Barriers to the provision of oral health care for people with disabilities

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Introduction

Both in dental care and wider healthcare services, people with disabilities face a particular range of barriers that can prevent them accessing appropriate care. These initially occur at the societal level but filter down to the clinical environment.[1] The Equality Act 2010 defines a disability as *'having physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities'*.[2] An estimated 16% of people in the UK are living with some form of disability be it physical, intellectual, mental, or sensory in nature.[3] In 1971, Hart's 'Inverse Care Law' stated that *'the availability of good medical care tends to vary inversely with the need for it in the population served'*.[4] The barriers that lead to this situation are still relevant today, meaning that people with disabilities report poorer access to healthcare, which exacerbates their poorer general[2] and oral health.[4]

Historically, language referred to peoples' disabilities instead of people, attributing problems faced to the disability rather than wider society. The social model of disability is seen as a more appropriate way of understanding the problems people with disabilities may face in receiving appropriate healthcare.[5] This model describes how it is society that erects barriers – by action, or inaction – that prevent people with disabilities living a life comparable to non-disabled people. In this model, to break down barriers to care, society must adjust by making far-reaching changes from legislation through to design of cities, transport, healthcare services and beyond to ensure people living with disabilities are not disadvantaged.

The Equality Act 2010 places a legal duty on organisations, including dental services, to make reasonable adjustments to reduce the barriers that may affect people accessing care.[2] Through increased waiting times, restrictions of certain services, patient shielding and additional PPE, the COVID-19 pandemic has introduced additional barriers which may disproportionately affect those with disabilities.[6] It is therefore more important now than ever that both general and specialist dental services consider how they can make adjustments to support people living with different disabilities.

'Reasonable adjustments' made in general dental practices can ensure that a substantial proportion of people with disabilities can

be treated in primary care without need for referral to specialist services. A general practitioner may be geographically closer, and the 'normalisation' of attending with family members, in a manner as 'close as possible to the norms and patterns of the mainstream of society'[7] is highly important to many. This aligns with the Commissioning Standards for Special Care Dentistry, where 'level 1' care, suitable for the majority of patients, can be provided by a general dentist, as per Table 1.[8]

Whilst it is not possible within this article to detail all possible adjustments, barriers to access can be highlighted within five dimensions: Availability, Accessibility, Accommodation, Affordability, Acceptability.[9] Although closely related, these can be considered individually to identify barriers to access and support reasonable adjustments that can be made in general and specialist dental services to reduce health inequalities.

Table 1 Levels of care for Special Care Dentistry. Taken from NHS England[8]

Level of Care	Summary
Level 1	Special care needs that require a skill set and competence as covered by dental undergraduate training and dental foundation training, or its equivalent.
Level 2	Is defined as procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register
Level 3a	Special care needs that require management by a dentist recognised as a specialist in Special Care Dentistry at the GDC-defined criteria.
Level 3b	Special care needs to be managed by a dentist recognised as a specialist in Special Care Dentistry at the GDC defined criteria and holding consultant status.

Availability

For all population groups, a lack of suitable available services can discourage health-seeking behaviours, including NHS or private dental care. The responsibility for making sure relevant services are available currently falls primarily on commissioners who should consider the nature and volume of treatment required in a region and strike a balance between ensuring care is available and using public funds suitably; this challenge affects both general and specialist services.

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Whilst many people with disabilities can be treated in general practice, a smaller proportion require specialist services with additional facilities, staff with additional training, access to conscious sedation facilities and general anaesthesia in hospital settings. Availability of sedation and general anaesthesia can vary, despite it being a crucial modality to facilitate effective dental care for people for whom treatment under local anaesthesia is not possible or appropriate. Lack of availability, or a substantial delay in availability due to prolonged waiting lists and high demand, act as a significant barrier to achieving oral health.

Accessibility

The appropriate service for dental care may be geographically far from where somebody lives, creating a further barrier to receiving dental care regardless of whether a person can travel independently.

In terms of physically and practically accessing care, people with disabilities may need specific facilities. These include disabled parking, wider doors, lifts or ground floor surgeries with ramp access, appropriate lighting and clear signage, or toilets with handrails. Others may require transport by ambulance services, yet certain ambulance services will not facilitate transport to general practices or community dental clinics. This acts as a specific direct barrier to people with disabilities accessing routine dental care.

Travelling a significant distance to appointments could pose an additional barrier on those who experience chronic pain and fatigue due to their disability. For some people the barriers to accessing a dental surgery may be too significant and it becomes necessary for a dentist to visit the patient, at least in the first instance. Domiciliary services are highly variable nationally[10] and can only go so far in breaking down barriers to dental care as the services that can be offered safely on a domiciliary basis are very limited.

