

**Older Patients' Views of Oral Health Care and Factors which Facilitate or Obstruct
Regular Access to Dental Care-Services: A Qualitative Systematic Review**

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Abstract

Objectives: The aim of this systematic review was to explore independently living older peoples' views of oral-health, and their experiences of accessing dental care-services within community settings.

Methods: Dentistry and Oral-Sciences Source, CINAHL, MEDLINE and AMED databases were searched to 15 January 2020. Assessment of methodological quality was undertaken using JBI Critical Appraisal Checklist. Extracted data underwent meta-aggregative synthesis; findings were assigned levels of credibility and categorised according to similarity. These categories were subsequently synthesised into themes.

Results: Five studies were identified and included within analysis. 46 findings were aggregated into 18 descriptive categories, which were synthesised into five themes. These themes were Aggregated oral health experience; Taking responsibility for individual oral health; Practical issues related to accessing dental services; Negotiation of cost associated with care and Role of the dental professional.

Conclusions: Previous dental healthcare experiences influence older peoples' health perceptions and health-seeking behaviours. Dental service provision and the perceptions of dental professionals requires adaptation to accommodate the needs of adults as they age. This includes need for provision of domiciliary services and nationally subsidised dental care.

Keywords: Aged; Dental Care; Health Services Accessibility

Introduction

The global population is ageing at an increasing rate. Between 2012-2015, the elderly population increased by over 55 million, a proportion of 8.5% of the total population. Between 2025-2050, the estimated number of older people will reach 2.1 billion (United Nations, 2017).

As populations age, challenges arise for healthcare-services and professionals; older people present with greater morbidity and dependency (Bots-Vantspijker *et al.*,2014). When considering oral care, trends toward tooth preservation has resulted in reduced edentulism (Peterson and Yamamoto, 2005). Dentistry is faced with management of an older population generally retaining at least part of their dentition using complex restorations and prostheses. This restorative shift has increased risk of oral disease in a population already predisposed due to reduced salivary secretions and challenges in maintaining high standards of oral hygiene (Strömberg *et al.*,2012). This includes caries, periodontal disease and tooth surface-loss (Fuller *et al.*,2009).

Oral-healthcare within the older population requires regular return to care-services to receive preventive reinforcement and early intervention (Razak *et al.*,2014). However, an association between age and loss of regular contact with dental professionals exists, particularly in populations above 65-years (Grönbeck-Linden *et al.*,2016). The reason for such a change in service use as patients age is multifactorial (Dolan, Atchison and Huynh, 2005).

There is gathering recognition, to identify factors which impede or facilitate older people's access to care-services. Literature searches yielded population-based analyses, but no qualitative review was identified exploring the views of independently living older people accessing dental care-services. With the intention of addressing this gap within the literature,

a systematic review was undertaken, conducted according to an a-priori protocol (Legge and Nasser, 2020).

The aim of this review was to identify, analyse, synthesise qualitative research exploring independently living older peoples' views of oral-health, and their experiences of accessing dental care-services within the community.

Methods

The review was conducted according to JBI methodology for qualitative systematic reviews (Lockwood et al.,2017). The protocol was registered with PROSPERO (CRD42020166436). Studies were limited to independent community-dwelling older males and females, living outside of institutionalised environments. Independently living, community-based individuals would not receive any structured oral-care programme; the authors acknowledge that individual circumstance would differ. However, individuals would face similar challenges being responsible or at least co-responsible for their healthcare. Definitions of older adult vary due to global discrepancies in age distribution. For this review, 'older' refers to those aged over 65 (Kinsella, 1994).

Studies exploring community-based older peoples' views of dental care, as well as experiences and preconceptions regarding accessing services were included. Quantitative studies and those addressing attitudes toward oral-health and barriers to healthcare perceived by others (e.g. dentists) were excluded.

Search-strategy

Dentistry and Oral-Sciences Source, CINAHL, MEDLINE and AMED were searched. Strategies utilised free-text and database specific MeSH terms.

