted to discuss private treatment options with medical card patients, and so the matter does not arise. Four dentists stated that older patients with a medical card were not prepared to pay for additional private treatment. However, three GDPs stated that medical card patients were prepared to pay for private treatment if they could afford to do so. One of the respondents queried the comparability of the quality of treatment provided to DTSS and private patients considering the DTSS fee levels; again, this issue is discussed further below.

Narrowing the focus to specific DTSS policies, the GDPs were asked if the DTSS policy, which does not allow the refilling of teeth within five years, presents a problem in providing adequate dental care to older people. A resounding majority of interviewees thought that this policy does present a problem; only two dentists believed it did not. Many interviewees felt very strongly about this issue and voiced their concerns at length. An image of older people with a fragile dentition containing many large restorations and high rates of dental decay due to the prevalence of a high sugar diet, dry mouth and poor standards of personal oral hygiene emerged from the GDPs' descriptions of their patients.

In this context, one GDP described the effect of the five-year bar on refilling as "supervised neglect". As another commented, "if you got a year out of it, two years maybe would be brilliant, but you're going to end up refilling the tooth". When this occurs, another GDP described the situation as " ... a nightmare. You see these patients coming through the door, constantly with the same [need for refilling]; you know who they are and you dread when you see them on your book." When refilling is a clinical necessity, GDPs frequently

reported or alluded to providing free treatment. Those GDPs who attempt to claim a fee via the DTSS for refilling found it “very bureaucratic,” and “utterly degrading to have to fill in ... that there’s a clinical necessity to fill this; and it really annoys me when they send back a form saying we’re not paying this claim because you have filled this tooth in the last five years. I mean, it may even be a different surface, and it’s ... really ... it’s absolutely ridiculous.” The two GDPs who did not view the DTSS five-year bar on the refilling of teeth as a problem in providing adequate dental care to older people did not explain their reasons for holding this view.

The final aspect of the DTSS discussed with the GDPs was the fees paid to dentists for providing dentures. First, the interviewees were asked if they thought that there needs to be an independent assessment of the actual cost of the provision of dentures by GDPs. Several respondents’ answers referred to a recent survey conducted by the Irish Dental Association (IDA) on this matter; at the time the interviews were conducted, the results of this survey had not been publicly disseminated. One interviewee thought that a further assessment, in addition to that conducted by the IDA, was unnecessary. Another GDP believed that the HSE already realises that there is a discrepancy between the fees paid to GDPs and the cost of the treatment they provide, and so a further assessment is unwarranted.

The remaining sixteen GDPs agreed that there needs to be an independent assessment of the actual cost of the provision of dentures by GDPs. Their views were summarised by one interviewee, who stated that there needs to be “a medical card fee set that would bear a relationship to the actual cost-base that the dentist has to work within”. The dentists cited the current costs of the dental materials and laboratory work involved in denture provision, in addition to the number and duration of visits, as their justification for this. However, some dentists had reservations about the conduct and results of such an assessment, specifically, that they “wouldn’t want civil servants adjudicating on the fees,” and that the results would not be significantly different to those obtained by the IDA survey.

To expand upon the issue of DTSS fees, the GDPs were next asked how much chair time, on average, is involved in providing a new full upper and lower denture, including easing (making small adjustments to the denture’s fit). Seventeen dentists provided answers to this question. Two dentists thought that, on average, providing a full new upper and lower denture took an hour or less. Six interviewees stated that one and a half hours was their average time for performing this procedure, though one did point out that this was “for an experienced practitioner to make them – for a younger practitioner, it probably takes a lot longer.” Five GDPs gave a slightly longer estimate of two hours, and one thought it could take between two and two and a half hours. One dentist gave a much longer estimate of “between four and five hours”. One interviewee highlighted the heterogeneity of the older population, stressing the difficulties and time-consuming nature of providing dental care for frail older people: “some people are very slow in everything that they do, ... others have a tendency to dry-retch, and all that sort of stuff, and there’s just general difficulties, which you do get more with older people. And you have to be more gentle with them - their skin and the tissues are more parchments-like.”

The final aspect of the DTSS fees that the interviewees were asked about was the laboratory fees for full dentures; specifically, they were asked “Are you able to obtain satisfactory denture manufacturing services

for the level of denture laboratory fees included in the DTSS full denture fee?" Seven GDPs were able to obtain satisfactory laboratory services for the DTSS fee, though four qualified their answers using "probably" or "just about," and one admitted that this has only recently become possible due to the establishment of a new dental laboratory in the area. Four dentists provided ambiguous answers to this question, indicating that it is "difficult" to obtain satisfactory dentures economically, and that the DTSS laboratory fee for full dentures should be increased. Six interviewees reported not being able to obtain satisfactory denture manufacturing services for the level of denture laboratory fees included in the DTSS full denture fee. Four of these dentist expressed the view that "... there is a compromise there ...on quality" and felt that the dentures they could obtain within the DTSS fee limits "would be completely rubbish and there'd be no point doing it in the first place."

Two respondents to the question above pointed out that, in their opinions, providing full dentures is "not a viable business ... with the money that we're getting from the medical cards". One GDP cited dissatisfaction with this issue as a reason they withdrew from the DTSS entirely. Indeed, the view that the fees paid to dentists for performing DTSS-funded treatment are not commensurate with the time and effort involved was repeatedly expressed throughout the interviews. As one interviewee explained, "the one major stumbling block is the level of fees in the DTSS, which is obviously quite low in comparison to typical fee levels in either the private dentistry or the PRSI (DTBS) scheme; ... it doesn't compare favourably ... at all with those." Returning to the theme of "supervised neglect," various interviewees pointed out that some of the treatments required by older people "take a long time to do and it would be uneconomic to do them from the dentist's point of view". Where treatment is provided, some GDPs wondered aloud "if dentists ... can offer the same level of treatment at that level of fee" to DTSS patients as they do to their private patients. Finally, one interviewee in particular highlighted the problems faced by older medical card holders in some parts of the country in locating a dentist who provides DTSS treatment. This was borne out by the experience of another interviewee, working in this region, who found that "other dentists in the area, who pulled out of the DTSS, were beginning to refer [DTSS patients] to me. I was becoming like the local clinic." As a clearly irate GDP said, "... it's only worthless to say, 'ya, you'll do that (provide free dental care to medical card holders),' when "older people in the built-up areas, especially Dublin, wouldn't have any cover under the medical card because you can't get ... dentists to operate the scheme because the costs would be too high."

#### **2.2.4. Dental Screening Services**

Both the General Dental Practitioners and Principal Dental Surgeons were asked about their views on the provision of dental screening services to older people. Firstly, they were asked if they thought that the DTSS should encourage annual recall of edentulous older people for a denture-fit check-up and screening of their oral mucosal health, for example, for oral cancer.

All of the GDPs were in favour of regularly recalling older patients for a check-up; however three respondents suggested that more than a year between check-ups would be sufficient. One third of interviewees commented that they already recall their edentulous patients, usually on an annual basis, in keeping with what is permitted by the DTSS fee schedule. Despite this, some GDPs find that "edentulous patients are ... really not as orally aware as patients who have teeth, generally speaking" and, as a result, "when they've got dentures, they're inclined to just go away and not come back." Finally, one GDP observed

that, within the current DTSS fee structure, “there isn’t money in [recalling edentulous medical card holders] really.”

The majority of PDSs were also in favour of recalling older people regularly for a check-up when asked a similar question; i.e. if they thought that the DTSS should support annual recall of edentulous older people for a denture-fit check-up and screening of their oral mucosal health, for example, for oral cancer. All but one of the seventeen respondents who provided an answer to this question thought that recall of older patients should be supported. However, two PDSs expressed the view that annual recall might be unnecessarily frequent. More fundamentally, two PDSs believed that as a public health measure, the HSE-salaried public dental service, rather than the GDPs contracted under the DTSS, should conduct this check-up. Many of the PDSs took a critical perspective on the issue, noting that “currently it actually does [support annual recall] in theory.” However, they also observed that the prior-approval process involved in conducting any denture alterations within five years of its production was at odds with the aim of an annual denture-fit check-up. Some PDSs also noted the same difficulties experienced by GDP with regard to edentulous patients; “The difficulty is that denture-wearers ... don’t understand that they need to have their gums and mouth checked.” One respondent suggested a potential solution to this problem; “we could have a recall system for patients ... because otherwise it’s up to the patients to contact the dentist. But if there was some kind of list, that we could encourage dentists to ... send out letters.” Another interviewee suggested “increasing awareness amongst the elderly ... about the ... benefits of screening.” Finally, one PDS did not support annual recall of older patients, as they thought a cost-effectiveness assessment was required.

