

Review Article

Challenges and Barriers to Access Oral Health Care needs among Elderly Population in India

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Abstract

Healthy life is always earned it plays a important role, but successful are those who play till the end. As a child is brought into the world he is in the safe hands of his loved ones and pampered so that lifestyle can flourish. As more people are becoming elderly, they are entering these years with hightened oral health expectations and are seeking care in much greater number than did similarly aged cohorts of previous generations. This article examines some determinants of older persons' dental service utilization, both barriers, as a means of understanding why some people continue seeking preventive dental care throughout their lives.

Keywords: Geriatric Care; Older; Oral Health

Introduction

The human life is full of different milestones and proportion of older people continues to grow worldwide, especially in developing countries. Non-communicable diseases are fast becoming the leading causes of disability and mortality. Globally, poor oral health among older people has been particularly evident in high levels of tooth loss, dental caries experience, and the prevalence rate of periodontal disease, xerostomia and oral precancer/cancer [1].

In today's dentistry many new exciting treatments and alternatives have been developed over the years that can help older people to restore their teeth to much functional, healthy and useful appearance but in India, elders do not show much concern about looks of their teeth. They are happy as long as they can chew and there is no pain. There are some problems which adult patients have to face, other than dental conditions mentioned above. The growing economic crisis have made elderly to think twice before they plan for dental treatment. As a result of above-mentioned facts, geriatric dentistry has taken a back seat in various dental treatments offered in India. As more people are becoming elderly,

they are entering these years with hightened oral health expectations and are seeking care in much greater number than did similarly aged cohorts of previous generations. What are the current issues and most recent findings with regard to care for elderly patients, and what might the future hold in terms of diagnostics and health issue for this population [2]. Management of oral disease and illness in older adults should be strengthened through organization of affordable oral health services, which meet their needs. In developing countries, the challenges to provision of primary oral health care are particularly high because of shortage of manpower. This review highlights certain difficulties to assess oral health care among older people.

Demographic Variables

Cohort and Age

Perhaps the most obvious factor in this discussion is age and cohort. We examine cohort first, because it shapes our socioeconomic and psychosocial lives. Historical events as well as social and health policies of a given era influence our view of the world. An interesting approach to the role of cohort differences in oral health was introduced by Ettinger [3]. Example the 1930s was a time of significant social and health policies in the United

States, with the passage of the Social Security Act in 1935 and the first health insurance plans through Blue Cross in 1933. Perhaps one should not expect current cohorts of older adults-born before 1940-to value oral health and dental esthetics in the same way younger generations do. Nevertheless, as we learn more about the link between oral and systemic health, and as more people keep their natural teeth into old age, it is critical to help older adults learn and practice preventive oral health care. This discussion of cohort effects suggests that it may not be age per se, but cohort differences that affect oral health practices and values.

The Age Crisis

- Isn't India a youthful nation in a fast-ageing world? New research bursts the bubble. Urban India and the South are greying fast.
- Life expectancy has shot up. With one grey in every 12, India is the second largest global hub of seniors.
- The rapid greying is working on an "astonishingly low" per capita GDP. Over 70 per cent elders are fully dependent.
- Lives are busy, women are working. Personal choice and privacy are the buzzwords. This generation is less inclined or able to care for parents.
- With young people migrating in search of better prospects, caring for the old has become an elusive ideal. Over 7 % of elderly couples live on their own.

Transportation

Transportation also emerged as a serious barrier to care for many elders in the Community. Seniors who cannot drive must rely on family members or public transportation, which can delay care for the elderly. Additionally, relying on family members to provide transportation may cause truancy from work or school.

Today in many dental colleges there are all nine specialty departments for dental treatment, care should be taken that department related to older people i.e. prosthodontics, endodontics should be on the ground floor, and if not possible then lift facility should be available.

Dental Services are Not Co-Located with Health Services
Low-income older adults have a number of chronic conditions that necessitate frequent trips to provider offices, but getting to those medical appointments is particularly challenging for older adults. As we age, we may lose the ability to drive or use public transportation because of physical and cognitive impairments. Co-locating dental services with health care services or community services would improve access for oral health. However, dental services are not frequently co-located with health services in California [4].

Racial and Ethnic Disparities

Racial and ethnic disparities persist among the 10 leading indicators identified in Healthy People 2010 Objectives. Whether one looks at chronic disorders common to aging populations or at the provision of essential preventive or intervention services, the experiences and outcomes of racial and ethnic elders are still distinct.