Reference lists of articles identified from the searches were analysed to identify further relevant studies. English-language articles were included. An additional limitation

was imposed; articles published within the last 15 years. Despite the changing oral-health needs of the elderly being noted prior to 2005, it was from this time that effects of oral health on the quality-of-life of older people was recognised as a public-health issue by the WHO (Peterson and Yamamoto, 2005).

Assessment of Methodological Quality

The JBI QARI Critical-Appraisal Checklist for Qualitative Research was utilised by two independent reviewers, to assess the papers' methodologies for validity and suitability for inclusion (Lockwood, Munn and Porritt, 2015). Disagreement was addressed via discussion to achieve consensus.

Data Extraction and Synthesis

Data extraction included details relating to the population, methodology, methods and context. Findings were identified through repeated reading. As findings were extracted, levels of credibility were assigned. Findings were identified through line by line coding. Descriptive categories were devised, pooling findings according to similarity. Categories then underwent meta-aggregation, producing a body of synthesised findings (Pearson, 2004).

Results

The search-strategy identified five studies (Figure 1). 423 articles were identified, pooled, and duplicates eliminated. Screening of titles and abstracts excluded 267 articles. This left 16 articles for assessment in full; 11 did not match inclusion criteria (Moher *et al.*,2009). Five articles remained for synthesis (Giddings *et al.*,2008; McKenzie-Green *et al.*,2009; Borreani *et al.*, 2010; Gregory *et al.*,2012; Derblom *et al.*,2017).

The JBI QARI critical-appraisal checklist was used to assess validity and methodological quality (Table-1). All studies committed to qualitative methodologies. However, only two explicitly stated philosophical frameworks (Giddings *et al.*,2008;

McKenzie-Green *et al.*,2009). When considering ‘*locating the researcher*’ and ‘*influence of the researcher*’, no studies scored favourably, indicating lack of high-quality reporting here. Such reflexivity and self-critique are key to qualitative research; they are invaluable when helping readers interpret data (Braun and Clarke, 2013).

To ensure that knowledge is not removed from the context within which it was generated, direct quotes should be available, as was the case for all studies (Yardley, 2007). The relationship between participants’ views and conclusions must be clear, and this was demonstrated. It should be considered that ‘scoring’ of qualitative critical appraisals, does not allow for distinctions to be made between poor reporting as opposed to poor study conduct (Noyes *et al.*,2018).

Characteristics pertaining to included studies are presented in Table-2. They took place in communities where participants were resident not institutionalised. The studies encompassed three countries; New Zealand, Sweden and UK. An area of challenge within this review was ability to determine participant independence. Despite limiting analysis to studies involving non-institutionalised individuals, this was not described in any of the studies.

Two broad phenomena were synthesised. The first concerned older people’s experiences and perceptions of healthcare. This phenomenon explored values placed on oral healthcare and allowed for insight into behaviours to be gained. This provided context for the second phenomenon, which investigated factors impacting upon older people regarding care access.

Forty-six units of analysis were extracted. Findings were graded as unequivocally, credibly or unsupported by the data. Forty-four units of analysis were supported unequivocally, and the remaining units credibly; interpretation could be logically inferred from data. Units of analysis were synthesised and placed into one of 18 descriptive

categories. The categories were inductively synthesised into themes. The meta-aggregation process is presented in Table-3.

The five analytical themes were: “Aggregated oral health experience”; “Taking responsibility for oral health”; “Practical issues related to access”; “Negotiation of cost” and “Role of the dental professional.”

Aggregated Oral Health Experience

This theme was formulated from five categories, supported by 13 findings. Older peoples’ perception of dental care is largely informed by emotional experience and satisfaction with the outcomes of previous visits over their lives. Of importance when it came to perception of oral-health and the need to regularly access care were emotions associated with childhood visitations. Such findings were evident across all studies.

‘The murder house was an appropriate name for the school dental clinics believe me.’

(Gregory,2012)

Moreover, older adults were aware that their experiences of dentistry in previous eras had a profound impact on their views of oral healthcare and the emotions associated with dental visitations. This anxiety surrounding care in turn influences willingness to access it.