Following this, the PDSs were asked if they saw merit in regularly screening older people for oral cancer, and if so, how often. Mirroring the responses to the previous question in relation to check-ups, sixteen PDSs responded positively to the oral cancer screening proposal, one negatively, and one PDS chose not to answer the question. Looking first at the single negative response, this interviewee believed that “oral cancer is a relatively rare disease” and expressed dissatisfaction with “the positive predictive value of screening” for oral cancer and the potential for “a lot of false negatives.” Many of the remaining PDSs were not unequivocally positive about the proposal. In particular, several respondents felt that resources constrained their ability to consider actually introducing such a scheme at the present time.

Many PDSs provided suggestions regarding the implementation of an oral cancer screening program in addition to commenting upon a desirable frequency for examinations. There was a consensus that while practical considerations may need to be taken into account, the ideal frequency of specific oral cancer screenings should be determined by the evidence base. However, a number of PDSs suggested that screening could also be conducted within the context of a general annual oral health check-up, or opportunistically whenever patients present at the dental surgery for treatment. Some PDSs differentiated between older people resident in the community and those living in residential care units, suggesting that any screening program design would need to take the diversity of these groups into account. In addition, campaigns to raise awareness of DTSS entitlements, general oral health, and oral cancer among older people were suggested. The need for training in oral cancer screening for both GDPs and practitioners working within the salaried service was noted as a barrier to implementation. Finally, one respondent put

forward a persuasive argument for maintaining an epidemiological database of oral cancer screening results to assess the pattern of the disease over time.

Finally, both groups of participants were asked if they would be prepared to participate in an annual oral cancer awareness week. All of the GDP and PDS interviewees responded positively; however, some GDPs had reservations about the time commitment, particularly during working hours, while some PDSs felt that resource constraints could impact negatively on the viability of the proposal. When asked about how the concept of an annual oral cancer awareness week might be implemented, both the GDPs and PDSs provided a wide range of innovative suggestions. Firstly, the majority of participants saw a need for targeted advertising through the local and national mass media to raise awareness of oral health, oral cancer and the DTSS entitlements among older people. Some participants suggested that this might best be conducted within the context of a general oral health awareness week rather than specifically focusing on oral cancer. In addition, the PDS interviewees in particular highlighted the need for a multi-disciplinary, multi-sectoral approach, involving the HSE-salaried, DTSS-contracted and private dental practitioners, hygienists and oral health promoters working in co-operation with the Irish Dental Association, the Dental Health Foundation and other healthcare professionals, such as GPs, public health nurses, care staff in residential and day care centres, perhaps headed by a national expert on oral cancer. The heterogeneity of the older population and the need to target all sectors involved was also highlighted.

#### **2.2.5. Accessibility of Dental Services**

As older people access dental care via GDPs and the HSE-salaried public dental service, both groups of participants were asked about the accessibility of their services. The individual questions each group were asked reflected the services they provide to older people and the manner in which they are delivered.

General Dental Practitioners were asked if they currently receive referrals of older people from other healthcare workers, such as medical doctors and nurses, public health nurses, care assistants and home helps. While all of the GDPs had some experience of receiving referrals, the source of these referrals and their frequency varied considerably. Ten GDPs specifically identified General Medical Practitioners as the source of their referrals, four mentioned referrals from nursing homes, while just a single GDP received referrals each from day care centres for older people and from district nurses. In addition, one GDP received referrals of DTSS patients from dental colleagues who do not participate in the medical card scheme. Comparing the frequency of referrals from other healthcare workers, five GDPs reported receiving referrals relatively frequently, three received referrals “occasionally”, four GDPs received referrals “very occasionally”, and six GDPs did not specify the frequency with which they receive referrals.

When asked how more referrals from other healthcare workers could be encouraged, the GDPs responses formed three broad categories. Firstly, nine GDPs suggested raising awareness of dental conditions among GPs and other healthcare professionals. GDPs recognised that “older people do attend their GPs a lot more frequently than they would attend the dentist,” and hence the GP is in a better position to “encourage them to have their mouth checked as well ... if they’re in having a check-up.” However, several GDPs noted a lack of awareness of oral health and dental disease among GPs; “doctors in particular, ... I find that most of them are unconscious of dentistry ... as distinct from conscious of it.” The interviewer noted a lack of familiarity

among several interviewees with the role played by other healthcare workers in the care of older people; hence the focus on GPs in participants' responses should not be interpreted as a deliberate exclusion of other healthcare workers from the referral process.

Secondly, nine GDPs identified raising awareness of dental conditions among older people themselves and their carers as a means of encouraging more referrals. Several GDPs believed that "a lot of people don't realise that ... if they have a medical card ... they have dental cover with it as well." Suggestions to counteract this, and improve older people's oral health awareness, included providing leaflets or other forms of information in GPs' surgeries, a poster campaign, and having other healthcare professionals tell older people about this service when they see them. Finally, three GDPs suggested conducting "screening visits to nursing homes" to identify older people in need of dental treatment as a means of increasing referrals to GDPs, as is currently the practice in the UK and NI.

Similar to the question asked of GDPs above, Principal Dental Surgeons were asked if they saw a role for other healthcare workers, such as medical doctors and nurses, public health nurses, care assistants and home helps, in referring older people to HSE-salaried dentists. Sixteen PDSs provided answers to this question, with only two respondents ruling referrals by other healthcare workers out completely. However, though the majority of PDSs were in agreement with the broad concept of accepting referrals, many expressed reservations about the level of knowledge other healthcare workers possess regarding oral health. For example, "I think dentists know a lot more about what doctors do than doctors know about what dentists do," and, "I work with student nurses in hospitals and it's amazing ... – they know nothing about oral health, and they're taught nothing about oral health." In particular, only two PDSs believed that healthcare workers should use formal assessment tools to identify dental problems and seek professional assistance. The remainder appear to believe the role of other healthcare workers in referrals should be more limited. One PDS thought that referrals of older people from other healthcare workers would "not [work] the way the current service is set up". The other PDSs who do not see a role for other healthcare workers in referring older people to HSE-salaried dentists did so because their service does not treat older people, rather than because they took issue with the referral process: "if they're referring them in to us, it's a waste of time for them because we don't tend to treat the elderly at the moment. ... if doctors send them in to here, we're only just sending them on to somebody else then."

For older people who are unable to access GDPs surgeries or HSE dental clinics, domiciliary care is the only means of obtaining dental treatment. The questionnaire results indicated that the majority of domiciliary care is provided by the HSE-salaried service. To explore this further, the PDS interviewees were asked if they would you be willing to increase the amount of domiciliary care their dental service provides to older people, and, if so, what would facilitate or prevent this. The consensus on this issue was overwhelming: Every single one of the eighteen Principal Dental Surgeons interviewed stated that that they would certainly be willing to increase the amount of domiciliary care they provide if, and only if, they had the resources, and in particular the manpower, to do so. Many PDSs were torn by their desire to provide a domiciliary service to older people which they recognised a clear need for, and the reality that providing such a service would take resources away from their other patients, in particular children – the intended target of the HSE-salaried service. As

one interviewee explained, “it just simply isn’t possible to ... consider doing that without ...letting some other part of the service go.”

Many respondents noted the resource intensive nature of domiciliary care, both in terms of time and manpower. Taking a pragmatic approach, three PDSs suggested conducting a needs assessment to establish the scale of the older population’s domiciliary care requirements. In particular, one PDS suggested the development of assessment tools to assist carers in differentiating between older people who absolutely require domiciliary care and those who could potentially be treated in a surgery or clinic setting. In addition, one PDS believed that a domiciliary care fee should be introduced under the DTSS to allow GDPs to conduct domiciliary care and reduce the demands on the salaried service. Finally, one respondent discussed the use of mobile dental clinics as a means of delivering domiciliary care. This will be discussed below.

To further explore the delivery of domiciliary care, the PDSs were also asked if they would consider using a mobile clinic to provide dental care on older people’s doorsteps, if they were given additional staffing and resources specifically for the care of older people. Overall, fifteen PDSs would consider using a mobile clinic, while three would not. However, it should be noted that while the majority of interviewees conceptualised a mobile clinic as a self-drive ambulance-like vehicle, others also included hand-held mobile units transported via car and used chairside or bedside in the patient’s residence.

