




'Was I still on the waiting list?'

A study about people waiting for public dental care

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The Project Reference Group provided advice and support. It comprised:

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Martin Whelan of Dental Health Services Victoria provided technical assistance with data collection.

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EXECUTIVE SUMMARY

This study explored the experiences and perceptions of public dental patients who had been on the waiting list for public dental care at Dianella Community Health, including those who did not end up using the service.

The aim of the study was to:

- ▶ Investigate factors (including health literacy) that influence decisions to keep or not keep appointments made by people on public dental waiting lists to attend dental clinics.
- ▶ Explore people's perceptions of their oral health status and general health status, and associated behaviours, while waiting for public dental care.

Study design

The study involved people who have been on the waiting list for public dental treatment at Dianella Community Health, Broadmeadows, for two years or more. People were recruited to take part in the study before they were sent a letter offering them dental appointments at Dianella. As it was anticipated that the interviews might affect behaviour in regard to making and keeping dental appointments, the behaviour of a control group offered appointments at the same time at Dianella were recorded and monitored as a comparison.

A Reference Group was set up to provide in-depth feedback at different points of the research, particularly following completion of the major part of the study.

Data collection and analysis

Data collection took place when:

- ▶ 150 consumers received letters of invitation to take part in the study
- ▶ 107 consumers took part in the pre-interview telephone calls
- ▶ 47 consumers including 11 from Arabic backgrounds took part in-depth interviews
- ▶ 60 consumer records were monitored without intervention as a control group.

The analysis incorporated quantitative and qualitative strategies, including simple statistics, content analysis and grounded theory strategies. The quantitative and qualitative analyses were then scrutinised together for further meaning, allowing a greater level of interpretation.

Key Findings

In answer to the question as to why people who are registered on the waiting list at Dianella decide to keep or not keep their appointment was found to be a combination of factors. These included changes that had occurred during long waiting periods, low English literacy and health literacy, family commitments and others associated with low socioeconomic and cultural backgrounds. These factors were considered to be complex and to include an interrelation of all the key findings below.

The following points cover key findings from this study:

- ▶ The numbers of consumers attending their dental appointment increased dramatically following participation in this study.
- ▶ People who spend long periods of time on the waiting list can face deterioration in their general and social health.
- ▶ Access to emergency dental care is acknowledged to be important to those waiting for public dental care, yet it is not readily available.
- ▶ The current database system at Dianella does not support ongoing engagement with people on the waiting list.
- ▶ The population on the public dental waiting list at Dianella are culturally and linguistically diverse with low levels of English literacy.
- ▶ There is a lack of knowledge and consequently a high level of misunderstanding about public dental care among those on the waiting list.
- ▶ Information about public dental care is not readily available to members of the Dianella community.
- ▶ There was a level of anger, frustration and unhappiness among participants; this impacted on their attitudes towards dental care and those providing that care.
- ▶ Preliminary telephone interviews provided an avenue for expression for those who did not wish or could not be interviewed.
- ▶ Study participants provided some excellent suggestions and alternative ways to manage some of the above.

Recommendations

1. When people are registered and put on the waiting list

- ▶ Record additional contact details including next of kin, mobile phone numbers and email if any.
- ▶ Consider a needs assessment (a more sophisticated triage) that indicates how long people can wait before their condition deteriorates.
- ▶ Give written as well as verbal information in the form of a brochure (as described below).

2. Develop a strategy for engagement

- ▶ Develop a brochure and make it available
- ▶ Design a poster that would be placed at the waiting area of the dental clinic, which could be read by those waiting for service at the dental desk
- ▶ Using Dianella health promotion services as a guide, develop peer connections with Dianella groups, external groups and community organisations. Using these links then develop a health literacy campaign to inform consumers about the health service system, public dental services and how to navigate through the system
- ▶ Work on a collaborative approach with local community organisations, ethnic media and small community groups promoting services at Dianella and encouraging peer education
- ▶ Develop culturally sensitive services with input from the above internal and external cultural services
- ▶ Consider engaging family members through the schools program.

3. While people are on the waiting list

- ▶ Make regular contact by phone and/or letters to provide information about the progression of the waiting list
- ▶ Enable two-way communication with consumers to facilitate telephone contact. Perhaps offer regular focus group discussions and/or random contact by telephone with consumers who are on the waiting list to ensure innovations are being targeted correctly, to learn about ways to improve public dental services at Dianella, including the development of prevention strategies.

4. When people have reached the top of the waiting list

- ▶ Letter of offer is to be made to appear more friendly with perhaps a colourful envelope
- ▶ Letter of offer is to be made simple, in plain English with a summary in key CALD languages
- ▶ Give a reminder by telephone or message once the appointment is made
- ▶ Ask for simple feedback at appointment and ask for suggestions for service improvements.

5. Institute service delivery changes

- ▶ Liaise and collaborate with primary care providers such as GPs about providing people with chronic conditions a care plan to enable them to receive dental treatment under the Medicare dental scheme
- ▶ Develop a set of protocols with dental reception staff for handling complex or problematic situations; that is, for staff to deal with the waiting list data and for dealing with anxious patients.

6. Explore the feasibility of a centralised emergency referral

- ▶ In collaboration with other local dental providers, consider the feasibility and development of a centralised emergency service that could direct people in need to a convenient and accessible emergency service. This should be considered in association with the delivery of information about local community and public transport availability.

1. BACKGROUND

This study built on findings of the Dental Costs Study conducted by the Health Issues Centre in collaboration with Dental Health Services Victoria and Dianella Community Health (Horey, Naksook, McBride, & Calache, 2008, p. 1). Several questions were raised by this study about the use (or not) of dental services, and attitudes of those on the waiting list towards dental care.

In particular we were interested in the following:

- ▶ Did they become ineligible for public dental care while waiting; for example, having found jobs?
- ▶ Had they sought dental care elsewhere, either through emergency care or from private dentists?
- ▶ Had people moved away from the catchment area?
- ▶ Did other issues, such as ill-health or family commitments, affect their ability to attend?
- ▶ Were they so frustrated by the anticipated or actual waiting time that they ignored follow-up communication from the service?
- ▶ Was poor literacy a barrier to understanding the offers made by the service?
- ▶ Was low level of health literacy a barrier to service use?

The Victorian Government is currently working on improving waiting time management in public dental services by consulting service providers and examining local and international approaches (DHS, 2007a). The intention of this study was to complement the focus on the service by looking at issues affecting consumers, the key stakeholders in the system. It explored the experiences of people on a dental waiting list to understand their circumstances and their reasons for using or not using the services, despite their needs.

1.1 Rationale for the Study

As noted above, Health Issues Centre, in collaboration with Dental Health Services Victoria and Dianella Community Health, conducted an earlier study at Dianella Community Health, Broadmeadows (Horey et al. 2008). The Dental Costs Study (DCS) was the first comprehensive study of comparative costs of public dental care in Victoria. It investigated costs to the system and to consumers of delayed dental treatment for users of public dental health clinics among two groups of dental patients. One group was on the waiting list for more than two years; another group was on the waiting list for two to four months. The study also explored the impact of delayed dental treatment on health and social behaviours.

Key findings from Horey et al. 2008 included:

- ▶ A higher average cost to the system for proposed treatment among the longer-waiting group for diagnostic services and periodontal, endodontic and restorative treatments, and for dentures.
- ▶ A majority of study participants reported social costs associated with their quality of life from issues related to oral health. For example:
 - In the previous month, over half reported avoiding cold foods (56%) compared with 17% of Australian adults in the 2004–06 National Oral Health Survey (NOHS [Slade, Spencer, & Roberts-Thomson, 2007]).
 - Over half reported experiencing pain because of problems with mouth or teeth (56% compared with 15% in the NOHS).
 - More than a quarter reported feeling self-conscious because of their oral health.
 - More than 20% reported experiencing interrupted or unsatisfactory meals often or very often in the previous four weeks.
 - One in four people said they felt embarrassed or tense fairly often or more frequently because of problems with their mouth or teeth, and one in six people in the study reported using over-the-counter medication to manage dental pain fairly.

- One in 10 people reported that problems with their oral health affected intimacy with others and with sleeping.

Importantly, the Health Issues Centre report suggested that the receipt of timely dental care is significant to overall dental health, and that it results in significantly less intervention and slightly lower cost to the dental service. At Dianella, however, the waiting list for non-emergency public dental care remains between two to three years. The intention of this study is, therefore, to investigate the significance of such waiting from the perspective of those who have arrived at the top of the waiting list.

1.2 Broader Context

The World Health Organization (1964) defines health as 'a state of complete physical, social and mental well being and not merely the absence of disease or infirmity'. Consistent with this definition, it follows that being 'orally healthy' means that 'people can eat, speak and socialize without discomfort or embarrassment, and without active disease in their mouth which affects their overall well being' (Oral Health Strategy Group, 1994). Good oral health is more than just having good teeth and healthy gums. According to the Australian Health Ministers' Advisory Council (AHMAC) Steering Committee for National Planning for Oral Health, dental professionals aim to achieve oral health by ensuring that 'people's lives are not affected by oral mucosal disease, oral cancer, jaw joint problems, malocclusion, malformation or trauma to the jaw and middle of the face' (2001). Timely treatment of dental problems helps prevent oral disease and tooth loss with the number of natural teeth present impacting on a person's capacity to chew and eat a balanced and nutritious diet.

A key study of public dental health by the Australian Institute of Health and Welfare (AIHW [Brennan, 2008]) showed that public dental patients have significantly worse oral health than the general Australian population. The higher prevalence of inadequate dentition with the increased presence of decayed teeth and periodontal pockets suggest that disadvantage in oral health status is related to lower socioeconomic status and inability to access timely dental services.

Recently a significant interim report for Australia by the National Health and Hospitals Reform Commission (2009) entitled *A Healthier Future for All Australians: Interim Report* proposed that public dental should undergo significant reform. Of particular concern are the findings that propose:

Many Australians suffer from poor oral health, sometimes waiting years to receive basic dental care through the public dental system as they cannot afford, or do not have access to, private dentists. Around 650,000 adults are on public dental waiting lists; the average waiting time is just over two years (27 months).

Also that ...

Public dental services are under-resourced. Services provided through public dental services are predominantly for emergency care such as extractions. There is limited focus on prevention and restorative work.

Also that ...

Good access to preventive and restorative dental care and, for those who need them, properly fitted dentures, is essential to good oral health, and is also important to maintaining good general health.

