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EDITORIAL

Oral health in older people: time for action

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The common Task and Finish (T&F) group on Gerodontology of the European College of Gerodontology (ECG) and the European Geriatric Medicine Society (EUGMS) recently published an expert opinion document on oral health assessment and promotion in older people by non-dental care providers [1]. That document provides geriatric oral health policy recommendations, with particular focus on frail and care-dependent older people. The need for these recommendations was prompted by the poor oral health in frail older people, facing multiple barriers to oral care, urging the need for interprofessional educational collaboration and practice. Target audience for these recommendations consists of health policy makers, but also all health care professionals treating older people, such as geriatricians, internists, general medical practitioners, dentists, nurses and nursing assistants, physical therapists, pharmacists, medical assistants, physiotherapists, occupational therapists, dieticians, and others.

Common oral diseases in old age are tooth loss, denture-related conditions, poor oral cleanliness, caries, periodontal disease, hyposalivation, oral precancerous conditions, and oral cancer [2–5]. These conditions may cause pain, local and systemic infection, chewing and swallowing problems, aesthetic problems, and occasionally increased mortality. In addition, bad breath and a poor dental appearance can increase social isolation. Oral infections and periodontal disease have been closely associated with general health such as cardiovascular disease, diabetes mellitus, and lower respiratory tack infections, while tooth loss may have negative effects on diet and nutrition [2–8]. At the same time, oral disease can be prevented by daily oral hygiene, appropriate lifestyle interventions (i.e. healthy diet and smoking cessation), and regular professional oral health care and follow-up [9].

Despite the high prevalence of oral problems in old age, dental attendance by frail older people is low. Therefore, the role of non-dental health care providers in assessing and promoting oral health becomes very important [10]. They have the opportunity to assess oral problems, recommend or perform basic preventive measures to patients and refer to the dentist or dental hygienist, when appropriate. However, this rarely happens due to lack of necessary knowledge, skills, and attitudes towards oral health promotion or lack of appropriate policies and legislations.

The T&F group on Gerodontology has identified three major sources of oral health barriers in old age: (a) person-related issues, such as physical illness, reduced mobility, cognitive impairment, care dependency, low socioeconomic background, living in rural areas or in residential care, financial problems etc. [3–5, 11–13], (b) lack of professional support, including limited training of non-dental health care providers in oral health [4, 13, 14], and (c) lack of effective oral health policies, including poor legislations, policies and regulations on dental care in the community and in institutional care, and limited public dental care coverage combined with the high cost of dental treatment.

Three areas requiring urgent interventions have been proposed: educational action plans, health policy action plans, and citizens' empowerment and involvement.

First, *educational action* plans should involve both dental and non-dental health care providers, offering interprofessional training opportunities, hands-on training and improvement of attitudes towards oral health promotion. Dental professionals require more training in oral care for frail and care-dependent older people, while non-dental health care professionals should be educated in oral health assessment and promotion at the undergraduate,

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postgraduate, and specialty level. A list of learning objectives has been identified including recognizing oral health as part of multi-morbidity, reflecting current medication regimens towards their impact on oral health, performing an initial assessment of the oral health status, demonstrating oral hygiene measures to the older adults and the carers, developing strategies to overcome barriers to oral health maintenance and access to dental care, deciding when to refer to the dentist, and supporting collaborative practice.

Second, the recommendations include a list of *health policy action plans*, prioritizing the integration of oral health into the general health assessment, the implementation of preventive oral health care in routine medical care schemes and the inclusion of oral care into public health care, as financial restrictions are significant barriers to dental care. Emphasis is also placed into domiciliary care and promotion of oral health prevention campaigns for the public.

A very important part of the recommendations is related to the development of policies and protocols on oral health promotion in institutional care settings, including oral health assessment upon entry, provision of daily oral hygiene, training the carers in oral health provision to residents, provision of a healthy diet, ensuring access to emergency and routine dental care, and provision of regular oral screenings for residents using appropriate validated tools.

Last but not least, the *empowerment and involvement of citizens* in actions related to oral care for the older adults was highly emphasised in the final part of the recommendations. Citizens may guide decision-makers in enforcing legislations for oral health promotion and coverage by state or social security, as well as strategies for promoting oral health literacy.

These recommendations, valid in Europe, may also prove beneficial to other countries facing similar socio-medical problems, particularly in the Americas, Asia, and Australia, and may be used as advocacy tools by national and international authorities to develop appropriate policies and legislations.

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Compliance with ethical standards

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