



Oral healthcare for older people: ‘I can’t afford not to go to the dentist, but can I afford it?’

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Aim The purpose of this study was to examine challenges older people encounter in maintaining satisfactory oral health status.

Method This interpretive qualitative study involved 19 in-depth interviews with participants aged 65 to 87 years. Data were examined using a three-level analytic process. NVivo Qualitative Software assisted data management.

Results Participants in this study didn’t ‘just go’ to the dentist. Much effort went into solving the dilemmas and tensions of maintaining their oral health through a process of option balancing. Balancing personal and financial costs, they continually assessed their ‘bottom line’. They negotiated issues of: dental cost versus service quality; basic treatment versus functionality and social appearance; future living costs versus current dental costs; and ‘how long will it need to last’ versus ‘how long will I live’?

Conclusion Problems exist in the provision of affordable oral health care for the older population in Aotearoa New Zealand. They struggle to afford dental care. They receive little financial support to access oral healthcare services and are dependent on developing their own strategies to enable such care. Health professionals and policy decisionmakers’ challenge is to bridge this gap.

As a result of global population ageing and technological advances in dental services, edentulism (no natural teeth) has decreased and oral healthcare needs have substantially increased.^{1,2} The ageing process itself, the increasing numbers of older people, and the dynamic relationship between oral health and general health, produces this care need.^{1,3,4}

The correlation between poor oral health and conditions such as respiratory infections, glycaemic control in diabetic patients,⁵ and cardiovascular disease has been established.⁴⁻⁶ As Ship asserts “oral health and function decline, in some cases rapidly, in medically, behaviourally, and physically compromised older persons”.³

Whether edentulous or dentate the older person can experience changes in chewing ability, and are at higher risk of nutritional deficiency as a result of poor oral health.⁶ Recent studies have reported that older people experience embarrassment if they have diseases of their mouth, teeth and/or gums and suggest that such situations can disrupt social life. Older people’s quality of life can thus be substantially affected by poor oral health.^{4,6}

International research has highlighted the relationship between good oral health and preventive activities, such as daily hygiene practices and fluoridisation, together with regular dental care services.^{1,6} Key to the effectiveness of these practices is peoples’ ability to afford and access these services.

Affordability is a critical issue for many older people as their incomes decrease and oral healthcare needs increase.⁷ One Australian study reported a decrease in the purchase of dental insurance in the 70 and over aged group together with reports of difficulty in meeting dental costs.⁸

The majority of the ageing population in Aotearoa New Zealand is caught by their increased need for oral healthcare services and their diminishing income.⁹ The situation is compounded by changes in their ability to physically access dental services. With the current government funding focus on subsidising general healthcare, oral healthcare is missing out.¹⁰ This gap in healthcare provision is evidenced by the paucity of specific social and public policies on the subsidised provision of oral healthcare services for the elderly.

The current focus of oral health policy and funding is on preventative care for children and adolescents.¹⁰ While such policy is essential for the general health of future generations, this does not negate the need to invest in the maintenance of oral health for older people. Yet, the majority of older people in Aotearoa New Zealand still continue to be “responsible for the full costs of their oral healthcare”.¹⁰

Carter et al¹¹ (p5) in reference to dependent elderly state that “oral health and oral disability is not seen as part of overall health by central government funders, and this (in part) negatively influences the delivery of care”. This argument could be extended to the community dwelling older population.

If good general health and a satisfactory quality of life are dependent on maintaining oral health, then policy needs to be implemented so that such services become affordable and accessible to our ageing population.¹² The purpose of this study was to examine the challenges that older people face to maintain their current oral health status and to inform policymakers of this critical health situation.

Method

Semi-structured interviews (45 to 90 minutes duration) were conducted with 19 older adults (5 male and 14 female), aged 65 to 87 years. Participants were predominantly white, middle-class and retired. The philosophic assumption underpinning this qualitative interpretive study was that the challenges to maintaining oral healthcare could be examined by focusing on older adult's experiences of this phenomenon. A qualitative approach can add depth and texture that complements the available quantitative data. Ethical approval for the study was obtained from the AUT University Ethics Committee.