‘He lost his teeth when he was 19 and that was what happened in those days and he hated his false teeth.’ (McKenzie-Green,2009)

Perceived success or failure of past treatment influenced older peoples’ opinions of oral-health and care. Individuals who received treatment improving function or appearance, particularly when they compared themselves to those who had not received such care placed great value upon oral health. Views of oral health could also be influenced through experiences of care which impacted negatively upon loved ones.

'I went to a dentist and they said I would have to have my teeth removed, my husband said 'no.' ...he hated his false teeth, so he said, 'I don't care how much it costs.'

(Giddings,2008)

The final two categories pertain to the fact that older people became tolerant of dental problems with age, accepting them as everyday experiences rather than health issues requiring attention. This marked a shift in older peoples view of oral-health and related to a consideration between net-benefit of accessing and receiving care against cost and inconvenience, when they may not live much longer.

'Well hang it all, I am 74 now, it can't really matter can it?' (Giddings,2008)

Taking responsibility for oral health

A perception within three studies was that 'oral-health' was a phenomenon which ceased to exist once people no longer had teeth. Several findings demonstrate ambivalence toward the concept of oral-health and that it pertains to more than health of teeth. They shared the view that once edentulous, there was no need to attend dental services.

'Well, I don't have any teeth and I don't have a problem so it [my oral-health] would be excellent, wouldn't it?' (Gregory,2012)

It was observed that older peoples' views on oral-health were affected by their knowledge of the subject area; some participants believed that they were individually responsible for gaining information about oral-health and accessing care, whereas others shared a view that organising dental appointments was only necessary if in pain or if the dentist called them in.

'I might go for a check-up if he rings but he always sends me a note or if I got toothache.' (McKenzie-Green,2009)

One finding demonstrates the view that oral-health is considered an extension of general health, and therefore a great deal of emphasis was placed upon maintaining high standards,

including through regular dental-visitations. For others, it was their appearance which informed their views regarding oral health.

‘It’s your image when you are mixing with other people; it’s... your relationship more personally for breath control....’ (McKenzie-Green,2009)

Older people shared the opinion that knowledge of oral disease and health prevention was lacking. Despite acknowledging need for self-care, many expected a natural and inevitable decline in oral health with age. This was compounded further by increased difficulties in maintaining standards of self-care due to degenerating mobility and sight.

‘...you become shaky and have bad sight, you don’t care in the same way as you get older.’ (Derblom,2017)

Individuals who experienced significant dental problems appeared resigned to poor oral health until the point of edentulism, where it ceased to be a problem. In contrast, for those who had not, maintaining oral health was a source of pride.

Practical Issues related to Access

This theme was formed via aggregation of two categories and six findings. The category “negotiation of convenience” refers to the fact that older people needed help arranging dental care and transport. The effort and complexity involved in organising transport and appointments was a sufficient barrier to accessing services for some, whereas for others, it was unwillingness to ‘put-upon’ family.

‘... you have to book transport or ask someone to drive, it gets complicated with everything.’ (Derblom,2017)

Lack of flexibility by dental staff to accommodate transport and timing issues when organising appointments also impeded access. The second category related to opinions that issues related to accessing services could be overcome through provision of domiciliary care-services.

‘...old people may have problems with forgetfulness, it would be helpful if someone could come here.’ (Derblom,2017)

Negotiation of cost

The theme summarises role of cost in informing decision-making when it came to accessing services and making treatment decisions. Older peoples’ care-seeking was strongly influenced by perceived cost. Even after experiencing prolonged pain, cost remained a barrier to care.

‘I can’t afford to go to the dentist. I have pain sometimes, and have for several months, but it’s so expensive.’ (Derblom,2017)

Elderly people reported that costs of restorative procedures meant that they would opt for more radical, yet less expensive options such as extraction. Cost became pressing as people relied on pension-based incomes, and other expenses such as general medical-care took priority. Maintaining oral health became less feasible for older adults.

Privatisation of the dental-sector was seen to compound issues surrounding cost of care and was viewed as unfair towards low-income older people, left without accessible state-subsidised practices. A linked category within this theme demonstrated the expression of the view that as lifetime taxpayers, they have a right to affordable care.

