Oral Healthcare for Older People

2020 Vision
Foreword

This publication on the dental care of older people is the first in a series of key policy papers from the British Dental Association devoted to a single issue. The aim is to highlight a specific subject area in order to stimulate debate and, we hope on many occasions, lead to action being taken to bring about change for the better.

The BDA’s work on older people is prompted by concern within the profession about whether those responsible for planning and delivering dental care are prepared for the very different oral health needs of an ageing population. Not only are people living longer but, thanks to improvements in dental care, many more of us will keep our teeth for life.

This paper brings together research carried out by the British Dental Association in 2002 and looks forward to the level of provision we believe will be required by 2020.

Thanks is due to our Representative Body, which has debated and approved the recommendations included in the paper, and also to the Expert Reference Group, the members of which brought a wealth of knowledge and experience to the project. Recognition must also go to the colleagues within the BDA policy directorate who have worked with such enthusiasm and commitment on this important work.

Policy is wasted effort if it is left to gather dust. The real test of this paper will be the impact it makes with dentists and other members of the dental team, and with all those who work with older people, especially carers. The paper also provides a fresh source of data for researchers and, perhaps most importantly, indicates to decision-makers the direction which must be taken if the oral care needs of older people are to be met.

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Oral Healthcare for Older People
2020 Vision

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Executive Summary

This policy paper brings together research undertaken by the British Dental Association into the dental service provision for older people that will be needed by 2020. Demographic changes and changing patterns of oral disease mean that the provision of oral healthcare for older people must change in order to meet anticipated future needs and demands of the older persons population in 2020.

Demographic change

The UK population is ageing. Increased life expectancy and mortality, coupled with a falling birth rate, mean that by 2020 the proportion of people aged 65 and above is projected to rise from a current figure of 15.7 per cent to 18.9 per cent. At the same time as the population of older people is growing, it will become more ethnically diverse; and the imbalance in numbers between women and men will continue to increase.

Older people in 2020 will exhibit a broad spectrum of dependence. They will largely continue to live in their own homes. Nursing and care homes will provide accommodation for a group of older people who are most likely to be frail with complex clinical needs. Ensuring access to appropriate oral healthcare for dependent older people will continue to be an issue for the National Health Service.

There will be a broadening disparity between the amount of disposable income available to wealthier older people compared to that available to poorer sections of this population, with a significant number of people who can fund their own oral healthcare and a significant number who cannot.

Changing clinical needs

The change in the composition of the UK population will have an effect on dental practice and an impact on the training and skills required by health and social care professionals. There will be increasing numbers of older patients who need, and would like to have, complex restorations to ensure that they retain many of their natural teeth. Conditions such as root caries and dry mouth will continue to be prevalent, although new clinical technologies may be developed to prevent and treat them. Dental teams will be providing oral healthcare to a greater proportion of older patients with a range of complex needs for which they will require appropriate training and experience.

As well as changing clinical needs, older people will have increasing expectations about retaining good oral health and appearance in old age; and many will have the resources to take advantage of advances in cosmetic procedures. They (and their relatives and carers) will also expect to relate to dental teams as consumers, and to receive both full information and a range of options relating their oral healthcare.

The combination of greater numbers of older people with more teeth needing restoration adds up to more and more complex work for the dental team:

\[
\text{More older patients} + \text{More teeth} \times \text{Wider range of clinical issues} = \text{CHALLENGES}
\]

The challenge for both the government and the profession is how this increased demand will be met.
Improvements in service provision

Changes in delivery of oral health services for older people will need to be made and subsequent education and training of health and social care professionals will be required.

Services will need to be more accessible and dentistry will need to be fully integrated within the NHS. General dental practice will remain at the heart of care provision; the role of the Community Dental Service as a provider of specialist care and advice for older patients will also need to be developed. Residential and nursing homes must offer residents preventative oral healthcare and access to treatment that is appropriate for the individual.

Information and advice on self-care and accessing oral health services need to be much more widely available in formats and media that are used by older people, particularly those who are part of hard-to-reach groups. The dental trade is an important and often forgotten source of oral health information for the public and very often its marketing strategies and products completely neglect older patients.

Care planning for older people must be undertaken on an organised basis, with a strategic approach adopted for patients who are at risk of requiring complex restorative care in the future. Delivering preventive care and advice, as well as screening for oral cancer for older patients should also be part of readily accessible services.

Education and training of health professionals providing oral healthcare services to older people is a priority. This should encompass the undergraduate curriculum, including experience of providing care in a variety of settings, as well postgraduate and CPD courses.

2020 Vision

In 2020, oral healthcare services for older people will need to be:

- recognised as an integral part of strategies to tackle inequalities in older people’s health and to increase the quality of older people’s lives;
- joined up and integrated at a local level with other health and social care services;
- accessible, of a high quality, available to all and patient centred;
- reflective of the diversity of the older persons population;
- in line with Government health policy (for example, helping enable older people to remain independent for longer);
- available equally to all older people on the basis of clinical need, regardless of age, geography or home circumstances.

Recommendations

To achieve the vision outlined above, we recommend that the following measures be implemented within the next two years:

1. The new locally commissioned system for the delivery of NHS primary care dentistry in England must take account of the needs of older people, and the demographic and clinical changes identified in this paper.

2. Local health authorities must look creatively at dental provision for older people and tie in dentistry with other services, such as General Medical Practice, chiropody and pharmacy. Voluntary organisations and day centres are also means through which care can be brought to people (using mobile units).

3. Work on new NHS Clinical Pathways for dentistry must reflect the needs of the older persons population and ensure that further clinical challenges for dentists treating older patients in the future are not inadvertently created.

4. A free oral health risk assessment should be available to patients from age 60, with referral to a dentist for a strategic long-term oral healthcare plan offered to those identified as likely to need complex restorative care.
5. Residential care homes should be required to provide potential residents and their carers with basic information on quality-of-life indicators relating to oral health. This would enable potential residents to prioritise their oral health requirements, thereby facilitating freedom of choice. There should also be basic local standards relating to the oral healthcare of residents with which homes would have to comply – for example, scheduled visits by a dental professional.

6. Marking of existing dentures for easy identification in residential homes should be available free to patients on the NHS.

7. Local health authorities should be encouraged to place simple contracts with local practices to provide care to a small number of residential care and nursing homes, with portable equipment for domiciliary work being made available on loan.

8. England, Wales and Northern Ireland should follow Scotland in passing legislation to enable people suffering some form of mental incapacity to appoint a Welfare Power of Attorney, normally a relative or carer, empowered to make decisions as regards appropriate healthcare on behalf of the person.

9. The BDA (with others) should produce information templates for older people, carers and residential care homes, about oral healthcare, services and costs that can be adapted by local health authorities and voluntary organisations.

10. Research, including controlled trials, should be undertaken, exploring ways of encouraging effective self-care by older people; and the results should be piloted.

11. NHS dental information and forms should be available in a variety of languages, in Braille and in large print format.

12. Information about full and partial exemption from NHS dental charges should be simplified and publicised to older people and carers.

13. Translation services and health advocates should be widely available, to make oral health services more accessible to older people from ethnic minorities.

14. Planned reform of NHS dental charges should take account of the growth in the older persons population and the fact that older people are more likely to require more complex treatment and also tend to be among the least able to afford to pay. Free NHS examinations should be available to patients aged 65 and over across the UK.

15. The undergraduate dental curriculum should continue to include teaching of complete and partial dentures, and should also give students experience of domiciliary visits and care homes.

16. CPD and postgraduate courses must be offered to equip dentists and PCDs with the clinical and communication skills they will need to treat the large caseload of older people by 2020.

17. Special care dentistry must become a recognised speciality.

18. Community Dental Services should be resourced properly, to enable CDS dentists to provide specialist services and clinical leadership to dentists and PCDs providing care for older people.

19. Anti-discrimination training should be introduced as part of the curricula for dental undergraduates and student PCDs.

20. Companies dealing in products related to oral health should recognise the potential market represented by older people who want to preserve their good oral health and appearance and develop appropriate products and advertising campaigns.

21. Dentists should be able to prescribe any drug in the BNF for NHS patients for dental use. The de facto inability of dentists to prescribe artificial saliva makes this of particular relevance to the treatment of older people.
This policy paper brings together research undertaken by the British Dental Association into the dental service provision for older people that will be needed by 2020. This chapter examines the methodological approach taken in preparing this paper.

The key mode of categorisation for older people is currently widely accepted as relating to functionality. This classification distinguishes, regardless of age, between people who are: functionally independent; functionally dependent; and frail. The English National Service Framework for Older People (Department of Health [England] 2001) talks about older people falling into three broad groups:

- **Entering old age** – Those who "have completed their career in paid employment and/or child rearing. This is a socially constructed definition of old age, which, according to different interpretations, includes people as young as 50, or from the official retirement age of 60 for women and 65 for men. These people are active and independent and may remain so into late old age."

- **Transitional phase** – "This group of older people are in transition between healthy active life and frailty. This transition often occurs in the seventh or eighth decades but can occur at any stage of older age."

