

INTERIM REPORT 4

Evidence-Based Oral Health Policy for Older People

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Report on Interviews with Oral Health Policy Makers

A project jointly sponsored by:

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1. 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 oral health care planners and providers on current practice in service provision for older patients, and their views on the challenges and opportunities the future presents. To address this objective, four key individuals involved in oral health policy development and implementation participated in a series of semi-structured interviews. This interim report describes this process and its results.

2. Methodology

2.1. Sampling Strategy

The key organisations involved in oral health policy development and implementation in Ireland are:

- the Department of Health and Children (DoHC),
- the Health Services Executive (HSE) Dental Service, and
- special interest groups, such as the Dental Health Foundation, the Dental Council, the Irish Dental Association, the Irish College of General Practitioners, and the Postgraduate Medical & Dental Board.

Five representatives from these organisations were selected by the Principal Investigator and invited to participate in a semi-structured telephone interview.

2.2. Interview Schedule Design

The interview schedule was intended to focus on current practices in the organisation and delivery of oral healthcare services to older people, and the challenges and opportunities facing the services delivering dental care to this group in the future. Specifically, the interview schedule was designed to assess the feasibility of various policy options for available, accessible and acceptable oral health services for older people that had arisen from the previous phases of the study. Thus it was informed by a consideration of the questionnaire and interview results from the General Dental Practitioners and Principal Dental Surgeons, the results of the focus groups and individual interviews with older people, the issues raised by the literature review, and the clinical data regarding older Irish people's oral health.

To address the differing perspectives of each of the interviewees on these policy options, it was decided to design an individually-tailored semi-structured interview schedule for each participant. The intention was to focus on each interviewee's individual areas of expertise and specialist knowledge, whilst also providing scope within the semi-structured format for them to comment upon other aspects of the findings. The interview schedules are presented in Appendix A.

To allow the interviewees to familiarise themselves with the study and the research findings to date, a research summary was also prepared and sent to each participant prior to their interview. This may be found in Appendix B.

2.3. Interview Procedure

Interview appointments with all of these individuals were scheduled at a mutually convenient time, as established by telephone calls and email. Their prospective interview schedule was available to each interviewee prior to the interview, though not all interviewees elected to view it.

All of the interviews were conducted by a single interviewer 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 interviewees 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.

3. Results

3.1. Response Rate

Two of the five individuals initially contacted by the Principal Investigator agreed to participate themselves and three nominated colleagues to participate; one of the nominees was already a participant. Thus, a Dept. of Health & Children (DoHC) representative, a Health Services Executive (HSE) Dental Service representative, a representative from a dental special interest group, and a representative from a medical special interest group were interviewed.

3.2. Content Analysis of Interview Transcripts

All four interviewees consented to the use of a loudspeaker telephone and digital voice recorder to record their interview. Each interview was transcribed in full (see Appendix C).

The interpretative framework for the data was based upon the topics of the sections in the interview schedules. As a basis for content analysis, a coding scheme was developed whereby each section in the schedule was given a code number. The content of the transcripts was then categorised according to these sections, with the relevant responses being systematically allocated one or more code numbers corresponding to one or more of the specific topics 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 sections 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 topic were analysed, and the responses for topics common to more than one of the interview schedules compared. The presentation of the results below is thematic, while still broadly reflecting the sequence of the questions in the interview schedules.

3.3. Need for an Oral Health Policy for Older People

The first topic interviewees considered was the basic concept of an oral health policy for older people. In particular, participants were asked about their organisation's view regarding the need for such a policy, any current plans to develop such a policy, and the priority given to the oral health of older people by their organisation. The representative from the medical special interest group was not asked about this topic as that organisation does not currently undertake activities related to oral health.

The DoHC and dental special interest group representatives both announced their organisations' intention to develop new oral health strategies in the near future, and a clear recognition of the need to specifically consider the oral health of older people during this process. Both interviewees noted that the DoHC intends to develop a new, comprehensive national oral health policy over the course of the next year (August 2007-8), and to include in it a discussion of, and hopefully recommendations relating to, older people's oral health. Similarly, the dental special interest organisation has itself prioritised the needs of older people, and views the inclusion of older people's oral health in the DoHC's national policy as an important means of achieving better oral health services for them.

The HSE representative was interviewed prior to the public DoHC announcement, but noted that the HSE's activities are dictated by DoHC policy, and thus a change in DoHC oral health policy in relation to older people would result in a corresponding change in HSE dental service activity. The HSE recently established an Expert Advisory Group (EAG) on the organisation, development and integration of health and social care services in Ireland. It was suggested that an effective means of ensuring that older people's oral health is a priority in the DoHC's new oral health policy would be to succeed in placing the issue on the EAG's agenda. It is envisaged that EAG recommendations will carry considerable weight within both the DoHC and HSE.

The interviewees made specific observations in relation dental professionals' failure to communicate effectively with the general public, other healthcare professionals, and policy makers. The value of oral health and dental research is frequently unrecognised, even by medical professionals, due to a historical absence of oral health research from the public domain. The need to ensure the final report from this project reaches the wider audience, as well as state bodies, was emphasised.

Despite the very positive perspective all interviewees shared regarding the prospect of an oral health policy for older people, two significant reservations were also expressed. Firstly, in improving oral health services for older people and developing a specific policy to guide this process, it is vital that older people do not feel marginalised or segregated from mainstream service provision by the focus on their specific needs. Older people's needs are shared by many members of other population groups, but older people need to be made aware of this rather than feeling part of a minority group.

Secondly, despite all of the evidence in favour of improving oral health services for older Irish people, one interviewee highlighted the need to neither over- nor under-estimate the value of oral health in the context of the Health Service's finite annual budget. While increasing the availability, accessibility and acceptability of oral health services for older people is a worthwhile goal, it must not be achieved to the detriment of other aspects of the health service. In-keeping with a person centred approach, the value older people themselves place on various aspects of their health care must also be considered.

3.4. Oral Health Promotion

Narrowing the interview focus, the first specific aspect of oral health service provision for older people discussed with each interviewee was oral health promotion. Specifically, the representatives were asked about their organisation's perspective on the need for oral health promotion initiatives targeting older people, including the provision of oral health promotion materials, and the need to educate older people about oral health, contemporary dental services, and the links between their oral and physical health. Several common themes emerged during these conversations.

A consensus was evident among all four organisations with respect to the need for oral health promotion initiatives specifically targeting older people. It was noted that oral health promotion in Ireland to date has predominantly focused on children – in line with the priorities of the HSE dental

service – and on the employed adult population. However, these measures are of relatively recent gestation, and the current cohort of older Irish people benefited neither from the provisions of the HSE dental service as children, nor targeted oral health promotion initiatives during their working lives. Thus, in general, older people have a lack of awareness of preventive dentistry and the services available to them via the DTSS, and furthermore are unfamiliar with health promotion recommendations regarding oral health.

The challenges posed by the need to promote oral health to older people in an appropriate manner were drawn upon by all participants. Several representatives discussed aspects of the need for an effective, evidence-based approach to oral health promotion for older people that is well-resourced, thoroughly planned, sustainable, and is built upon a collaborative partnership of health promotion professionals, a wide range of stakeholders involved in service provision for older people, and older people themselves. The interviewees observed a need for research to determine appropriate means of fulfilling this need as none was aware of the existence of applicable guidelines at present.