‘...dental health is part of ordinary health. We shouldn’t have to pay so much to have to go to the dentist, like we don’t have to pay so much to go to the doctor.’ (Giddings,2008)

Role of the dental professional

The part played by dental professionals in informing older peoples view of oral-health and their willingness to access services is recognised. Across studies, there was an accepted trust in dentists and respect for their decision-making. Dentists and their behaviours were important contributors to altering peoples’ perspectives, and to portraying oral-health and

care positively. Confidence in the practitioner was a major facilitator to older people accessing care-services.

'I think it is very important when they say hello and smile and say: 'how are you?' They give that smile and it relaxes you.' (Borreani,2010)

In two studies, elderly people expressed mistrust when receiving care from auxiliary dental-staff such as hygienists. There was a lack of understanding regarding their role and were seen to be less well-qualified; patients expressed a desire for all care to be undertaken by dentists.

Discussion

Much information is available surrounding experiences of oral health and care access within the care-home environment, but little is known about community-dwelling older people.

Previous research shows that past healthcare experiences influence an individual's subsequent perceptions and health-seeking behaviours, and this review corroborates this (Lovgren, Engstrom and Norbery, 1996; Lee *et al.*,2010). Synthesis of rich, in-depth qualitative studies provides valuable insight into needs and concerns of older adults from their perspective and allows for common themes to be identified from amongst different people groups. This is a useful means of prioritising aspects of dental and social-care provision where changes can be made and where future impact studies can focus.

Older people expressed views of oral health and maintenance which were often incorrect. Despite acknowledging the role of self-care hygiene; pain was often seen to be the indicator of dental disease.

Oral health practices and perceptions are established and institutionalised over a lifetime. It is imperative to consider the social context of care, where outcomes depend on generational or socio-economic circumstance or beliefs (Gibson *et al.*,2019). There are those older adults for whom oral hygiene practices have never been established or perceptions of dentistry have not

changed with the times. It is these older adults who are resigned to losing their teeth, which is in turn interpreted negatively by those who see the maintenance of their dentition as an accomplishment.

The role of the dentist in providing health education was supported by the findings, although it is important to consider that only those regularly accessing care benefit from such advice. Most significantly, practitioners needed to be trusted individuals whom older adults were comfortable to visit regularly and collaboratively work towards maintenance and improvement of health.

One of the practical challenges that older people face in accessing care is inflexibility of healthcare systems to accommodate their needs and abilities. A lack of understanding into difficulties faced when organising and attending appointments is corroborated by literature citing dental professionals having inaccurate perceptions of the impact of aging and an apathetic view towards older adults (Kiyak and Reichmuth, 2005).

The review found that there was consumer-demand for the provision of domiciliary services. However, studies show dental-care providers perceived that poor remuneration and logistical challenges when providing domiciliary care make service provision unattractive (De-Visschere and Vonobbergen, 2006).

Older people raised concerns around receiving treatments from auxiliary staff. Considering the trend toward increasing numbers of dental auxiliaries to improve access, it will be useful to conduct further studies on why patients were concerned and how to address this (Brickle and Self, 2017). Despite differences in dental commissioning across the three included countries, all papers included findings which reflected cost as a barrier to care. Such findings within New Zealand may be anticipated given private-sector dominance of dental services (Birch and Anderson, 2005). In contrast, in Sweden, government subsidies are available to contribute towards costs of care, including subsidised prosthetic treatment for over-65s

(Kravitz et al.,2015). Cost perceived as a barrier here may also reflect challenges in understanding and negotiating social-insurance entitlements. The authors recognise that healthcare provision differs globally, and that study generalisability to other contexts is unclear, especially low resource communities.

Conclusion

Experiences aggregated over a lifetime informs older adults' perceptions of oral-health and care providers, which in turn acts as a barrier or facilitator to accessing care. Past experience has lasting implications as does the perception that loss of teeth is a normal part of aging.