Another recent report by the Australian Institute of Health and Welfare (AIHW), 2009 emphasised that:

The cumulative effects of past dental disease and treatment are reflected in tooth loss and the wearing of dentures ... People with no natural teeth have limited oral function and, although they wear dentures, they report more oral health problems on average than people with natural teeth. (2009)

AIHW found that public dental care patients who attended emergency care typically attended for relief of pain. They also found that: public dental patients were much more likely to have fewer teeth compared with the general Australian population; their dental decay was higher; and they were more likely to have larger periodontal pockets.

Added to the complications resulting from long waiting lists was the issue discussed by Teusner, Chrisopoulos, and Spencer (2008) in their AIHW report into the supply and demand of dental practitioners. They concluded that there was a chronic undersupply of dental practitioners, which, they estimated, would increase into the future. However, in response to this, there has been a significant increase in the number of oral health students being trained, funded by the federal government, in the last two years.

Despite population trends showing a general improvement in oral health, Australian adults eligible for public dental care have consistently shown lower levels of oral health compared to other Australian adults in studies based on self-report (AIHW., 2001, 2005, 2006). They are also more likely to rate their oral health as poor and to be dissatisfied with life (Sanders & Spencer, 2005). These self-perceptions of poor oral health are confirmed by clinical assessments of public dental patients, which reveal a higher rate of extractions and emergency dental treatment compared to the Australian population (AIHW, 1999, 2002(a), 2002(b); Brennan, Spencer, & Slade, 1997, 2001).

One of the main reasons attributed to poor oral health among low income Australians is their pattern of dental attendance. They are less likely to attend dentists regularly than people from higher income groups and this is the only known dental self-care behaviour that differs between people of different socioeconomic status (Chen & Hunter, 1996; Harford, Ellershaw, & Stewart, 2004; Sanders, Sanders, Carter, & Stewart, 2004).

Access to timely clinical examination is likely to be beneficial because it enables early detection and diagnosis with the use of preventive interventions (Wright & Satur, 2000). Organisational barriers, such as extended waiting times, may limit the effectiveness of dental health services to provide timely care. Limited resources in the public sector have led to waiting times exceeding five years in some parts of Victoria (Scopelianos, 2006). In 2006, the average waiting time for all public patients in Victoria was 26 months, although patients at the Royal Dental Hospital in Melbourne waited less than a month for dental care (Department of Human Services [DHS], 2007a, 2007b).

Cultural diversity is a key characteristic of the Dianella catchment. A report on racial difference in dental health care use, conducted in Florida (Gilbert et al., 1997) concluded there were racial differences in responsiveness to new dental symptoms, and there were differences in other predictors of dental care utilisation. These differences may contribute to racial disparities in oral health in areas such as Dianella, where there is significant racial diversity.

Extended waiting times for dental visits therefore could have a number of important consequences for both the dental service and those receiving care. First, oral health is likely to deteriorate, leading to a need for more extensive restorative treatment or increased risk of tooth loss. Second, delayed treatment is likely to increase demand for emergency dental services, which generally results in tooth extraction rather than tooth preservation. This pattern of care shifts costs from preventive to emergency treatments.

1.2.1 Social perspective of dental care

The Australian Council of Social Services (2006) undertook a report entitled *Fair dental care for low income earners: National report on the state of dental care*. In this report some key statements were made that are pertinent to the situation of people on waiting lists for public dental care:

The social impacts of poor adult oral health are immense. Over a quarter of Australian adults experienced painful aching because of problems with their teeth, mouth or dentures in 2002. A quarter reported avoiding foods and nearly a third reported that they found it uncomfortable to eat. Just under a quarter of Australian adults reported that they felt self-conscious or

embarrassed because of oral health problems. (Australian Council of Social Service, 2006 p.1)

Consequently, some recommendations stated that:

- ▶ *All eligible adults should receive at least one course of general oral health care every two years on average. Adults with greater dental needs should be recalled more frequently*
- ▶ *No one should have to wait longer than 24 hours to receive emergency dental care for swelling, infection and bleeding, or serious and persistent pain.*

The above recommendations serve as a comparison by which to appraise consumer experiences of waiting for dental care.

1.2.2 Medicare funding of dental care

Since 2007 there has been a limited provision of Medicare funding for dental care. This has been offered to people with a chronic disease under the *Medicare chronic disease dental scheme* (Australian Government, 2007). To be eligible under this scheme a person must be deemed by their GP to have a chronic medical condition with complex care needs and in which their oral health must be impacting on, or likely to impact on, their general health. The Australian Government website defines a chronic medical condition as:

... one that has been or is likely to be present for at least six months. It may include, but is not limited to, conditions such as asthma, cancer, cardiovascular illness, diabetes mellitus, arthritis, mental illness, musculoskeletal conditions and stroke. (Australian Government, 2007)
<<http://www.medicareaustralia.gov.au/provider/medicare/initiatives/teen-dental.jsp#N10035>>

The limited nature of this scheme means that those who think they may qualify must attend their local GP for assessment and referral to a dentist.

1.3 Victoria's Public Dental Service

Dental Health Services Victoria (DHSV) is responsible for the delivery and purchase of public dental care for children and disadvantaged adults in Victoria. The major service is located at the Royal Dental Hospital in Melbourne. DHSV subcontracts community health services to provide community-based dental care under conditions set by the Victorian Department of Human Services (DHS), which funds the system. While the average waiting time for general dental care across the state in 2006 was 26 months (DHS, 2007a) waiting times varied at different public clinics, from less than one month to 68 months. In one-third of the clinics, waiting times were 10 months or more above the state average (DHS, 2007a).

Another report (DHS, 2007b) concentrated on waiting times in the public dental system and the drivers of waiting times in the public dental system. It identified possible solutions to reduce waiting times at a local and state-wide level but did not address to a great degree the need for increased funding. While the project looked specifically at waiting times, they suggested there were broader demand management issues within the public dental system. People who are seen from waiting lists account for around half the people receiving care. Children, youth, special needs, emergency and priority care clients are among the clients seen outside the waiting lists.

The report recommended that, locally, agencies with access to DHS-funded private sector vouchers could help reduce waiting times through the provision of such vouchers. In the longer term, it was considered that additional infrastructure would reduce waiting times.

Other suggestions included:

- ▶ Better use of and stronger relationships with private sector.

- ▶ Systems to ensure clients are only on one waiting list and not being seen at one or more clinics; for example, central waiting lists, catchment areas.
- ▶ Sterilisation nurse for all medium to large clinics to increase productivity.
- ▶ Central recruitment and employment of clinicians, perhaps through large hub-and-spoke type partnerships.
- ▶ Better information provided to clients about managing their own oral health when they join the waiting list, and/or health promotion initiatives to support those already on waiting lists.
- ▶ Extension of fluoridation.
- ▶ Focusing on prevention through integrated health promotion and targeting effort to children.

Long-term solutions to progress both policy and funding support were proposed.

1.4 Dianella Community Health

Dianella Community Health (DCH) has a large catchment area, covering most of the City of Hume on Melbourne's northern urban-rural fringe. It provides primary and community health services to one of the poorest and most diverse communities in the state. Broadmeadows is ranked as the third most disadvantaged suburb in Melbourne (Hume City Council, Dianella Community Health, & Sunbury Community Health Centre, 2007). More than 130,000 people live in the area. The average age is 32.5 years, making it one of the youngest municipalities in Victoria. The population is expected to grow by about 40% over the next 10 years, especially among those aged 65 years and more. It is a culturally diverse community, with over one-third of the population born outside Australia. In the last seven years, people from Iraq, Turkey and Lebanon have moved to the area. Other than English, the major languages for residents include Turkish, Italian and Arabic. Hume has the highest proportion of Catholic and Muslim residents compared to other local government areas in Melbourne. The unemployment rate in Hume is above the Victorian average and individual and household incomes are below average (Hume City Council et al., 2007). In 2006, less than two-thirds of the population were in the paid workforce and nearly one in 10 was unemployed.

It is important to note that the population as depicted can be described as low socio-economic and in a 'hard to reach' category as considered in recent research by Swinburne Institute of Social Research entitled *Community Consultation and the 'Hard to Reach'* (Brackertz, 2007). This group was identified as requiring special communication strategies to engage them.

1.4.1 Dental Services at Dianella

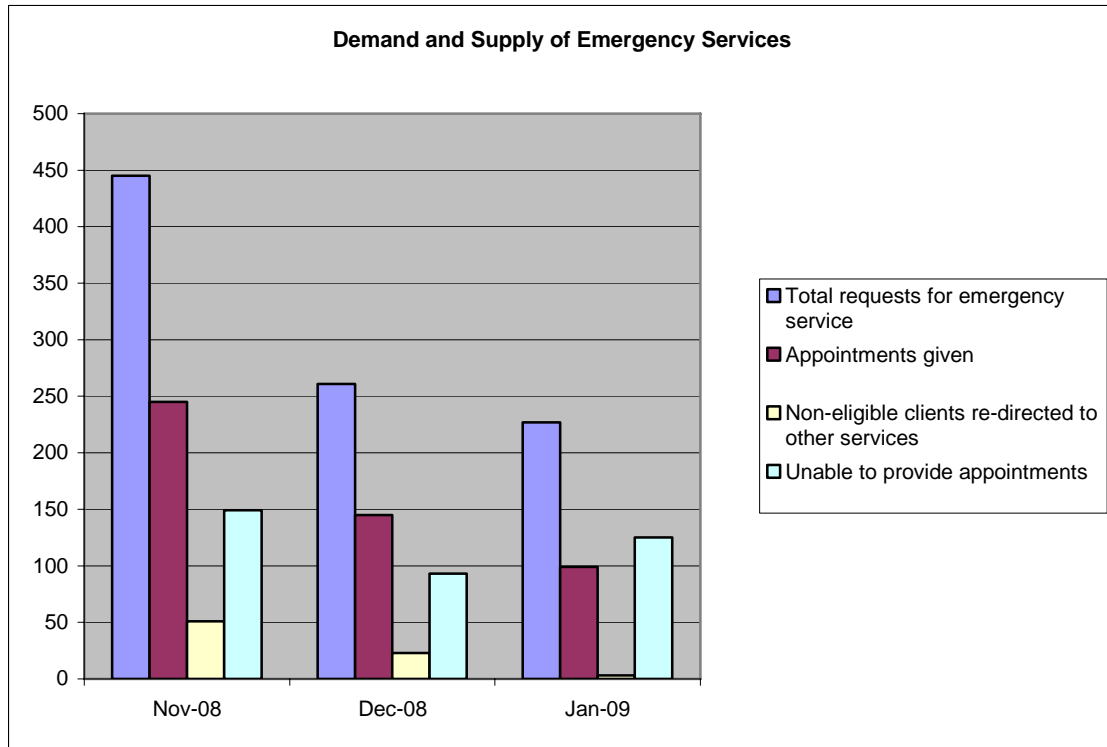
The community dental program is offered to eligible clients by Dianella Community Health's Broadmeadows clinic. To participate, clients must qualify for a concessions card that is either a Pension or a Health Care Card, and be above 18 years of age. A co-payment applies.