Purposive sampling using the snowball technique was employed for recruitment. Initial participants responded to flyers distributed to retirement villages and health clinics. Once enrolled, participants were encouraged to invite others to contact the researchers. Inclusion criteria were English speaking men and women over 65 years, who could comprehend the study details.

Interviewers (x3) were trained in qualitative data collection techniques. Training sessions (2x2 hours) included interviewing techniques and the application of open ended reflective questioning.¹³ Removing all identifying information from the audio taped and hard copy transcripts ensured confidentiality and public anonymity.

A three-level iterative analytic approach as described by Grbich was applied.¹⁴ At the first level of analysis prominent concepts were systematically coded. The relationships between concepts were then examined, followed by a movement of concepts into themes. Each theme was dimensionalised according to the meaning participants attached to the concepts, the strategies that arose out of that meaning and the conditions which shifted a participant's strategy with regard to their oral health.

Analysis for all themes followed this iterative approach to coding, conceptualising and examining relationships between concepts and themes. Two investigators collaborated on all phases of data

analysis. QRS NVivo software was used for organisation of data and concept modelling. Analytic decisions were by mutual agreement and were documented.

Results

A full description of the themes conceptualised during data analysis has been reported in a previous article.¹⁸ In this paper we focus on how the participants navigated the complex process of option balancing. This process was used by the participants to arrive at decisions regarding their oral healthcare given their resources. The major condition which shifted decision-making was affordability.

Option balancing included all or some of the following dimensions: the need to weigh future and current health service requirements; price against dental service access and perceived professional competence; deciding between tooth extraction and tooth preservation; functionality versus appearance; health maintenance with ongoing dental checkups against problem-oriented dental visits, and value against years left. Those in a couple relationship also talked of prioritising the person whose needs were most urgent. Not all option balancing resulted in decisions that led to optimal dental health.

For these participants option balancing was mediated by 'bottom lines' which were figured according to individual perspectives and personal circumstances. For some, the bottom line was met when they required a root canal. For others, when treatments became too costly.

I mean if I had toothache or things like that all the time I might have them out but I wouldn't waste the money on having caps or root canals (9/250).

As this example illustrates, the bottom line could be future-oriented and decided before they entered the process of option balancing.

While many participants decided that, regardless of personal and financial costs they would continue to access dental services, all participants indicated affordability of dental services was the major consideration.

...As you get older of course, the money pot that you have is steadily eroded...The bank balance withers away and up goes the price of most commodities, but dentistry, for some reason, you don't look forward to having to [go]. You shudder when you think how much he is going to [cost] (18/472).

The following findings and examples illustrate the complexity of the option-balancing process.

Decisions led to strategies for preventive or problem-oriented dental visits. Some participants found their negative childhood experiences played a role in their decision not to seek preventive dental care. Others decided that preventive visits had become too expensive (a bottom line) and commenced a pattern of problem oriented care. While in contrast, in spite of negative experiences and cost, others continued to maintain a schedule of preventive dental visits.

One participant reported her response to the dentist.

He [the dentist] said to me...well, why do you want to keep your teeth? I said, "Well I eat with them" (1/165).

Regardless of the care pattern, participant strategies involved balancing cost containment with access and quality of outcome.

I went to a dentist and they said I would have to have all my teeth removed but my husband...he said 'no'. He had to lose his teeth at 19 like a lot of young people did in those days...He hated his false teeth so he said 'I don't care what it costs go to someone else' (2/85).

Dental services were carefully considered, particularly when there was a change in participants' ability to access the clinic. To decide about service quality, cost, and accessibility they asked friends, neighbours, and those with local knowledge, with the aim of finding the best accessible service at the lowest cost.

I didn't know the area and I asked him about it and he said there is that one...in [suburb that] was very good and...the cheapest one around (33/313).

Some prioritised maintaining their current dentist and would 'co-opt' transport from friends or family or use taxis when they could no longer drive.