- **Frail Older People** – "These people are vulnerable as a result of health problems such as stroke or dementia or social care needs or a combination of both. Frailty is often experienced only in late old age, so services for older people should be designed with their needs in mind."

The NSF mainly uses data concerning people who are aged 65 and over, with some relating to those who are 60 and over. Broadly, we have used the same approach to the inclusion of data. When considering oral health services, we believe that the different needs of all three groups must be met.

This paper relates current official projections for the population of older people in 2020 to the delivery of oral healthcare and makes some specific recommendations for dental service provision, education and health promotion. **In the BDA’s view, future oral health services for older people will need to be:**

- recognised as an integral part of strategies to tackle inequalities in older people’s health and to increase the quality of older people’s lives;
- joined up and integrated at a local level with other health and social care services;
- accessible, of a high quality, available to all and patient centred;
- reflective of the diversity of the older persons population;
- in line with Government health policy (for example, helping enable older people to remain; independent for longer);
- available equally to all older people on the basis of clinical need, regardless of age, geography or home circumstances.

Putting policies in place to meet the demands that are outlined in this paper is necessary now. Dental service provision for older people is not adequate now in many localities, particularly in respect of preventative care and dental treatment in residential care homes. Action is required by the Government to include oral healthcare in the implementation of the NSF for older people and require local health authorities to improve care provision, improve access to dental services and ensure that the benefits of new technology in dentistry are available to everyone. In this way, the potential negative social, physical and emotional consequences of poor oral health for older people will be avoided.
We would like this paper (which represents BDA policy on oral health services for older people) to be used as a reference document by policy makers and voluntary organisations campaigning to improve health services for older people. The present Modernisation Programme for NHS Dentistry, which is taking forward the recommendations of the Options for Change report in England and the intended eventual replacement of the General Dental Services with primary dental care commissioned by Primary Care Trusts, must take into account the future oral health needs of the older persons population. The BDA will be campaigning strongly to ensure that the recommendations contained in this document are put into practice at both national and local levels during the next two years.

Methodology

The preparation of this policy paper went through the following stages

- a literature review (see bibliography);
- assembling an Expert Reference Group to provide input throughout the research. The Group met twice, the first time to brainstorm the issues from the future demand perspective and the second time to look at the consequent issues for the supply of services in 2020;
- meetings with voluntary organisations, such as Age Concern, Help the Aged, the Alzheimer’s Society and the Centre for Policy on Ageing, to examine general issues for older people and their vision of 2020;
- visits to four care homes to gain a closer understanding of providing oral health services in a care environment;
- meeting with the Older People’s Reference Group convened by Age Concern, to look at oral care from the user perspective and gain feedback on the research.

During the research process we decided that the best way of approaching the work was to look at the demand for oral healthcare in 2020, based on demographic projections and clinical predictions, and then to speculate on what changes to service provision would be required to meet the anticipated changes in demand. After gathering this information and advice, we produced the first draft of this paper, which was commented on by members of the Expert Reference Group and given to the BDA’s Representative Body as a work-in-progress document in October 2002.

In December 2002, a further draft was presented to the audience at the autumn meeting of the British Society of Gerodontology, the theme of which was Oral Care for Older People in 2020. Four speakers (Professor Anthea Tinker, Professor A. Damien Walmsley, Dr Janet Griffiths and Ms Hilary Wainwright) gave presentations on the older persons population in 2020, clinical issues, service provision and access requirements; some of the issues were also debated in workshop sessions. Information presented by the speakers has been used in the paper and attributed.

The final draft document was then considered and approved by the BDA’s Representative Body in January 2003.

Structure of the paper

This chapter has introduced the paper and described the research methodology. It has also set out the approach that we have used for classifying the older persons population.

Chapter two summarises the socio-demographic characteristics of the older persons population and includes projections for 2020.

Chapter three reviews the changing clinical needs of the older persons population in 2020 and suggests some improvements in clinical technology that may occur.

Chapter four examines the changes in delivery of oral health services for older people that need to be made and the subsequent education and training of health and social care professionals that will be required. The chapter also looks at potential opportunities for improvement, especially if the Government’s intention of moving to local commissioning of NHS dental services is put into practice.

Finally, chapter five contains our recommendations that will enable our “2020 vision” of oral healthcare services for older people to be realised.
Chapter Two:
The Socio-Demographic Context For Oral Healthcare Provision in 2020

This chapter looks at evidence relating to the demand for oral healthcare for older persons in 2020. The conclusions we reach are not forecasts – demand for oral healthcare is affected by factors that cannot be safely predicted, such as social attitudes, economic prosperity and technological innovations. Population projections should also be treated with caution; they are affected by changes in fertility, mortality and migration, as well as medical advances (Tinker 2002). The information presented here sets the context for the recommendations we make regarding changes to oral healthcare services that are required to meet the varying needs of older people in 2020 and beyond.

Demographics – now and in 2020

The UK population is ageing and this demographic change will have a significant impact on the demand and supply of oral healthcare in the future. The 2001 UK Census, conducted by the Office for National Statistics (ONS), revealed that adults aged 60 and over account for 21 per cent of the population, with children under 16 accounting for 20 per cent (ONS 2002). The latest published UK population projections (2000-based) from the Government Actuary’s Department (GAD) show that by 2020 the population of the UK is projected to reach 63.9 million.

The proportion of people in the UK population aged 65 and above is projected to rise from a current figure of 15.7 per cent to 18.9 per cent in 2020 (GAD, 2000-based). Whilst a factor in this shift is the “baby boomers”, born between the mid-1940s and the mid-1960s, reaching older age, the major determinant of the growth in the proportion of older people is that people in the UK are living longer, whilst the birth rate is falling (Tinker 2002).

Fertility rates are continuing to fall. According to the Office for National Statistics (ONS 2002a) in 1961 there were 91 live births per thousand women aged 15–44; in 2000 this figure had fallen to 55. Over the next decade, the growth in the number of old and very old people in the UK will exceed that for the population as a whole. Population projections from the Government Actuary’s Department (2000-based) show that the UK population will grow by 2.3 per cent between 2003 and 2010. Over the same period, the number of people aged 65–84 will rise by 5.2 per cent and those aged 85 or more by 16.8 per cent. Further into the future, in 2020, the UK will be home to almost 12.1 million people of pensionable age, and within the 85 and above cohort there will be almost twice as many females as males.

Ethnic minority older people

At the same time as the population of older people is growing larger, it is also becoming ethnically more diverse, as both first and second-generation immigrants reach older ages. The 2001 UK Census showed that the proportion of minority ethnic groups in England had risen from six per cent to nine per cent since 1991 (although this was partly as a result of the addition of mixed ethnic groups in 2001).

Most members of ethnic minorities in the UK live in England and are concentrated in urban areas, particularly in southern England – nearly half of all members of ethnic minorities in the UK live in London. In London alone, the number of older ethnic minority persons (65 and over) is projected to increase from 98,000 in 2001 to 138,000 in 2011 – an increase of over 40 per cent according to Greater London Authority (GLA) population projections. Whilst we have not been able to obtain forecasts for 2020, the indications suggest strongly that the number of older people from ethnic minority communities in the UK is set to rise further.
There is evidence that members of ethnic minority communities have generally worse health (Acheson 1998) and are less likely to regularly visit a dentist (DoH 1999). This poor oral health means that older people from ethnic minority communities will require targeted services that are culturally appropriate and accessible and tackle their particular needs.

Health, social and economic factors
Just like any age-defined group, older people are not homogeneous but, of course, are drawn from an array of different backgrounds and have had diverse life experiences. People who are very old (particularly those aged 75 and over) are likely to be the most "in need" in the population, whilst the population cohort who in ten years time will be of pensionable age (currently 55–64) are amongst the most economically powerful in society (Help the Aged 1999). However, there will still be many older people in 2020 living in relative poverty (Age Concern 2002).

Gender differences
There are differences in health between older men and older women. Tinker reports that "women have higher rates of disability … have different kinds of conditions e.g. they are more likely to have arthritis. Women are more likely to be obese … more likely to suffer from anxiety and depression. Women have higher expectations of life, less likely to drink excessively, have stronger social networks." (Tinker 2002). She also points out that "Women are less likely to use the services of a dentist than older men". The 1998 General Household Survey reported that only nine per cent of female interviewees aged 85 and over reported using dental services in the last three months before interview, compared with 13 per cent of male interviewees of the same age.

Physical health
Mobility is important for accessing dental services, particularly in rural areas and other locations where patients have to travel considerable distances to access NHS care. The most popular physical activity for older people is walking (ONS 1998), however, frailty and restricted mobility are more likely to occur with increasing age. The 2000 General Household Survey reported that of those respondents aged between 65 and 74, over one third reported that they had a long-term illness that limited their mobility. For those aged 75 and above the proportion was nearly half. The greatest decline in mobility is among those aged 75 or above (ONS 1999). Over one third of people aged 65–74 report a loss in mobility and this proportion rises to over half for those aged 75 and above. It is worth noting, however, that loss of mobility is not an inevitable consequence of ageing, and that mobility can be regained and maintained with appropriate aids.