In the financial year 2006–2007, the dental team treated 4,829 clients and provided 42,188 treatments (Horey et al. 2008) These included services for 2,532 patients who received emergency dental care (Dianella Community Health, 2007). In 2006 and 2007, Dianella had 4.06 effective full-time (EFT) dentists and 4.32 EFT dental nurses for the adult dental programs. It has six dental chairs, two of which are for school dental services. On most days dentists receive 13 to 14 dental visits each (Raju, 2006). Dianella dental service operates at capacity for both adult and school dental services. It has a stable dental workforce, which allows it to maximise its resources (Dianella Community Health, 2007a).

Horey et al. (2008) also described how the dental service at DCH received between 30 and 40 telephone calls every working day—about half of these for emergency care. Calls are assessed over the phone by the dental receptionist and allocated to either the general waiting list or the denture waiting list. On average, 170 patients were added to the waiting lists each month—137 for general dental services and 33 for prosthetic services (Raju, 2006).

People who reported pain were transferred to a computerised triage system that assesses the urgency of their treatment needs. Some emergency patients would be given an appointment on the same day while others might wait up to five weeks (Raju, 2006), depending on the urgency category level that is assigned to them. Dianella Dental Services has a limited capacity to provide emergency care to its patients. For example, during November 2008 to January 2009, just over 50% of the people who called for urgent attention were given the appointments (Rognrust, 2009). See Figure 1 below and Table 2 in Appendix 1.

Figure 1: Demand and Supply of Emergency Services



In February 2006, there were 5,116 patients waiting for dental treatment on the electronic dental database at Dianella. These comprised 4,381 people waiting for general services and 735 people waiting for prosthetic or denture services. The estimated waiting time was 30.9 months for general patients (Victorian Minister for Health, 2006). This was higher than the state-wide average waiting time for general care in March 2006 of 26 months (DHS, 2007a).

It is usual practice at Dianella to mail out offers of dental appointments in batches. Letters are sent to the 150 to 200 people at the top of the waiting list every few weeks. They are given about four weeks to make an appointment. Only about 30% of those offered appointments for general services, and 60–70% of those offered appointments for denture services make appointments. The waiting time for appointments is about three to four weeks (Raju, 2006).

Dianella is estimated to require an additional 10 dental chairs. These chairs are planned to be located in Craigieburn, but not until 2011 (Dianella Community Health, 2007a, 2007b). Also documented (Dianella, 2008) was the high level of morale among dental staff.

1.4.2 Management of waiting lists at Dianella

For a detailed account of the management of waiting lists at Dianella please see Appendix 1.

1.5 Impacts of Oral Health Status

According to Horey et al. (2008) oral health is closely linked to general health, to the selection and preparation of food which in turn influences whether there is an adequate diet, nutritional status and general health status. They argue that adults with reduced chewing capacity that leads to diets low in fibre and Vitamin C are at increased risk of cardiovascular disease. Reduced dietary fibre and Vitamin C intake has also been associated with an increased risk of diabetes, stroke and cataract formation. Horey et al. (2008) included evidence in their study on how a reduced intake of fruit, vegetables and dietary fibre is associated with an increased risk of cancers in the digestive system such as colorectal cancer.

Poor oral health is also seen to reduce people's quality of life in many ways and it is estimated that the quality of life of one in six Australian adults is adversely affected by oral health problems (AIHW, 2006). About one in 10 respondents in a national health survey reported frequently experiencing painful aching, uncomfortable eating, poor sense of taste and trouble pronouncing words; and one in 12 reported frequently feeling tense, embarrassed or self-conscious because of problems with their mouth or teeth (AIHW, 2006). People who suffered dental problems have also been found to lack the social confidence for successful job interviews.

2.1 Dental Waiting Study

In this study we wanted to explore the experiences and perceptions of public dental patients who had been waiting for public dental care, including those who did not end up using the service.

Aims

The study aimed to:

- ▶ Investigate factors (including health literacy) influencing decisions of people on public dental waiting lists to attend dental clinics.
- ▶ Explore people's perceptions of their oral health status and general health status, and associated behaviours, while waiting for public dental care.

The study therefore investigated the participants':

- ▶ Perceptions of oral health care needs
- ▶ Knowledge of oral health services
- ▶ Previous experience of service use
- ▶ Intentions to make appointment with public dental health services
- ▶ Reasons underlying their appointment intentions
- ▶ Experiences of waiting for a public dental appointment
- ▶ Reasons for behaviours that differ from their stated intentions.

We hoped this would give us increased understanding of the factors motivating consumer behaviour, especially:

- ▶ Barriers and motivators to the use of public dental services by eligible consumers
- ▶ Life stories around the knowledge and perceptions of oral health needs and oral health services among people in a hard-to-reach group.

Combined quantitative and qualitative research methods were employed for this study.

A pre-interview telephone call was utilised for recruitment and collection of initial data.

This was followed by structured face-to-face interviews with a sample of people who have been waiting for public dental care at Dianella Community Health, Broadmeadows. Qualitative data collection was supported by a quantitative assessment of the Oral Health Impact Profile (OHIP).

The appointment behaviour of interviewees was subsequently tracked, and a brief telephone interview undertaken with those participants who changed their mind about taking up, or not, their appointment for care.

As the interviews were judged to potentially affect behaviour in regard to making and keeping dental appointments, the behaviour of a control group being offered dental appointments at the same time was also monitored.

2.2 Study participants

The study involved people who had been on a waiting list for public dental treatment at Dianella Community Health, Broadmeadows, for two years or more. Sixty people were to be recruited to take part in the study's in-depth structured interviews shortly before they were sent a letter offering dental appointments at Dianella. Further feedback was received from a number of consumers via telephone calls after the interviews.

Broadmeadows is a culturally diverse community with a high number of new immigrants arriving from Iraq, Turkey and Lebanon (Hume City Council, Dianella Community Health et al., 2007). Around 17% of participants in the Dental Costs Study were born in the Middle East and Arabic is the second most common language spoken at home (after English [Horey, Naksook, McBride, & Calache, 2008]). For these reasons, the study aimed to recruit up to 20% of the participants from Arabic-speaking backgrounds.

Participants in the study included adults aged 18 and over who would be receiving a letter offering a dental appointment from Dianella within two months. People who were unable to consent or with no capacity to consent, such as those with mental disability, were not recruited.

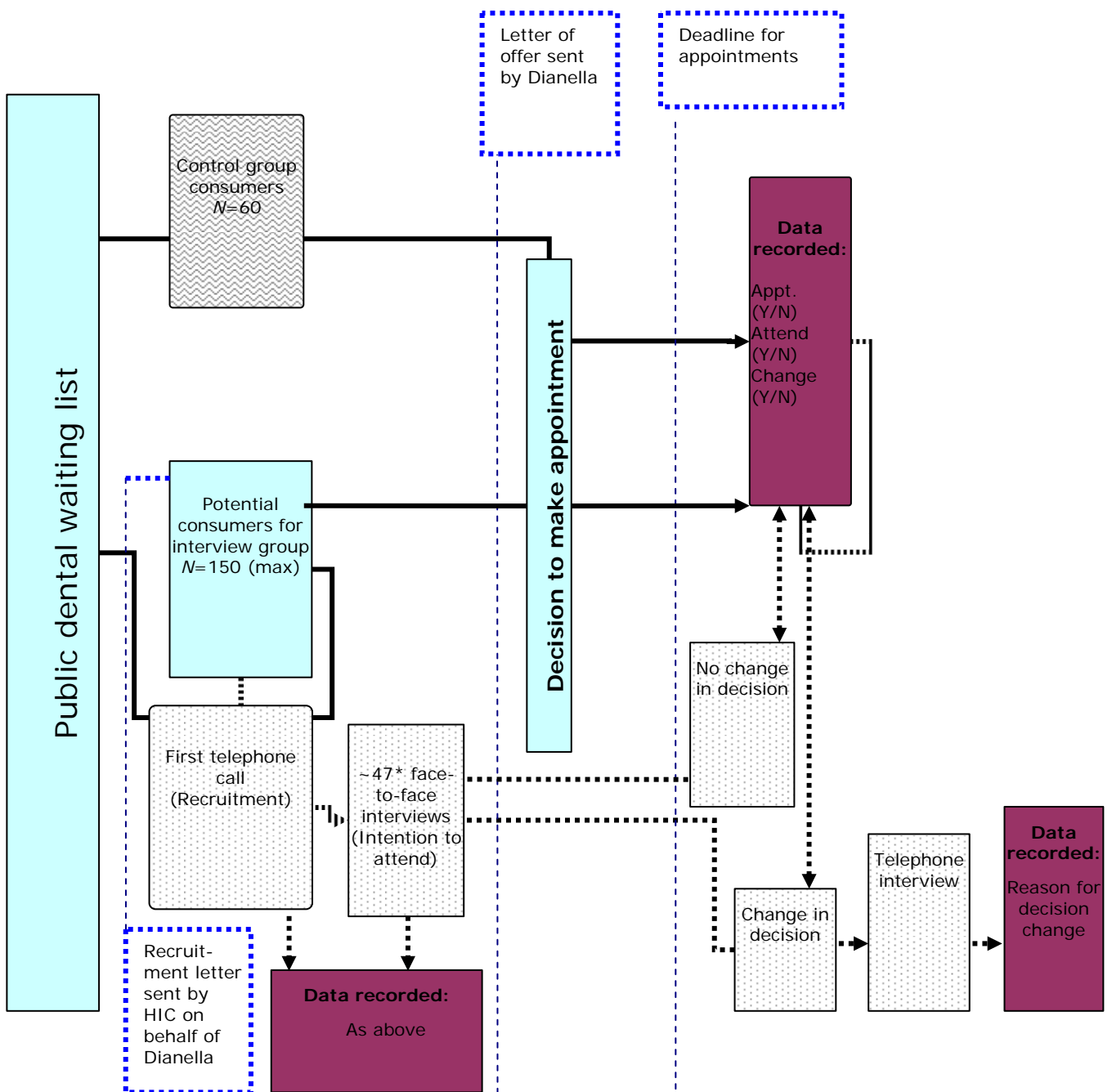
2.3 Project Steps

The study was undertaken in the following steps:

1. Obtained approval from Dental Health Services Victoria Human Research Ethics Committee.
2. Established a Project Reference Group comprising project partners, other public dental researchers and consumer representatives. The group was regularly informed of project progress and any issues. Members were invited to give feedback via e-mail. The group met once to provide input to the analysis and draft final report.
3. Accessed the dental waiting list at Dianella Community Health and identified people on the list who would be sent an offer of a dental appointment within eight weeks. One hundred and fifty consumers were contacted by letter, which explained the study and how to participate in it. A short description of the study in the Arabic language was included. Attached to the letter was project information and consent form in plain English.
4. One week after sending the letter, Health Issues Centre researchers made telephone contact with all potential participants (150), providing further information about the study and answering questions. If they wanted to participate in the study, a schedule for an interview at Dianella was made.
5. Face-to-face interviews were conducted with 47 participants at Dianella Community Health. It had been planned to interview 60 people, but for several reasons, including data saturation discussed later, 47 were eventually interviewed (see section 2.3.3). The interviews included a mix of structured questions, such as the Oral Health Impact Profile (OHIP), plus open-ended qualitative questions. With the participant's consent, the interview was digitally recorded. Interviews lasted approximately 30 minutes. Interpreters were used if necessary. The participant was paid \$30 for their time and transportation to the interview.
6. When the consumers recruited for the study reached the top of the dental waiting list, letters offering dental appointments from Dianella Community Health were sent to them. Consumers were given four to six weeks to make an appointment. Health Issues Centre researchers recorded responses of all potential participants and those in the control group.
7. Rates of response to letters offering dental appointments and attendance at appointments were compared between groups.
8. Follow-up interviews by telephone were conducted with interviewed participants who had seemed to behave differently to their stated intention at interview; that is, with those who said that they intended to make an appointment but failed to do so, and vice versa.

The project steps are presented in Diagram One displayed on the following page.

Figure 2: Project Steps



* For explanation see 2.4.3 page 20

2.4 Recruitment

The Health Issues Centre obtained a list of the 210 consumers at the top of the dental waiting list from Dianella Community Health in November 2008. Of these, 65 (31%) were born in Australia and 141 (67%) were born overseas, in 27 countries. The largest groups of consumers were born in Turkey (29), Italy (23), Iraq (21) and Lebanon (19).

The 210 consumers were arbitrarily divided into 150 potential participants for telephone calls and face-to-face interviews (intervention group) and 60 consumers to be monitored for records of responses to dental appointment offers (control group). They were recruited in three consecutive stages of 50+20 at a time. For example, when a letter of invitation to take part in the study, containing project information and consent form, was sent to the first 50 consumers on the waiting list, another 20 consecutive consumers on the list were marked as members of the control group.

There were some irregularities on the Dianella database; for example, 11 consumers were part of the preceding project, the Dental Costs Study. These consumers had joined the waiting list shortly before being recruited for the first study (i.e., were at beginning of list, not end) and they had completed their course of care as part of the Dental Costs Study in 2007. According to Dianella Dental Services, people who have completed their course of care need to wait for 12 months before they can join the waiting list again. Consequently, their records should have been removed from the current database. Nevertheless, as they would receive a letter offering a dental appointment from Dianella, Health Issues Centre considered them eligible for recruitment in this study.

An Arabic sub-sample was assured from the large number of people on the waiting list who identified themselves as Arabic.

2.4.1 *Pre-interview Telephone Calls*

Health Issues Centre researchers made telephone calls to the first 50 consumers in the first week of December 2008. The next round of telephone calls to another 50 consumers was made in mid-January 2009, and the third round to the last 50 consumers in the beginning of February 2009. Between each batch of recruitment, 20 consecutive consumers after the first 50 on the list were allocated to the control group. Their records of responses to the offer of dental appointments and appointment attendance would be monitored.

2.4.2 *Criteria used*

The telephone calls were made by Health Issues Centre researchers one week after the letters of invitation and project information were posted to the consumers. The following criteria were used for the telephone calls:

1. Every consumer on the list was called once during business hours on a weekday. A message was left with an answering machine if the consumer was not available.
2. Consumers who did not answer the first call were called again at a different time of day and a different day of the week, within business hours. The calls that were responded to by an automatic message or where the line could not be connected were also tried again for a second time.
3. Those who did not answer the second call were called again outside business hours; that is, evening or the weekend. The 'could not be connected' lines were not tried again.
4. If an automatic message indicated that the number could not be reached, or the number given was wrong, or the consumer did not have the phone number on the record, the researchers searched for correct telephone numbers from the White Pages telephone directory and repeated steps 1 to 3.
5. If consumers could not be reached after all the steps above, no more attempts were made.

6. Consumers who responded to the telephone call with limited English were offered a telephone interpreter in their language. Once a telephone interpreter was arranged, another call was made to the consumers. An interpreter in the consumer's language was also offered for face-to-face interviews with consumers with a limited understanding of English.

2.4.3 Responses to recruitment

The number of pre-interview telephone contacts finally reached 107 consumers. Forty-seven consumers were found after one call, 36 in the second call and 24 were found after calling three to six times. Although a formal Arabic interpreter was not used in these phone calls, family members were recruited on four occasions to relay information and to assist in setting up an interview with an interpreter. It seemed that the Arabic information included in the invitation letter provided an adequate introduction to the study.

The response to recruitment was slow in December but improved in January. Yet at the conclusion of the last batch of the recruitment in February, the number of participants had not reached the required number of 60. The researchers made additional efforts to recruit more consumers. The White Pages were searched for correct telephone numbers of people who were not originally reached and new letters sent if addresses had changed. We went back to consumers who had indicated in the early round that they could participate at a later time. We also offered in-depth interviews by telephone to consumers who wanted to be part of the study but were unable to come to Dianella.

In the meantime, interviews with consumers recruited early in the third batch revealed that data had reached saturation. That is, that there was no further new information being discovered as the interviews progressed (Strauss & Corbin, 1998). Together with the rich information collected at the pre-interview telephone call, it was decided to stop recruiting.

In total, 50 consumers agreed on the phone to take part in the in-depth interviews, but one failed to attend, one was sick and one had to attend to her sick mother. Finally, 47 consumers (31% of all potential consumers and 43.5% of consumers spoken to on the telephone) took part in the interviews. Five of these had taken part in the previous Dental Costs Study.

Eleven interview participants (23%) came from Middle Eastern backgrounds, where people speak or understand Arabic; these included eight from Iraq and three from Lebanon.

2.5 In-depth interviews

The date and time of the interview were arranged on the telephone with consumers who agreed to take part in the study. Consumers reported to Dental Reception on arrival and/or were met by a Health Issues Centre researcher in the waiting area. Interviews were conducted in a private office at Dianella Community Health, by the researchers experienced in in-depth interviews. The researcher explained project information to the consumers and answered any questions they may have had. Consent to the interview and digitally recording the interview was then obtained. Though structured, the interview was nevertheless informal. Rating scales as well as open-ended questions were used. The researchers prompted interview participants for extensive information where appropriate.

Of the 47 interviews, four interviews were conducted via an Arabic interpreter, and four were conducted over the telephone. Three consumers did not want to have an interpreter and brought a partner or a family member to assist with the interview.

Interviews were recorded in a digital recorder and hand-written notes.

Interview participants were remunerated \$30 for their participation.

The focus of these interviews is described in section 2.7 below.

2.6 Responses to offer of appointment and appointment attendance

About four weeks after the study recruitment began, Dianella Community Health started to send letters to consumers on the dental waiting list who were potential participants of the study (the intervention group) and whose records only would be monitored for the study (the control group). The letter informed consumers they had reached the top of the waiting list and that they could now make an appointment with the dentist. These letters were sent in three batches, with appointments to be made within four weeks. An appointment time would be allocated immediately or within four weeks.

The Dental Services at Dianella systematically recorded evidence of consumers making appointments and appointment attendance with clinical information on their electronic database. The appointment data was analysed for study participants after eight weeks (four weeks for consumers to make an appointment after receiving their letter and another four weeks to attend a given appointment, before accessing the records).

The researcher retrieved the consumers' record of responses to an offer of an appointment and appointment attendance twice. From the database we checked when the letter of offer was sent to the consumers, whether they made an appointment, attended, cancelled, re-booked or never attended the appointment. Records of all 210 consumers on the recruitment list were created. These included: interview participants; consumers who were reached by telephone but did not participate in face-to-face interviews; consumers who were not reached by telephone; and those in the control group who were not contacted by the researcher. Only the first appointment, the dental examination, was considered in this study.

2.7 Follow-up telephone calls

The attendance or non-attendance of the 47 interview participants was compared with their initial intention, as stated in their face-to-face interviews. Ten people (21%) seemed to behave differently from their intention. All said that they would like to make an appointment but the records showed that they did not respond to letters of offer of appointment. The researchers made a short telephone call to the 10 consumers to ask about the circumstances that made them change their mind (see Appendix 5).

2.8 Data Items

In-depth interviews with study participants collected the following data:

Consumer demographic information, including: gender; level of education attained; main life occupation (either current or previous); country of birth; year of arrival in Australia (if relevant); and language spoken at home.

Oral Health Impact Profile (OHIP)-14, a validated 14 item measure developed to rate the perceptions of social impact relating to oral health over the preceding four weeks (Slade, 1997). It is a shortened form of the original 49-item OHIP instrument (Slade & Spencer, 1994). It includes the dimensions of functional limitation, physical pain, psychological discomfort, physical disability, psychological disability, social disability and handicap. It uses a five-point Likert-type scale with the response categories: never; hardly ever; occasionally; fairly often; and very often, to assess the frequency of symptoms.

Open-ended questions included: perceptions of oral health care needs; knowledge of oral health services; previous experience of service use; intentions to make appointment with public dental health services; reasons underlying their appointment intentions; and experiences of waiting for a public dental appointment.

Post-interview telephone calls provided qualitative data about reasons for using or not using public dental services that vary from consumers' intention.

Pre-interview telephone calls collected data about communication and literacy levels of consumers and reasons for not taking part in the study.

2.9 Data Analysis

Most data were analysed using qualitative research method strategies of content analysis (that asks who, what, where and how questions) together with grounded theory strategies of constant comparison, open coding and the identification of emergent themes. Interview data was reviewed and transcribed as required by the researchers for the purpose of the analysis. Open coding involved the development of coding categories to reflect the content of the data collected rather than the interview questions. Themes, patterns, categories, descriptive examples and quotations emerged through the analysis from interpretation of the findings.

Data from the structured questions such as the OHIP-14 was statistically analysed. A simple statistical analysis was undertaken on responses to letters offering appointments and attendance rates. This included records of consumers in the intervention group (those who participated in the face-to-face interviews) being compared against records of the control group (those not contacted by the study in any form), and those who were contacted by letters or telephone calls but did not participate in the interviews.

