Barriers to primary dental care for special care patients

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How can we tell whether those that need dental care receive it, asks **Charlotte Bowes**.

Dental provision is essential for the growing number of elderly (and dentate) people. The scope of this article is to highlight barriers to primary dental care for medically compromised elderly patients who are dependent on carers and/or family.

Introduction

In the UK, life expectancy is increasing. Currently, 77% of elderly (over 75 years old) people have at least one natural tooth.[1] At some stage, they will need to access dental care, sometimes for the treatment of painful conditions.[2] As we age, there are health and social problems which may prevent us from both seeking and accessing primary dental care and this can have a negative impact on quality of life.[3]

Medically compromised elderly patients may be dependent on others, whether for everyday tasks or routine appointments, such as attending the dentist. Care-workers have commented on how difficult it is to access dental primary care. This is despite the oral health assessment which is completed for each new care-home patient to facilitate decision-making for oral care pathways.[4] There is no such resource when the burden of care lies with family members.

By age 65, most of the population will have one chronic health condition as a minimum; this increases to a minimum of two by age 75.[5] This has implications for the elderly cohort as health is a barrier to accessing primary care dentistry. For example:

- An appointment could be cancelled if a patient is acutely unwell
- Health conditions may prevent a patient accessing a dental practice
- Obesity may limit whether there are facilities for the patient and mobility issues may prevent attendance
- Inadequate wheelchair access
- Neurological impairments.

Patients with dementia become more dependent as the disease progresses which can be very frustrating for the patient. I have been aware of times where dementia patients

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can become aggressive and refuse to attend dental appointments and family members/ carers are unable to bring them. Furthermore, it can be very difficult to motivate and dress dementia patients and therefore appointment times may be missed accidentally.

Pain

Patients who attend an urgent dental appointment may be in pain. Anecdotally, due to this negative association, medically compromised elderly patients may not wish to attend an appointment at all. Equally, this cohort may refuse to attend routine appointments, also with respect to negative associations. Alternatively, pain may have prompted an initial appointment to be made; however, if the pain dissipates in the meantime the patient or family/carers may decide the appointment is no longer warranted.

are all barriers that can potentially slow down a treatment plan. This may mean delayed treatment, longer waiting times and, perhaps, more frequent appointments.

Financial burden

Lastly, there is the issue of cost. Unless a patient specifically carries an exemption then, irrespective of age, he or she is liable to pay. This can cause problems. There have been times in our practice where a patient has been escorted by a carer and has been ineligible for an exemption. This is particularly challenging when the carer is unable to consent and cannot understand the patient record form and then risks being fined if they incorrectly tick that the patient is eligible for exemption. Often patients are escorted by family members who are left to carry the financial burden of the dental appointment. It's particularly distressing when end of life patients are not exempt and wish to have new dentures and the family member can't afford to pay.

'ORAL HEALTH CARE INFORMATION SHOULD BE MORE READILY AVAILABLE AND AUDIENCE-APPROPRIATE WHEN FAMILIES INHERIT THE BURDEN OF CARE FOR ELDERLY RELATIVES.'

Consent

Patients who are heavily or solely dependent on a care-giver may not be able to consent for themselves. This can make it extremely difficult for patients to receive the treatment they need, not least because a GDP may feel uncomfortable treating a person who cannot give valid consent. The Mental Capacity Act 2005 outlines how to obtain valid consent from a patient and if this cannot be done due to the patient not being competent, then the clinician must act in the patient's best interests. However, this can be contentious if the care-giver disagrees. Commonly, patients with dementia will have assigned power of attorney to a relative who can make decisions on their behalf when they lose competence. In these circumstances, treatment can be provided following discussion with the patient and the carer. The difficulty lies when the carer does not have authority to provide consent and the patient lacks competence. Legal safeguarding such as IMCA (Independent Mental Capacity Advocate) can support in such circumstances however these are all barriers that can potentially slow down a treatment plan.

What can be done to reduce these barriers?

From a GDP perspective, it would be prudent to ensure there is appropriate commissioning of services. People in care-homes are not included in the Adult Dental Health Surveys and therefore we cannot be sure that there is appropriate funding for them. It may be prudent to collect data specifically surrounding those in care-homes/ hospitals to demonstrate the need for this service. There has been a decrease over the years in the number of primary care dentists providing a domiciliary service[6] and this should also be addressed. Perhaps decreasing the burden of domiciliary visits on community dental services and sharing care with GDPs may be an option? This may require a change in how GDPs are remunerated. Alternatively, an increase in the number of salaried dental services may be an option.

Oral health care information should be more readily available and audience-appropriate when families inherit the burden of care for elderly relatives. For example, leaflets with advice on when a patient should attend the dentist and where the nearest dental practice is, including information on accessibility to the dental practice. This should make it easier for caregivers to find out whether their dependents are entitled to free dental care.

Conclusion

There are a multitude of barriers to accessing primary care for the elderly, medically compromised patient but there is some scope for improving this access. In light of an increasing elderly population there is need for further commissioning of services to ensure patient oral needs are met; this could be helped by further Adult Dental Health Surveys focusing on the ageing population.

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DOI: 10.1038/s41407-019-0070-1

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