When we turn to adults, these disparities persist: nearly 62% of black and 55% of Hispanic adults aged 20-64 have lost permanent teeth compared to just 49% of white individuals of the same age [5]. And for black individuals 65 and over, 29% have complete tooth loss (edentulism) compared to 16% of the white individuals [6]. Similarly, 39% of older adults who have less than a high school education have complete tooth loss.3 Disparities in access to dental services for older adults also exist. While approximately half of all older adults 65 and older nationally have been to the dentist within the last year, this is only true for 37% of black and 38% of Hispanic older adults [7]. Worse yet, only 30% of adults 65 and over with incomes below the Federal Poverty Level had a dental visit within the last year.

The way individuals view their oral health also differs by income level and health insurance coverage. In California, nearly one in five low-income adults report that their mouth and teeth are in poor condition [8].

Physical Barriers

Access to Health Care

Recently, it was found that the importance of barriers varies according to various population segments. The main barriers are availability, accessibility, accommodation, affordability and acceptability. Barrier to dental care occurs for both the functionally dependent individual and the functionally independent person residing at home or in an institution. The main barrier is the perceived need for oral health care [9]. Additional barriers include the functional and medical status of the individual, transportation and accessibility difficulties, financial considerations, lack of education and fear.

Health Status

One would posit that dental service utilization is related to oral health status. Certainly, the studies comparing edentulous and dentate elders support this hypothesis; the 1996 MEPS revealed that dentate elders are 6.5 times more likely to seek dental care than their edentulous counterparts. However, the presence of large numbers of decayed root and coronal surfaces and deep periodontal pockets does not necessarily mean the individual will seek dental care, as illustrated by the barriers described above. Poor systemic health and multiple chronic diseases can also deter the older

person from obtaining needed dental care. Indeed, those who make frequent medical visits and who spend more on medications and medical visits are less likely to use dental services.

This is most likely due to their focus on the chronic conditions that impair their activities of daily living and the time and energy required to deal with medical problems [10].

Old Age Blues

- What does the affluent lot fear the most? Time - loneliness, lack of work and poor leisure hours. Insufficient economic resources and dependence on children hurt middle classed the most.
- Lower classes fret about poor health, disease, lack of mobility and living alone with disability.
- Disrespect, neglect, abuse and humiliation make old age a 'disease', feel all seniors [9].

Psychological Barriers

Dental Attitudes

A related barrier to seeking dental care is the attitude of the individual toward oral health and toward dental providers. The Florida Dental Care Study interviewed dentate African American and white adults ages forty-five and older to determine the impact of dental attitudes and demographic characteristics on dental service utilization. As noted above, race and poverty (both objective income levels and perceived ability to pay for dental care) had independent effects on utilization patterns. However, six attitudinal constructs significantly discriminated regular users of dental services from irregular and nonusers. These included questions regarding respondents' beliefs about the importance of dental visits in preventing future problems, perceived quality and effectiveness of dental care received in the past, cynicism toward dentists and dental care, eventuality of dental decline, and the impact of costs on their previous use of dental treatment.

Effects of Language on Patient Access and Care

There is compelling evidence that language barriers have an adverse effect on initial access to health services. These barriers are not limited to encounters with physician and hospital care. Language barriers have been associated with increased risk of hospital admission, increased risk of intubation for asthmatics, differences in prescribed medication, greater number of reported adverse drug reactions, and lower rates of optimal pain medication. Findings from these studies are consistent with general research on provider-patient communication, which finds that communication is a key factor in patient adherence to the treatment plan.

Psycho-Social Factors as Barriers to Accessing Dental Health Care

From the 1980s through to the 1990s [11,12] studies were conducted to find out why this state of affairs existed. The word barrier replaced the word obstacle and was coined as a means of conceptualizing the difficulties people experienced when accessing dental care. Nevertheless, it led to the idea that one factor relating to access to dental care could be thought of in physical terms. For some patients, physical problems did arise (for example, managing stairs) when trying to gain access to the dental surgery. To think of barriers as mere physical structures barring the patient's way for treatment, excludes the role of psycho-social factors as obstacles to dental attendance [13].

The Federation Dentaire Internationale (FDI) suggested that three separate categories of barrier should be considered. The first of these related specifically to the individual and included: 'lack of perceived need, anxiety and fear, financial considerations and lack of access'. The second category related to the dental profession. They included: 'inappropriate manpower resources, uneven geographical distribution, training inappropriate to changing needs and demands and insufficient sensitivity to patient's attitudes and needs'. The third and final category of barrier related to society: 'insufficient public support of attitudes conducive to health, inadequate oral health care facilities, inadequate oral health manpower planning and insufficient support for research [14]. The FDI classification of barriers reflects their psycho-social composition. Thinking in this way provides the means by which barriers to accessing dental care could be understood, first from the patient's and, secondly, from the dental health professional's points of view. This gives practitioners an increasing understanding of the difficulties they and their patients may experience when they, respectively, provide and access dental care.