Older people share the perception that the lack of affordable care prevents regular dental-service access. Consensus existed that oral healthcare fell down the list of personal priorities as they lived on pension-based incomes. Older adults considered the stark reality of whether oral care and access were worth costs and inconveniences, when they may not live much longer. They perceived that service access could be improved through increased availability and flexibility of dental care – particularly state-sponsored care.

Dentists need to be sensitive to generational differences in dental experiences, considering that practice has changed dramatically over time. Practitioners need to be perceptive to the fact that older adults value establishing long-term relationships with a practitioner who has gained their trust. Healthcare staff should appreciate that aging impacts upon an individual's ability to reach dental care-services. When arranging appointments, practices could organise times to coincide with the arrival of public-transport services. Liaison between local councils and dental services would help to make public-transport routes conducive to reaching the dentist. Dental commissioners should consider that shifts from nationalised to private practice within the community has impeded access for older people. Future service-commissioning needs to focus upon reinvigorating numbers of state-

subsidised general practices. Commissioners should be aware that demand for domiciliary services exists, and that there is a need to make it more attractive to care providers.

This review offers pragmatic recommendations to improve older peoples' ability to access dental care, whilst accounting for past experiences and perceptions of oral health. Further research is needed to determine how the implementation of such recommendations change older people's ability to access care-services.