In addition to impaired mobility, conditions such as diabetes and strokes are common in older age. It is also important to consider the communication needs of older people, as most people with hearing loss are over 60 and this will affect the way dental services are delivered.

Mental health
The Alzheimer's Society estimates that there are currently 750,000 people in the UK with dementia, of whom the overwhelming majority are aged 65 years or over. This suggests that at least seven per cent of people of state pensionable age have dementia and the chances of having the condition rise sharply with age. By 2010 the number of people with dementia is projected to rise to 840,000 with 845,000 in 2020.

Drug therapy is currently used to affect how far and how fast dementia progresses. Several of the common drugs used to treat Alzheimer's disease are available in syrup form and so have all the oral health drawbacks associated with such medicines. Also, a number of medicines often prescribed to older people cause dry mouth; these include neuroleptics. However, newer drugs, in tablet form, which treat mild to moderate dementia, show fewer oral health drawbacks. Developments in drug therapy could have the result of delaying individuals' entry into care homes. It is likely that in future more sufferers will have the disease contained at different stages of severity, as a result of drug interventions. The Alzheimer’s Society estimates that one third of those with Alzheimer’s disease live at home alone, one third at home with day-care from relatives or professionals and the remaining third in a long-
term care facility. Alzheimer’s sufferers may be physically well yet totally functionally dependent in mental terms. The majority of those living at home are quite mobile. Most older people with dementia who enter long-term care facilities do so because they are unable to cope alone, or because their behaviour is becoming increasingly challenging.

The National Service Framework for Older People (2001) specifically refers (at paragraph 8.12) to “the importance of providing older people with oral healthcare and advice on oral health”. However, the Alzheimer’s Society Food for Thought research suggested that only eight per cent of dementia sufferers had seen a dentist in the previous year, despite the fact that approximately half of them had reported dental problems. Community dentists, who are currently felt to be the most appropriate professionals to treat older people with complex additional needs, are overworked in some areas, leading to long waiting times.

Another major obstacle to access to dentistry relates to care staff and their training. Many care staff have minimal exposure to people with dementia, and are often not trained in caring for them. Consequently, this, combined with inadequate information and training on oral healthcare for older people and specifically for those with dementia, leads to carers being unable to recognise oral health needs. Additionally, the tools available for the Single Assessment Process may not be adequate to properly identify oral healthcare risk factors.

The majority of people with dementia in residential care are likely to require domiciliary care, although it would be difficult to estimate an exact proportion. Also it is very hard to estimate in general how many people with dementia need domiciliary oral healthcare, as it is impossible to generalise about people with the condition. Dementia affects different people in different ways; some will have no problem visiting the dentist, others will find it mentally distressing to the point where it is impossible and will need to have domiciliary care.

There is new legislation in Scotland, which allows a relative or other carer, to be nominated to consent to medical treatment on the patient’s behalf. Current laws in the rest of the United Kingdom allow such proxy decisions only relating to financial matters. Whilst the Government has responded sympathetically to lobbying on this issue, there are no plans for legislative change at present. However we can speculate that by 2020 people throughout the UK will, if they wish, be able to nominate someone to consent to treatment on their behalf if they become incapacitated. This may remove a barrier to people with a range of mental health issues accessing care.

Older people, just like the rest of the population, can experience and live with various sorts of mental illness. Depression is also common among older people. This means that as the relative numbers of older people increase, there will be an increased demand on oral health services to provide appropriate care for these patients.

Home circumstances
Current provision

Across the UK, there is a trend towards older people continuing to live at home, rather than going into institutional care. However, the proportion of older people living in sheltered housing or long-stay hospitals (or care homes) does increase with age. In the UK, 99 per cent of people aged 65–69 live in their own home; but between age 85 and 89 this reduces to 80 per cent. Overall, 95 per cent of people aged 65 and over live in their own homes, with just under half a million older people, approximately five per cent, living in institutionalised care (Tinker et al 2001).

The current emphasis of Government policy is that care for older people should be provided in their own homes. Department of Health data indicates that during one week, in England, in 1998, 445,900 households received some help or home care services. Of these, almost one in five were aged 65–74, and around two thirds were aged 75 and over. Results from the 2000 General Household Survey show that the likelihood of living alone increases with age in Great Britain. In 2000, for people aged 65–74, almost one in five males lived alone, with almost two in five females living alone. For the cohort aged 75 and over, one third of males and three in five females lived alone. For the whole population, ONS Social Trends 32 reveals that 29 per cent of households were single person with 15 per cent of households in 2002 having one person over state pension age.
Homeownership in the UK has become the predominant form of property tenure – nearly seven out of ten households are now owner-occupiers. The 2001 report *Half the Poor: Home-owners with Low Incomes* by the Council of Mortgage Lenders concluded that the average housing equity held by home owners within the lowest three income deciles in 1996 was about £50,000. There are also currently many equity release schemes available to enhance the incomes of retired homeowners although relatively few homeowners have thus far found them attractive.

**Future trends**

The growth in homeownership combined with the trend towards older people residing in their own home (rather than care or nursing homes) will continue into 2020. Care and nursing homes in 2020 will be dominated by frail and functionally dependent older people with complex clinical needs (DoH 2002), although the desire to remain in one's own home could result in there being a growing number of frail and functionally dependent older people living at home. This will have repercussions and increase the pressure to focus upon older people’s mobility requirements meaning localised transport arrangements will need to be developed. However, older people in 2020 are likely to have access to more information on health and healthcare in general (through the Internet, for example). This, then, could potentially mean that the inequalities between older people may increase, not solely according to age, but from lack of access to information, as well as the impact of health inequalities.

By 2021 there will be some 2.4 million homeowner household heads aged over 75 – a 70 per cent increase over current levels (The Future Foundation 2001).

**Income**

There is a growing polarisation of income within the older persons population that commentators predict will increase over the next twenty years. Levels of disposable income have an effect on the demand for oral healthcare, particularly cosmetic care. Entitlement to free NHS treatment and the cost of complex restorative procedures are also issues.

**Low incomes**

The older a person is, the more likely they are to live on a low income. Figures from the Pensioners’ Incomes Series 2000/01 show recently retired couples received an average of £331 per week, compared to £276 a week for couples aged 75 and over. Around 69 per cent of pensioner households depend on state benefits for at least half of their gross income. Because of uneven employment histories and a lack of savings for retirement, there will be considerable numbers of older people who will experience a gap between what they receive in their retirement and what they actually need. Older people from minority ethnic groups may be particularly badly hit where benefits depend on lifelong National Insurance contributions, since people who moved to the UK as adults may not have contributed enough to receive full support.

Older people living alone who are mainly dependent on state benefits experience the most severe deprivation in the UK. These people tend to be women living alone. They are amongst society’s most economically and socially vulnerable groups. They have the lowest household incomes and levels of expenditure, and the highest instance of poor health and immobility (Help the Aged 1999). Currently older people do not automatically receive free NHS dental treatment by virtue of age but only if they are on Income Support; however, free NHS dental examinations are available for people in Wales aged 65 and over.

**High incomes**

A report by The Future Foundation, *The emergence of the mass affluent* (November 2000), found that six per cent of individuals have £50,000 or more in liquid assets and by 2005 this will rise to eight per cent. Eleven per cent of individuals currently have over £25,000 and this will rise to 15 per cent by 2005. Of those with £50,000 or more in liquid assets, 38 per cent were aged 65 and over.

The older persons population in 2020 will be more diverse and will experience more social extremes than previous generations; their dental needs will reflect this increased diversity. Many will choose to spend a small part of their income on oral healthcare and many will have other priorities. There will
be many, particularly couples in early old age, who will have the financial resources to access whatever oral healthcare they wish. However, there will also be many older people who are economically vulnerable and may not have the resources or mobility to access the range of complex treatment which would enhance their quality of life even if they wanted it – these people’s oral needs must be the priority for state provision.

Social trends
The *Britain towards 2010* report contends that in 2010, "We will see greater individualism, personal mobility, individual freedom and choice …" (Scase 1999). It also goes on to state that there will be a "… changing composition of households – fewer children, more single persons, high rates of divorce and the ‘churning’ of partners". The report also concludes that the population will demand more from the services that they receive, in particular publicly provided services, such as health, education and the police. Focusing on demographics, there is likely to be a change in the attitude of older people and in particular "lifestyles traditionally associated with different age categories will disappear".

The changes in the age structure will have a marked effect on the future proportion of dependants in the population. The ratio of the population of pensionable age to the population of working age is projected to rise from the current 0.29 to 0.3 in 2020. Longer-term projections indicate that in 2040 this ratio will be around 0.41 (GAD 2000). As a result, pensioners in the future will have a smaller proportion of those of working age to fund their state pensions. There are commentators, however, who consider the aging "time bomb" to be a myth, arguing that society has coped with such issues, through mechanisms such as increased productivity as a result of technology, in the past and can do so again (Mullan 2000).