The oral health stakeholder representatives also shared a common perspective on the need for an improvement in the quality of the oral health promotion materials provided to older people, again founded upon evidence-based guidelines. While recognising the need to engage in research to determine the appropriate nature and content of such materials, interviewees also expressed their own suggestions in relation to the distribution of printed oral health promotion materials in particular; e.g. distribution by a trained oral health promoter, public health nurse, or other suitably informed healthcare worker, on a one-to-one or small group basis. It was also observed that due to the heterogeneity of the population aged 65 and over, it is unlikely that a single approach to oral health promotion will be effective across the cohort.

Two of the interviewees highlighted the position of older people in Irish society today, and the many roles they perform. In particular, the role of older people as the grandparents, and frequently the child-minders, of the next generation of oral health service users was remarked upon. It was suggested that a campaign focusing on the positive role grandparents can play in promoting their grandchildren's oral health might be an effective means of introducing oral health promotion recommendations and the concept of preventive dentistry to older people¹. Grandparents could then be encouraged to also apply their newfound knowledge to their own oral health.

3.5. Dental Service Provision

The third topic covered by the interview schedule was dental service provision. Questions were included in relation to two aspects of this topic: the resourcing of oral health services for older people; and, the implications of the new Primary, Community and Continuing Care (PCCC) structures for oral health service provision for older people. This section considers the first of these issues, while the PCCC structures are discussed in the following section.

¹ This innovation should be attributed to the Dental Health Foundation.

In relation to the resourcing of oral health service provisions for older people, the stakeholder representatives were asked about potential measures to address General Dental Practitioners (GDPs) low preference for providing dental services to older people, the human resource issues faced by both the HSE-salaried and DTSS-contracted oral health services, and the prospect of introducing of ring-fenced funding and staff for domiciliary dental care, community-based dental services, and dental services in residential units for older people.

In discussing the resourcing of older people's oral health services, the interviewees were careful not to create unrealistic optimism among a sector of the population which already finds that the health service does not always live up to its expectations. Instead, the focus of responses was predominantly on examining the feasibility of the issues raised. It was recognised that the combination of current demographic, oral health and dental disease trends will result in a greatly increased demand for oral health services by older people in the coming decades, and that the DoHC and HSE will have to rise to this challenge. However further research is required to examine their feasibility and the evidence base regarding their effectiveness.

3.6. The PCCC Structures

The second aspect of dental service provision for older people concerned the implications of the new Primary, Community and Continuing Care (PCCC) structures for oral health service provision for older people, including the provision of oral cancer screening. While the original intention was to specifically focus on plans for the organisation and operation of the Primary Care Teams and Primary Care Networks, the stakeholder representatives used this opportunity to also discuss the broader issues of health and social care integration and a collaborative, holistic approach to older people's needs.

The interviewees acknowledged that the PCCC structures are at an early stage of development; while the team structures are currently being operationalised around the country, the implementation of the broader network structures – which would include oral health professionals – has yet to be discussed, let alone acted upon. However, it is envisaged that one of the key issues which the DoHC's new national oral health policy will address is integration, and the development of a synergy between General Medical Practitioners, Primary Care Teams and oral healthcare professionals, including GDPs. It is intended that a closer working relationship between medical and dental primary care staff would not only improve the standard of healthcare service users - including older people - experience, but also provide a context within which opportunistic screening and referral for oral health problems, including oral cancer, could be developed.

In addition to integrating oral health care with other primary care services, the stakeholder representatives noted the need to include oral health in the general health assessments and health promotion activities of other healthcare workers who are regularly in contact with older people. The training implications of such a measure are discussed in section 3.9. below.

Finally, it was observed that a closer working relationship between General Dental and Medical Practitioners could be used to reduce the barriers to oral health care posed by older people's medical conditions and polypharmacy. GPs could provide GDPs with information and advice regarding the interaction of clients' physical health, medication, and proposed dental treatment, perhaps leading to a reduction in referrals to HSE-salaried special needs dental services. Research to assess the efficacy of introducing oral healthcare protocols regarding physical health issues common among older people was also considered useful as a means to assessing the need for specialists in older people's oral healthcare within the HSE-salaried service.

3.7. The DTSS

As the state-funded Dental Treatment Services Scheme (DTSS) is the primary mode of dental service provision for older people, the DoHC and HSE representatives were asked about the prospect of changes to the existing scheme. The issues considered were: a reduction in the age limit for universal DTSS eligibility from 70 to 65 years; the introduction of a domiciliary care fee for contractor GDPs; an increase in the range of treatments available via the scheme; and, an increase in the level of fees for contractor GDPs.

Both interviewees prefaced their response to this topic with a consideration of the current DTSS contract negotiations. At the time of writing, the DoHC had spent the previous eighteen months conducting a complete review of the DTSS, including the GDP fee schedule, and had begun negotiations regarding this with the Irish Dental Association. However based on advice received from the Attorney General in relation to the Competition Act, discussion of the issue of professional fees was forced to cease. The IDA subsequently withdrew from negotiations, and the process is currently stalled while the DoHC attempts to resolve the legal issues involved. Meanwhile the HSE is working toward approaching individual GDPs with a draft DTSS contract as a means of making some progress on the issue. The stakeholder representatives envisaged that the range of treatments available and the level of GDP fees will form part of the DTSS contract negotiations when they recommence; they did not attempt to pre-empt this process. However, both representatives did comment specifically upon the issue of the DTSS full-denture fee. The DoHC and HSE are patently aware of the current discrepancy in GDP costs and payment for this service, and it is intended to redress this issue in the new DTSS fee schedule.

With respect to a reduction in the age limit for universal DTSS eligibility from 70 to 65 years, neither stakeholder representative envisaged this occurring, at least in the medium term. However, further research to assess the likely impact of such a measure would be welcomed. Finally, as outlined in section 3.5. above, research is required to examine the feasibility of and evidence base regarding the most effective means of providing dental treatment to older people who cannot attend clinic-based services.

3.8. Accessibility

All of the oral health stakeholder representatives were asked about their organisation's perspective on a range of issues relating to the accessibility of oral health services to older people. Due to the diversity of issues which have potential to affect service access, questions were tailored to interviewees' areas of expertise. The full range of topics encompasses: the provision of information regarding the DTSS and PRSI schemes, and on finding a new dentist; a system of regular recalls for DTSS dental patients; innovations intended to increase the accessibility of dental services, such as assisted dental visits, mobile dental clinics, and community-based oral health promoters and hygienists; and, the role of other healthcare professionals in assisting older people with their oral self-care.

In considering the provision of service-related information to older people, the interviewees returned to the issues addressed in their discussions regarding oral health promotion (section 3.4., above); specifically, the need for research to determine the appropriate means of providing older people with health-related information was reiterated. In addition, it was suggested that the service integration process referred to in section 3.6. would likely include the development of a cross-referral system, whereby each circumstance in which an older person is in contact with the health service would be used to provide them with information about other services which they could avail of, and appropriate referral as necessary.