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Tables and Figures

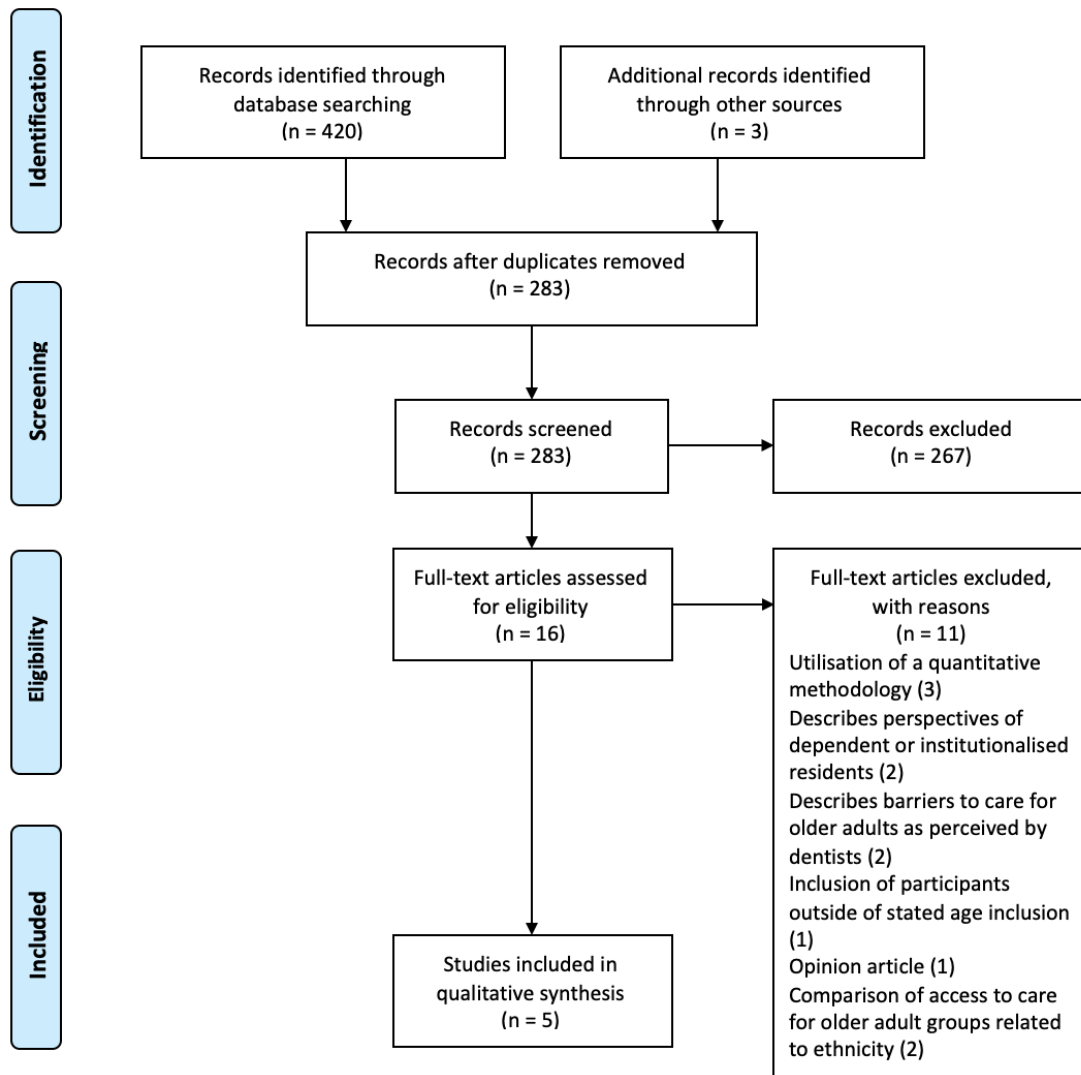


Figure 1. PRISMA flow diagram of the search-strategy (Moher et al.,2009).

Table 1. JBI QARI critical-appraisal checklist: Assessment of methodological quality

Study	Borreani et al. 2010	Derblom et al. 2017	Giddings et al. 2008	Gregory et al. 2012	McKenzie-Green et al. (2009)
Q1. Is there congruity between the stated philosophical perspective and the research methodology?	U	U	Y	U	Y
Q2. Is there congruity between the research methodology and the research question or objectives?	Y	Y	Y	Y	Y
Q3. Is there congruity between the research methodology and the methods used to collect data?	Y	Y	Y	Y	Y
Q4. Is there congruity between the research methodology and the representation and analysis of data?	Y	Y	Y	Y	Y
Q5. Is there congruity between the research methodology and the interpretation of results?	Y	Y	Y	Y	Y
Q6. Is there a statement locating the researcher culturally or theoretically?	U	U	U	U	N
Q7. Is the influence of the researcher on the research, and vice-versa, addressed?	N	N	N	N	U
Q8. Are participants, and their voices, adequately represented?	Y	Y	Y	Y	Y
Q9. Is the research ethical according to current criteria?	Y	Y	Y	Y	Y
Q10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	Y	Y	Y	Y	Y

Y – Yes; N – No; U – Unclear

Table 2. Characteristics of the five included studies

Author	Methodology and Method	Phenomena of Interest	Participants and Sample Setting	Data Analysis	Authors Conclusion
Borreani et al. (2010)	Qualitative (no specific philosophical framework mentioned); Individual in depth semi-structured interviews and focus groups	Explanation of the perspectives of older people of oral health and oral healthcare services. Gaining an insight into the oral health behaviours of this group and whether or not oral healthcare services are of value	Community dwelling older adults, South London, United Kingdom; Ten focus groups involving 39 older adults and their carers. 39% aged 65-74 years, 49% aged 75-84 years and 5% over 85 years	Framework Analysis	The cumulative effects of dental experiences and events throughout an older person's lifetime has a major influence on their perceptions of oral health and dental attendance. Participants consider oral health to be important as well as the right to accessing state-funded oral healthcare
Derblom et al. (2017)	Qualitative (no specific philosophical framework mentioned); Semi-structured interviews	To achieve an understanding of older peoples' views of the benefits of regular dental care and investigate the factors that facilitate and impede regular dental care	Community dwelling older adults attending senior social centres (unclear of number), Uppsala, Sweden; 15 interviews, participants recruited via advertisements within community senior social centres in both strong and weaker socio-economic communities	Content Analysis	Elderly participants describe obstacles to accessing dental services to include costs of care and challenges of understanding insurance systems. Practical obstacles such as using the telephone or travel also exist, in addition to a lack of confidence in the profession and lack of understanding of the benefits of good oral health in older age. Participants acknowledge individual responsibility for looking after teeth, but also the need for the adaptation of dental services to the needs of the elderly
Giddings et al. (2008)	Qualitative – interpretative phenomenological analysis; Individual semi-structured interviews. This study formed a further analysis into themes identified by McKenzie-Green et al. (2009).	An examination of older people's experiences of oral health and the challenges of option balancing faced when accessing services to maintain their current oral health status	Community dwelling older adults, New Zealand; 19 in depth interviews. Participant ages between 65-87 years. Participant recruitment via purposive snowballing technique.	Interpretative Phenomenological Analysis framework	The study identifies a lack of awareness of oral health needs by professionals and limited public funding within this area as major barriers to accessing oral health care. Older adults are having to strike a balance between affordability and quality of life
Gregory et al. (2012)	Qualitative (no specific philosophical framework mentioned); Semi-structured interviews	Experiences and perceptions of older people regarding their oral health and oral health care	Community dwelling older adults, Otago and Invercargill, New Zealand; 24 in depth interviews. Patients selected at random from electoral rolls. Mean participant age 71	Thematic analysis	The study identifies shared experiences which affect older peoples' ability to maintain oral health given certain material and social barriers to accessing oral health care. Older adults are more satisfied with care received as their expectations are often lower