Present emerging social trends (such as women being equally present in the labour market and choosing lifestyles that in the past were mainly experienced by men and increasing attainment of higher education qualifications) will all potentially have an effect on health, mortality and social attitudes. These will all influence the older persons population in 2020, in turn affecting the need and demand for oral healthcare.

Technology
Professor Anthea Tinker has drawn attention to the impact of uses of relevant technology on older people in relation to oral healthcare (Tinker 2002). Older people have joined in with the rest of society in making use of the new information technology. Seventeen per cent of two-adult households where one or both were 60 plus had Internet access, with 38 per cent having access to a mobile phone (ONS 2002; General Household Survey 2000). Access to this technology can be used by providers of oral healthcare services for relaying advice and information, booking appointments and, in the future, on-line consultations for patients who are unable to travel to the practice (using digital cameras, for example).

Conclusions
Our study of the demographic trends affecting the provision of oral healthcare shows that by 2020:

- there will be significantly more older people in the population who will need oral healthcare.
- at the same time as the older persons population is growing, it will be becoming more ethnically diverse and more female.
- older people in 2020 will present a broad spectrum of dependence.
- many older people will continue to live in their own homes, and the numbers doing so will increase. Nursing and care homes will be home to older people who are frail and/or functionally dependent with complex clinical needs.
- lack of access to care because of mobility problems will continue to be an issue.
- there will be a broadening gap in the amount of disposable income within the older persons population, with a significant proportion of older people who can fund their own oral healthcare and a significant proportion who cannot.
Chapter Three:
Future Oral Health Characteristics of Older People

Current situation
After 1948, the National Health Service greatly widened access to oral healthcare, meaning that many more teeth were saved by restorative work than was previously the case, and habits of attendance for, and expectations of, oral healthcare were established among large sections of the population. The widespread use of fluoride toothpaste, from the early 1970s, has led to a dramatic improvement in oral health in the UK in the space of just one generation. Greater awareness of oral hygiene and changes in eating patterns, as well as water fluoridation in some areas, have also played their part in improving oral health.

In respect of oral health, three broad cohorts are clearly present in the UK population:

■ people who are old and very old, of whom a large proportion are edentulous (without any natural teeth);
■ those now entering old age, who have retained much or most of their natural dentition, but in a state that requires a lot of maintenance if dentures are to be avoided;
■ those now in middle age and younger, who are retaining their dentition in a good state and, assuming the status quo, are unlikely to need complex oral healthcare, but who may opt for cosmetic dentistry.

Adult dental health surveys
In 1968 over one third of the total adult population of the UK had no natural teeth, and only a small number of people of pensionable age had any teeth at all. The 1998 Adult Dental Health Survey (ONS 2000) shows that a major change has occurred in the past thirty years – currently only 13 per cent of adults have no teeth; and, even more impressively, over half those of pensionable age have some of their natural teeth. The 1998 Adult Dental Health Survey also shows that older people now are much more concerned with preserving their natural teeth than was the case before. Over the last decade, a growing proportion of dentate 65–74 year olds would consider having a tooth crowned; in addition, a growing proportion of those aged over 55 expect to keep some of their natural teeth for life.

A preventive attitude to dental disease seems to be becoming more prevalent among older people. In 1998, one third of adults aged 55 and over had regular dental check-ups – this proportion was the highest for any age cohort and is more than double the level found in 1978. It is also interesting that adults over 65 with some natural teeth are less affected by concerns about cost, fear and the organisation of dental visits than the average adult with no natural teeth. Additionally, older people are more concerned about the long-term value of oral healthcare.

Overall, 62 per cent of adults with some natural teeth in the UK recall having been given some advice or information about tooth brushing or gum care. Older adults were, however, the least likely to say they had been given such advice. Fifty-one per cent of those aged 55 and over said that they had been shown how to clean their teeth or been given advice on gum care. The proportion reporting that they had received such advice declines as the age cohort rises.

Predictions from the 1998 Adult Dental Health Survey indicate that the proportion of UK adults with no natural teeth will fall to eight per cent in 2008 and five per cent in 2018. The proportion of adults of pensionable age with some natural teeth will rise dramatically over the next two decades. For example, by 2018, 56 per cent of people aged 85 and over will have some natural teeth, compared with a figure of 19 per cent in 1998. Even so, it is important to remember that, despite the fall in the proportion of edentulous adults, they still represent a significant number who will require oral health services.

With the growing proportion of ethnic minority older people, it needs to be borne in mind that risk behaviours associated with oral cancer are more prevalent among certain ethnic groups (BDA 1996). Chewing tobacco products such as betel quid or paan (containing betel leaf, areca nut, tobacco and
slaked lime) is quite common in certain Asian communities. The 1998 Adult Dental Health Survey suggested that Bangladeshi, Irish and Black Caribbean men were more likely to smoke cigarettes than the general population. In addition, the Survey found that individuals from minority ethnic groups were less likely to visit the dentist for a regular check-up and to go only when in pain. This means that oral cancer in these groups is unlikely to be seen until the late stages when the morbidity and mortality associated with its treatment are greater.

**Significant clinical issues**

Against the background of these general improvements in oral health, changing patterns of dental disease among older people are apparent, and will become more so. In consequence clinical treatment will be more complex, as will be the task of defining what that treatment should be for the particular circumstances of the patient. The following clinical issues are of the greatest significance:

**Restorative issues**

**Decay** – Teeth retained into old age can become more prone to decay as a result of a number of inter-related factors (discussed further below). Given the prevalence of gingival recession in old age, the resulting decay is likely to take the form substantially of root-surface caries, which can be difficult to manage. Patients’ desire to retain their teeth into later life will lead to an increasing need for endodontic treatment, particularly molar endodontics (Steele et al. 2001).

**Collapsing / failing dentitions** – Advanced tooth wear, tooth loss, large restorations involving substantial loss of tooth tissue, increasing periodontal problems and difficult endodontic treatment can all combine to cause a rapid collapse in the dentition, often necessitating a transition to partial or complete dentures. This poses problems for the dental practitioner as regards establishing and maintaining appearance, function, occlusal stability and comfort, as well as the need to prevent future dental problems (Carpendale 1999).

**Deteriorating oral hygiene** – Maintenance of good oral hygiene is the key to good oral health. Extended old age brings greater risks of disease and disability, with conditions such as heart disease, cancer, stroke, diabetes and Alzheimer’s disease occurring more frequently as people grow older. The resulting physical infirmity, impaired manual dexterity, mental deterioration and failing eyesight can all have a dramatically negative effect on oral hygiene, leading to a marked increase in oral disease. The same factors can also lead to changes in eating habits. Older people often choose, or are advised, to eat little and often. This practice can mean an increase in the frequency of sugar intake. Changes for the worse in eating habits (from a dental perspective) can also be associated with entry into residential care. General health problems and physiological changes in the mouth (impairment of saliva function; repeated ingestion of sticky, sugary medicines) brought about by pharmacotherapy and radiotherapy can further contribute to a sharp downturn in oral health (Fiske and Lloyd 1992; Frenkel et al. 2000; Merelie and Heyman 1992; Steele and Walls 1997; Walls and Steele 2001).

**Tooth-wear** – Chronic erosion, attrition and abrasion can have a significant impact on the dentition by the time a person reaches old age (this is a further example of how problems resulting from cumulative factors can have a serious impact in old age). Persistent vomiting and gastro-oesophageal reflux, related to general ill health and medication, leads to the erosion of tooth enamel. Loss of tooth surface leads to pain and a greater risk of decay. This is an area where technical advances in dental adhesives could treat tooth wear (Donachie and Walls 1995).

**Gum disease** – Chronic medical conditions (for example, diabetes and immunosuppressant disease) and medications (for example, anti-hypertensive drugs, seizure drugs and oestrogen replacement therapy) that are common among older people can aggravate gingivitis. Cumulative steady loss of gum attachment over time will eventually lead to serious periodontal conditions, which can be exacerbated by deteriorating standards of oral hygiene in old age. It is now accepted that a patient’s oral hygiene status is of more significance than chronological age in the development of periodontal disease. Periodontal disease among older people is not due to aging itself, but rather to other influencing factors, such as certain chronic conditions (for example, diabetes and osteopenia associated with oestrogen deficiency), health behaviours (for example, smoking, stress and coping habits) and poor oral hygiene. Periodontal disease can lead to gingival recession, increasing the risk of root-surface caries (Abdellatif and Burt 1987; Steele et al. 1996). It should also be noted that some evidence
appears to show that periodontal disease may be a risk factor for a number of chronic systemic diseases (coronary heart disease, stroke and diabetes) that are prevalent in older people.

**Oral medicine**

**Xerostomia** – Dry mouth syndrome affects a substantial proportion of older adults. The condition is often an unintended consequence of radiotherapy and pharmacotherapy (for example, alpha blockers, beta blockers, diuretics, calcium channel blockers, antidepressants, neuroleptics, central analgesics, anti-allergy medications and antacids, which are commonly used in conditions affecting older people, have all been shown to affect salivary function adversely). Saliva plays a significant role in the protection and maintenance of the oral and pharyngeal tissues, and diminished salivary function may lead to oral complications, such as dental caries, loss of taste, difficulty swallowing – and candidal infections, difficulty in chewing and other problems affecting denture wearers. As well as its clinical consequences, dry mouth syndrome can, of course, also have a significant impact on quality of life (Osterberg et al. 1992; Locker 1995; Narhi 1994).