In a continuation of the current oral health promotion policy, it was thought that publicity regarding the recommendation that everybody attend the dentist for regular check-ups would be preferable to the introduction of a recall system for older DTSS patients. However, the oral health stakeholder representatives repeated their view that this (see section 3.5, above), and other suggestions intended to increase the accessibility of dental services to older people, require further research to examine their feasibility and the evidence base regarding their effectiveness. Interviewees were in favour of the inclusion of older people's daily oral health care in the role of care assistants, both in residential units and domestic settings. The training implications of such a measure are discussed in section 3.9. below.

The stakeholder representatives also raised two further issues affecting the accessibility of oral health services to older people. Similarly to previous phases of the research, it was suggested that the inclusion of transportation to and from dental clinics in oral health service provision would significantly reduce older people's difficulty in accessing oral health care. In addition, research is required to examine the efficacy of providing dental treatment to older people outside of normal working hours so that family members could provide the older person with transport and support during their visit.

3.9. Training of Healthcare Professionals

The final topic considered by the oral health stakeholder representatives was the training implications of the measures discussed above for health care professionals, including oral health professionals. The initial set of questions pertained to: providing GDPs and HSE-salaried dentists with further training regarding older people's physical health issues; providing auxiliary dental staff with appropriate training in the management of older patients; providing other healthcare professionals with training to raise their awareness of oral health; and, the introduction of a Senior Dental Surgeon for Gerodontology to provide oral health care for older people with complex needs.

The interviewees noted the need for research to establish the baseline level of knowledge oral health professionals possess regarding the provision of dental care to older people, and to investigate the desirable level of education regarding this issue. The point was made that, in general, the dentistry involved in older people's treatment is relatively basic; it is the constellation of physical health issues and medications which must be considered alongside the proposed dental treatment plan which frequently result in the referral of older patients from DTSS-contracted GDPs to the HSE-salaried service. An assessment of the efficacy of an educational intervention to reduce GDP's need to refer older patients in this circumstance was suggested, as was the development of treatment protocols for a number of the more common physical health problems associated with increasing age. It was also recommended that the management of older patients, including appropriate communication skills training, establishing familiarity with older patients' unique needs, and sufficient information regarding pharmacology to equip practitioners for the treatment of today's older population be included in dental students' curriculum, and in Continuing Professional Development (CPD) activities for dentists in active practice.

With respect to auxiliary dental staff, such as hygienists and oral health promoters, the interviewees welcomed the prospect of increasing their involvement in older people's oral health care, both from the perspective of providing new, useful oral health services to older people, and freeing up dentists' time to concentrate on the provision of dental treatment. Similar to dentists, the needed to assess and facilitate the training requirement of auxiliary dental staff was deemed important.

It is intended to include a consideration of specialisation, manpower planning, and training in the DoHC's new national oral health policy. HSE-salaried special needs dentistry - which currently includes dental service provision for older people with special needs - has been identified for examination in the context of policy formulation. However both the DoHC and HSE representatives emphasised the need for empirical research to scope service requirements and to introduce a new specialisation only where the evidence base indicates a beneficial effect for patients.

Finally, the stakeholder representatives expressed similar views regarding their belief that all healthcare professionals would benefit from an appropriate level of education and training in relation to oral health awareness; the need for care assistant training regarding daily oral hygiene, and for GP

training regarding screening of the oral mucosa for oral cancer were emphasised. However the challenges posed by such an undertaking were also touched upon, most notably the very limited number of suitably qualified oral health professionals available nationally to provide training on oral cancer detection for GPs. It was suggested that as a useful first step, GPs and GDPs could undertake training regarding each others' disciplines at a more grass-roots level through a simple series of meetings between local GPs and GDPs, leading to a useful cross-pollination of ideas regarding older people's medical and dental care.

4. Summary & Implications for Oral Health Policy for Older People

The interviews with oral health policy makers focussed on current practices in the organisation and delivery of oral healthcare services to older people, and the challenges and opportunities facing the services delivering dental care to this group in the future. Specifically, the interviews assessed the feasibility of various policy options for available, accessible and acceptable oral health services for older people that had arisen from the previous phases of the study.

The principal findings from the consultation with oral health policy makers in relation to policy options are as follows:

- Oral health stakeholders recognise the need for an oral health policy for older people; it is intended to incorporate this in the DoHC's new national oral health policy.
- Research is required to guide the development of an evidence-based approach to oral health promotion and information provision for older people that is well-resourced, thoroughly planned, sustainable, and is built upon a collaborative partnership of health promotion professionals, a wide range of stakeholders involved in service provision for older people, and older people themselves.
- Further research is also required to examine the feasibility and evidence base regarding the effectiveness of potential solutions to the increased demand which will be placed on the oral health services in the future by current demographic, oral health and dental disease trends, including the demand for non-clinic-based dental treatment provisions.
- The DoHC and HSE will continue to working toward increased integration of primary dental and medical care services.
- While the DTSS contract negotiations are currently stalled, the statutory stakeholders are working toward circumventing the legal issues causing the delay as a priority issue.
- Research is required to assess the feasibility and evidence base regarding the effectiveness of measures intended to improve the accessibility of oral health services to older people.

Appendices

Appendix A: Interview Schedules

- A.1. Introduction & Consent to Audio Recording
- A.2. Interview Schedule for Dept. of Health & Children Representative & for Health Services Executive (HSE) Dental Service Representative
- A.3. Interview Schedule for Special Interest Group 1 Representative
- A.4. Interview Schedule for Special Interest Group 2 Representative

Appendix B: Research Summary

Appendix C: Transcripts of Interviews with Oral Health Policy Makers

- C.1. Transcript of Interview with Dept. of Health & Children Representative
- C.2. Transcript of Interview with Health Services Executive (HSE) Dental Service Representative
- C.3. Transcript of Interview with Special Interest Group 1 Representative
- C.4. Transcript of Interview with Special Interest Group 2 Representative

Appendix A: Interview Schedules for Oral Health Policy Makers

A.1. 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./Mr./Ms. X> agreed to participate in a telephone interview; it will take approximately ten minutes.
 - Is he / she available to talk now or will I call back later?

Following connection or call-back:

- Hello <Dr./Mr./Ms. X>,
 - I'm Tara Crowley, a researcher working with the Oral Health Services Research Centre at UCC.
 - Thank you for agreeing to assist us in developing policy recommendations regarding oral health services for older people.
- The interview will last approximately ten minutes.
 - Is now a good time to conduct it, or would you prefer me to call back later?

Immediately or following call-back:

- The first question I have to ask you <Dr./Mr./Ms. 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':

- Would you be willing to provide written answers to my questions via email rather than pursuing the interview format?

If 'No':

- I will need to discuss this with the Principal Investigator.
 - I will call back as soon as possible.