She gets a taxi to go and she goes to the hygienist quite often. I don't think she's got that much money to waste...I think she is trying to preserve the teeth she's got rather than...at this age having to get them out and having dentures (33/214).

Relationships with the dental staff were included in discussions about dental clinic choice with some participants prioritising the quality of that relationship. They reported during interview their discussions with dentists, their comfort with questioning the dental staff, learning new dental care techniques and assistance with decisions about treatments as well as their preferences in these matters.

I like the younger ones because I feel they are up with all the new technology (23/199).

Cost containment extended to the type of services accessed. Those with dentures would access technicians rather than a dental clinic and attend to their teeth but not always their gum conditions.

I've usually gone to a technician because it was always cheaper ...at one time you had to go to the dentist to get your dentures, but I've only been to a technician (22/213).

Others chose between regular dental and hygienist treatment.

I would go to a dentist by choice [who has] a degree because I feel that I would have more confidence in a fellow that's got further in his dental expertise. I don't care whether it's a man or a woman (19/319).

A number of participants negotiated directly with the dentist.

I got a quote from him, \$300 or something and I had an argument...whether if I paid cash would he take the GST off...which he did. He put some money in his pocket and I went away with a set of dentures much cheaper than I intended on paying. But if he mentioned my lower teeth I wouldn't have given him a look (18/128).

Other participants negotiated within the family.

She had dentistry done initially. Well, her teeth are falling apart and she is a regular attender and that's what keeps her going. This sort of thing, her going and me not, saves us money (18/426).

A constant backdrop that accompanied this deliberating, deciding and action process was 'making ends meet' or planning for the unexpected. One participant had

experiences of Accident Compensation Corporation (ACC) payments that did not meet her accident related costs and found that her spare money had almost disappeared.

“...it [dental work] took all the spare cash I had...a bit frightening to think that okay I might have something else and I won’t be able... and then of course I did my glasses in...So I was down financially over \$5000 (22/114).

Other participants had made earlier decisions about their dental care based on perceived time left to live.

Now I’m 85 I wonder what better things I might have done when I was 74 and I had taken the advice that I was offered, which I didn’t (1/9).

Most participants’ reports revealed the uncertainty that ageing brings. Decisions to have particular treatments or not involved a balancing between cost and expected length of life.

I remember saying to him “Well hang it all I am 74 it can’t really matter can it” (1/290).

For all participants, uncertainty extended to the continued health of their body, teeth, and mouth as well as their acceptability to others.

I like to know that they are clean, that when I smile they are not all grubby and dirty although they are getting older looking. But...I certainly would hate to be without them...so in that way they’re precious (5/343).

Participants reported in their ageing they experienced discoloured teeth, fillings falling out, teeth cracking and decay. Infection and inflammation of the gums were more frequent. Dentures required replacement or adjustment as gums receded. Food choices were limited and foods became trapped between teeth, making social occasions difficult. Others felt watched and sometimes judged for the state of their teeth.

I think it’s the cost with most people when they are older. They are frightened of being without something at the back of them and a lot of them have only got their pensions...I go to [suburb] where there is a lot of older people and to me their mouths don’t look as though they are very healthy and it’s probably because they can’t afford to go. I think dental health is part of ordinary health. They shouldn’t have to pay so much to have to go to the dentist like they don’t have to pay so much to go to the doctor (22/374).

People balanced cost against the real need of comfort and nutrition versus their personal appearance to have an acceptable public self or a self that was authentically them.

If you’ve got a nice healthy mouth and teeth then the rest of your body is going to be a lot healthier isn’t it? (1/22)

Participants talked about their teeth and mouth looking aged and old like them, but **were** ‘them’ and that was important.

I’m still quite conscious that some of the gaps in my mouth show when I laugh and I talk a lot and so people I’m with must be very familiar with what my mouth looks like (4/362).

Some participants covered their mouth with their hand when talking, while others maximised their attractiveness by the use of particular toothpastes, mouthwashes, flossing, and whitening products—and made regular dental clinic visits. Many participants had learned earlier in life that chewing gum (particularly in public) was unacceptable and either would not use these oral health products or would do so privately where no-one could see.