**Taste problems** – Loss or impairment of gustatory function (which is associated with xerostomia) can be a significant quality-of-life issue for older people, and can impact on both general health and oral health if it leads to changes in diet and eating habits (Wayler et al. 1990; Chavez and Ship 2000).

**Prevention**

**Change in denture-wearing experience and skills** – The transition from a natural dentition to dentures nowadays often comes at a time in the patient’s life when there is a reduced ability to cope, due to the changes occurring in the ageing mouth (bone support is lost, the covering mucosa begins to thin and ageing muscles are less able to control the denture). Making the change to dentures in later life requires some psychological adaption and learning to live with them, and this can evoke real psychological distress in some patients (Davis et al. 2000; Davis et al. 2001).

**Denture care** – Many distressing problems with dentures go unresolved because the denture wearers have not been made aware that ill-fitting and uncomfortable dentures are not inevitable. Also, the benefits of a clinical examination of all oral tissues once a year (even if no teeth are present and particularly where the older person is in a high risk group for oral cancer) are not well known. It is likely that such attitudes will change in the future as people with higher expectations (making them more insistent on their rights as consumers and more concerned about issues affecting their health and appearance) move into old age.

There is also a balance to be struck about wearing and cleaning dentures. Best clinical practice dictates that dentures should be left out of the mouth for at least four to six hours, preferably eight hours, in every 24, since leaving dentures in place 24 hours a day makes the denture-bearing tissues more prone to atrophy (Awath-Behari and Harper 1990). However, due to a range of practical and social factors, people may be reluctant to remove complete dentures at all and prefer to clean them by brushing with toothbrush and toothpaste and this, for them, can be right for their lifestyle. People in residential homes adopting this approach minimise any risk of lost or mixed up dentures. The present NHS dental fee scale provides a fee for dentists for the identification marking of new dentures but not existing ones. So if relatives want this to be done it has to be paid for privately.

**Future clinical trends**

We are currently experiencing a rapid increase in the number of older people with retained teeth, leading to a shift in dental practice within a generation from an older population which is largely edentulous to one which can benefit, if people choose, from continued restoration and maintenance of strategically important teeth well into old age. The onset of old age can mean that members of this generation find their need for oral healthcare increasing dramatically, as existing restorations fail and various factors, including increasing frailty and lifestyle changes, lead to new disease. Given the low levels of dental disease among the young, older adults will very soon become the main consumers of oral healthcare in the UK (Ettinger 1993; Ettinger and Mulligan 1999; Kelly et al. 2000; Pine et al. 2001; Steele et al. 2000; Walls and Steele 2001).

At the same time, clinical thinking about illness among older people has moved away from a focus on declining physical and social functioning, in which the aging process was seen as an inevitable

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“Given the low levels of dental disease among the young, older adults will very soon become the main consumers of oral healthcare in the UK”
downward spiral which had to be managed. Gerontologists now think in terms of “successful” or "robust" aging, i.e. the maintenance of (physical and psychological) health and functional capacities in the later years (Kiyak 2000; Kiyak et al. 2000). Older people have a choice of how much time, money and effort they wish to devote to preserving their teeth. How individuals prioritise oral healthcare varies amongst people who are older in just the same way as it does for other people, and delivery systems for dental services need to reflect this.

The increasing pharmacological management of disease, including, potentially, dental disease, will have an impact on demand. Where medicines have side effects that increase dental decay (the most common example being xerostomia), if the patient wishes to preserve his or her dentition, then this dental care must be available. Work is continuing on the development of a caries vaccine but it is unlikely that this will have had an impact on dental health by 2020.

Current general dental services provision
In terms of adult spending on dentistry in 2020, the demographic, clinical and registration trends indicate that the older persons population will become one of the major cohorts using oral healthcare over the next two decades and beyond. This has implications for service provision, the dental market and the oral healthcare products markets.

There are currently over three million people in England and Wales aged 65 and over who are registered with an NHS dentist; and a further 2.7 million registered aged 55–64 – these two age cohorts account for nearly one third of all registered adults. NHS take-up rates (registrations per 100 people) for older people have historically been below those for adults as a whole. Data from the Dental Practice Board relating to England and Wales show that the adult take-up rate for NHS dentistry in the General Dental Services in 1997 was 53 per cent; this compares with take-up rates of 42 per cent for 65–74 year olds and 33 per cent for those 75 and over. By 2002, the adult take-up rate had fallen to 44 per cent, whilst the rate for 65–74 year olds was 43 per cent and that for those 75 and over was 31 per cent.

Data relating to England and Wales (from the Department of Health) indicate that, in the year ending March 2001, General Dental Service items of service for adults (individual dental treatments) cost £988 million. £104 million (or 10 per cent) was attributed to people aged 65–74, whilst a further £67 million (or seven per cent) was spent on those aged 75 and over. Of course, these costs do not include the resources expended by the Community Dental Services and Hospital Dental Services to address the oral needs of older people. Nor do they include the cost of private oral healthcare.

New clinical technologies
The last twenty years have seen new clinical technologies that have had a positive effect on the oral health of older people (for example, dental implants, and new adhesive materials and techniques). There is no reason to suspect that new technologies will not continue to be developed, particularly with the increase in private dental practice. Some technical advances will be driven by the aging of the population, for example darker shades of composites, ceramics and denture teeth needed to match the shade and opacity of aged teeth (Walmsley 2002). Dental computer-aided design and manufacture (CADCAM) of prosthetic devices might be brought into wider use, particularly if there were a restructuring of the UK dental laboratory industry. Devices for caries detection without the use of visual inspection or radiography are now in the marketplace and could prove very useful in care home environments. Advances in gene therapy may also provide biological therapies to help treat dental disease and restore function (Walmsley 2002).

Conclusions
There will be an increasing need to deliver oral healthcare to patients with complex additional needs due to physical and/or mental impairment as more people live longer lives, but with protracted periods of chronic ill-health in old age. “Healthy life expectancy” is increasing over time, but not as much as life expectancy. Although people in England can now expect to live to an average age of 77.5, they are likely to suffer 9.2 years of ill health in later life (Bissett 2002).
In terms of clinical need, those entering old age over the next few decades will need more complex restorative treatment to retain their natural dentition. In addition to this, the clinical needs of people who will be very old in 2020 (those who retired during the last ten years) will continue to centre on the fitting and maintenance of dentures. There is also a strong likelihood that people who are 85 and over, who have the financial means, will opt for more advanced oral healthcare, for example, replacing dentures with implants. Given the higher risk of oral cancer that some ethnic minority older people in 2020 will face, this may result in a much more diverse range of clinical (and cosmetic) dental needs for the older persons population than currently exists.

There is likely to be an increased demand among older people for expensive and cosmetic dentistry (i.e. treatment which is justified primarily in terms of appearance rather than functionality – such as tooth whitening and veneers). People are becoming less resigned to the physical effects of aging on their faces as they get older and growing numbers expect to be able to maintain and enhance their physical appearance into old age by means of cosmetic products and procedures (Goldstein and Nissen 1998; Holtzman 1999; Morley 1999; Scase 1999; York and Holtzman 1999).

Demand for restorative oral healthcare is potentially huge, and for those who have the money, provision will be easy to access. Repair and maintenance of restorations will comprise a large amount of the care provided to older people by 2020. Teeth that have been saved by molar endodontics, for example, will then require ongoing attention. The future growth of the corporate sector in dentistry means that, through their economies of scale, they may drive down the cost of certain treatments, such as dental implants. This may result in dentures being very much the exception rather than the rule within restorative dentistry. There may also be adoption of the use of the reduced dental arch (premolar to premolar), which can still be functional and may be a preferable option for some older patients.

What does this mean for demand in 2020?

In summary, putting together the key findings from the preceding two chapters, we have greater numbers of older people who have more teeth needing restoration – which adds up to more and more complex work for the dental team:

More older patients
+ More teeth
× Wider range of clinical issues

CHALLENGES

The challenge for both the government and the profession is how this increased demand will be met.
Chapter Four: 
The Supply of Oral Health Services for Older People in 2020

The previous chapters presented a picture of an older persons population that by 2020 will be more numerous, more diverse, have increasingly complex clinical needs and expect to play a full and active part in all aspects of life, including choosing whether or not to access oral healthcare and what type of oral healthcare to have.

This chapter looks at what sort of oral health services will be needed in order to meet these demographic, clinical and social changes. It focuses on key areas for action, such as oral healthcare within a residential care or nursing home environment, care planning, access to information and education and training and skill mix.

Service provision 2020

Planned legislation for primary dental care services in England is likely to move service arrangements away from a centralised, unmanaged, one-size-fits-all GDS contract, plus a locally commissioned Community Dental Service. Instead, a locally managed agreement between Primary Care Trusts (PCTs) and local providers (both general practices and Salaried Primary Dental Care Services) will provide oral healthcare that reflects the health needs of the local population.