Several PDSs noted that a needs assessment would be required prior to the purchase of such a large and expensive piece of equipment. In comparing the various treatment options available to older people, some respondents were unsure if older people who could tolerate transportation out of their homes to a mobile unit would be better served by clinic-based treatment. In addition, it was observed that for those who are confined to their homes, a mobile unit is not useful; only a hand-held unit can be used. However, in favour of the use of a mobile unit, interviewees noted its suitability for providing care to concentrated numbers of older people in nursing homes and day care centres, and those in very isolated rural settings. In addition, one PDS argued that the risk of fire, damage and cross-infection when conducting care within a patient’s dwelling is unacceptable in the context of modern dentistry, and a mobile unit provides a controlled treatment environment. On the other hand, two PDSs expressed concern regarding cross-infection control in a mobile unit. Finally, of the three PDSs who would not consider using a mobile unit, two work in inner city locations where logistics would prohibit the use of a large vehicle and one did not view it as an appropriate use of limited resources.

Turning to the issue of domiciliary care by other oral healthcare workers, the Principal Dental Surgeons were asked if they would be prepared to deploy HSE-salaried hygienists to older people living in the community and/or to residential care units on a daily or weekly basis. All eighteen PDS respondents were in favour of deploying HSE-salaried oral healthcare staff. However, several of the interviewees drew a distinction between the clinical and oral health promoting roles hygienists fulfil. While some of the PDSs explicitly illustrated the need for hygienists’ clinical skills in community and residential care settings, two PDSs felt that dentists, rather than hygienists, would be better positioned to provide the appropriate level of clinical care. In addition, where the goal was oral health promotion and education, an oral health promoter was seen as the most appropriate HSE staff member to provide such services by some respondents. However, for the

majority, hygienists do appear to have a role to play in the delivery of domiciliary care, and indeed, at least four of the PDS respondents already have programs involving hygienists in operation in their area.

Next, the role of older people's carers in delivering domiciliary care was considered. The PDSs were asked if they would be willing to participate in the delivery of regular training programs for older people's carers on denture care and dental hygiene, and if so, what would facilitate or prevent this. Each and every PDS is in favour of training older people's carers to maintain their clients' oral health and at least ten of them already do so at some level. Without exception, a lack of resources, specifically staff, was regarded as the greatest barrier to providing this service. In addition, two of the PDSs made the point that "most ... areas in ... the country don't actually have oral health promotion funded and structured. ... It would need to be properly funded so that we can do this in an ongoing, structured and evaluated way." Finally, the "high turnover of staff" in residential units, and carers' accessibility to and willingness to become involved with the dental services were regarded as potential impediments to this type of training program.

Finally, the role of direct oral health promotion, via literature for older people themselves, was considered. General Dental Practitioners were asked if they saw a need for greater availability of oral health promotion literature for older people. Fourteen GDPs responded affirmatively to this proposal; some of these respondents were particularly emphatic about the need to empower older people "to make decisions for themselves and be informed themselves" by making them "aware of ... how they can promote their own oral health, rather than a health professional telling them what needs to be done for them." Five GDPs specifically identified a need for information leaflets in GPs' waiting rooms and other healthcare locations frequented by older people, such as clinics and day care centres. "Video presentations for waiting rooms" were also suggested as a means of promoting older people's oral health.

Two interviewees suggested distributing literature to older people via the postal system. While one of these interviewees thought that "they might just consider it to be more junk mail," another interviewee countered this by suggesting that information leaflets should be included with the ESB bill – a piece of mail regularly received by every household in the country. With regard to the content of the proposed literature, those who provided details felt that any literature distributed outside of the GDPs' surgery should simply recommend that older people go to see their dentist. Additionally, the need for detailed literature for distribution by GDPs directly to patients in relation to their specific oral health problem was also mentioned.

However, four GDPs did not see a need for greater availability of oral health promotion literature for older people. One believed that while older people may accept literature from the GDP, they "put it in their bag and don't read it." A second GDP felt that many older people would not be able to cope with oral health promotion literature; "I just don't think it would be on the agenda for a lot of older people." The remaining two GDPs thought that a written format was inappropriate for conveying oral health promotion information to older people. One suggested that "instruction and actually speaking to them face-to-face would be a better way to get the message across," while the other suggested the introduction of a regular television and radio broadcast informing people of their medical card entitlements and the need for dental check-ups.



Looking at the broader context in which older people access dental services, the Principal Dental Surgeons were asked if the development of the primary care network impacted upon the provision of dental services for their older patients. To date, none of the interviewees reported any impact on dental services as a result of this reorganisation process within the HSE. In fact, most noted that the process of forming primary care teams and networks was either in the very early stages of development in their area, or was still under discussion at a management level.

Both the General Dental Practitioners and Principal Dental Surgeons were asked the same final question about the accessibility of dental services to older people: do you think that we need a register of dental surgeries that are accessible to people with poor mobility, such as those in wheelchairs? Fifteen GDPs and seventeen PDSs thought that a register would be beneficial. Examining the GDP responses in more detail first, many of the interviewees related incidents of patients telephoning the surgery to determine its accessibility; twelve of the eighteen GDP participants' surgeries were wheelchair accessible. While those in favour of a register tended not to justify their view, those who did not support the proposal cited the small scale of the issue and the possibility of creating divisions between practices on and off the register. One GDP also noted that it is not only those in wheelchairs who experience mobility problems; "you'd gradually discover with some of them over the years they have difficulty in accessing the surgery."

Perhaps due to their managerial role, the PDSs tended to provide considerable justification for their view that a register of accessible dental clinics is required. To summarise a series of similar arguments, they believe a register is required which includes the HSE clinics and all DTSS contractors and private GDPs willing to have their names placed on it. Going forward, many PDSs expressed the hope that all HSE clinics would become wheelchair accessible, and that an accessible surgery may be required for the awarding of a DTSS contract in the future. The PDS who did not agree with the proposed register actually went further, believing that all dental services, both HSE and GDP, should be fully accessible, and therefore a register is unnecessary; "creating a register for those that have is really creating a register for people who are disgracefully providing what should be basic services."

#### **2.2.6. Human Resources & Training Issues**

Most older people receive their dental care from General Dental Practitioners. However, in a minority of cases, often when the special needs of an older person preclude GDP treatment, the public dental service provides care to the older person. As the population ages and the number of older people - particularly dentate older people - increases, demand for public dental service treatment by older people is likely to increase.

In light of this, the Principal Dental Surgeons were asked if they thought there was a need in the public dental service for dedicated posts for specialists in the care of older people, for example, a Senior Dental Surgeon for Gerodontology. Fifteen PDSs believed that there is a need for this type of post, while three did not. Examining the arguments against the creation of this post first, one PDS held the view that specialist posts make it more difficult for patients to access care, one did not regard the discipline as sufficiently distinct to warrant specialist posts as yet, and a third PDS viewed this area as a branch of special needs dentistry rather than a distinct specialism unto itself. Those in favour of the introduction of a Senior Dental

Surgeon for Gerodontology post provided a number of additional pieces of information regarding their preference. Firstly, nine of the fifteen respondents argued that the appointee should have a Masters level qualification in Gerodontology, or a cognate discipline. Some respondents also noted the importance of integrating the role into the existing areas of dentistry, providing support so that the person in-post does not have to take on the care of all older people entering the service, and extending the breath of the role to include multi-disciplinary working with medical colleagues and private dental practitioners.

Despite this proposal, the majority of older people will continue to receive their dental care from General Dental Practitioners. Thus GDPs were asked if they would welcome training from the HSE in the provision of dental care to older people, including awareness of medical conditions and complications. Fifteen GDPs expressed at least some enthusiasm for this suggestion, while three were not in favour of it. In terms of the specific areas GDPs felt would be beneficial to them, three GDPs mentioned an interest in further training in oral medicine (oral health care of patients with chronic, recurrent and medically-related disorders of the oral and maxillofacial region), and three also indicated that they are interested in learning more about the impact of medications on oral health and dental treatment outcomes. Other areas which were also requested include “issues relating to ... cardiac conditions, and ... autoimmune conditions,” root caries and “the provision of ... new dentures.”

However even the GDPs in favour of further training expressed reservations around the issues of time, cost and location of training. In addition, two GDPs believed that the HSE was not the appropriate body to undertake GDP training. One of these dentists felt that the HSE's relations with general dental practices are already overly intrusive and bureaucratic, and so they would not welcome further regulation. The other GDP thought that such training “would have to come from the dental hospitals - I don't think the HSE would have the expertise to do that.” In addition, three GDPs were not in favour of further training in the provision of dental care to older people as they believed they were already competent and experienced in this area.