If 'Yes':

- Thank you; I now need to turn on the recorder and get an audio record of your consent by asking you the same question again, so ...
 - <Dr./Mr./Ms. 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 current study and the interview procedures to you:
 - The aim of this project is to devise evidence-based options for the development of an equitable, person-centred oral health policy for older people in Ireland; specifically, to develop policy options 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.
 - As you will have seen in the research summary, to date we have conducted a variety of desk and field research.
 - A detailed analysis of existing clinical and epidemiological data and a review of the literature regarding the oral health of older Irish people have been conducted.
 - We have also consulted with older people themselves, general dental practitioners and HSE principal dental surgeons regarding the current organisation and delivery of dental services to older people and their views on the challenges and opportunities in service provision for older patients in the future.
 - We are now attempting to gauge the feasibility of their suggestions by interviewing a number of individuals involved in the development and implementation of oral health policy, prior to formulating policy options in our final report for the National Council for Ageing and Older People.
 - 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 dental policy makers as a group; no individual respondents will be identified.
 - However, if there is any aspect of the interview you would like to take ownership of and have attributed to yourself, please let me know either during or after our interview.
 - 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.

A.2. Interview Schedule for Dept. of Health & Children Representative & for Health Services Executive (HSE) Dental Service Representative

- As a representative of <your organisation>, we would like to discuss and examine the feasibility of a range of policy options regarding older people's oral health with you.
- Beginning with the general concept of an oral health policy for older people, the questions we would like to ask you are:
 - Are you aware of any plans at national or regional levels to develop a policy to improve oral health services specifically targeting older people?
 - Do you think that the Department of Health / Health Service currently perceives a need for an oral health policy for older people?
 - Does the Department of Health / Health Service consider older people's oral health a priority for resource allocation at present?
- The second set of questions relate to oral health promotion.
 - Both General Dental Practitioners and Principal Dental Surgeons have observed a need for oral health promotion materials for use with older people. Health services research has shown that older people are often not aware of good oral healthcare practices and health promotion recommendations related to oral health. The current cohort of older Irish people have low expectations in relation to their oral health, and have no childhood experience of preventive dentistry. Despite oral health promotion recommendations that older people should visit the dentist annually, only 53% of dentate and 9% of edentulous older people do so. Notwithstanding clinical evidence to the contrary, the most common reason older people give for dental non-attendance is that they have "no need" of dental treatment. In addition, many older Irish people appear to lack an understanding of the links between oral health, physical health and quality of life.
- The questions we would like to ask you about oral health promotion are:
 - Do you think it would be worthwhile to develop oral health promotion initiatives specifically targeting older people and their carers?
 - Do you think it would be beneficial to make older people aware of dental professionals' meaning of "oral health"?
 - Do you see a need to educate older people about the changed nature and quality of contemporary dental services?
 - Which do you think is the appropriate body to make older people aware of the links between oral health, physical health and quality of life?
 - How do you think oral health promotion materials might best be provided to older people?

- The third set of questions relate to dental service provision for older people.
 - Our research revealed that General Dental Practitioners often have a low preference for treating older people, and service provision for older people is not a priority for the HSE-salaried dental service. The majority of Principal Dental Surgeons we consulted believed that “inadequate manpower” is the single most important barrier to the provision of dental treatment to older people, either through the HSE-salaried service or the DTSS. All eighteen of the Principal Dental Surgeons interviewed stated that they would be willing to increase the amount of domiciliary care they provide, and to release hygienists and oral health promoters to work with older people and carers in the community and residential care units. However this was conditional upon the resources, in particular the manpower, being available to do so.
 - The questions we would like to ask you about dental service provision are:
 - Do you see any potential within the Department of Health / Health Service to address the low preference for providing dental services to older people among General Dental Practitioners; for example, economic incentives or a capitation system via the DTSS?
 - Do you think there is any scope to address the human resource issue in relation to the care of older people either in the HSE-salaried dental service or among DTSS-contracted General Dental Practitioners?
 - If so, are there any plans to do so at present?
 - Do you think there is any potential for the introduction of ring-fenced funding and staff for domiciliary dental care, community-based dental services, or dental services in residential units for older people?
- We would also like to discuss the implications of the new PCCC structures for dental service provision for older people.
 - As yet, the introduction of the new PCCC structures has not impacted upon the provision of dental services for General Dental Practitioners’ older patients. Over half of the General Dental Practitioners we spoke to receive referrals from General Medical Practitioners, but these are often informal, with patients simply being encouraged to go to see a dentist; many subsequently do not do so. Finally, the prevalence of oral cancer is similar to that of cervical cancer; the evidence-base favours opportunistic screening for oral cancer, but as already mentioned, older people rarely attend the dentist. However, almost all of the dentists we contacted would be prepared to support and participate in an annual oral cancer awareness week.

- The questions we would like to ask you about the new PCCC structures are:
 - As implementation of the new Primary Care Teams and Networks begins, how would you envisage the relationship between General Dental Practitioners and General Medical Practitioners evolving?
 - How do you envisage the relationship between General Dental Practitioners and other healthcare professionals developing?
 - Do you think General Practitioners and other healthcare professionals should be encouraged to refer their older patients to General Dental Practitioners for regular check-ups, and if so, how could this be achieved?
 - Do you see a role for General Medical Practitioners and other healthcare professionals in the opportunistic screening of older people's oral mucosa for oral cancer?
 - Do you think that there is any scope to introduce an oral cancer awareness week in future policies or service design?
- The fourth set of questions relate specifically to the provision of dental service to older people via the DTSS.
 - The primary providers of dental services to older people are private sector dentists contracted via the DTSS. However, health services research has shown that cost is a barrier to oral health care for some older people, particularly those aged 65-69 who are ineligible for a medical card, and thus the DTSS. Some older people require domiciliary dental care, but the absence of a DTSS domiciliary fee for General Dental Practitioners, and the general reluctance to shift the priority of the HSE-salaried service towards older people, means that regular domiciliary dental care is rare in Ireland today. Our research with older people indicates a high level of dissatisfaction with dentures, particularly lower dentures. When we spoke to General Dental Practitioners about this issue, many of them highlighted the laboratory fees for full dentures, claiming that the DTSS fee are not commensurate with the laboratory fees and other expenses incurred by dentists in the production of high quality dentures. More than half of the General Dental Practitioners we surveyed stated that the 'DTSS range of services is not adequate' when providing dental care to older people. Three quarters of the General Dental Practitioners we interviewed stated that the 'DTSS fee levels are not adequate,' and more than half of them suggested increasing the DTSS fees across the board.
- The questions we would like to ask you about the DTSS are:
 - Do you think there is any scope to reduce the age limit for the DTSS from 70 to 65 years?
 - Do you think it would be worthwhile to introduce a DTSS domiciliary fee?
 - Do you think there is any scope to increase the range of treatments available to older people via the DTSS?