Accommodation

Accommodation refers to the relationship between the organisation of services and the patient's needs. This could include barriers created by poor transitional arrangements between services, or the timing or length of appointments.[1] For example, someone may require an appointment at a time planned around when it is possible to use a bus pass or have a carer support them. Someone with Parkinson's disease may plan appointments around when medication is having the maximum therapeutic effect, or person with

autism may rely on appointments fitting a set daily routine.

One barrier is created from a lack of knowledge regarding what services are available and how to make contact with these. Another significant barrier may be a result of difficulty accessing and processing oral health information in the format it is provided to the patient. Facilitating alternative forms of communication promotes inclusion and independence and is essential from the point of booking appointments to the treatment decisions. A reasonable adjustment for someone with a hearing impairment could be booking appointments via email rather than telephone, or, provision of easy read leaflets for someone with learning disabilities. The pandemic creates additional barriers, and adjustments can be made such as transparent masks to allow lip reading,[6] or accommodating an additional person in the clinic to support communication. Maximising communication is also important as part of The Mental Capacity Act[11] requirement to support patient involvement in treatment decisions.

Acceptability

The nature of services themselves, even when adjustments are made, must be acceptable for people with disabilities. Every individual may have their own view on what is deemed acceptable, therefore when deciding on a treatment plan for a patient, it is important that the clinician adopts a person-centred approach whilst consulting to seek their views and values.[12] Clinicians must take into account how any proposed treatment may affect a patient's quality of life and their individual circumstances. For example, some patients would happily lose a carious anterior tooth whereas others would certainly refuse such a plan. For some patients, oral health may be a lower priority than other comorbidities or activities of daily living.[1] Tailoring a plan to support an individual's needs, in the broadest sense,[13] should consider both the treatment and the manner by which it is delivered. So that treatment deemed acceptable can be delivered in a manner that is also acceptable to each patient, it is sometimes necessary to consider conscious sedation, general anaesthetic, or non-pharmacological approaches such as acclimatisation and modelling.

Non-professional caregivers can be involved in supporting best interests decision making for patients with disabilities that affect their cognition, such as severe intellectual disability or dementia. In these instances, the caregivers must be actively involved to determine what is acceptable based on their unique knowledge of the person for whom care is being planned. With either a patient or a caregiver, an in-depth discussion of the person's wider circumstances, preferences, views and tolerance of dental treatment will support a process of shared decision-making. This can break down many barriers to care by facilitating appropriate treatment, and ways of delivering this, that are acceptable to patients and – where applicable – those involved in their care.

Affordability

One of the largest barriers to healthcare for people with disabilities has been shown to be cost. Not only is this the direct cost of dental treatment itself, but indirect costs such as transport, prescriptions and loss of earnings for non-professional care givers. People with disabilities have, on average, lower income and employment, and higher cost of living and rates of poverty than the general population.[3] Although exemptions and benefits are available, they can be difficult for people with disabilities to obtain, particularly those with fluctuating conditions. Disability assessments for benefits have been reported to be 'superficial, dismissive, and to contradict the advice of doctors'.[14] Another barrier is *perceived* cost, where fear of *potential* cost and uncertainty about being able to pay can lead to services not being utilised.[15]

Whether true or perceived, affordability can be a barrier to care, and clear information prior to appointments on charges, payment options, and exemptions can help to reduce this barrier.

Conclusion

There are many barriers to oral care for people with disabilities, some of which have been exacerbated by the pandemic. We as a profession are responsible for making adjustments to minimise these in all settings, whether in NHS or private. To practically address these barriers, dental teams could consider training such as Dementia Friends (www.dementiafriends.org.uk) auditing access to their services[16] for people with disabilities, or contacting their local community and special care dentistry team. An example audit tool is shown in Table 2. These adjustments may be made at a level within the clinic, but also at a societal and legislative level. As new services are commissioned, designed and start to operate, there is a duty to facilitate equitable access and to resolve barriers in each of the dimensions described. ◆

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Table 2 Audit Tool: A simple audit tool that can be utilised by dental practices to highlight potential barriers to access and compliance to the Equality Act
Accessibility Audit of ..... Dental Clinic