GDPs were also asked if they thought their staff would welcome training in the care of older people. Thirteen GDPs thought that their staff would like further training in this area, while five did not. Where staff would welcome training, dental care *per se* was not the only priority as “a lot of it boils down to the dentist at the end of the day.” However one GDP did highlight the need for increased awareness of general health conditions and medical emergencies among auxiliary staff. GDPs in particular noted the need for staff training in the general management of older patients, e.g., transferring older people from wheelchairs to the dental chair, assisting ambulatory patients with poor mobility, and dealing with organisational issues, such as transport and taxis. Those GDPs who believed that their staff would not welcome further training in the care of older people appeared to share the view that, “they feel that ... in the end, it'd be up to me;” hence further training “should really be for the dentist's benefit.”

The PDSs were also asked if they thought their staff would welcome training in the provision of dental care to older people, including awareness of medical conditions and complications. Again, the Principals spoke with one voice on this issue: all PDSs were in favour of further staff training, even though some were not entirely sure if their staff would welcome it. Two PDSs noted that their staff would probably be “fearful about getting involved” due the expectation of an increased workload with a new client group subsequent to the training.

The areas in which further training was recommended are diverse: four PDSs cited (poly-)pharmacology and denture making (including copy-dentures), two mentioned medical issues and complications, and one PDS mentioned gerodontology, the physiology of ageing, the dementias of old age, chronic diseases, oral cancer, oral medicine, oral pathology, restorative dentistry and health promotion/people skills. In addition, one PDS recommended providing oral health education to public health nurses as they are in more frequent contact with older people in the community than the dental services.

Finally, it is notable with respect to human resources that every suggestion for the provision of additional services by the HSE-salaried public dental service produced a clamour of voices chorusing “more resources, more manpower.” Clearly any innovation within the public dental service can only be achieved if accompanied by the provision of ring-fenced staff and funding.

### **2.2.7. Changes to Dental Service Provision**

This final section of the interview results presents the culmination of over nine hours or 160 pages of individual interviews. It summarises the General Dental Practitioners’ and Principal Dental Surgeons’ views on two crucial issues: how the GDP and the HSE-salaried dental services can be encouraged to care for more older patients, and how dental policy can be changed to improve service provision for older people.

The GDPs were first asked what else they thought would be needed to encourage the provision of care for larger numbers of older people by GDPs. Firstly, in relation to the DTSS, seven GDPs suggesting increasing the DTSS fees across the board, two suggested introducing a domiciliary care fee, and a further two suggested restructuring the administration of the DTSS. One GDP also suggested training in the provision of dental care to older people for GDPs. To encourage dental attendance by older people, seven GDPs suggesting raising awareness of oral health and the medical card entitlements among older people via advertising campaigns. One GDP also suggested providing older people with oral hygiene instruction, and one also suggested automatically labelling dentures with the patient’s name. Finally, reintroduction of means-testing for very wealthy medical card holders was suggested by one GDP.

The PDSs were asked a very similar question regarding what else they thought would be needed to encourage the provision of care for larger numbers of older people by the HSE-salaried dentists in their service. Perhaps unsurprisingly, the most popular proposal was increased resources/staffing, with thirteen respondents suggesting this; of these, three specifically mentioned a need for more hygienists. To accommodate a staff increase, one participant suggested building more dental clinics, and another suggested a change in policy, allowing hygienists to be allocated to residential care units. In addition, five PDSs suggested a need for training in the provision of dental care to older people, two suggested the need for a senior clinical appointment, three suggested a need to improve the pay structure for HSE-staff and one PDS suggested the provision of more career opportunities to encourage experienced clinicians to remain in the public service. One PDS also noted the need for a mindset change among HSE staff from viewing older people as “evening sessions” to viewing them as an important client group. To encourage older people to attend HSE clinics and dentists, the introduction of flexible appointments times and an advertising campaign regarding both oral health and the DTSS entitlements were suggested. A needs assessment to facilitate the planning of dental services for older people was suggested, as the data currently available is apparently

inadequate for financial planning. Finally, two PDSs thought that without a fundamental re-focusing of the public dental service objectives, considerable service enlargement would not be permitted.

Finally, both groups of participants were asked: If you could introduce just one new policy to improve dental services for older people, what would it be? Ten of the GDPs suggested increasing the DTSS fees and the range of treatments available, including two who suggested the introduction of a domiciliary fee. Four GDPs advocated advertising to encourage dental attendance and increase oral health awareness, and two suggested targeted oral health promotion initiatives. Finally, two GDPs thought that healthcare professionals should be provided with oral healthcare training and one believed access to dental hospital services should be improved.

The PDSs' policy suggestions were more diverse than those of their GDP colleagues. Perhaps the most powerful suggestion was from a PDS who proposed appointing a Chief Dental Officer to produce a national oral health strategy and drive it forward. This incorporated the suggestion of another PDS to develop a strategy detailing the future role of the HSE-salaried dental service. On a slightly less grand scale, one PDS suggested introducing a policy whereby all older people should be able to access care via the HSE dental service. Regarding staffing, two PDSs suggested assigning a dental hygienist and/or oral health promoter to every nursing home and residential centre in the country; another proposed the introduction of Senior Dental Surgeons for Gerodontology, accompanied by auxiliary staff and ring-fenced funding. With regard to the DTSS, two PDSs proposed the introduction of a higher fee for the treatment of older people, making them financially more attractive to the DTSS practitioner in respect of the increased time required for their dental care. Two PDSs also suggested introducing a DTSS domiciliary fee, and another suggested increasing the HSE-salaried service's domiciliary care capacity. In addition, one PDS suggested introducing grants for DTSS-contractors to make their practices wheelchair accessible. At a more practical level, one PDS suggested developing a database of older people, thus permitting the dental services to target them. Another suggested that the HSE-salaried service and DTSS-contractors should work together to screen all older people's oral health every two to three years. Similar to the GDPs, three PDSs suggested advertising to encourage dental attendance and increase oral health awareness among older people, and one suggested an oral health promotion initiative focusing on denture care and hygiene. At a public health level, one GDP suggested introducing a health check-up - including oral health, for everyone at age 65, and another suggested introducing screening for oral cancer.

## 2.3. Discussion of Implications for Oral Health Policy for Older People

The main findings from the questionnaire and interview consultation with general dental practitioners (GDPs) and public service principal dental surgeons (PDSs) in relation to current practice and their views on challenges and opportunities in service provision for older patients are as follows:

- Service Provision

The primary providers of dental services to older people are private sector dentists: 85% of GDPs are listed on the DTSS register. The HSE-Salaried Public Dental Service serves as the 'fallback' provider – public service dentists are responsible for ensuring care to those older people who are entitled to DTSS services but cannot access care from GDPs. While services are thus 'available' for older people, the questionnaire results reveal that, on the one hand, GDPs as a whole have a low preference for treating older people, and that on the other hand, service provision to older people is not a priority for the HSE-salaried service; the interviews confirmed these broad trends. GDPs in general do not wish to increase the number of older people attending their practice, and PDSs are of the opinion that the present priority of the HSE-salaried service should not be shifted to provide more care for older people.

'Inadequate manpower' was cited by 83% of respondent PDSs as the single most important barrier to the provision of treatment, either through the Public Dental Service or the DTSS, to older people. Thirteen of eighteen PDSs suggested more resources/staffing as a means of increasing service provision to older people by the HSE.

The introduction of primary care teams and networks have not, as yet, resulted in any changes in the provision of care by the HSE-salaried service to older patients. The advent of a register of dental clinics and GDP surgeries accessible by wheelchair is favoured by most interviewees.

- Access to Care

Though they may not avail of their entitlements, everyone aged 70 and older has access to dental services via the DTSS. Access to oral health care for older people aged 65-69 depends on their financial means and entitlements to dental benefits. A third of the GDPs interviewed stated that they thought 65-69 year olds without a medical card were not prepared to pay for an adequate quality of care to ensure good oral health and function. All of these respondents cited financial reasons for this decision. More than two-thirds of the GDPs surveyed 'often' and 'sometimes' provide treatment to older people for which they receive no payment.

Ten GDPs interviewed had older patients arriving to their practice as a result of 'referrals from medical GPs'. Older adults visit GPs more frequently than GDPs, thus it was acknowledged by many GDPs that GPs would be a useful conduit through which awareness of oral health could be raised and need for oral checks could be communicated. However, the need to educate GPs themselves about the importance of oral health in the elderly was raised. These findings could also be extrapolated to other healthcare workers.