Services provided in this more locally sensitive way will have an impact on oral healthcare services for older people. It is clear that, whatever the size and shape of state oral care provision in 2020, it will be more fully integrated within the NHS, there will be fewer small practices and there will be a further expansion of the private dental market. When PCTs have a greater responsibility for dentistry there will be greater opportunities for services for older people to receive more priority. The present GDS contract does not encourage the provision of domiciliary care. The new arrangements encourage the placing of local contracts for the provision of such care, where need is demonstrated and resources can be allocated accordingly on the basis of priority.

Oral health in a care home environment

According to current Department of Health projections, the number of older people in residential care and nursing homes in England and Wales will rise by 23 per cent between 2000 and 2020, from around 375,000 to 460,000. However, the National Beds Inquiry in 2000 predicted that the number of homes would be 10 per cent lower than predicted by purely demographic considerations, because of an increasing propensity for people to be cared for at home. This would mean that the number of people in residential and nursing home care would fall to 410,000. This will still be a very small proportion of the total older persons population but it remains significant in terms of representing one of the most vulnerable groups in society.

As part of the work for this project, a short review of dentistry provided in care homes was undertaken; this is available from the BDA (BDA 2003). In summary, we found that current provision of oral healthcare within residential homes was very patchy. Various reasons are suggested, including lack of appropriate information for care staff, lack of availability of dentists (from both the CDS and GDS) for emergency care, difficulties in training staff to be aware of oral health and hygiene issues. Broadly speaking, for homes and residents, oral healthcare is generally just not seen to be as important as maintaining good general health and adequate nutrition. Increasing consumerism and rising standards of care expected from public services mean there will need to be provision for access to appropriate oral healthcare services for care home residents (which may be emergency or routine care).
Edentulousness is proportionately higher in older people living in residential settings than among those in their own homes (Frenkel et al. 2000). This is unsurprising, as recent studies report significant associations between severity of disability and tooth loss (Lester et al. 1998). However, the consequent high concentration of denture-wearers and partial denture-wearers in residential settings can cause significant difficulties for care home staff (for example in denture loss). They also constitute a group who, in terms of awareness of and access to appropriate dental services, present one of the greatest challenges for suitable future service provision. This is just one example where problems identified across the population are severely exacerbated within a residential setting as a result of higher levels of frailty.

With adequate training procedures in place, there is no reason why carers without nursing qualifications would be any less proficient in the identification of oral health problems and consequent dental needs than nurses (Lin et al. 1999). Unfortunately, such training is neither commonly available nor easy to organise. One reason for this is the high turnover of care staff working on a seasonal basis, particularly in the private and voluntary sectors, as well as the number of part-time staff. It is worth noting that the projected rise of the population of older adults, as a percentage of the population of the UK as a whole, will be mirrored by a corresponding reduction in the young adult population (although this could be counterbalanced by immigration). Young adults provide by far the largest pool for nursing and care staff and, as such, it can be assumed that difficulties in finding suitable times and cover to allow training sessions will not only continue but also worsen. What is required is “cascade training”, where link workers are given basic oral health training which they then pass onto other members of the care team.

Older people in residential care homes should be able to make the same choices about their oral health as other people. If they cannot, then this might amount to age discrimination. This necessarily means they have the right to refuse treatment even when a dentist or carer may consider it in their best interests. This can be of particular significance as regards issues such as replacing old sets of dentures. Conversely, although it is well documented that subjective complaints about dental problems decrease with age (Sheiham 1990), an older person should always be given the opportunity to obtain the treatment they desire, where a professional considers it appropriate. Clearly, these statements are true for the entire older person population, however, they have added significance for frail older people in institutions where communication difficulties, mental frailty and forms of dementia are more prevalent.

The BDA’s ethical guidance currently recommends that “where a patient is judged unable to consent due to mental incapacity, the dentist must use professional judgement to decide whether the treatment is necessary and must act in the best interests of the patient” (BDA 2000). The Alzheimer’s Society, however, believes that older adults suffering from dementia are regularly denied necessary treatment on the grounds that dentists feel unable to obtain informed consent. Research does support this view (Fenwick 1998) and anecdotal evidence collected in the process of compiling this report also concurs. In Scotland, the Adults with Incapacity Act 2000 entitles people suffering from some form of mental incapacity to appoint a Welfare Power of Attorney, normally a relative or carer, empowered to make decisions as regards appropriate healthcare on behalf of the person. In England, proxy decisions such as this are permitted only with respect to matters of finance. Whilst any change in legislation must be considered in the context of its full implications, and this system would have to be carefully monitored, the Alzheimer’s Society is campaigning for this right to be extended to the rest of the UK. We would tentatively support this view, with the proper safeguards in place, in the interests of older people’s right to obtain the same level of healthcare as the rest of society. This particularly applies to those in long-term care incapacitated by dementia or any mental illness. This already marginalised group should not be disadvantaged further by the denial of the right to appropriate treatment solely on the grounds of mental incapacity.

**Information**

When older people or their relatives/carers are choosing a residential care or nursing home (assuming that in 2020 there is still freedom of choice in this regard) then written information should be provided to potential residents, their families and carers, to assess the quality of oral healthcare provided by the home. This will improve choice and enable the needs and priorities of the consumer to be included in their selection process. These would not be standards as such but some simple quality-of-life indicators relating to, for example, diet, oral hygiene and access to regular oral healthcare. These indicators could...
be set nationally or locally but, given that they will be very simple, national indicators would seem to be preferable. Older peoples interest groups, professionals together with the Care Standards Commission (or its successors) should set the indicators. Some examples might be:

- standards of oral hygiene;
- arrangements in place for the provision of regular and emergency care;
- use of sugar in the diet;
- use of sugar-free medicines.

This does not mean that we are looking for residential care homes to ban sweets or insist that residents brush their teeth twice a day. We are just recommending basic information that older people and their carers/relatives can use to see if the home will meet their needs in terms of oral healthcare. Use of sugar in the diets of frail older people is often nutritionally necessary and adds to quality of life, and this is probably more important than risks to oral health. Fluoride gel can be used as a preventive measure in these circumstances anyway. As well as information for potential residents and their families, some quality standards relevant to dentistry need to be put in place, which would be monitored by the appropriate local body. Some examples might be:

- availability of personal toothbrushes and other oral hygiene tools (residents should be provided with their own toothpaste, toothbrush, denture cleaners and other oral hygiene aids; residents should be offered the opportunity to clean their teeth or dentures every day; if functionally unable to achieve a standard of oral hygiene compatible with oral health, they should be offered assistance; if accepted, that assistance should be given by appropriately trained care-providers);
- assessment of oral health problems within 24 hours;
- programme of contact with appropriate dental professionals or proportion of residents who are cared for by a local dentist;
- clear guidance for staff on oral care and prevention;
- marking of dentures.

### Care planning

**Free oral care risk assessment for older people**

From our analysis of the clinical needs of older people in 2020, we conclude that they will require more treatment, re-treatment and repair in order just to meet the standards that are being currently achieved by NHS dentistry. In older age, this treatment is technically demanding and highly customised, and is very much dependent on the patient’s general health, wishes, needs and lifestyle. Within the present NHS system there is very little scope for considered planning of oral care for older people. If this situation continues, then as people live longer there will be a lot of treatment that needs to be redone or treatment will be provided that is not justified given the patient’s priorities and needs. We believe that a much more strategic approach is needed now and will be essential in 2020 if large amounts of resources are not to be wasted in preventable treatment. We propose that a free oral healthcare risk assessment should be available to everyone around the age of 60. The timing of the check is open to debate and the existence of an age limit in itself could be said to be discriminatory. In some senses, its timing should coincide with retirement, when there is usually a major change in lifestyle. In clinical terms, most people would benefit from it being between the ages of 60 and 70. However, there is also a case for a second check to take place around age 75 when free medical health checks are performed by GPs. In practical terms, we would recommend piloting this measure beginning at age 60.

The risk assessment could be undertaken by a PCD or any other health or social care professional with suitable training; or it could be done by the patient via a self-assessment questionnaire. The purpose of the assessment would be to identify risk factors for future dental treatment need by asking questions about lifestyle, diet, previous dental attendance and treatment experience and any medical conditions likely to have a negative impact on oral health. A suitable starting point for consideration of this idea would be the NHS single assessment process. Where individuals were identified to be at risk of requiring major oral healthcare in the future a referral would be made to a dentist to produce, with the patient, a strategic oral healthcare plan. The purpose of the plan would
be for the patient to identify how their oral health needs can be met over the next 15 to 20 years; and for the dentist to provide information and advice on availability of care and the effect of lifestyle changes on oral health and oral cancer screening. The plan would include prevention, planned maintenance, restorations that may be needed (within the context of the patient’s general health and lifestyle), as well as, where appropriate, planning for edentulousness. This would enable proper discussion and consideration, as well as the adoption of a long-term approach. A check would also fit in with oral health assessments for the general population that will be piloted as part of the Options for Change programme.