3. RESULTS

3.1 Limitations of the study

As with other qualitative research, results of this study cannot be generalised and are not necessarily representative of all public dental patients using other services, although they may be indicative.

Within its limited timeframe and budget, we did not intend for this small study to include more than one group of culturally and linguistically diverse (CALD) consumers. The Arabic-speaking group was chosen because it is a major CALD group in the catchment, many of whose members arrived relatively recently. Nevertheless, due to very diverse population in Broadmeadows, consumers born in Turkey, Italy and other countries have actually participated in the study.

We anticipated that being contacted by Dianella about the study as well as taking part in the study could influence potential participants' and participants' intentions to make dental appointments. To measure this impact, we monitored the records of another 60 people on the waiting list, that is, their responses to the letters offering dental appointments and patterns of keeping appointments.

With the short timeframe, Health Issues Centre decided to begin recruitment at the beginning of December. This was not ideal timing given the approaching school holidays and Christmas activities. Hence, the lower rates of response to the initial telephone contact and the face-to-face interviews in the first batch of recruitment were not surprising.

It was assumed that another limitation to recruitment was due to the length of waiting time. The records we were using were created over two years previously, making it impossible to reach many consumers on the list.

3.2 Demography of study participants

A general description of the study participants is presented here.

3.2.1 *Pre-interview telephone calls*

Of the 150 consumers who were sent letters of invitation, 107 (71%) were reached and were contacted by telephone.

Of these, 37(34.6%) were males and 70 (65.4%) were females. Twenty-three (23) were born in Australia, 17 in Turkey, 14 in Italy, 12 in Iraq, 11 in Lebanon and the rest in other nine countries.

Figure 3: Gender

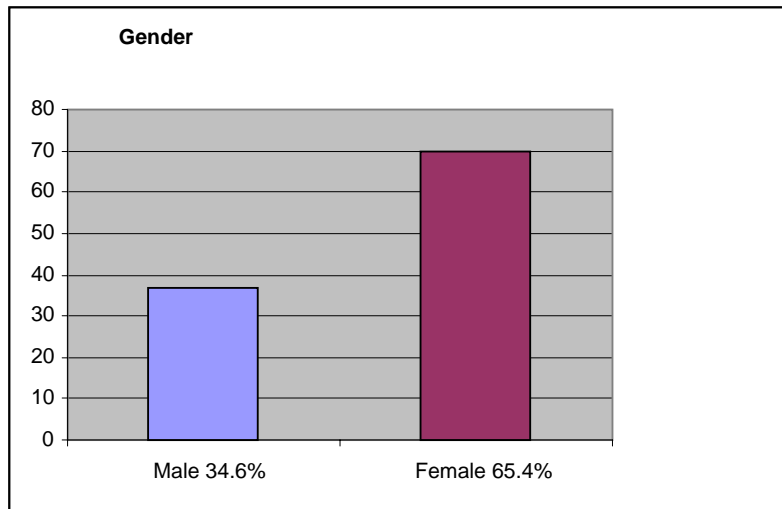
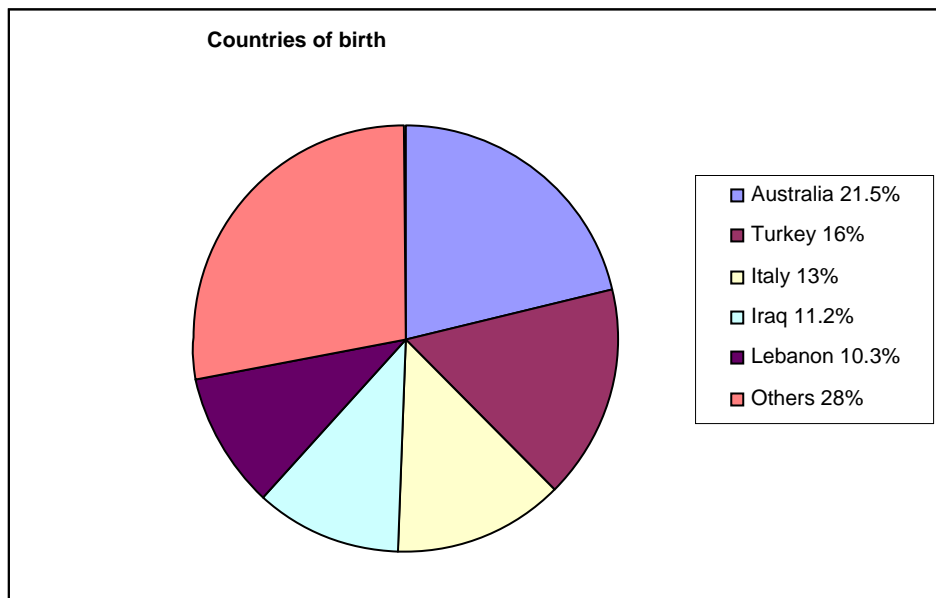


Figure 4: Countries of birth



3.2.2 In-depth interviews

The majority of interview participants (72.4%) were female. Of the 47 interviewees, 13 were born in Australia, eight in Iraq, seven in Italy, five in Turkey, three in Lebanon and the rest in another nine countries. Their ages ranged from 22 to 85 years. The largest number of interviewees (38.3%) was in the 66 to 85 age groups.

Of the 47 interviewed, three people (6%) told us that they had never been to school. Seventeen per cent (17%) finished primary school and another 17% completed secondary school. Thirty per cent (30%) did not complete secondary education. The same proportion (30%) had some form of education after secondary level; of these, nine (out of 14) completed tertiary education.

Twenty-eight per cent (28%) of interviewees had unpaid jobs, predominantly doing home duties. Fifteen per cent (15%) used to work as tradespeople. Another 15% were in production and transportation jobs and the same proportion were in clerical and sales work. Nine per cent (9%)

were professionals such as teachers and engineers; six per cent (6%) used to be managers or worked in administration.

Details can be found in the tables and diagrams below.