In addition, GDPs highlighted raising awareness of dental conditions among older people themselves and their carers as a means of encouraging more referrals.

Among PDSs, the most important actions for increasing uptake by older people are to 'encourage uptake via Public Health Nurses' (50%), 'develop domiciliary services' (40%) and, jointly in fourth place, 'provide incentives for DTSS providers to relocate to rural areas' (33%) and 'run oral health awareness campaigns'(33%).

- Domiciliary Care

Payment considerations aside, older peoples' access to care is also dependent upon their ability to avail of services in a clinic-based setting or whether their only treatment option is domiciliary care.

Domiciliary care to older people on a regular basis is rare among GDPs and is provided by less than half of the HSE service areas, mainly to residential care units. On an emergency basis, domiciliary care is provided by almost all HSE service areas (97% in residential care units, 94% in patients own homes, 68% in day care centres) but by less than 40% of GDPs (36% in residential care units, 30% in patients' own homes, 19% in day care centres). Overall, the majority of domiciliary care is reactionary, providing for emergency-based care as distinct from preventative care or oral health promotion.

'DTSS financial support/incentives for domiciliary care' was listed as being within their top three most important recommendations for improving health services to older people by 27% of respondent GDPs and 32% of respondent PDSs.

All eighteen Principal Dental Surgeons interviewed stated that that they would be willing to increase the amount of domiciliary care they provide if, and only if, they had the resources, and in particular the manpower, to do so. Fifteen PDSs would at least consider using a mobile dental clinic to deliver this care. All of the PDSs, in principal, were willing to release dental hygienists and oral health promoters to work with older people and carers in the community and residential care units. Both groups of interviewees also made policy suggestions in relation to domiciliary care, specifically regarding the introduction of a fee to compensate DTSS-contracted GDPs for performing this treatment.

- Role of the HSE-Salaried Service

The roles perceived by PDSs for the HSE-Salaried Service with regards older people relate to the provision of care for medical card holders unable to access the services of GDPs via the DTSS, care for those with special needs, care for those in institutions, screening for oral health problems, provision of domiciliary services and oral health promotion.

The majority of PDS interviewees favour the evidence-based introduction of a screening program for oral cancer and almost all interviewees, both GDP and PDS, would be prepared to support and participate in an annual oral cancer awareness week.

- The DTSS

The majority of older people have DTSS entitlements. Thus, when discussing the barriers to providing care, it is not surprising that the inadequacies of the DTSS rank as the most important for GDPs. 'DTSS fee levels

are not adequate' and 'DTSS range of services is not adequate' were among the top three most important barriers to providing care to older people for 73% and 58% respectively of respondent GDPs. That 50% of GDPs surveyed 'often' and 'sometimes' provide additional treatment to their older DTSS patients which must be paid for privately also indicates that DTSS coverage may be inadequate to the needs of older people.

Private sector GDPs must necessarily operate their practices along economic principles: The GDPs interviewed reiterated their dissatisfaction with the remuneration and range of treatments provided within the DTSS. In particular, dentists highlighted the issue of laboratory fees for full dentures: DTSS fees are not commensurate with the lab fees and other expenses incurred by dentists in the production of high quality dentures. Many practitioners felt that the quality of the work available within the DTSS fee constraints is not acceptable. Confirming this, one of the PDS interviewees reported encountering the same issue when attempting to provide dentures via the DTSS for medical hospital patients.

A resounding majority of interviewees thought that the DTSS policy which does not allow the refilling of teeth within five years presents a problem in providing adequate dental care to older people. An image of older people with a fragile dentition containing many large restorations and high rates of dental decay due to the prevalence of a high sugar diet, dry mouth and poor standards of personal oral hygiene emerged from the GDPs' descriptions of their patients. In this context, DTSS policy patently prevents the delivery of necessary care.

One useful suggestion was that labelling of dentures (within the acrylic) with the identity of the owner should be made routine within the DTSS.

When the GDP interviewees were asked what else they thought would be needed to encourage the provision of care for larger numbers of older people by GDPs, suggestions relating to the DTSS included increasing the DTSS fees across the board, introducing a domiciliary care fee, and restructuring the administration of the DTSS.

Both groups of interview participants were asked: If you could introduce just one new policy to improve dental services for older people, what would it be? Ten of the GDPs suggested increasing the DTSS fees and the range of treatments available, including two who suggested the introduction of a domiciliary fee. Two PDSs proposed the introduction of a higher DTSS fee for the treatment of older people, in respect of the increased time required for their dental care, to make them financially more attractive to the DTSS practitioner. Two PDSs also suggested introducing a DTSS domiciliary fee, and one PDS suggested introducing grants for DTSS-contractors to make practices wheelchair accessible.

- Uptake of services

With regards uptake of services by older people, GDPs report no difference in attendance for regular check-ups between private patients and DTSS patients. However, GDPs report a marked difference in attendance for regular dental check-ups between dentate and edentulous (toothless) patients. Linked to this, while 82% of GDPs will issue reminder letters to their older dentate patients, only 51% do so for their older edentulous patients, despite the fact that 80% of GDPs feel that their edentate patients should be encouraged to attend

for check-up at least every 2 years. Almost one fifth of GDPs reported that 'None' of their toothless patients came in for regular check-ups.

'Advertise availability of DTSS services for medical card holders' is recommended as a priority action by a majority of both GDPs (54%) and PDS (68%).

All of the GDPs and most PDSs interviewed were in favour of regularly recalling older patients for a check-up; one third of GDP interviewees commented that they already recall their edentulous patients, usually on an annual basis, in keeping with what is permitted by the DTSS fee schedule. However, both GDPs and PDSs highlighted the issue of dental non-attendance by edentulous patients. When suggesting means of increasing service uptake, seven GDPs suggesting raising awareness of oral health and the medical card entitlements among older people via advertising campaigns. Four GDPs and three PDSs carried this forward as a potential new oral health policy.

- Oral health promotion

GDPs regarded running oral health awareness campaigns and encouraging uptake via family doctors/GPs and via mass media as important actions the HSE should undertake.

Verbal instruction is the main method used by most GDPs in promoting good oral health care to their older patients. Given that supplementation of verbal information with written leaflets with a prompt to read the leaflet, results in a greater increase in knowledge than verbal information alone, provision of dentists with well designed denture care instruction leaflets to give to their patients would be a worthwhile exercise.

Suggestions to counteract older peoples' lack of awareness of oral health included providing leaflets or other forms of information in GPs' surgeries, a poster campaign, and having other healthcare professionals tell older people about this service when they see them.

Among the many suggestions for oral health education to empower older people were pamphlets, videos and one to one communication.

- Training in the oral health care of older people

As the primary provider of dental care to older people with special needs, fifteen PDSs believe their services should introduce a specialist post, such as a Senior Dental Surgeon for Gerodontology, to address the demands placed on the service by these patients' complex needs.

'Medical complications of older people' was cited among the three most important barriers to care for older people by 50% of respondent GDPs. The majority of GDPs interviewed would welcome further training in the management of older people. The Dental Schools were perceived to be the appropriate agencies for the delivery of such training, however cost was seen to be a barrier. (Perhaps the HSE could sponsor such training for those providing DTSS services to older adults, it could be seen as a perk).



GDPs and HSE-salaried dentists alike would welcome training in the care of older dental patients. In particular, the issues of polypharmacy, medical conditions and complications, and denture manufacture. In addition, it was felt that, in general, auxiliary staff would also welcome training at an appropriate level. This also carried through to the suggestions for policy changes.

## **Appendix:**

Private Dental Practitioner Questionnaire

Principal Dental Surgeon Questionnaire

Interview Schedule for Principal Dental Surgeons

Interview Schedules for General Dental Practitioners & Principal Dental Surgeons

# Evidence-Based Oral Health Policy for Older People

## Private Dental Practitioner Questionnaire

### INSTRUCTIONS

- This questionnaire is about your **current practice** and **views on challenges and opportunities in dental service provision for people aged 65+**.
- To answer the questions, please put an X-mark ☐ , tick-mark ☒ , or rank number  in **the box by your chosen response**. For open-ended questions, please give as full an answer as possible. **Please answer each question.**
- Please give the response that **best describes your opinion/experience**. We are interested in the reality of the current organisation and delivery of dental services to older people, not best practice guidelines or ideal situations.
- Your responses will be confidential. The data will be used for statistical purposes only, and no individual participants will be identified.
- Completed questionnaires should be returned at your earliest convenience, preferably before 12<sup>th</sup> March 2007, to **Dr. Helen Whelton, Oral Health Services Research Centre, Cork University Dental School, Wilton, Cork.**

**Your Dental Practice:**

1. Please **rank** the following age groups in terms of your overall preference to treat.  
A score of 1 indicates your most favourite and 7 your least favourite.