- Do you think there is any scope to increase the level of DTSS fees available to General Dental Practitioners who provide dental care to older people, either for dentures or across the board?
- The fifth set of questions relate to the accessibility of dental services to older people.
 - Health services research and our own fieldwork support the view that older people lack knowledge and information about the dental services available to them, particularly via the DTSS. Many older people do not have a personal dentist. Many dentists do not issue reminder letters to older people, particularly if they are edentulous. Some older people are unable to attend the dentist without assistance; some cannot go to the dentist and require domiciliary dental care. The older people we spoke to suggested that dentists visit older people in locations where they already congregate (e.g. day care centres) to reduce the barriers they face in accessing dental services. Our older interviewees also suggested the use of mobile dental clinics to provide domiciliary care to older people who are unable to go to the dentist. Fifteen Principal Dental Surgeons stated they would consider the use of a mobile dental clinic to deliver domiciliary care, provided resources were sufficient. Some community-dwelling older people are unable to perform daily oral self-care unassisted.
 - The questions we would like to ask you about the accessibility of dental services are:
 - How do you think older people might best be provided with information about their eligibility for dental treatment funded by the DTSS, or subsidised by PRSI?
 - How do you think older people might best be provided with information about finding a new dentist?
 - Do you think that there would be merit in a system whereby dentists were required to recall all DTSS-eligible older people for a regular dental check-up appointment every 1-2 years?
 - Do you think it would be worthwhile to provide assisted dental visits for older people who cannot attend the dentist alone?
 - Do you think the Department of Health / Health Service would be willing to invest in ring-fenced HSE-salaried oral health promoters and hygienists to work with older people in the community and residential care units?
 - Do you think the Department of Health / Health Service would be willing to invest in ring-fenced HSE-salaried staff and funding for the provision of mobile dental clinics?
 - Do you see a role for other healthcare professionals, such as Public Health Nurses and care assistants in assessing and assisting older people with their daily oral self-care?

- The sixth set of questions relate to the training of healthcare professionals in the provision of dental care to older people.
 - Both the General Dental Practitioners and Principal Dental Surgeons we interviewed reported that the older people's physical health poses a significant barrier to the provision of dental treatment to them. Dentists would welcome further training in the provision of care to older dental patients, particularly in the areas of polypharmacy, medical conditions and complications, and denture manufacture. In addition, it was felt that auxiliary dental staff would benefit from appropriate training in the management of older patients, particularly frail older people. As the primary provider of dental care to older people with special needs, most of the Principal Dental Surgeons we interviewed believe that their service 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. The dentists we interviewed also provided a variety of anecdotal evidence suggesting that other healthcare workers, such as medical doctors and nurses, public health nurses, cares assistants and home helps, possess only a limited awareness of oral health and older people's oral treatment needs.
- The questions we would like to ask you about the training of healthcare professionals are:
 - Do you think it would be worthwhile to provide General Dental Practitioners and HSE-salaried dentists with training so that they can better manage the treatment of older people with complex medical issues?
 - Do you think it would be useful to also provide auxiliary dental staff with appropriate training in the management of older patients?
 - Do you think there is any scope to introduce a Senior Dental Surgeon for Gerodontology in future policies or service design?
 - Do you think it would be beneficial to provide other healthcare professionals with training to raise their awareness of oral health?
- The Research Summary also included information about other aspects of oral health policy for older people.
 - Would you like to comment upon any other aspects of the Research Summary?
- Thank you very much for your time Dr./Mr./Ms. X>.

A.3. Interview Schedule for Special Interest Group 1 Representative

- In keeping with the role of <your organisation> in facilitating and supporting the promotion of oral health in Ireland, we would like to explore the options for oral health promotion and dental service provision for older people with you.
- The first set of questions we would like to ask you relate directly to oral health promotion.
 - Both General Dental Practitioners and Principal Dental Surgeons have observed a need for oral health promotion materials for use with older people. Health services research has shown that older people and their carers are often not aware of good oral healthcare practices and health promotion recommendations related to oral health. The current cohort of older Irish people have low expectations in relation to their oral health, and have no childhood experience of preventive dentistry; most attend the dentist only when they require treatment. Despite clinical evidence to the contrary, the most common reason older people give for dental non-attendance is that they have “no need” of dental treatment. In addition, many older Irish people appear to lack an understanding of the links between oral health, physical health and quality of life.
 - The questions we would like to ask you about oral health promotion are:
 - Do you think it would be worthwhile to develop oral health promotion initiatives specifically targeting older people and their carers?
 - Do you think it would be useful to make older people aware of dental professionals’ meaning of “oral health”?
 - Do you see a need to educate older people about the changed nature and quality of contemporary dental services?
 - Which do you think is the appropriate body to make older people aware of the links between oral health, physical health and quality of life?
 - Which do you think is the appropriate body to provide oral health promotion materials for use with older people in clinical settings and more general materials to be located in places frequented by older people?

If organisation is not mentioned

- Do you see a role for <your organisation> in this regard?

- The second set of questions relate to dental service provision for older people.
 - Health services research and our own fieldwork with older people, General Dental Practitioners and Principal Dental Surgeons all support the view that older people lack knowledge and information about the dental services available to them, particularly via the DTSS. Many older people do not have a personal dentist. In addition, some older people require domiciliary dental care. However, the absence of a DTSS domiciliary fee for General Dental Practitioners, and the general reluctance to shift the priority of the HSE-salaried service towards older people, means that regular domiciliary dental care is rare in Ireland today.
- The questions we would like to ask you about dental service provision are:
 - How do you think older people might best be provided with information about their eligibility for dental treatment funded by the DTSS?
 - How do you think older people might best be provided with information about finding a new dentist?
 - Do you think it would be worthwhile to advocate for the increased provision of domiciliary dental services for older people?
 - How could this best be achieved?

If organisation is not mentioned

- Do you see a role for <your organisation> in this regard?
- The Research Summary also included information about other aspects of oral health policy for older people.
 - Would you like to comment upon any other aspects of the Research Summary?
- Thank you very much for your time <Dr./Mr./Ms. X>.

A.4. Interview Schedule for Special Interest Group 2 Representative

- In keeping with the role of <your organisation>, the policies we would like to discuss and examine the feasibility of with you are related to the role of General Practitioners in older people's oral health care.
 - Firstly, does <your organisation> currently engage in any activities directly related to oral health?
 - Does <your organisation> engage in any activities specifically focusing on the health of older people?
- The first set of questions we would like to ask you relate to oral health promotion.
 - Both General Dental Practitioners and Principal Dental Surgeons have observed a need for oral health promotion materials for use with older people. Health services research has shown that older people are often not aware of good oral healthcare practices and health promotion recommendations related to oral health. The current cohort of older Irish people have low expectations in relation to their oral health, and have no childhood experience of preventive dentistry. Despite oral health promotion recommendations that older people visit the dentist annually, only 53% of dentate and 9% of edentulous older people do so. However, utilisation of General Practitioner services among older people is very high, with over 90% of older people visiting their doctor at least once a year. Despite clinical evidence to the contrary, the most common reason older people give for dental non-attendance is that they have "no need" of dental treatment. In addition, many older Irish people appear to lack an understanding of the links between oral health, physical health and quality of life.
- The questions we would like to ask you about oral health promotion are:
 - Do you think it would be worthwhile to develop oral health promotion initiatives specifically targeting older people?
 - Do you think it would be beneficial to make older people aware of dental professionals' meaning of "oral health"?
 - Do you see a need to educate older people about the changed nature and quality of contemporary dental services?
 - Which do you think is the appropriate body to make older people aware of the links between oral health, physical health and quality of life?
 - How do you think oral health promotion materials might best be provided to older people; for example, via mailshots, doctors' surgeries, etc.?