Figure 5: Gender

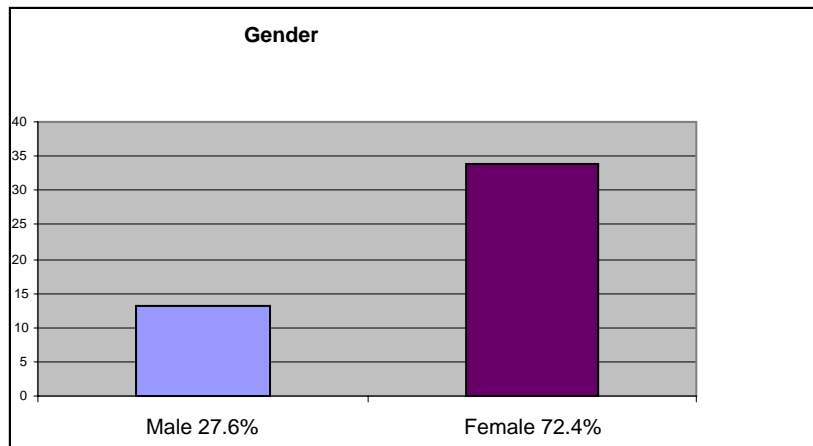


Figure 6: Countries of birth

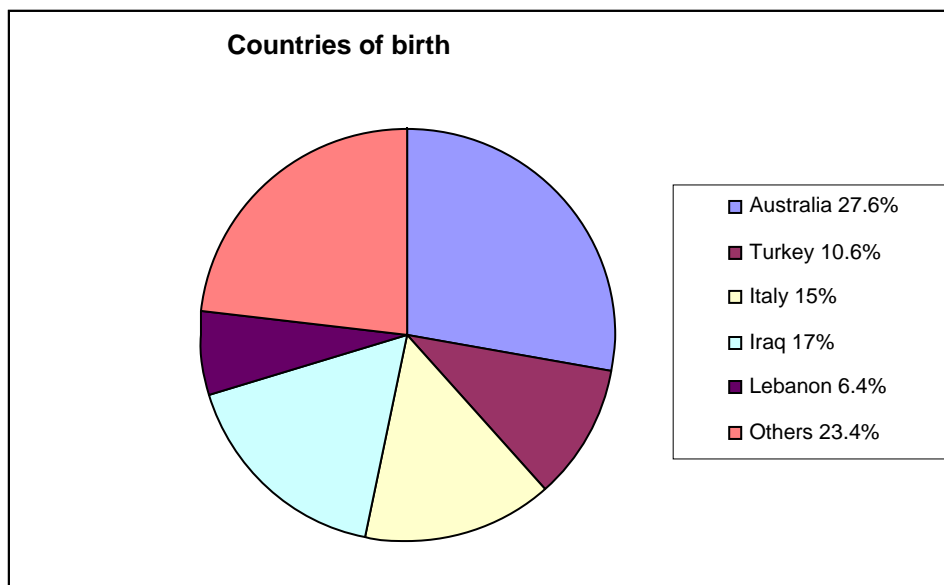


Figure 7: Ages

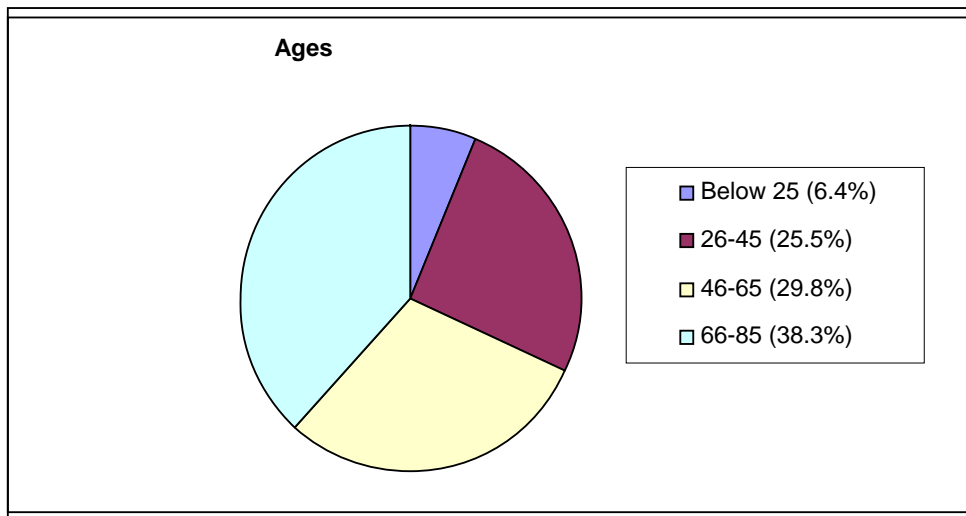


Figure 8: Education

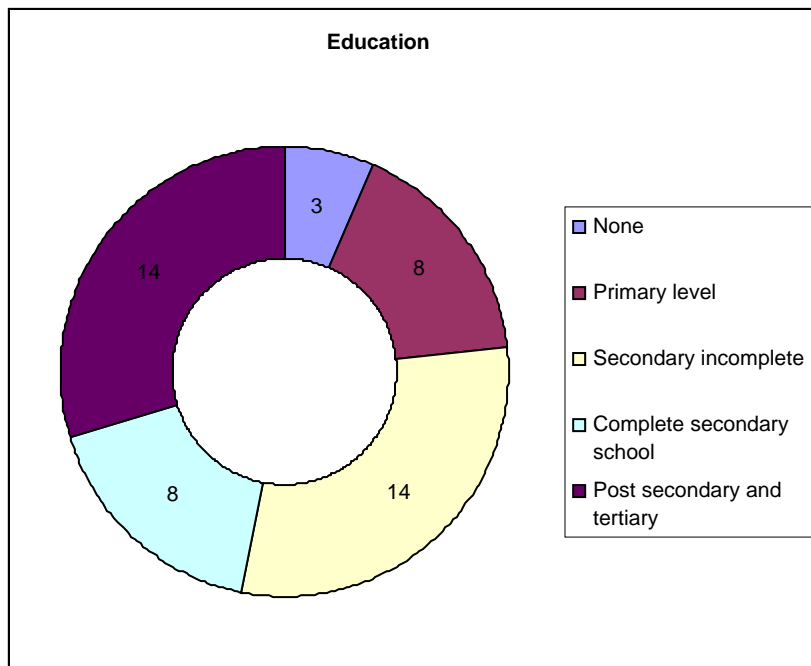
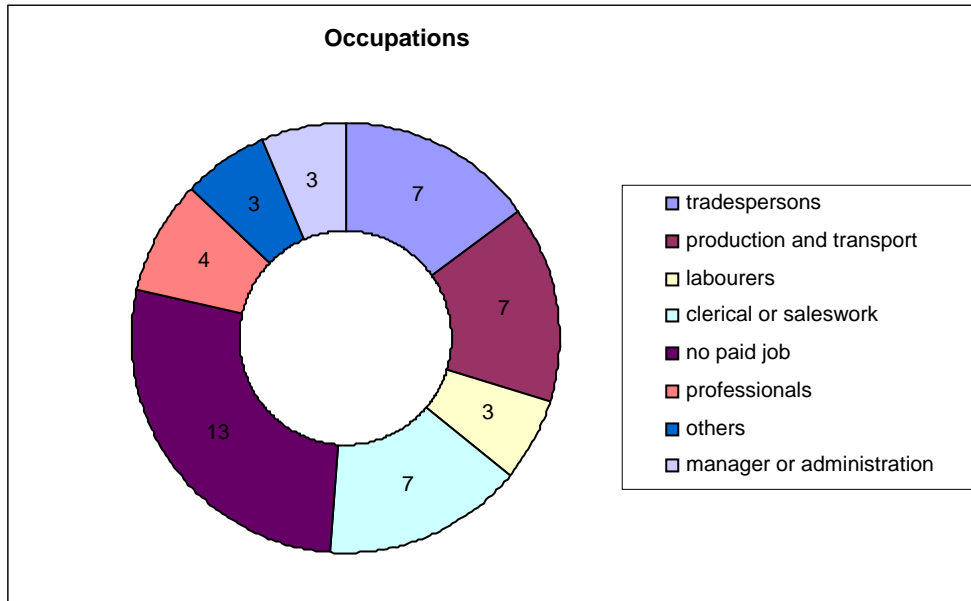


Figure 9: Occupations



4. PRE-INTERVIEW TELEPHONE CALLS

Informal data collected while undertaking the recruitment telephone calls provided a key contribution to this study. The calls served as an introduction to those who were to participate in the study, but at the same time provided insights into both the issues consumers were confronting, and also those facing Dianella in accessing their clientele.

4.1 Problems accessing consumers

The pre-interview telephone calls revealed several problems with the currency of the records of people on the dental waiting list. Of 150 consumers on the list, 48 could not be contacted by phone. This was largely due to missing or wrong phone numbers, disconnections and numbers no longer in use.

In the first round of telephone calls, 13 out of 150 potential participants were found to have no telephone numbers on the database. Another two had incomplete records and researchers were unable to identify the right ones. A further seven records were also incomplete but the researchers were able to guess the correct numbers and hence reached the consumers on mobile telephones.

Of the remaining numbers on the database, nine were wrong—including eight numbers that did not match the person and the address on the database and one that reached the right person and right address, but the person insisted that he had never been on the dental waiting list at Dianella. Seventeen telephone lines could not be connected with an automated message of disconnection; one was turned off and another had an incoming calls restricted. Five lines were never answered despite several calls being made at different times.

Again, researchers made an effort to search the White Pages for telephone numbers of those who had no records, had wrong numbers or problematic lines. Three more consumers were accessed. Of note are two consumers with no telephone numbers on the database but who heard about the project and rang Health Issues Centre and subsequently took part in the telephone calls. The number of people reached by telephone totalled 107.

See Table 1 for details of problems accessing consumers on the database.

Table 1: Problems with patients' record and telephone lines

	No.
Lines could not be connected	17
No phone numbers/incomplete numbers on database	15
Wrong – number did not match person and address	8
No answer after at least three attempts	5
Wrong – person was never on the waiting list	1
Telephone was turned off	1
Incoming calls restricted	1

4.2 Why they did not want to participate

Despite every effort made by Health Issues Centre researchers to reach consumers, only 50 out of 107 consumers indicated they would participate in the project by attending the face-to-face interviews. Three of these did not come to the interviews.

Reasons for not participating in the study are presented in the table below. The total number of responses does not represent the number of consumers who did not want to take part, as some consumers had more than one reason for not participating. Some people indicated that they had problems with communicating in English and understanding the letter. Others did not say so but probably had such problems, which became evident while the researcher conducted a telephone conversation with them. These consumers were thought to have communication problems, and, unless they understood the Arabic text in the letter, literacy problems.

Table 2: Reasons for not participating in face-to-face interviews

	No. of responses
Communication problems/ not good in English	28
Literacy	19
Health and physical reasons	7
Burdened, busy with caring for family members	7
Not interested, not giving reasons	7
Frustration over waiting too long	6
No longer eligible for public dental care	4
No longer need dental treatment	4
Other reasons; e.g. going overseas, just too busy	5

The reasons for not participating are now considered in turn.

Communication problems

About four in five consumers (79%) on the list were born overseas: the vast majority in non-English speaking countries. Twenty-eight out of 107 (26%) did not want to take part in the face-to-face interviews because they had problems communicating in English. Some of these consumers did not have enough capacity to speak English to the researcher on the phone. In many cases, a young family member, partner or a friend spoke on the consumer's behalf.

A telephone call was made to a consumer who was born in Italy. The Dianella database indicated that her preferred language was English. On the phone, she did not speak English very well and asked a man to take over the conversation. The man spoke English with a heavy accent. The researcher was not sure if he understood what she said. When she tried to explain slowly, he said, 'Sorry' and hung up the phone.

Note: the lady did not respond when a dental appointment was offered.

Literacy with English language

It appeared that a number of consumers reached by phone did not understand information contained in the letter. At least 19 (18%) could be classified as having English literacy problems. Although they could conduct a conversation in English and understood questions asked, their capacity to read in English was not enough to understand information in the letter.

Consumers who could read Arabic reported that they read the Arabic text in the letter.

A woman from Malta answered the call from Health Issues Centre. Both she and her husband were on the dental waiting list and eligible for participation in the intervention group. When asked if they had received a letter about the study, she replied, 'Yes, but I sent it back. My English is no good. My husband's is worse than me.' A further conversation was attempted and her English became more limited. She insisted that she did not want to be part of the study.

We found later that this woman and her husband went to Dianella and presented the letter to the dental reception. They understood that in the letter they were asked to make an appointment and they did so. The reception explained to them that the appointment was not yet available to them, and that they will get another letter which will offer them an appointment.

In both letters that they left with the reception, the project information sheets were still attached. Despite saying the opposite on the telephone call, the couple had signed their names to show their consent to participate in the project.

Note: husband and wife made and kept their appointment

Health and physical reasons

Seven consumers did not participate in the face-to-face interviews for health reasons. Being on the waiting list for a long time meant that circumstances had changed; for example, the husband of an elderly consumer informed the researcher that his wife had had a stroke and now stayed in a nursing home. Another consumer from Italy, 86 years of age, told the researcher on the phone that he was not good with his memory.

One consumer did not want to take part because she had a disability and was in a wheelchair. Of note is how this woman had finished her dental treatment elsewhere through the government's arrangement for people with disability to the value of \$4,000. She was well-informed and said that she would take part in the study if she wasn't home-bound.

Burdened with caring for family members

Seven consumers said that they were too busy with family members to come to face-to-face interviews. In the first round of recruitment that took place around the beginning of school holidays, before Christmas, many consumers were busy with looking after children. One woman said that she could not take part because, "I have to look after five children, I can't go anywhere".

Some consumers were burdened with caring for sick people in the family. One woman had been very busy as her husband is sick and often in hospital. Another woman had a sick grandchild in hospital. One of the consumers who agreed to come to the face-to-face interview changed her mind later for a similar reason. The researcher reached her on the phone after several calls, and found that her mother has been hospitalised and she was now too busy to take part in the study.

Not interested or no reasons given, possibly suspicious about the study/system

Seven consumers, many of whom were overseas-born, insisted they were not interested in the study. Often one partner answered the call and said his or her partner was not interested. They did not wish to engage in further conversation and their wish was respected. Some consumers said they only wanted to have dental treatment and nothing else. Some felt that they were asked too many questions and were uncomfortable.

The researcher rang a consumer on the waiting list. Database showed that she was born in Syria, preferred language Arabic. Her adult daughter answered the call. The consumer received the letter and understood the information in it. Yet she was not interested in taking part in the face-to-face interview.

Researcher: Can I please ask why?

Consumer's daughter: My mum is not very good in English.

Researcher: We can organise an Arabic interpreter for her on the day.

Consumer's daughter: No, no, I said no. We are not interested.

Note: upon receiving a letter from Dianella, they made an appointment and kept it.

Frustration expressed over waiting too long

Six people expressed their frustration over the phone about waiting too long for dental care, and they did not want to take part in the face-to-face interview. Some consumers were so upset that they responded negatively to any contact from the service. For example, one said, 'Waiting for dental care makes me sick. I just threw out the paper'.