McKenzie-Green et al. (2009)	Qualitative – interpretative phenomenological analysis; Individual semi-structured interviews	Exploration into the perceptions of older adults with regard to their oral healthcare practices	Community dwelling older adults, New Zealand; 19 in depth interviews. Participant ages between 65-87 years. Participant recruitment via purposive snowballing technique.	Interpretative Phenomenological Analysis framework	The study describes the spectrum of factors which influence older adults' perceptions of oral health care and inform their health care practices, including the role of past dental experiences. Despite the fact that access to and affordability of dental care becomes more challenging with age, participants demonstrated a resilience and devised strategies to mitigate the impact of these barriers. Older adults still recognise the social impact of poor oral health, and the authors acknowledge the role of the GDP in supporting or hindering the care needs of this generation.
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Table 3. Results of meta-synthesis

Findings	Categories	Synthesised Findings
Perception of Dentistry: ‘I’ve been scared of the dentist my whole life; I was ready to faint – I was petrified Derblom (2017) p.316	Assimilation of past experience and perception of dentistry	Aggregated Oral Health Experience
Oral health over the life-course of older people: ‘A lot of fear comes from when you are young, when we were at school’ Borreani (2010) p.13		
Satisfaction with outcomes of dental care: ‘Having worked in an old people’s home and seen the state of peoples teeth, I thought I’m glad I’ve got dentures.’ Gregory (2012) p.58	Satisfaction with outcomes from past dental treatment	
Results of dental care: ‘I’ve had no problems today thanks to the implant. It was the best thing I’ve done. Even though it cost a lot of money.’ Derblom (2017) p.316	Net benefits of dental care	
Benefits of dental care with older age: ‘If you think you’re going to die soon, you don’t want to spend more money on it.’ Derblom (2017) p.317		
Balance between cost and expected length of life: ‘Well hang it all, I am 74 – it can’t really matter can it?’ Giddings (2008) p.76		
Acceptance of dental problems: ‘I’ve got a plate which keeps just falling out, so I’ve just given it up at the moment.’ Gregory (2012) p.60	Tolerance of dental problems	
Acceptance of past clinical practice: ‘He lost his teeth when he was 19 and that was what happened in those days and he hated his false teeth.’ McKenzie-Green (2009) p. 34	Dental ‘norms’ of previous eras	
Vogues within dentistry: ‘Well, it was fashionable to have dentures. Practically, not all my friends, but a hang of a lot of them were having teeth out, can’t be bothered to pay to get them filled all the time.’ Gregory (2012) p.57		
Knowledge of oral health: ‘Many people of my age don’t know anything about dental hygiene. The ones who don’t go to the dentist have no idea.’ Derblom (2017) p.317	Knowledge of oral health	
Older people’s perceptions of their own oral health: ‘As I had it checked yesterday by the dentist; I would think that it was OK... I think the more you go to the dentist, the better it is for you.’ Borreani (2010) p.13		
Perceptions of oral health: ‘Well I don’t have any teeth and I don’t have any problems so it would be excellent wouldn’t it?’ Gregory (2012) p.60		
Incorporation of oral hygiene advice: ‘I was put onto Coalbase Neutro-Fluro 5000-plus. And you do it every night and you brush for about 2 min and then you don’t rinse and you are not supposed to drink for half an hour.’ McKenzie-Green (2009) p. 36	Harmony between social beliefs and oral hygiene instruction	
Personal hygiene and mobility: ‘...you become shaky and have bad sight, you don’t care in the same way as you get older.’ Derblom (2017) p.316	Self-care experiences and changes with age	
Acceptance of responsibility: ‘I’ve had well, I’ve had toothache because it’s been my own fault. I’ve neglected, I haven’t gone to the dentist on a regular basis and I’ve suffered for that.’ Gregory (2012) p.60	Attitudes towards oral health	
Prioritisation of oral care needs: ‘There was never time and money to look after myself, the family came first... it was like that for a lot of older women – they forgot about themselves.’ Derblom (2017) p.317		