**Rank 1-7**

- |       |   |                      |
|-------|---|----------------------|
| 0-4   | 1 | <input type="text"/> |
| 5-12  | 2 | <input type="text"/> |
| 13-18 | 3 | <input type="text"/> |
| 19-25 | 4 | <input type="text"/> |
| 26-40 | 5 | <input type="text"/> |
| 41-65 | 6 | <input type="text"/> |
| 65+   | 7 | <input type="text"/> |

2. On average, what proportion of your patients are **older people aged 65+**?  
Please give your best estimate.

- |                                  |   |                      |
|----------------------------------|---|----------------------|
| Less than 1 in every 20 patients | 1 | <input type="text"/> |
| 1 or 2 in every 20 patients      | 2 | <input type="text"/> |
| More than 2 in every 20 patients | 3 | <input type="text"/> |

3. Would you like to increase the number of older patients (65+) attending your practice?

- |     |   |                      |
|-----|---|----------------------|
| Yes | 1 | <input type="text"/> |
| No  | 2 | <input type="text"/> |

4. Are the majority of your patients (**all ages**):

- |   |   |                      |
|---|---|----------------------|
| Private patients?                             | 1 | <input type="text"/> |
| DTSS patients?                                | 2 | <input type="text"/> |
| Half private patients and half DTSS patients? | 3 | <input type="text"/> |

5. Are you on the DTSS register of dentists?

- |     |   |                      |
|-----|---|----------------------|
| Yes | 1 | <input type="text"/> |
| No  | 2 | <input type="text"/> |

6. In your experience, are your older patients **aged 70 and older** aware that they are entitled, irrespective of income, to a medical card and hence DTSS treatment?

- |      |   |                      |
|------|---|----------------------|
| Most | 1 | <input type="text"/> |
| Some | 2 | <input type="text"/> |
| Few  | 3 | <input type="text"/> |
| None | 4 | <input type="text"/> |

7. Do you provide additional treatment not covered by the DTSS to your older **DTSS patients** (65+) which are paid for privately?

Often 1 ☐  
Sometimes 2 ☐  
Rarely 3 ☐  
Never 4 ☐

8. Do you ever provide pro-bono treatment to older patients (65+)?

Often 1 ☐  
Sometimes 2 ☐  
Rarely 3 ☐  
Never 4 ☐

**Oral Health Promotion Practices:**

9. What is your **main** method for promoting good oral health care to your **dentate** older patients (65+)?

**Tick one**

Verbal instruction 1 ☐  
Demonstration 2 ☐  
Written instruction/leaflets 3 ☐  
Referral to hygienist 4 ☐  
Discussion with patient on their current practices 5 ☐

10. What is your **main** method for promoting good oral health and denture care practices to your **edentate** older patients (65+)?

**Tick one**

Verbal instruction when denture is fitted 1 ☐  
Demonstration 2 ☐  
Written instruction/leaflets 3 ☐  
Discussion with patient on their current practices 4 ☐

11. Do you normally issue recall or reminder letters to your older patients (65+)?

**Dentate patients:** Yes 1 ☐  
No 2 ☐  
**Edentate patients:** Yes 1 ☐  
No 2 ☐

12. Do your **private** patients aged 65+ come in for regular (every 2 years or more often) dental check-ups?

**Dentate patients:** Most 1 ☐  
Some 2 ☐  
Few 3 ☐  
None 4 ☐  
**Edentate Patients:** Most 1 ☐  
Some 2 ☐  
Few 3 ☐  
None 4 ☐

13. Do your **DTSS** patients aged 65+ come in for regular (every 2 years or more often) dental check-ups?

**Dentate patients:** Most 1 ☐

Some 2 ☐

Few 3 ☐

None 4 ☐

**Edentate Patients:** Most 1 ☐

Some 2 ☐

Few 3 ☐

None 4 ☐

14. In your opinion, how often should edentate patients be encouraged to attend for a check-up?

Every year 1 ☐

Every 2 years 2 ☐

Every 3 years 3 ☐

Every 4 years 4 ☐

Every 5 years 5 ☐

Other: \_\_\_\_\_ 6 ☐

15. How do the majority of your new patients aged 65+ present at your practice?

**Tick one**

Referrals from medical GPs 1 ☐

Referrals from private dental colleagues 2 ☐

Contracts with the HSE 3 ☐

Phone book/ business listing 4 ☐

DTSS listing 5 ☐

Word-of-mouth 6 ☐

Patients just walk in 7 ☐

**Domiciliary Care:**

16. Do you engage in the *domiciliary treatment* of older people (65+) **in residential care** (extended care unit, welfare home, hospital, nursing home) on

a routine basis? Yes 1 ☐

No 2 ☐

an emergency basis? Yes 1 ☐

No 2 ☐

17. Do you engage in the *domiciliary treatment* of older people (65+) **in day care centres** on

a routine basis? Yes 1 ☐

No 2 ☐

an emergency basis? Yes 1 ☐

No 2 ☐

18. Do you engage in the *domiciliary treatment* of older people (65+) **in their own homes** on

a routine basis? Yes 1 ☐

No 2 ☐

an emergency basis? Yes 1 ☐

No 2 ☐

**Your Perceptions relating to Service Provision for Older People:**

19. What are the main barriers you encounter in the provision of treatment to older people (65+)? (*Tick all that apply*)

No barriers 19a ☐ **1**

Inadequate training in the care of older people 19b ☐ **2**

Time-consuming/difficult to treat older people 19c ☐ **3**

Treatment outcomes not as successful as in younger age groups 19d ☐ **4**

Personal dislike for treating older people 19e ☐ **5**

Older people are more demanding 19f ☐ **6**

Older people have a fear of dental treatment 19g ☐ **7**

Medical complications of older people 19h ☐ **8**

Older people don't come in for check-ups/treatment 19i ☐ **9**

Older people not aware that their medical card entitles them to dental care 19j ☐ **10**

DTSS fee levels are not adequate 19k ☐ **11**

DTSS range of services is not adequate 19l ☐ **12**

Surgery not set-up for patients with disabilities (e.g., not wheelchair accessible) 19m ☐ **13**

No staff to help or staff not trained in lifting older people who use wheelchairs onto dental chair 19n ☐ **14**

Other (please specify): 19o ☐ **15**

19a. Please rank your answers to the question above in order of importance by writing their identifying number in the boxes below.

Most important 1 ☐

Second most important 2 ☐

Third most important 3 ☐

20. What would you suggest to improve oral health services to older people (65+)?  
(Tick all that apply)

- Oral health services for older people do not need to be improved 20a ☐ 1
- Expand HSE-Salaried Public Dental Service to cater for older people 20b ☐ 2
- Increase number of DTSS-registered dentists 20c ☐ 3
- DTSS financial support/incentives for domiciliary care 20d ☐ 4
- Improve the range of services covered by DTSS 20e ☐ 5
- Improve DTSS fee levels 20f ☐ 6
- Improve undergraduate training on the oral health care of older people 20g ☐ 7
- Create a course specialisation on the oral health care of older people 20h ☐ 8
- Provide training to carers on the oral health care of older people 20i ☐ 9
- Advertise need for regular dental visits (including edentulous elderly) 20j ☐ 10
- Make DTSS information readily available (e.g., in doctors' surgeries) 20k ☐ 11
- Increase oral health care awareness among health care workers 20l ☐ 12
- Include basic oral health questions to determine if a dental referral is required as part of routine medical check-up by GPs / Public Health Nurses 20m ☐ 13
- Dental visits to day care centres 20n ☐ 14
- Other (please specify): 20o ☐ 15

20a. Please rank your answers to the question above in order of importance by writing their identifying number in the boxes below.

Most important 1 ☐

Second most important 2 ☐

Third most important 3 ☐

21. In your opinion, what actions should the HSE undertake to increase the uptake of dental services by older people (65+)? (Tick all that apply)

- No action 21a ☐ 1
- Advertise availability of DTSS services for medical card holders 21b ☐ 2
- Provide incentives for DTSS providers to relocate to rural areas 21c ☐ 3
- Provide transport to assist access by older people aged 65+ 21d ☐ 4
- Run oral health awareness campaigns 21e ☐ 5
- Encourage uptake via Public Health Nurses 21f ☐ 6
- Encourage uptake via Day Care Centres 21g ☐ 7
- Encourage uptake via Family Doctors/GPs 21h ☐ 8
- Encourage uptake via mass media (tv/radio/newspapers) 21i ☐ 9
- Develop domiciliary services 21j ☐ 10
- Other (please specify): 21k ☐ 11



21a. Please rank your answers to the question above in order of importance by writing their identifying number in the boxes below.