A man with an Arabic background migrated to Australia recently. He was frustrated and clearly distressed. When asked by the researcher whether he wanted to take part said 'I would like to help [with the study] but it [the interview] would be a nightmare for me ... but I don't mind talking to you on the phone'.

He had difficulty with sitting in an interview room as he had previous experiences of forced and lengthy interviews. He said, 'I am very embarrassed. I am damaged internally.' But he wanted to express his frustration at having to wait for his dental appointment. He had work that needed completing but it was not considered to be an emergency so he would have to wait. In the meantime he said 'I am very embarrassed about my teeth'.

Note: this consumer did not receive a letter offering a dental appointment from Dianella. He completed the dental treatment in 2008 but due to a record error, his name was still on the waiting list.

No longer eligible for public dental care

Four consumers admitted that they now worked and no longer qualified for public dental care. After over two years of waiting for dental care, they had found a job and could not use the Health Care Card anymore. Their names are still on the waiting list. Working makes them too busy to come to the face-to-face interview.

No longer in need of dental treatment

Four consumers said that while on the waiting list, the condition of their dental health got worse and they had their dental treatment through the emergency department at Dianella or through other services. One had her treatment from an alternative service provided by a mobile van. She had received information about this from her general practitioner; she registered her interest and received the service in just a few weeks. Some had dental treatment from the government special allowance for people with disability or chronic illness. One consumer added that she no longer needed dental treatment, and was therefore not interested in the interview.

Other reasons

Five consumers gave reasons other than the above for not wanting to take part in the face-to-face interviews. For example, an Iraqi couple said that it was too difficult for them to take public transport to Dianella, mainly because they did not understand the system very well. Others had reasons such as going overseas or just being too busy.

5. FACE-TO-FACE INTERVIEWS

5.1 Oral Health Impact Profile (OHIP)

The face-to-face interview included 14 questions about the impact of oral or dental problems on quality of life (Oral Health Impact Profile or OHIP 14). Table 3 below shows the distribution of people's responses to questions of how often, over the previous four weeks, they had troubles related to problems with teeth, mouth or dentures.

The most common problems among interview participants were discomfort with eating, followed by feeling self-conscious and constant pain. More than 40% of the people found eating uncomfortable fairly often or very often in the previous month because of problems with their teeth or mouth. About one-third (34%) felt self-conscious because of their oral health fairly often or very often. Painful aching in the mouth was experienced fairly often to very often by one in three people interviewed (32.6%).

Over thirty per cent (30.4%) of people in the study felt that their diet had been unsatisfactory fairly often to very often in the past four weeks. Because of problems with their teeth or mouth, 27.7% had been a bit embarrassed, about one in four (24.4%) felt tense, 23.4% had their meals interrupted, and about one in five (19.1%) had been a bit irritable with other people fairly often or very often.

Our findings on the frequency of problems reported by consumers in this study over the previous four weeks were consistent with those of the recent Dental Costs study. The most common problems were uncomfortable eating and feeling self-conscious.

Of note is a limitation of the Oral Health Impact Profile in that the questions only relate to the four weeks preceding the interviews. Researchers from this study reported that many of those interviewed remarked they would have given different answers to these questions if they had been asked before they had received interim treatment. One consumer said *'It's hell ... You should have asked me about this before I went to Turkey to fix my teeth. I had rotten teeth here [showing researcher], I had sore gums, I couldn't eat. It was awful.'*

Table 3: Distribution of responses to oral health impact profile (OHIP) (%)

During the PAST FOUR WEEKS, how often have you	Never (0)	Hardly ever (1)	Occasionally (2)	Fairly Often (3)	Very Often (4)
had trouble pronouncing any words	83	2.2	4.1	2.2	8.5
Felt that your sense of taste has worsened	75.5	4.5	8.9	0	11.1
had painful aching in your mouth	34.8	6.5	26.1	6.5	26.1
found it uncomfortable to eat any foods	29.8	8.5	21.3	8.5	31.9
been self-conscious	40.4	2.2	23.4	0	34.0
felt tense	35.6	2.2	37.8	2.2	22.2
thought your diet has been unsatisfactory	50.0	2.2	17.4	4.3	26.1
had to interrupt meals	53.2	4.3	19.1	6.4	17.0
found it difficult to relax	49.0	10.6	23.4	6.4	10.6
been a bit embarrassed	44.6	12.8	14.9	2.2	25.5
been a bit irritable with other people	57.4	6.4	17.1	8.5	10.6
had difficulty doing your usual jobs	74.5	4.3	12.7	0	8.5
felt that life in general was less satisfying	55.6	8.9	20.0	0	15.5
been totally unable to function	76.0	10.9	10.9	0	2.2

5.2 Qualitative analysis of in-depth interviews

A detailed analysis of the 47 in-depth interviews that were conducted is outlined below. The key intent of this analysis was to consider the contributing factors that influenced the decisions of those on the dental waiting list to attend or not to attend their appointment, as well as to gather their experiences of waiting for dental care. The qualitative analysis took account of emerging themes from the interviews that considered participants’:

- ▶ Perceptions of oral health care needs
- ▶ Knowledge of oral health services
- ▶ Previous experience of service use
- ▶ Intentions to make appointment with public dental health services
- ▶ Reasons underlying their appointment intentions
- ▶ Experiences of waiting for a public dental appointment.

This analysis is illustrated with the use of case studies. These case studies act as descriptors of the analysis under the review in which they are included. These case studies present a shortened version of the whole experience as told by consumers. They portray many of the varied points being analysed throughout the study and not merely the one being considered.

5.3 Themes from in-depth interviews

Presented here are main themes arising from the interviews. Quotes have been used to describe these themes and are purposively selected to demonstrate the findings. Case studies provide individual stories of consumer experiences on the waiting list.

Positive perceptions about public dental care

Although considerable anxiety and anger was expressed, many participants also gave positive feedback about public dental services. Participants who expressed these sentiments said they would, if possible, attend their dental appointments. There was often, perhaps inevitably, comparison with private dental care. Representative quotes are listed below:

- ▶ 'I always get good care here'
- ▶ 'It's cheap, cheaper than private which is so expensive'
- ▶ 'There is no difference between here and private in the care that you get, it's just it's much too expensive for me to go to a private person now'
- ▶ 'Private care is too expensive for what you get'
- ▶ 'Going private is just not possible – it's too expensive for me.'

Having to wait – documenting the experiences

Many different experiences about waiting for dental services were recorded. Such experiences were important factors in determining whether participants attended their dental appointment or whether they would not. These are documented below:

- ▶ Communication breakdown because of the length of the waiting period and lack of sufficient interim communication. For some consumers, the following reasons made contact or communication difficult:
 - Moving from previous address (and not notifying service)
 - Change of telephone number (and not notifying service)
 - Poor language skills in English
 - Change in health conditions
 - Busyness of life
 - Lack of knowledge about the public dental health system.

This often resulted in participants:

- Losing contact with dental services
- Wondering what was happening to their place on the list
- Being uncertain as to what they should do with their oral health problems
- Being worried about whether they had made a mistake.
- ▶ Difficulty making contact with Dianella, either for emergency care or when asking general questions, because consumers were:
 - Unable to get through on the phone
 - Unable to communicate with staff when arriving in person.
- ▶ Many of those interviewed reported health implications as a direct result of dental difficulties:
 - Poor diet and a lack of energy
 - Changed diet – 'I just can't chew'
 - 'I'm sure my health is not so good. I can't chew properly so meat and fruit is out of the question'.
 - Mental health – 'Just living with all that pain for so long ... it has changed me as a person I'm sure'.
- ▶ Many of those interviewed described social issues arising from poor dental health while on the waiting list and their implications socially:
 - Angst caused by poor perceptions of self and lack of confidence on social occasions

- Isolation – ‘I don’t feel like going out’
- Lack of energy – ‘No energy to carry on as I did before’
- Embarrassment – ‘I feel embarrassed to laugh and I need to cover my mouth with my hand like this. My uncle said “you must be doing something wrong” and that’s awful for people to think that’.
- Anxiety – ‘I would be happy to have all my teeth removed rather than go through another three-year wait’
- ‘I hate living like this. The longer I wait the worse it gets and my husband complains about the smell in my mouth’
- A sister-in-law told one interviewed woman that she had too many rotten teeth. It became ‘awful’. ‘I knew I had to wait but I didn’t think it would be this long’.

Issues for Dianella

These factors in turn undoubtedly affect Dianella. From our contact with Dianella, it is clear that staff in turn experience:

- ▶ Total loss of contact with some consumers
- ▶ No response from significant numbers of invitations to attend the dental clinic
- ▶ Anxiety and anger from clients who have experienced the weaknesses in the system, especially the long wait.

Information and knowledge about dental services

- ▶ There was a consistent lack of information received by participants and an associated apparent lack of general knowledge about dental services that could result in misunderstandings:
 - About the Australian health system (especially those from a non-English speaking background)
 - About what to do – ‘what happens with this waiting list?’
 - About emergency dental health – ‘Well what do I do in an emergency? It’s very difficult’.
 - About paying for public dental care – ‘I need to plan ahead and save the money out of my pension’.
 - ‘I didn’t know what to do – I phoned the emergency number but the phone just rang out ... I was desperate’
 - About community health in general and about Dianella in particular – ‘I didn’t know this place was here until I was told to put my name down by the GP’
 - About their health rights – many participants had not heard about the Medicare Chronic Disease Dental Scheme or had any understanding about alternatives to Dianella in an emergency.
 - About their options – ‘I just couldn’t afford to go to a private dentist ... I would have liked a brochure or something, anything really whilst I was on the waiting list so I could plan and have some idea what to expect’.
 - About their place on the waiting list – ‘I would really like written information as to where I am on the waiting list – otherwise ... how am I to know what to do?’

I’m angry, frustrated, confused ...

There was a considerable amount of anger, frustration and confusion about why it was necessary to wait so long for dental care. It seemed to be understood that ‘you’ll just have to wait’. The chief issues seemed to be:

- Not knowing what to do next
- No obvious alternatives
- ‘I can’t even get emergency care for what I think is an emergency’

- The seeming alternative to public dental care being private is too expensive – ‘I’m having to afford emergency treatment that I can ill afford’
- Having to rely on family and friends was, for some, demeaning and difficult especially when financial assistance.

Finding out what to do but then not being successful contributed to the stresses of trying to access dental care. This happened when some people:

- Could not get through to Dianella for information or for an emergency care appointment
- Had to find an alternative that is difficult to access (Royal Dental Hospital) or too expensive (private care)
- Had no obvious other source of information beyond friends and family.