Patients would obviously be completely free to follow the plan or not, and would not be required to obtain their future care from the dentist who provided the plan. There may be concerns from patients that, as a result of the check, they will be committed to a major treatment plan, which is unaffordable. Dentists would need to receive training in undertaking these assessments, which would be provided under contract to the local health authority. Assuming that patient-held records are a reality in 2020, the details of the plan would be held by the patient, with dentists and others providing care having access to it.

Referral for an oral healthcare plan could also be arranged via general medical practices. By 2020, dentistry will be part of the NHS IT system and it will be technically possible to ensure that everyone who has a GMP will be offered a risk assessment. This idea has funding and workforce implications, but we feel that it would yield substantial benefits in terms of helping patients look after their oral health and significantly reduce wasted resources in terms of short-term treatments being undertaken that need to be replaced over time.

Prevention, oral health promotion and patient self-care

Promoting good oral health and preventing disease must be the focus of care planning for older people. Encouraging and supporting patients in achieving good oral hygiene and giving advice on overcoming the obstacles posed by reduced manual dexterity, medication and chronic conditions, will be a major challenge for the dental team. There are also many older people in hard-to-reach groups such as ethnic minority communities, travellers and homeless people, asylum seekers, patients with dental phobia and people who are prejudiced against dentists. Building on research into effective health promotion strategies for these hard-to-reach groups will mean that in dentistry, dental professionals will see their role very much as supporting their patients in retaining good oral health rather than as restorers of failing dentition.

The fruition of present Department of Health initiatives on patient and public involvement may also have an impact on demand. The rollout of the Expert Patient Programme from 2006 will result in an increasing number of patients with chronic conditions being more involved in their care and expecting to actively manage their conditions in partnership with the health professionals that care for them. The impact of other new structures, which will have the power to inspect dental facilities such as Patients Forums and the Commission for Health Audit and Inspection, will help to improve the accountability of dental services to the local population and improve quality.

What is needed is information on the best ways to encourage self-care amongst older patients; we would recommend that more research be carried out into this issue, possibly including some controlled trials.

With regard to older people from ethnic minorities, imaginative ways of encouraging take up of care will need to be found, possibly through local community centres, places of worship, libraries and the ethnic minority press, to promote services. Information services need to be provided in different languages, and health advocates and interpreters need to be much more readily available.

Generally, older people in 2020 will be more consumer-focused and many will have both the financial stability and desire to purchase consumer goods, including healthcare. There will be considerable numbers of older people who will choose to buy both preventative and cosmetic dental options. Patients who are much better informed about their care will expect to make joint decisions about planning their oral healthcare. Older people and their carers will expect to be very much part of this process.
Promoting better access to appropriate services

Access to NHS oral healthcare can be difficult for many older people, in terms of transport, accessibility of premises and ability to be treated outside their home, as well as the general challenge of access to NHS care experienced by the population as a whole.

The cost of NHS care is also a significant barrier. Older people are not automatically exempt from dental charges, as they are from prescription charges and NHS sight tests. Free NHS dental examinations should be available to patients aged 65 and over in England, Scotland and Northern Ireland as they already are in Wales. This must be funded through additional resources (where complex restorations or dentures are needed, the costs can be considerable). Entitlement to NHS exemption is not clear for patients or carers and the need to pay for a basic NHS examination is a significant barrier. From a patient’s viewpoint, the NHS oral healthcare system is in need of reform in almost all aspects but its deficiencies particularly hit many older people who wish to access care. It is very difficult to predict how the NHS oral healthcare system will look in 2020, so this section looks at services in a generic way and does not distinguish between NHS and private provision.

We believe that in 2020 there will need to be a mix of services that are locally determined, with patients at the centre and fully integrated with other health services. The provision of adequate domiciliary services will be essential to provide professional advice and treatment to nursing and care homes as well as the increasing numbers of frail people living at home or in sheltered housing. Local health organisations will have to look creatively at dental provision and tie in dentistry with other services such as General Medical Practice, chiropody and pharmacy. Voluntary organisations and day centres are also means by which care can be brought to people (through mobile units) who are not ambulant or who find access to care difficult for other reasons.

Physical and mental infirmity will, each in their own ways, constitute potential obstacles to accessing oral healthcare. So too will barriers presented by general dental practitioners in terms of reluctance to perform home visits, lack of time and lack of resources, particularly within the present NHS General Dental Services. The replacement of the General Dental Services with locally commissioned services based on health need is a great opportunity to break down barriers and improve the availability of services for older people. Dementia in particular is becoming a huge challenge to all healthcare sectors. As discussed earlier (p14), it is estimated that by 2010 there will be about 840,000 people with dementia in the UK (Alzheimer’s Society; Ettinger 2000; Fiske and Hyland 2000; Nordenram et al. 1997).

General Dental Practitioners should also be more fully brought into the provision of domiciliary care services by local health and social care organisations, either by contracting with local healthcare providers (e.g. PCTs) directly to provide care to residents or by being properly funded by Government for domiciliary visits. The availability of domiciliary kits on loan would be very helpful. Another idea would be for each dental practice to be contracted with their local health commissioning body to provide domiciliary care to a small number of residential homes. This would share responsibility and mean that there were no homes without a relationship to a practice.

Presently, the Community Dental Service provides a very valuable service to many care homes and local clinics/day centres but the CDS will not be able to cope with the increasing demands on its resources without major investment in the form of funding for extra staff. The role of the CDS must be redefined with regard to the care of older people. It should be available to provide specialist care where necessary, but the bulk of the care of the older persons population should be the responsibility of general dental practitioners.

Transport is also a major issue and with the increasing concentration of dental services in multi-surgery practices, rather than single-handed practice, there will be an increasing need to organise transport to and from dental practices by voluntary and statutory organisations. The report A Helicopter Would Be Nice (Age Concern 2000) emphasises this point.

Diversity and discrimination

There is a clear need to recognise the ethnic diversity of the older persons population. The presence of age discrimination within society and its effect on the clinical care provided to older people should also be recognised.
It has often been assumed in the past that ethnic minority elders will be looked after by their families and this may have led to a deficit in service provision. It is no longer appropriate to assume this. Ethnic minority older people often face a double discrimination of race and age.

There is negative direct discrimination (age limits on services) and indirect discrimination (attitudes, structures which disadvantage older people) within healthcare as well as positive discrimination (for example, free dental examinations for those 65 and over in Wales). It is important that dental professionals have awareness training regarding age discrimination so that negative assumptions about older people can be challenged. The way in which service delivery is structured can foster discrimination and this requires further analysis. In the next few years there is a real opportunity for new structures to be built whilst local commissioning of NHS services is put in place. Practical steps, such as larger fonts for NHS dental leaflets, communication aids within dental practices, and the better design and location of practice premises, can be taken by the NHS. Evidence based on past clinical practice, which may have indirectly discriminated against older people, must also be carefully considered. Where the Department of Health in England is currently considering clinical pathways for NHS care, the need to ensure that the protocols do not discriminate must be emphasised.

Dentists will also need to be aware of the various sensitivities regarding treatment of people from different religions/beliefs and cultures, for example dietary habits and gender issues.

**Access to information**

Appropriate and timely information is needed/will be needed for older patients and care providers on:

- available dental services;
- self-care and prevention;
- cost;
- how to access care.

This information should be provided in the most accessible formats, which ideally are those provided by the broadcast media and the Internet. Leaflets are not the only medium to demonstrate tooth brushing or denture care. During the research process we talked to a group of older people who felt that the most effective way of informing them about dental issues would be through daytime television advertising. Where leaflets are provided, they must be produced in a range of languages and along the lines of the new NHS patient leaflet templates (DoH 2002a). Another way would be to ensure that people working with older people are more fully informed of services.

Translation services must also be provided by PCTs; interpreters are not always available and this can produce significant barriers for members of ethnic minority communities seeking care.

Many outdated beliefs persist about oral health in older age (for example, that complete dentures should always be removed at night). There is a need to provide clear and simple information now; it is likely that by 2020 media for the promulgation of information will have benefited from improved technology and consequently this should increase the awareness of simple oral healthcare (such as the value of brushing teeth with a fluoride toothpaste) and facilitate its acceptance as received wisdom. If the present emphasis within healthcare on patient empowerment and involvement continues and is fully brought into dental practice, then the changes to practice that this results in will apply equally to dental services to older patients.

In order to start this process, the BDA should work in partnership with older people and other representative organisations, for example from the voluntary sector, to provide some guidelines and templates for appropriate information for patients and carers to improve their oral health. This information can be much more effective if it is locally produced to reflect the specific needs of the older persons population in the locality. General Medical practices also have a role in providing and displaying information.
Training and skill mix

Undergraduates

Changing clinical needs and patient demands require changes to the training of dental professionals (dentists and PCDs), as well as workforce planning. This begins for dentists at the undergraduate level. Dentists who will be working in clinical practice in 2020 and beyond (that is, dentists who are now approximately 45 years old and under) are going to need increased clinical skills to cope with the challenging restorative work that they will need to perform. There are also communication skills that will be increasingly necessary, particularly for patients with dementia, as well as other disability awareness training. These skills are best taught as part of the undergraduate curriculum and through vocational training. We can speculate that, as undergraduate training will increasingly take place in a primary care setting, there will be a good opportunity for training and experience in the use of domiciliary equipment and providing care in a home environment. As general practitioners, dentists will be spending an increasing proportion of their time advising, planning treatment for, and actually treating, older people, and they need to be fully prepared to do this.