- The second set of questions relate to dental service provision for older people.
 - Health services research and our own fieldwork with older people, General Dental Practitioners and Principal Dental Surgeons support the view that older people lack knowledge and information about the dental services available to them, particularly via the DTSS. Many older people do not have a personal dentist, whereas 99% of older people have a personal doctor. As yet, the introduction of the new PCCC structures has not impacted upon the provision of dental services for General Dental Practitioners' older patients. Over half of the General Dental Practitioners we spoke to receive referrals from General Practitioners, but these are often informal, with patients simply being encouraged to go to see a dentist; many subsequently do not do so. Both the General Dental Practitioners and Principal Dental Surgeons we interviewed reported that older people's physical health poses a significant barrier to the provision of dental treatment. Finally, the prevalence of oral cancer is similar to that of cervical cancer; the evidence-base favours opportunistic screening for oral cancer, but as already mentioned, older people rarely attend the dentist.
- The questions we would like to ask you about dental service provision are:
 - As implementation of the new Primary Care Teams and Networks begins, how would you envisage the relationship between General Practitioners and General Dental Practitioners evolving?
 - Do you think General Practitioners should be encouraged to refer their older patients to General Dental Practitioners for regular check-ups, and if so, how could this be achieved?
 - Could you suggest any other General Practitioner-based approaches to make dental services more accessible to older people?
 - Do you see a need for the inclusion of oral health in General Practitioner training or continuing professional development programs?
 - Do you have any suggestions regarding how the barrier to dental treatment posed by the medical conditions and complications of older people, and their attendant polypharmacy, could be overcome?
 - Do you see a role for General Practitioners in the opportunistic screening of older people's oral mucosa for oral cancer?
- The Research Summary also included information about other aspects of oral health policy for older people.
 - Would you like to comment upon any other aspects of the Research Summary?
- Thank you very much for your time <Dr./Mr./Ms. X>.

Evidence-Based Oral Health Policy for Older People

Protocol number: OHSRC00105

Research Summary

A project jointly sponsored by:

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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.

Both desk and field research have been conducted to pursue this aim. A review of the literature and a detailed analysis of clinical data regarding the oral health and treatment needs of older Irish people have been performed. Older people themselves, general dental practitioners and HSE principal dental surgeons have also been consulted regarding the current organisation and delivery of dental services to older people and their views on the challenges and opportunities in service provision for older patients in the future. The following document synthesises the results of this research to date.

The final phase of the project is intended to gauge the feasibility of their suggestions by interviewing a number of individuals involved in the development and implementation of oral health policy, prior to making policy recommendations in the final report for the National Council for Ageing and Older People.

1. Background

A review of the literature pertaining to dental services for older people was conducted to inform the process of direct consultation with older people. Its purpose was to establish themes for incorporation in the interview process, and to sensitise the researchers to the salient issues. These themes are summarised below as they provide a useful introduction to the topic for the reader.

Population ageing is a progressive trend in Ireland. The projected increase in the absolute number of persons aged 65+, individual life expectancy, and the proportion of the population aged 65+, will have profound consequences for oral health service provision. Dental services for older Irish people are currently provided via four routes: (i) the Dental Treatment Benefit Scheme subsidises dental care for PRSI contributors; (ii) the Dental Treatment Services Scheme (DTSS) provides free dental care for medical card holders; (iii) private health insurance provides members with nominal sums toward the cost of dental care; and (iv) private dentistry is available to all who can afford it; some treatments are eligible for tax relief.

Dental professionals believe that oral health is achieved when the teeth and oral environment are healthy and free from infection, functional, comfortable, and socially acceptable. Oral health and dental disease can impact upon physical health, and also have social and psychological consequences for those affected. However, lay perceptions of oral health, and lay people's understanding of the relationship between oral health and other aspects of health, frequently do not correspond to the professional perspective.

'Oral health-related quality of life' (OHRQoL) encompasses the subjective impact of oral health and dental disease on people's physical and psychosocial well-being and quality of life; these impacts can be both positive and negative. Data on Irish people's OHRQoL was collected during the Irish National Survey of Adult Oral Health 2000-2. Results show that older people have worse OHRQoL than younger age groups. Older people with poor OHRQoL report lower morale, more life stress and lower levels of life satisfaction.

Older Irish people appear to lack appreciation of the impact of their oral health on QoL; in a focus group study, those in residential care, "generally did not express any idea that oral health impacted on any aspect

of their daily lives either positively or negatively." Utilisation of dental services among people aged 65+ is very low; in 2001, only 9.5% of medical card holders used the DTSS. This is despite clinical evidence (see below) that the majority require some dental treatment. Older people may not be motivated to seek the dental treatment they need because they do not believe it will impact upon their quality of life.

The high level of unmet need for dental treatment among older Irish people documented by the National Survey is discrepant with their infrequent dental attendance. A number of barriers to oral health care for older people have been identified in health services research; for example:

- Lack of knowledge and information regarding oral health services;
- Lack of awareness of good oral healthcare practices;
- Lack of knowledge regarding health promotion recommendations related to oral health;
- Inability to perform daily oral self-care unassisted;
- Dental anxiety;
- Cost, particularly for those aged 65-69 who are ineligible for a medical card;
- Lack of social support;
- Communication problems related to visual/hearing impairment and literacy problems;
- Physical location and layout of dental practices;
- Transport poverty; and
- Ageism.

2. The Oral Health & Treatment Needs of Older Irish People

This section summarises results from 714 people aged 65 years and over examined by dentists during the recent Irish National Survey of Adult Oral Health (NSAOH) 2000-2. The average age of these participants was 71 years 8½ months (range 65 to 95 years) and 65% had a medical card. (Medical cards for all persons aged 70 and over, regardless of income, were introduced in 2001 while the survey was underway.)

Common measures of oral health and dental disease were used to create an oral health profile of older people in Ireland. Lifestyle factors affecting the oral health knowledge, attitudes, and behaviour of older people were also examined. The dental treatment needs of older people were used to identify the socio-demographic characteristics affecting need and to compare the treatment provided to low-income older people (medical card holders) through the DTSS with their treatment need as assessed by dentists.

Older Irish People's Oral Health

In the results below, individuals with no natural teeth are classified as *edentulous*. Those who have at least one natural tooth remaining, regardless of whether they wear dentures or not, are classified as *dentate*. The 2000-2 survey indicated that 41% of older Irish people were edentulous. A full set of natural teeth is regarded as 32 teeth; in 2000-2, the average older person had 8 teeth.

A full denture is usually provided if all of the teeth are missing in a jaw; if some teeth remain in the jaw, a partial denture can be provided. In 2000-2, the proportion of older people wearing full and partial dentures in either or both jaws was 44% and 30%, respectively. In over one third of those wearing partial dentures, the denture was adversely affecting the adjacent teeth and gums. Regular review and replacement of dentures every 5-10 years is important. However, 48% of edentulous older people had dentures that were more than 10 years old and a further 19% had dentures that were 5-10 years old in 2000-2.