While a number of dimensions were taken into account during option balancing processes, and while participants had differing bottom lines, the final consideration which shifted their decision was cost. The first to go were regular dental visits. Whether the participant went to the dentist from a problem oriented or preventive perspective, for most they went 'because they could not afford not to' while wondering 'whether they could afford it'.

Discussion

Increasing healthcare needs of older people—With the ageing of our Aotearoa New Zealand population, the oral healthcare needs of older people is on the increase.¹⁷ Yet our healthcare system appears poorly prepared for this situation. Although the inter-relationship between oral health and general health is well known by health professionals, there is evidence that they place oral healthcare as a low priority when caring for the elderly. Oral health assessments are poorly conducted and few professionals give advice concerning oral health maintenance.¹¹

This study has shown that for an older person, the maintenance of a healthy mouth and teeth is not a simple matter. The intersection of increasing general healthcare needs and decreasing resources and income can cause a shift from preventive to problem oriented dental care.⁶ While many receive subsidies for general healthcare, dental care is minimally supported.¹⁰

In Aotearoa New Zealand, people on lower incomes have access to emergency dental care only. It was not surprising to find therefore, that affordability was at the centre of these participants' deliberations concerning their oral healthcare. Only one participant reported the use of a refund programme, namely ACC. Even though an appeal was lodged, this participant was refunded a small proportion of the actual costs incurred from an accident.

While an increase in the availability of dental care insurance could assist those who are still working or in their early retirement years, research has shown that those who have been retired for many years can no longer afford insurance costs.⁸

Government funders, maybe rightly so, are concerned with cost effectiveness and there is an increasing focus on the provision of accessible and affordable primary healthcare. Yet older peoples' oral healthcare needs do not feature prominently in future planning. For example, a 1997 report to the National Health Committee¹⁵ on preventive dental strategies for older populations recommended "a systematic review of the current formula by which publicly-funded dental care is allocated" (p2). However, Carter et al¹¹ reported that the results of their "Christchurch study show little evidence of implementation of the recommendations of that report" (p8). Additionally, there is little indication that the current government plans any focused response to these recommendations.¹⁶

It would seem from this study and from international research that this hands off approach will not meet the current and future needs for oral healthcare for older people.¹²

This study has not provided epidemiological data. Critically, it gives voice to those who otherwise may not be heard, the older people in an urban New Zealand community. It provides insight into the lengths older people go to maintain their oral

health and quality of life.¹⁸ These findings stand alongside national and international research that report affordability and access as central to the maintenance of oral health for older people.^{12,19} They could also complement the findings from the current national Oral Health survey commissioned by the Ministry of Health to be published in 2009.²⁰

The participants' stories reflect determination and steadfastness; they challenge health practitioners, policymakers and public funding agencies to become equally determined to support policies that direct funding towards accessible oral healthcare for older people. To not do so would be more costly. Research has clearly linked the relationship between poor oral health and exacerbations of chronic health conditions.⁴⁻⁶

Future research and study limitations—This study raises questions for further investigation. From the stories of these participants it is evident that dental practitioners are also involved in a balancing act when advising older people about their dental healthcare needs. We propose to examine the situation related to older people from the perspective of these practitioners.

A limitation of this study is the homogeneity of the participants. Most participants were from working or middle class backgrounds and owned their own homes and cars. With only five men, the majority of participants were women. Additionally, we recruited few Māori. The findings therefore, are more representative of mainstream European oral healthcare experiences. A more ethnically heterogeneous sample could have added complexity to this study.

Conclusion

Health professionals' lack of awareness of oral healthcare needs combined with the limited public funding in this area, does not auger well for the general health standards of Aotearoa New Zealand's ageing population. The message given by the participants in this study is clear, 'access to oral healthcare matters'. Their stories of 'balancing' affordability with their quality of life need to be listened to. Publicly funded oral healthcare for the older population is an urgent healthcare need. A decision by health professionals and policymakers to take joint action and change current policy to include publicly funded oral healthcare for the older population will make a difference.

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