By the time age discrimination legislation is put into effect in 2006, we would expect dentists and PCDs to be receiving awareness training as it applies to patient care, as part of their curricula.

Specialist care

The eventual recognition of special care dentistry (which includes gerodontology) will be a very positive step in establishing training pathways for dentists who wish to become specialists. In recent years, postgraduate courses in gerodontology have been closed, which in the long term will have serious repercussions for the treatment of older people. We do not see special care dentistry as being a hospital based speciality; it should be focused in primary care, with specialists holding clinics in the community rather than patients having to attend a hospital.

The present trend of drastically reducing the teaching of removable denture provision within the undergraduate dental curriculum will have the effect of moving this aspect of care to the specialist arena. As new graduates move into the workforce, there will be a reduction in access to this treatment in primary care, as well as a reduction in access to specialist practitioners and hospital consultants. Funding for the training of specialists in mono-specialties, to ensure there are sufficient specialists in the right locations, must be addressed.

Continuing professional development

With increased need and demand for complex treatment for older people, it will be vital to improve the clinical skills of practitioners and PCDs. Courses need to be developed in restorative dentistry to meet this need, and work should be undertaken now by the Workforce Development Confederations to facilitate this.

Professionals complementary dentistry

At present, we are at a crossroads as regards the mix of skills provided in dental practice. The introduction of dental therapists into general dental practice and the increased numbers being trained, as well as the new PCD regulatory regime operated by the GDC from 2004, will have an effect on who is providing care to older patients. If the General Dental Council removes the restrictions on PCDs carrying on the business of dentistry, this will also have an impact on service provision.

We would argue that there is a good case for considering the use of dental therapists (or other suitably trained PCDs) for routine screening examinations to identify residents of nursing and care homes who are at risk of poor oral health, as well as for the provision of oral hygiene advice. In 2020, dentists will be better employed diagnosing, planning and treating the complex oral health needs of older patients than in screening.

In 2020 the reforms in the dental workforce to be introduced in 2004 will have been in place for some 15 years. Clinical dental technicians will have been established for this time period and are likely to be fully recognised members of the dental team. It is likely that PCDs will be providing a much wider range of oral care, hopefully within dental teams that are still led by dentists. The increasing amount of restorative care that will need to be provided will mean that there will be a real need for more
dental professionals trained to undertake restorative work. This will require a larger dental workforce in better more accessible premises with a full range of pharmaceutical products and new technologies at their disposal.

Interdisciplinary training
As with every aspect of oral healthcare, there is a need for dentistry to be integrated with other relevant branches of healthcare and for dentists to work with dieticians, health visitors, occupational therapists, GMPs and pharmacists. Training for dentists in gerontology is complementary to similar training that other health professionals receive. There is a need for specific interdisciplinary training for all these groups, involving older peoples organisations, to provide a patient perspective.

The dental industry and prescribing
There are presently excellent products available to prevent dental caries in older people – for example, high fluoride toothpaste, fluoride mouthrinses, fluoridated milk, sugar free chewing gum and chlorhexidine mouth rinse. Much greater use needs to be made of these products to reduce the number of restorations that will need to be provided. Steps need to be taken to ensure that general dental practitioners can provide products that require a prescription (for example, artificial saliva). Partnerships should also be developed with the dental oral hygiene products industry, which more or less exclusively focuses marketing strategies on people who are under 40. There is a large market for these products, particularly within the older persons population.

The dental trade in particular has the potential to promote better oral health to older patients and to place equal emphasis on this area of the market, as they do for children’s products.

Conclusion
This chapter has looked at the sort of oral health services that will be needed in order to meet anticipated demographic, social and clinical changes over the next two decades.

Services will need to be more accessible and dentistry will need to be fully integrated within the NHS. General dental practice will remain at the heart of care provision; the role of the Community Dental Service as a provider of specialist care and advice for older patients will also need to be developed. Residential and nursing homes must offer residents preventative oral healthcare and access to treatment that is appropriate for the individual.

Information and advice on self-care and accessing oral health services need to be much more widely available in formats and media that are used by older people, particularly those who are part of hard-to-reach groups. The dental trade is an important and often forgotten source of oral health information for the public and very often its marketing strategies and products completely neglect older patients.

Care planning for older people must be undertaken on an organised basis, with a strategic approach adopted for patients who are at risk of requiring complex restorative care in the future. Delivering preventive care and advice, as well as screening for oral cancer for older patients should also be part of readily accessible services.

Education and training of health professionals providing oral healthcare services to older people is a priority. This should encompass the undergraduate curriculum, including experience of providing care in a variety of settings, as well as post-graduate and CPD courses.
Chapter Five: Recommendations

In order to achieve the above, we would recommend, as a starting point, that the following actions be implemented within the next two years:

1. The new locally commissioned system for the delivery of NHS primary care dentistry in England must take account of the needs of older people, and the demographic and clinical changes identified in this paper.

2. Local health authorities must look creatively at dental provision for older people and tie in dentistry with other services, such as General Medical Practice, chiropody and pharmacy. Voluntary organisations and day centres are also means through which care can be brought to people (using mobile units).

3. Work on new NHS Clinical Pathways for dentistry must reflect the needs of the older persons population and ensure that further clinical challenges for dentists treating older patients in the future are not inadvertently created.

4. A free oral health risk assessment should be available to patients from age 60, with referral to a dentist for a strategic long-term oral healthcare plan offered to those identified as likely to need complex restorative care.

5. Residential care homes should be required to provide potential residents and their carers with basic information on quality-of-life indicators relating to oral health. This would enable potential residents to prioritise their oral health requirements, thereby facilitating freedom of choice. There should also be basic local standards relating to the oral healthcare of residents with which homes would have to comply – for example, scheduled visits by a dental professional.

6. Marking of existing dentures for easy identification in residential homes should be available free to patients on the NHS.

7. Local health authorities should be encouraged to place simple contracts with local practices to provide care to a small number of residential care and nursing homes, with portable equipment for domiciliary work being made available on loan.

8. England, Wales and Northern Ireland should follow Scotland in passing legislation to enable people suffering some form of mental incapacity to appoint a Welfare Power of Attorney, normally a relative or carer, empowered to make decisions as regards appropriate healthcare on behalf of the person.

9. The BDA (with others) should produce information templates for older people, carers and residential care homes, about oral healthcare, services and costs that can be adapted by local health authorities and voluntary organisations.

10. Research including controlled trials should be undertaken, exploring ways of encouraging effective self-care by older people; and the results should be piloted.

11. NHS dental information and forms should be available in a variety of languages, in Braille and in large print format.

12. Information about full and partial exemption from NHS dental charges should be simplified and publicised to older people and carers.

13. Translation services and health advocates should be widely available, to make oral health services more accessible to older people from ethnic minorities.

14. Planned reform of NHS dental charges should take account of the growth in the older persons population and the fact that older people are more likely to require more complex treatment and also tend to be among the least able to afford to pay. Free NHS examinations should be available to patients aged 65 and over across the UK.

15. The undergraduate dental curriculum should continue to include teaching of complete and partial dentures, and should also give students experience of domiciliary visits and care homes.
16. CPD and postgraduate courses must be offered to equip dentists and PCDs with the clinical and communication skills they will need to treat the large caseload of older people by 2020.

17. Special care dentistry must become a recognised speciality.

18. Community Dental Services should be resourced properly, to enable CDS dentists to provide specialist services and clinical leadership to dentists and PCDs providing care for older people.

19. Anti-discrimination training should be introduced as part of the curricula for dental undergraduates and student PCDs.

20. Companies dealing in products related to oral health should recognise the potential market represented by older people who want to preserve their good oral health and appearance and develop appropriate products and advertising campaigns.

21. Dentists should be able to prescribe any drug in the BNF for NHS patients for dental use. The de facto inability of dentists to prescribe artificial saliva makes this of particular relevance to the treatment of older people.

Implementing the above requires action by Government, statutory bodies, the BDA, specialist societies, the NHS, the General Dental Council and the voluntary sector. This will not be easy, as oral healthcare for older people has not been given the priority it deserves. However, the situation can and must be addressed starting now by taking steps to ensure appropriate and accessible oral health services will be available for the older persons population.

It is often said that the way in which a society treats its older people – including the provision of healthcare for them – is a measure of how civilised that society is. Whilst dental care is, of course, only one facet of healthcare for older people, it can, nevertheless, have a significant impact on an older person’s quality of life and general health. Making provision now for adequate, appropriate and accessible oral healthcare for all older people in future would be a clear sign of a continuing commitment to building a caring and inclusive society.
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