The most common oral disease is dental decay (caries). A count of the average number of Decayed, Missing and Filled Teeth (DMFT) is used to measure dental decay. Higher DMFT scores indicate more serious dental decay; subjects with no natural teeth are given the maximum score of 32 missing teeth. The average older Irish person had 25.9 Decayed, Missing and Filled Teeth in 2000-2. Only 52% of older people who still possess some natural teeth reported brushing their teeth at least twice a day. Brushing twice per day or more prevents more dental decay than brushing once a day or less.

Gum (periodontal) disease affects the supporting structures of the tooth and is the second most common oral disease. In 2000-2, only 7% of older people who still possessed some natural teeth had healthy gums that required no treatment. Four percent had bleeding gums, while 30% of older people required professional cleaning of the teeth. A full half (50%) of the older people examined required complex periodontal treatment, such as cleaning the root surface under the gum, or surgery. These results demonstrate a high level of need for gum disease treatment among dentate older Irish people.

It is recommended that all older people (with or without natural teeth) visit the dentist at least once a year for early diagnosis and prevention of disease, including oral cancer. Among dentate older people, 22% never visit the dentist and 25% visit only occasionally. The situation among those without any natural teeth is considerably worse: 71% never visit the dentist and 20% visit only occasionally.

The most common reason for infrequent dental attendance was the perception that there was 'No Need' to attend; 37.8% of dentate older people and 87.4% of those who are edentulous gave this reason. For older Irish people with no third-party funded care, cost was cited as a barrier to dental attendance by 10.5% and 7.7% of those with and without teeth respectively. It is interesting to note that for older Irish people, other reasons – such as not knowing a good dentist, distance to and accessibility of the dental clinic, and time – were cited as reasons for not going to a dentist more frequently than either dental anxiety or cost.

In addition to perceiving 'No Need' to see a dentist, many older medical card holders may also simply not be aware that they can visit private dentists through the Dental Treatment Services Scheme (DTSS). Analysis of the DTSS data base revealed that even though 397,590 of those aged 65+ were eligible for treatment, only 9.5% of older Irish people made a dental visit in 2001.

Oral Treatment Needs of Older Irish People

This segment assesses the oral treatment needs of older Irish people as recorded by the NSAOH 2000-2. It uses statistical analysis to identify the characteristics influencing treatment need, and compares the treatment provided to medical card holding older people through the Dental Treatment Services Scheme (DTSS) with their assessed need.

The majority (65%) of older Irish people examined in the NSAOH 2000-2 possess medical cards. When questioned regarding which dental scheme they could avail of, 60% of respondents indicated medical card, 12% indicated PRSI, 20% indicated none (i.e. private patients) and 6% did not know. By eligibility status, treatment needs were highest amongst medical card holders.

Statistical methods were used to disentangle the complex relationships between the socio-demographic characteristics of older Irish people and their need for dental treatment. To allow more in-depth analysis, three different forms of treatment need were examined:

- The *need for any dental treatment* - 79% of older people examined had a clinical need for some form of dental treatment;
- The *need for denture treatment* - 47% of older people examined required denture treatment; and
- The *need for gum disease treatment* - 24% of older people examined had a need for gum disease treatment.

Older females had less need for any dental treatment than older males. Being a regular user of dental services significantly reduced the likelihood that an older person needed any dental treatment. Regarding need for denture treatment, being female or a regular user of dental services significantly lowered the probability of an older Irish person needing denture treatment. The need for gum disease treatment is significantly lower for older females (who had fewer teeth than males).

The estimated dental treatment needs of medical card holders aged 65 or over were compared with the actual treatment provided to this group by the DTSS during the period of the survey (October 2000-June 2002). Dental treatment needs were based on the findings of the NSAOH 2000-2; actual treatment provided were based on utilisation data obtained from the former GMS (Payments) Board.

This comparison showed a significant shortfall between the treatment needs of medical card holders aged 65+ as estimated by the NSAOH and the DTSS treatment provided for dental decay and gum disease. However, only 20% of older Irish people with DTSS eligibility actually made a dental visit within the period under study. When utilisation data is restricted to these regular DTSS users, treatment provided exceeds estimated need for 'Fillings' and 'Dentures/prosthetics' and unmet need falls to 0.71 teeth on average for 'All Treatment'.

3. Older People's Experiences of the Oral Healthcare Service

Twelve focus group discussions and thirty individual interviews were conducted with older people to identify factors which facilitate and impede the delivery of dental services to them. The focus groups included a total of 134 participants, ranging in age from 58-93 years, while the 30 individual interviewees had an age range of 61-92 years. The focus group sessions and interviews confirmed and clarified a number of issues previously revealed by the oral health questionnaire in the NSAOH 2000-2 (see above and the table below).

Firstly, older Irish people have low expectations in relation to their oral health and oral health-related quality of life. The origin of this attitude may be shared with the culture of oral neglect apparent in many of the focus groups; a lack of oral health awareness, poor access to services as a child, and a childhood association of dental treatment with a response to pain were reported.

The association of dental treatment with a response to pain is particularly revealing as it allows us to contextualise the attitudes of this age cohort. Today's older people have no childhood experience of preventive dentistry. Sixty five or more years ago, the causes and prevention of oral disease were less well understood, and there was little focus on dental care for prevention of disease, either in the clinic or at home. Hence members of this age group have developed different attitudes to preventive dental care, and different oral health expectations, than those which are prevalent among younger age cohorts. Unfortunately this older-style culture also includes a lack of awareness of the capacity of the dental service to improve quality of life with regard to oral function, comfort and appearance.

Number and Percentage of Focus Groups and Individual Interviewees Highlighting Issues				
Section	Topic	Issues	Groups n=12 (%)	Individuals n=30 (%)
Older People & Health	How older people are regarded by society	Improvement in services	10 (83%)	11 (37%)
		Waiting lists for hospitals	5 (42%)	6 (20%)
		Reduced hours for home helps	3 (25%)	0 (0%)
	Being healthy	Ability to do daily tasks	9 (75%)	4 (13%)
	Attitudes to oral health	Positive change in treatment methods	8 (67%)	12 (40%)
Quality of Life	Negative impacts	Total	11 (92%)	17 (57%)
		Eating	8 (67%)	8 (27%)
		Appearance & smiling	4 (33%)	2 (7%)
		Speech (new dentures only)	3 (25%)	0 (0%)
		Comfort	7 (58%)	12 (40%)
		Eating in front of others	5 (42%)	0 (0%)
		Embarrassment	5 (42%)	0 (0%)
	Positive impacts	Total	7 (58%)	3 (10%)
		Eating	5 (42%)	3 (10%)
		Appearance & smiling	4 (33%)	0 (0%)
		Speech	3 (25%)	0 (0%)
		Comfort	2 (17%)	0 (0%)
Teeth & Dentures	Wearing dentures	Still have some of own teeth	9 (75%)	12 (40%)
		Never wear lower set	9 (75%)	2 (7%)
		Take them out at home	3 (25%)	1 (3%)
	Age of dentures	Dentures more than 30 years old	9 (75%)	6 (20%)
		New dentures in last 5 years	5 (42%)	6 (20%)
	Problems	Sore gums / mouth / lips	8 (67%)	12 (40%)
		Badly fitting dentures	7 (58%)	9 (30%)
Access to Services & Treatment	Visits to dentist	Fear of dentists	9 (75%)	1 (3%)
		No Dentist	12 (100%)	17 (58%)
		In emergencies	12 (100%)	19 (63%)
		Regular check-ups	7 (58%)	6 (20%)
		Awareness of problems related to oral ill-health	2 (17%)	0 (0%)
	Dental treatment schemes	Having to pay affecting seeking treatment	7 (58%)	4 (13%)
		Aware of medical card dental scheme for over 70s	10 (83%)	15 (50%)
		Feel badly informed	6 (50%)	15 (50%)
		Not satisfied with last treatment	5 (42%)	1 (3%)
		Medical card treatment inferior	6 (50%)	1 (3%)
	Barriers and ways of improving access to services	Difficulty travelling to dentist	9 (75%)	4 (13%)
		Mobile dental units	6 (50%)	2 (7%)
		Dentists visiting community centre, etc.	10 (83%)	3 (10%)
		Transport to dentist	6 (50%)	4 (13%)