Issue	Question	Compliance	Measures needed to comply	Action plan
Outside				
Car Park	Is the surface even and well maintained?			
	Is there lighting in the car park for when it is dark?			
	How many 'disabled' parking spaces are there?			
	Are the 'disabled' parking spaces near to the entrance of the practice?			
	Are the 'disabled' parking spaces of adequate width? (UK 3.6m wide)			
	Are the 'disabled' parking spaces monitored to prevent inappropriate use?			
	Are the 'disabled' parking spaces clearly signposted?			
Entrance and external door(s)	Is the door width adequate to accommodate wheelchairs? (UK 800mm)			
	Is the door frame painted a contrasting colour to the door?			
	Are the door handles at an adequate height above the ground (UK 1000mm)			
	Is the door handle easy to grip?			
	Is the door handle circular in diameter?			
	Has the external door got an accessible threshold? (UK < 13mm)			
	Is there a ramp?			
Outside				
Entrance and external door(s)	Is the ramp at the correct gradient (UK 1:12 to 1:20 depending on ramp length)			
	If the ramp is <2m long, does it have continuous hand rails either side of it?			
	Is the entry bell positioned at the correct height for wheelchair users?			
Inside				
Reception Area	Is the reception desk well sign posted?			
	Does the reception desk have chair level facility?			
	Is the reception area adequately lit?			
	Is the reception area adequately sound-proofed?			
	Does the reception area have measures to aid communication for patients with a hearing impairment? (e.g. induction loop, type talk, text phone).			
	Is there a practice information leaflet?			
	Is the practice information leaflet available in formats to facilitate communication (e.g. Braille, large print, in audio form, in different languages).			
Waiting Room	Is the furniture visible in contrasting colours to the walls?			
	Is the furniture positioned safely?			
	Does the furniture have rounded corners?			
	Is there seating at different levels?			
	Are there arms on the chairs?			
	Is there space for wheelchairs?			
	Is the waiting room adequately lit?			
Inside				
Waiting room	Is there contrast in colour between the floor, walls and ceilings?			
	Are there signs advertising alternative communication formats? (e.g. hearing loops, Braille translation, language interpreting services).			

Issue	Question	Compliance	Measures needed to comply	Action plan
Signage	Are signs clearly visible? (i.e. unobstructed)			
	Are signs printed either with dark lettering on a white background or white/yellow lettering on a dark background?			
	Is the font size on signs correct?			
Doors	Are the door widths adequate to accommodate wheelchairs? (UK 800mm)			
	Are the door frames painted a contrasting colour to the doors?			
	Are the door handles at an adequate height above the ground (UK 1000mm)			
	Are the door handles circular in diameter?			
	Are the door thresholds at a maximum height of 13mm?			
	Are fire doors held open by automatic closers?			
Flooring	Are door mats flush with the floor?			
	Are door mats secured to the floor?			
	Are all the floor surfaces even?			
	Are all the floors non-slip?			
	Are the floor surfaces non-reflective?			
Inside				
Corridors	Are all the corridors of adequate width (UK >1200mm wide)			
	Are all the corridors clear of obstruction?			
Decoration	Is there contrast in colour between the floors, walls and ceilings?			
Surgery/Surgeries	Is there access to a ground-floor dental surgery?			
	If surgeries are on upper floors, are they accessible (e.g. by means of a lift, stair-lift).			
	Is there room in the surgery to accommodate a wheelchair?			
	Are aids available to facilitate transfer from wheelchairs to the dental chair, where appropriate? (e.g. transfer board, portable turntable, hoist).			
	Is the surgery well lit?			
	Is the furniture visible in contrasting colours to the floors and walls?			
Accessible toilets	Are accessible toilets available in the surgery?			
	Is the accessible toilet well signposted?			
	Is the accessible toilet adequate in size? (UK at least 1.5m x 2.0m)			
	Is the accessible toilet equipped with transfer bars, hand rails, a raised seat and an alarm pull cord?			
	Are the taps on the basin and drying facilities accessible?			
Inside				
Accessible toilets	Is there contrast in colour between the floors, walls, ceilings and fittings?			
Miscellaneous				
Fire Evacuation	Is there a visual fire alarm for people with hearing impairments?			
	Is there an audible fire alarm for people who are visually impaired?			
	Are their accessible exit routes for wheelchair users to evacuate the building?			
Staff Training and Awareness	Have staff undertaken Equality and Diversity training?			
	Have staff undertaken dementia awareness training (e.g. 'Dementia Friends'			
	Have staff been trained in communicating with people who have visible and invisible impairments?			
	Is there a practice / service protocol for staff to raise concerns regarding disability inequality?			
Maintenance	Is equipment for the use of people with impairments routinely maintained?			

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