Mouth and teeth embody 'self': 'It's your image when you are mixing with other people; it's... your relationship more personally for breath control, bad breath.' McKenzie-Green (2009) p. 36		
Utilisation of dental care services: '... I have a private dentist and go regularly, and more than regularly, because of the problems with my teeth.' Derblom (2017) p. 316	Casual Symptomatic vs. Regular dental service usage	
Dental calling rituals: 'I might go for a check-up if he rings but he always sends me a note or if I got toothache.' McKenzie-Green (2009) p. 35		
Practical obstacles to visiting dental services: 'You're a bit shaky and don't see well. You have to book transport or ask someone to drive, it gets complicated with everything... there is a lot of factors to take into account.' Derblom (2017) p.317	Negotiation of convenience and lack of support	Practical Issues related to Access
Negotiating convenience: 'the one dentist who got me sort of a bit muddled up with what he expected, because I'd said to him that I lived out here and I didn't drive... he couldn't see that I had to rely on other people to bring me in and there was no alternative...' Gregory (2012) p.56		
Availability of domiciliary care services: 'Old people may have problems with forgetfulness, then it would be helpful if someone could come here and examine the teeth.' Derblom (2017) p.317	Availability of domiciliary dental care	
Cost of dental care: 'I can't afford to go to the dentist. I have pain sometimes and have had for several months, but it's so expensive.' Derblom (2017) p.316	Role of cost when no longer earning	Negotiation of Cost
Negotiation of cost: 'We elderly folk too have to make ends meet and perhaps for some people having your teeth seen to is not a priority. There are other things more important.' Gregory (2012) p.57		
Availability of dental services: 'They are all going private which I think it's a bit unfair... (to)... elderly people with low incomes.' Borreani (2010) p.15	Privatisation of dental care	
Access to healthcare as older adults: 'I think that dental health is a part of ordinary health – they shouldn't have to pay so much to go to the dentist like they don't have to pay so much to go to the doctor.' Giddings (2008) p.76	Subsidised care for older adults	
Right to healthcare as older citizens: 'We've worked all our lives and paid all our dues; we are on the scrap heap and there is nothing we can do about it.' Borreani (2010) p.14		
Relationships with care professionals: 'I like the younger ones because I feel they are up with all the new technology.' Giddings (2008) p.75	Confidence in dental practitioner	Role of the Dental Care Practitioner
Behaviour of the dentist: I think it is very important when they say hello to you, and they smile and say, 'How are you?' They give you that smile, and it relaxes you.' Borreani (2010) p.14		
Trust in dental surgeon: 'I haven't regretted having them taken out – they [dentists] have taken them for a very good reason and I respect their decision – they are the professional not me.' Gregory (2012) p.59	Shared care and joint decision-making	
Collaboration with dental surgeon: 'I know I went back to my original dentist and I said to him I had left you because you keep nagging me because I can't open my mouth and I can't open my mouth. He never nagged me anymore.' McKenzie-Green (2009) p. 37		
Lack of trust in other dental care professionals: 'I think at this hour of my life I'd prefer a dentist' Gregory (2012) p.59	Relationship with other dental care professionals	