Most important 1 ☐

Second most important 2 ☐

Third most important 3 ☐

**Personal Details:**

22. Name: \_\_\_\_\_  
Gender: \_\_\_\_\_  
Age: \_\_\_\_\_  
Number of years in private dental practice in Ireland: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Telephone number: \_\_\_\_\_

23. Would you be willing to participate in a follow-up telephone interview?

Yes 1 ☐

No 2 ☐

***Thank you for your co-operation in completing this questionnaire.***

**Please return to:  
Dr. Helen Whelton  
Oral Health Services Research Centre  
Cork University Dental School  
Wilton  
Cork**

# Evidence-Based Oral Health Policy for Older People

## Principal Dental Surgeon Questionnaire

### INSTRUCTIONS

- This questionnaire is about your **current practice** and **views on challenges and opportunities in dental service provision for people aged 65+**.
- To answer the questions, please put an X-mark ☐ , tick-mark ☒ , or number  **1** in the **box by your chosen response**. For open-ended questions, please give as full an answer as possible. **Please answer each question.**
- Please give the response that **best describes your opinion/experience**. We are interested in the reality of the current organisation and delivery of dental services to older people, not best practice guidelines or ideal situations.
- Your responses will be confidential. The data will be used for statistical purposes only, and no individual participants will be identified.
- Completed questionnaires should be returned, preferably before the 12<sup>th</sup> of March, to **Dr. Helen Whelton, Oral Health Services Research Centre, Cork University Dental School, Wilton, Cork.**

**Your HSE Dental Service:**

1. Does the treatment of older people (65+) form part of your annual service plan for HSE-salaried dentists?

Yes <sup>1</sup> ☐

No <sup>2</sup> ☐

*If yes, please describe briefly what treatments are provided:*

2. Do you or any of the HSE-salaried dentists in your service engage in the **clinic-based treatment** of older people (65+) on

a routine basis? Yes <sup>1</sup> ☐

No <sup>2</sup> ☐

an emergency basis? Yes <sup>1</sup> ☐

No <sup>2</sup> ☐

3. Do you or any of the HSE-salaried dentists in your service engage in the **domiciliary treatment** of older people (65+) **in residential care** (extended care unit, welfare home, hospital, nursing home) on

a routine basis? Yes <sup>1</sup> ☐

No <sup>2</sup> ☐

an emergency basis? Yes <sup>1</sup> ☐

No <sup>2</sup> ☐

4. Do you or any of the HSE-salaried dentists in your service engage in the **domiciliary treatment** of older people (65+) **in day care centres** on

a routine basis? Yes <sup>1</sup> ☐

No <sup>2</sup> ☐

an emergency basis? Yes <sup>1</sup> ☐

No <sup>2</sup> ☐

5. Do you or any of the HSE-salaried dentists in your service engage in the **domiciliary treatment** of older people (65+) **in their own homes** on

a routine basis? Yes <sup>1</sup> ☐

No <sup>2</sup> ☐

an emergency basis? Yes <sup>1</sup> ☐

No <sup>2</sup> ☐

6. Does your HSE-salaried service provide any other oral health support to residential/day care centres?

Yes 1 ☐

No 2 ☐

*If yes, please tick all that apply:*

Training/education in oral health care for carers 6a ☐

Training/education in oral health care for residents/day care users 6b ☐

Information leaflets on dental service entitlements of older people 6c ☐

Guidelines/ information (e.g. denture care, good oral health practices) 6d ☐

Oral health assessment on entry of new residents/day care users 6e ☐

Oral health screening on a regular basis 6f ☐

Other (please specify): 6g ☐

7. Does your HSE-salaried service provide screening facilities to older people (65+) for oral health problems (such as oral cancer or pre-malignant lesions) ?

Yes 1 ☐

No 2 ☐

*If yes, where?*

In clinic 7a ☐

In primary care centres 7b ☐

In residential care units 7c ☐

In day care units 7d ☐

In patients' own homes 7e ☐

In mobile units 7f ☐

**Your Perceptions relating to Service Provision for Older People:**

8. Do you perceive a role for the HSE-Salaried Public Dental Service in the provision of dental care to older people (65+)?

Yes 1 ☐

No 2 ☐

*If yes, please describe briefly:*

9. In your opinion, what are the main barriers to the provision of treatment, either through the Public Dental Service or the DTSS, to older people (65+)? (*Tick all that apply*)

- |   |    |                          |           |
|---|----|--------------------------|-----------|
| No barriers   | 9a | <input type="checkbox"/> | <b>1</b>  |
| Inadequate manpower   | 9b | <input type="checkbox"/> | <b>2</b>  |
| Inadequate training of clinicians in the care of older people                                       | 9c | <input type="checkbox"/> | <b>3</b>  |
| Time-consuming/difficult to treat older people  | 9d | <input type="checkbox"/> | <b>4</b>  |
| Treatment outcomes not as successful as in younger age groups                                       | 9e | <input type="checkbox"/> | <b>5</b>  |
| Negative attitudes towards treating older people on part of clinicians                              | 9f | <input type="checkbox"/> | <b>6</b>  |
| Older people are more demanding   | 9g | <input type="checkbox"/> | <b>7</b>  |
| Older people have a fear of dental treatment  | 9h | <input type="checkbox"/> | <b>8</b>  |
| Medical complications of older people   | 9i | <input type="checkbox"/> | <b>9</b>  |
| Older people don't come in for check-ups/treatment  | 9j | <input type="checkbox"/> | <b>10</b> |
| Older people not aware that their medical card entitles them to dental care                         | 9k | <input type="checkbox"/> | <b>11</b> |
| DTSS fee levels are not adequate  | 9l | <input type="checkbox"/> | <b>12</b> |
| DTSS range of services is not adequate  | 9m | <input type="checkbox"/> | <b>13</b> |
| Clinics not set-up for patients with disabilities (e.g., not wheelchair accessible)                 | 9n | <input type="checkbox"/> | <b>14</b> |
| Lack of specialist equipment (e.g., domiciliary kits, mobile dental units)                          | 9o | <input type="checkbox"/> | <b>15</b> |
| No staff to help or staff not trained in lifting older people who use wheelchairs onto dental chair | 9p | <input type="checkbox"/> | <b>16</b> |
| Access problems to day care centres/ residential centres  | 9q | <input type="checkbox"/> | <b>17</b> |
| Other (please specify):   | 9r | <input type="checkbox"/> | <b>18</b> |

- 9a. Please rank your answers to the question above in order of importance by writing their identifying number in the boxes below.

- |                       |   |                          |
|-----------------------|---|--------------------------|
| Most important        | 1 | <input type="checkbox"/> |
| Second most important | 2 | <input type="checkbox"/> |
| Third most important  | 3 | <input type="checkbox"/> |

10. In your opinion, should the present priority of the HSE-Salaried Public Dental Service be shifted towards providing more care for older people (65+)?

- |     |   |                          |
|-----|---|--------------------------|
| Yes | 1 | <input type="checkbox"/> |
| No  | 2 | <input type="checkbox"/> |

11. What would you suggest to improve oral health services to older people (65+)?

(Tick all that apply)

- Oral health services for older people do not need to be improved 11a ☐ 1
- Expand HSE-Salaried Public Dental Service to cater for older people 11b ☐ 2
- Increase number of DTSS-registered dentists 11c ☐ 3
- DTSS financial support/incentives for domiciliary care 11d ☐ 4
- Improve the range of services covered by DTSS 11e ☐ 5
- Improve DTSS fee levels 11f ☐ 6
- Improve undergraduate training on the oral health care of older people 11g ☐ 7
- Create a course specialisation on the dental treatment of older people 11h ☐ 8
- Provide training to carers on the oral health care of older people 11i ☐ 9
- Advertise need for regular dental visits (including edentulous elderly) 11j ☐ 10
- Make DTSS information readily available (e.g., in doctors' surgeries) 11k ☐ 11
- Increase oral health care awareness among health care workers 11l ☐ 12
- Include basic oral health questions to determine if a dental referral is required as part of routine medical check-up by GPs / Public Health Nurses 11m ☐ 13
- Dental visits to day care centres 11n ☐ 14
- Other (please specify): 11o ☐ 15

11a. Please rank your answers to the question above in order of importance by writing their identifying number in the boxes below.