Individuality of the Dentist

The final barrier to utilization of dental services by older people identified in this study related to characteristics of the dentists themselves and their mode of working. Issues raised here related to the communication skills of the dentist and confidence in the dentist as a practitioner; perceptions of the public/private divide in relation to standards of treatment; and experiences of dental hospitals. The personality of the dentist seemed to have a big role in orientating positive or negative feelings towards dental treatment. There were many statements describing how a friendly, polite and professional approach could facilitate positive feelings in older people; on the other hand a hasty manner was seen as a barrier to dental treatment. A range of generally negative views of dentists were displayed:

Unique Needs of Older Adults

Today, one out of five older adults in California live in poverty [15]. If California's older population is estimated to double from about five million to over ten million by 2050 [16]. Many of these older adults will also age into poverty and will rely on public programs like Denti-Cal [17] to meet their oral health needs. While many of these older adults will have better overall oral health than earlier generations, due to improved access to fluoride and dental services, the current systems, if left unaddressed, will continue to fail older adults.

Conclusion

Throughout life, oral health is integral to general health and a determinant of quality of life. This relationship is reciprocal and complex, and magnified in older adults as they disproportionately suffer from chronic disease. Despite the improving socioeconomic status of future cohorts of older adults, it is unrealistic to expect all baby boomers to enter old age with high levels of education, income, and private Medigap and dental insurance. It is also unreasonable to assume that a lifetime of poor utilization patterns and low priority attributed to oral health can be modified in old age. Community-based health-promotion efforts are one method of addressing this problem. Health promotion has become an important means of improving older adults' behaviours in a variety of areas, including exercise, weight loss, management of diabetes, and hypertension. Unfortunately, it has received less attention in dentistry except for some early efforts twenty or more years ago.

The dental care community must find creative ways to reach out to underserved segments of older adults. One way to increase elders' access to elder oral health care is by requiring dentists and hygienists to promote oral health care in underserved areas (nursing homes, community clinics, etc.) as part of a continuing education requirement. Such clinical programs may take place through dental education or by performing necessary dental care procedures on older patients. The communities in need can also be accessed through mobile dental units. This can make oral health care accessible to more elders and give back to the community [18].

References

1. Petersen PE, Yamamoto T (2005) Improving the oral health of the older people: The approach of the WHO Global Oral Health Programme. *Community Dent Oral Epidemiol* 33: 81-92.

2. Slaughter YA and Malamud D (2005) Oral diagnostics for geriatric populations: Current Status and Future Prospects. *Dent Clin North Am* 49: 445-461.
3. Ettinger RL (1992) Attitudes and values concerning oral health and utilisation of services among the elderly. *Int Dent J* 42: 373-84.
4. Oral Health in California: What About Older Adults? ISSUE BRIEF JULY 2016 Written by Amber Christ Senior Staff Attorney, Justice in Aging.
5. Healthy people (2010) understanding and improving health, U.S Department of health and human services.
6. "Dental Caries and Tooth Loss in Adults in the United States, 2011-2012," U.S. Dept. of Health and Human Services (May 2015).
7. "Treatment Needs in Seniors (Age 65 and Over)," National Institute of Dental and Craniofacial Research.
8. California's Oral Health and Well-Being," (2015) Health Policy Institute, American Dental Association.
9. Barriers in Access to Health Care.
10. Kuthy RA, Strayer MS, Caswell RJ (1996) Determinants of dental user groups among an elderly, low-income population. *Health Serv Res* 30: 809-25.
11. Tinker A (2003) Ageing in the United Kingdom - what does this mean for dentistry? *British Dental Journal* 1947: 369.
12. Tinker A (2002) The social implications of an ageing population. *Mechanisms of Ageing and Development* 123: 729-735.
13. Illich I (1976) Limits to medicine- medical nemesis: the expropriation of health. Harmondsworth, Penguin Books Ltd.
14. Cohen L K (1987) Converting unmet need for care to effective demand. *Int Dent J* 37: 114-116.
15. A State by State Snapshot of Poverty Among Seniors" Kaiser Family Foundation (May 2013).
16. "Interim Population Projects for California and its Counties 2010-2050" State of California, Department of Finance, Sacramento, California 2012.
17. "Fixing Denti-Cal," Little Hoover Commission 2016.
18. Kiyak HA, Reichmuth M (2005) Barriers to and enablers of older adults' use of dental services. *Journal of Dental Education* 69: 975-986.