The findings also indicate that any oral health promotion programmes designed to address the attitudes and behaviour of this cohort of older people should include information on the availability, scope and quality of dental services. Given the scale of the negative childhood and young adulthood experiences by many focus group participants, oral health promotion efforts should address the changed nature of contemporary dental services. Such efforts should be directed at increasing confidence in visiting the dentist. Oral health promotion must also address the lack of awareness of the rationale for, and considerable benefits of, regular dental check ups for those with and without their own natural teeth.

Many of the focus group participants were unaware of their eligibility for the DTSS. A publicity campaign could address this information deficit and may help to increase uptake of this service. Older people also reported a number of barriers to accessing oral health care. The difficulty of finding a companion to help them negotiate their journey to the dentist during working hours was highlighted. Transport was also a problem, with the cost of taxis prohibitive for many older people.

The difficulties reported during the focus groups indicate a high level of dissatisfaction with dentures. This may indicate a need for the training and employment of specialists to deal with those who have persistent difficulty with denture wearing.

The focus group participants made some innovative suggestions to overcome the barriers to dental care they experience. These included the use of mobile dental clinics and an arrangement whereby dentists could visit older people at day-care, community, and sheltered accommodation centres.

In conclusion, the focus groups identified:

- The need for effective oral health promotion programmes targeting older people which would promote the benefits of regular dental visits and increase awareness of available and accessible high quality dental services;
- A high level of dissatisfaction with dentures;
- The need for new approaches to make dental services more accessible to older people.

4. Service Providers' Views on Dental Services for Older Patients

The key stakeholders involved in the organisation and delivery of oral health services to older people are the Department of Health & Children, the Health Services Executive (HSE) Dental Service, and General Dental Practitioners (GDPs). The views of GDPs and HSE Principal Dental Surgeons (PDSs) on dental service provision for older people were sought, with the intention of developing proposals based on the results of this phase and subsequently interview policy makers regarding the feasibility of their suggestions.

The questionnaires and interviews used to elicit GDPs' and PDSs' views focused on the current level of service provision for older people and the challenges facing those involved in the delivery of services to this group. Separate questionnaires and interview schedules were designed for each group to reflect the differing issues faced by private practitioners and the public dental service. Seventy five GDPs in active practice (an estimated 5% sample) returned questionnaires; 18 of these also participated in a follow-up telephone interview. Thirty one of the 32 PDSs returned completed questionnaires; coincidentally, 18 PDS interviews were also conducted. The main findings are outlined below.

Service Provision

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

The role perceived by PDSs for the HSE-salaried service with regard to older people includes 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. 'Inadequate manpower' was cited by 83% of PDS questionnaire respondents as the single most important barrier to the provision of treatment to older people, either through the Public Dental Service or the DTSS. Similarly, thirteen of 18 PDS interviewees suggested more resources/staffing as a means of increasing service provision to older people by the HSE. 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.

Access to Care

Though they may not avail of their entitlements, everyone aged 70+ has a right to access dental services via the DTSS. However, access to oral health care for those aged 65-69 depends on their financial means and eligibility for other dental benefits. One third of GDPs interviewed 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 constraints as the reason for this behaviour. More than two-thirds of the GDPs surveyed 'often' or 'sometimes' provide treatment to older people for which they receive no payment. The creation of a register of HSE dental clinics and GDP surgeries accessible by people with poor mobility, such as those using wheelchairs, was favoured by most interviewees.

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. Regular domiciliary dental care for older people is rarely provided by GDPs, and is provided by less than half of the HSE service areas; on an emergency basis, domiciliary care is provided by almost all HSE service areas but by less than 40% of GDPs. At present, the DTSS schedule does not include a domiciliary care fee for GDPs. In response to the questionnaire, 'DTSS financial support/incentives for domiciliary care' was listed in the top three recommendations for improving oral health services to older people by 27% of GDP respondents and 32% of 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. In

principle, all of the PDSs 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.

The Dental Treatment Services Scheme (DTSS)

The majority of older people have DTSS entitlements. Thus, when discussing 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' (73%) and 'DTSS range of services is not adequate' (58%) were among the three most important barriers to providing care to older people for GDPs who completed the questionnaire. 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 for the needs of older people. 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.

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, claiming that the DTSS fees are not commensurate with the laboratory 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.

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 also suggested this. 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 DTSS practitioners.

Uptake of Services

With regard to the uptake of dental services by older people, both GDPs and PDSs noted the marked difference in attendance for regular dental check-ups between dentate and edentulous (toothless) patients, in keeping with the NSAOH results above. All of the GDPs and most PDSs interviewed were in favour of regularly recalling older patients for a check-up. '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%) responding to the questionnaire, and by seven of the GDPs interviewed. Four GDPs and three PDSs suggested this as a potential new oral health policy.

Over half of GDPs interviewed receive referrals from medical GPs. Older people visit their doctor more frequently than their dentist; thus it was acknowledged by many GDPs that GPs would be a useful conduit through which awareness of oral health could be raised and the need for oral checks communicated. However, the need to first educate GPs, and other healthcare workers, about oral health was highlighted. GDPs also mentioned raising awareness of dental conditions among older people themselves and their carers as a means of encouraging dental attendance. Among PDSs surveyed, the most important actions for

increasing uptake by older people are to 'encourage uptake via Public Health Nurses' (50%), 'develop domiciliary services' (40%), 'provide incentives for DTSS providers to relocate to rural areas' (33%) and 'run oral health awareness campaigns'(33%).

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, providing dentists with dental self-care instruction leaflets for their patients would be worthwhile.

Training in the Oral Health Care of Older People

As the primary provider of dental care to older people with special needs, fifteen of eighteen 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. GDPs and HSE-salaried dentists alike would welcome training in the care of older dental patients, in particular in the areas of polypharmacy, medical conditions and complications, and denture manufacture. The Dental Schools were perceived to be the appropriate agencies for the delivery of such training; however, cost was seen to be a barrier. 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.