Most important 1 ☐

Second most important 2 ☐

Third most important 3 ☐

12. In your opinion, what actions should the HSE undertake to increase the uptake of dental services by older people (65+)? (Tick all that apply)

- No action 12a ☐ 1
- Advertise availability of DTSS services for medical card holders 12b ☐ 2
- Provide incentives for DTSS providers to relocate to rural areas 12c ☐ 3
- Provide transport to assist access by older people aged 65+ 12d ☐ 4
- Run oral health awareness campaigns 12e ☐ 5
- Encourage uptake via Public Health Nurses 12f ☐ 6
- Encourage uptake via Day Care Centres 12g ☐ 7
- Encourage uptake via Family Doctors/GPs 12h ☐ 8
- Encourage uptake via mass media (tv/radio/newspapers) 12i ☐ 9
- Develop domiciliary services 12j ☐ 10
- Other (please specify): 12k ☐ 11

12a. Please rank your answers to the question above in order of importance by writing their identifying number in the boxes below.

Most important 1 ☐

Second most important 2 ☐

Third most important 3 ☐

**Personal Details:**

13. Name: \_\_\_\_\_  
Gender: \_\_\_\_\_  
Age: \_\_\_\_\_  
Number of years in public dental service in Ireland: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Telephone number: \_\_\_\_\_

14. Would you be willing to participate in a follow-up telephone interview?

Yes 1 ☐

No 2 ☐

***Thank you for your co-operation in completing this questionnaire.***

**Please return to:**  
**Dr. Helen Whelton**  
**Oral Health Services Research Centre**  
**Cork University Dental School**  
**Wilton**  
**Cork**

## Interview Schedules for General Dental Practitioners & Principal Dental Surgeons

### Introduction & Consent to Audio Recording

#### *On initial contact:*

- Hello, I'm Tara Crowley.
  - I'm calling from the Oral Health Services Research Centre at UCC.
  - Dr. X agreed to participate in a telephone interview; it will take between ten and fifteen minutes.
  - Is he / she available to talk now or will I call back later?

#### *Following connection or call-back:*

- Hello Dr. X,
  - I'm Tara Crowley, a researcher working with the Oral Health Services Research Centre at UCC.
- Thank you for returning the questionnaire regarding older people's oral health a few weeks ago; your answers were very helpful.
  - On the questionnaire, you indicated that you were willing to participate in a follow up telephone interview; are you still willing to participate?

#### *If 'No:'*

- Thank you very much for your time Dr. X, and thanks again for your participation in the questionnaire phase of the study.

#### *If 'Yes':*

- The interview will last between ten and fifteen minutes.
  - Is now a good time to conduct the interview, or would you prefer me to call back later?

#### *Immediately or following call-back:*

- The first question I have to ask you Dr. X is:
  - Do you consent to your voice being recorded during the interview?

#### *If 'No:'*

- Would you consent to me taking written notes during the interview instead?
  - This will probably increase the duration of the interview slightly.

#### *If 'No:'*

- Thank you very much for your time Dr. X, and thanks again for your participation in the questionnaire phase of the study anyway.



*If 'Yes':*

- Thank you; I now need to turn on the recorder and get an audio record of your consent ...
  - Dr. X, do you consent to your voice being recorded during the interview?
- Before we begin the interview proper, I'm going to briefly outline the interview procedures to you:
- The interview will consist of a fixed set of questions for all General Dental Practitioners/Principal Dental Surgeons.
  - As with the questionnaire, we're interested in your opinions and experiences of the reality of the current organisation and delivery of dental services to older people, not best practice guidelines or ideal situations.
  - We would appreciate it if you could give as comprehensive an answer as possible to each question; however, if for some reason you do not wish to answer a particular question, that's not a problem.
- Your answers will be anonymous.
  - The responses we receive will only be reported at the level of General Dental Practitioners/Principal Dental Surgeons as a group.
  - No individual respondents will be identified.
- You are also free to withdraw, without penalty, from the study at any time, either during the interview or by contacting us at a later date.
  - If you would like to make a note of our phone number here, it's: 021 4901210.
- Do you have any questions yourself before we begin the interview proper?

*If 'Yes', answer question(s) in so far as is possible.*

*If 'No', proceed to appropriate interview schedule.*

## Interview Schedule for General Dental Practitioners

- The first set of questions relates to the economics of providing dental care to older people, those aged 65 and over.
  - As you know, universal eligibility for the medical card begins at 70 years of age; however, most older people retire at age 65.
    - Do you think that in general 65-69 year olds without a medical card are prepared to pay for an adequate quality of care to ensure good oral health and function?
  - As you also know, the medical card covers some, but not all, possible treatments.
    - Do you think that their medical card entitlements provide an adequate quality of care to ensure good oral health and function for older people?
- If 'No:'*
  - Do you find that older medical card holders are prepared to pay for any extra care required?
- Does the DTSS policy, which does not allow the refilling of teeth within five years, present a problem in providing adequate dental care to older people?
- Do you think there needs to be an independent assessment of the actual cost of the provision of dentures by GDPs?
  - On average, how much chair time is involved in providing a new full upper and lower denture, including easing?
  - Are you able to obtain satisfactory denture manufacturing services for the level of denture laboratory fees included in the DTSS full denture fee?
- The next set of questions relates to the provision of dental screening services to older people.
  - Do you think the DTSS should encourage annual recall of edentulous older people for a denture-fit check-up and screening of their oral mucosal health, for example, for oral cancer?
  - Would you be prepared to participate in an annual oral cancer awareness week?
    - Have you any ideas about how this might be implemented?
- The following set of questions relates to training in the provision of dental care for older people.
  - Would you yourself welcome training from the HSE in the provision of dental care to older people, including awareness of medical conditions and complications?
  - Do you think your staff would welcome training in the care of older people?

- The next set of questions relates to the uptake of dental services by older people.
  - Do you currently receive referrals of older people from other healthcare workers, such as medical doctors and nurses, public health nurses, care assistants and home helps?
    - How do you think we could encourage more referrals?
  - Do you see a need for greater availability of oral health promotion literature for older people?
  - Do you think that we need a register of dental surgeries that are accessible to people with poor mobility, such as those in wheelchairs?
    - Is your surgery wheelchair accessible?
- And finally ...
  - What else do you think would be needed to encourage the provision of care for larger numbers of older people by GPs?
  - If you could introduce just one new policy to improve dental services for older people, what would it be?
  - Thank you very much for your time once again Dr. ...; Goodbye!

## Interview Schedule for Principal Dental Surgeons

- The first set of questions relates to the provision of dental screening services to older people, those aged 65 and over.
  - Do you see a role for other healthcare workers, such as medical doctors and nurses, public health nurses, care assistants and home helps, in referring older people to HSE-salaried dentists?
  - Would you see merit in regularly screening older people for oral cancer?
    - How often?
  - Do you think the DTSS should support annual recall of edentulous older people for a denture-fit check-up and screening of their oral mucosal health, for example, for oral cancer?
  - Would you be prepared to participate in an annual oral cancer awareness week?
    - Have you any ideas about how this might be implemented?
- The next set of questions relates to the accessibility of the HSE dental service to older people.
  - Would you be willing to increase the amount of domiciliary care your dental service provides to older people?
    - What would facilitate/prevent this?
  - Would you be prepared to deploy HSE-salaried hygienists to older people living in the community and/or to residential care units, such as extended care units, welfare homes, hospitals and nursing homes, on a daily or weekly basis?
  - If you were given additional staffing and resources specifically for the care of older people, would you consider using a mobile clinic to provide dental care on their doorsteps?
  - Has the development of the primary care network impacted upon the provision of dental services for your older patients?
  - Do you think that we need a register of dental clinics that are accessible to people with poor mobility, such as those in wheelchairs?

- The next set of questions relates to the staffing of dental services for older people.
  - Do you think there is a need for dedicated posts for specialists in the care of older people, for example, a Senior Dental Surgeon for Gerodontology?
  - Would you be willing to participate in the delivery of regular training programs for older people's carers on denture care and dental hygiene?
    - What would facilitate/prevent this?
  - Do you think your staff would welcome training in the provision of dental care to older people, including awareness of medical conditions and complications?
- And finally ...
  - What else do you think would be needed to encourage the provision of care for larger numbers of older people by the HSE-salaried dentists in your service?
  - If you could introduce just one new policy to improve dental services for older people, what would it be?
  - Thank you very much for your time once again Dr. ...; Goodbye!