In summary, the main themes from this study provide a complex picture of disadvantage for consumers who rely on public dental care. It becomes apparent therefore that public dental services are faced with considerable challenges to address these difficulties. Both parties are trapped, doing their best within a flawed funding system.

Ways of finding out

Most people found out about Dianella dental health services from family or friends. However, there were other ways reported by those who had come to put their name on the waiting list:

- ▶ ‘I’ve told all my friends about this place and now all my friends have come to put their name on the waiting list. I’ve gone back to my group and told them all about it. There are 20,000 Turkish people in this area – I would like information about public dental care given to the Turkish population in their language’
- ▶ ‘I came into the centre for podiatry and the eye specialist – so I thought I’d come in to the community centre and have a check-up on the teeth’
- ▶ ‘My son [at school] is on the public care – so thought it was a good idea’
- ▶ ‘The hairdresser said, “you’re a fool if you don’t go to Dianella”’
- ▶ ‘I heard from my husband who had been told by his friends about it’.
- ▶ ‘I listen to Arabic radio on SBS and I read Arabic newspapers and I go to an Arabic GP who is also Iraqi. But I got my information about Dianella from my cousin’
- ▶ ‘I find out things from the Neighbourhood House’

Two consumers (one a volunteer at Dianella) had found out about public dental services by coming to the health centre.

Emergency/interim care while waiting

Emergency care was identified as being important to the majority of consumers, particularly their need to be able to receive emergency care when they were in pain and distressed. Twenty-eight out of 47 consumers interviewed (60%) needed emergency care while on the waiting lists. Of these, 13 managed to get into the public emergency service at either Dianella or the Royal Dental Hospital, 12 went to private dentists because they could not reach the public system, and three could not go anywhere despite their immediate need for dental treatment.

Tooth pain, broken teeth and other difficulties were reported to have occurred frequently in between appointment times; sometimes more than once. Many respondents reported feelings of disappointment and of being left alone. These were precipitated by either not having received

information about emergency dental services or by knowing about such care but not being able to access it. Key reasons for these included difficulties in obtaining an appointment and not being able to get through on the phone number provided.

One young woman explained that she thought her plate breaking was an emergency but when she phoned up: 'They told me that they can't take me as it's not strong pain. They told me to call emergency if it's really bad. But I can't use my old plate any more. I can't use it'.

Important information about the range of dental care options seemed not to have been disseminated successfully to most participants. One Egyptian woman had diabetes but although she had recently received emergency care, she was not aware of the possibility of the Medicare dental scheme. She said: 'Well, it's a problem for me having diabetes you understand. My friends say "just go private" but I can't afford private and I can't tell them that... It seems when you can pay you can have everything done your way'.

An elderly woman, born in Australia, was concerned that her generation found it difficult to find information. She thought there was more information for people from different cultural backgrounds than for English speakers, and that for older people it was particularly difficult because: 'My generation don't question and don't find out unless you are told specifically. We didn't know, I wasn't told, though I wanted to know so had to do it by myself'. She was concerned that often things were given verbally but not provided as written backup and 'I don't particularly like to ask questions anyway'.

Different ways of dealing with emergency situations were reported. Such ways included:

- ▶ **Persisting with emergency care at Dianella.** Several people reported trying to gain emergency care without success. However, one woman said: '... if there's a rush on you try the next day or keep trying for half an hour or more ... I tried and I tried to get through on the phone but it was always busy. So I turned up there. I was desperate but they said they couldn't do anything. I was very angry'.
- ▶ **Attending the Royal Dental Hospital.** 'There's always the dental hospital if you have to – but I don't like to'.
- ▶ **Putting name on other waiting lists.** 'We have our name on lots of lists so I just need this appointment for a check up'.
- ▶ **Attending a private dental clinic.** 'So I spent over \$600 getting it fixed and I couldn't really afford to'. Another woman explained: 'I had a lot of pain about six months ago so I took a lot of Panadeine and got better but then it got really bad but I couldn't get in at Dianella. I then went to a private dentist because I felt so bad and they said I had done a lot more harm because I should have come for treatment earlier. So I only have one back tooth left now'.
- ▶ **Going to a foreign country and receiving dental care.** Two of those interviewed said they returned to their respective families in Turkey and Lebanon to receive cheap, effective dental care. 'In the end it was much cheaper than going privately'.
- ▶ **Not knowing about emergency care.** Many of those interviewed did not know emergency care was available. A Turkish man said: 'Is there emergency care? I didn't know that otherwise I would have tried'.

Ways of understanding their situation

Many consumers told of how they understood the risks associated with not doing anything:

- ▶ 'A small filling became a larger filling until it became infected ... I waited so long the tooth decay seemed to spread from one to the other until the original one became infected'.

- ▶ 'It seems I've been losing teeth steadily whilst I've been waiting'.
- ▶ 'I can't eat steaks, any meat really, that's why I feel bad'.
- ▶ 'I need a plate 'cause I've lost so many teeth but I have to wait until my appointment even though I should have had the work done a long time ago. I was told I would need to wait eight months but it's two years later now. I have my daughter's engagement party in January and it's embarrassing for the photos as you don't want to smile'.
- ▶ 'I've had these teeth out whenever I came to the dentist – so I get this phobia now about the dentist'

Adile (not her real name) was in her mid-thirties and originally came from Turkey. She finished high school before she came to Australia and before she married was a process worker at a local factory.

She heard about Dianella from her sister-in-law after she had been complaining about problems with her sore teeth. It was difficult to eat and she was feeling constantly unwell, which was difficult with an active baby.

Adile put her name on the wait list at Dianella and was shocked at how long she would have to wait "but" she said:

... it was even longer than I expected, it has been at least four years ... It was awful. I knew I had to wait but I didn't think it would be this long.

Adile soon developed problems with infected teeth and she felt couldn't wait to be treated. She managed to get an appointment for emergency dental treatment where they said:

I had a lot of infected teeth which was bad and so they took some more teeth out. Then [whilst waiting again] I had no teeth with which to eat my food – I had three on this side and two on that ...

Adile was very unhappy. Although she had a lovely little girl she felt her life was unsatisfactory. She checked with a private dentist about having a plate and some other work but was told it would cost over \$10,000. She could not afford that. So:

I went overseas to have my teeth done as I couldn't afford it here ... The reason I went there was partly because of my teeth but even with the plane tickets it's cheaper than having it done privately here ... now I can eat my food whereas before I couldn't.

When she returned from Turkey she decided:

I don't think I'll come again for emergency [treatment] as it wasn't so nice as in private. I have private insurance now – just in case I can't wait any longer another time. It's been a very long time that I've been waiting and I've already fixed my teeth as they were rotten and I don't know what I'll do when my name comes up.

Later Adile said 'I'll come for the check up at least.'

Note: Adile did make an appointment.

Caleb (not his real name) was born in Lebanon; he is about 40 years old. In Lebanon he had completed a computer course at the equivalent of TAFE level in Australia. In Australia he had worked as a mattress maker but had injured his back and was on a disability allowance.

Caleb had reluctantly signed up for the waiting list at Dianella for a dental check-up. He thought it was embarrassing but his school-aged children were seen there so he thought it would be OK. Then a time came while he was still on the waiting list that he started having a lot of dental pain. He thought it might have been an abscess:

So I phoned the dental people at Dianella and they said to phone the emergency number. So I said "thank you" but when I did the next morning at the time I was told it rang and rang but no one answered the phone. I kept on ringing as I thought I must have phoned too early – but I still couldn't get through. Then my neighbor said "just go to the dental hospital in the city" – so I did and though I had to wait it was OK... But every time I have an emergency I don't want to have to go in there – it's difficult to find parking and it's a long way to go.

At the Royal Dental Hospital they couldn't finish everything, such as giving him a crown for his tooth, and he said, 'I don't like students playing with my teeth'. He went to a private dentist who said the work he needed would cost many thousands of dollars but 'I don't have that sort of money'. As it happened he had to return to Lebanon to see his mother who was aged and sick:

Well, whilst I was there I thought [at his family's suggestion] I should go to the dentist to see how much it would be. For about \$350 I was able to have two root canals and a crown. It was beautiful.

Caleb found it very difficult to understand the Australian dental system and he found accessing emergency dental care particularly difficult. 'The more I phone and no one answers the angrier I felt – so I went to complain.'

When asked if he would attend his next appointment he explained how he had to go back to Lebanon again and:

I'll probably have it done there [Lebanon]; it's much easier.

Note: Caleb did not respond to Dianella's offer of appointment and was overseas when a follow-up call was made.

Many who could not access emergency care gave up trying. The following describes accounts of consumers' ways of managing this situation.

Ways of coping while waiting

When emergency care access was either unavailable or not understood, participants in this study utilised various ways of coping with the emergencies or difficulties they faced while waiting for their appointment.

1. Going Private

Many of those interviewed decided that they couldn't wait for public dental care so they decided to attend a private dentist. Following are quotes from some participants who had made this decision:

- ▶ 'I came into the health centre after the first year as I had some pain and they said I was still in the waiting line ...so I went privately'.
- ▶ 'Really needed to see the dentist so I went to the private dentist ... but I really need 6 monthly checkups but can't afford that so I use a mouthwash to prevent having to come back and I haven't been for over a year.'

- ▶ 'They [under the Medicare scheme] organised for me to go to a private dental clinic to get my broken tooth fixed. It was very easy and didn't cost me anything.'
- ▶ 'Private care's so expensive so there's no choice but public care.'
- ▶ 'Can't really go to private because too much money to pay'
- ▶ One woman told of how she was 'foolish enough to go to private care' and spent \$900 on care which she could have had at Dianella at a much cheaper price.

2. '... But what else can I do?'

Some of those interviewed found alternative ways of coping, other than going privately.

- ▶ 'We thought all we would need to do is wait – but it was too long ... 'We tried the Royal Dental Hospital but it was too difficult really ... it was too difficult to park and a long time to wait at the clinic so we won't be doing that again.'
- ▶ 'I'm seriously thinking about having all my teeth removed – that's what my friend did and she says it's OK.'
- ▶ 'I put my name down [registered] at another centre [named] because my husband did that and he got his appointment after six months...it's a long way to go but it's much quicker and you don't have to wait very long at all.'
- ▶ 'I could also quite easily go to Dousta Galla as I live very close to it, you know, its the next door area. I took a friend there because it was very handy – good parking and it on a tram stop. ... It's also easier to get emergency care there 'cause when I got a broken tooth – I just went and had it fixed. It was easy. In fact I'm just as happy with Dousta Galla maybe happier.'
- ▶ 'I eat menthol lollies to take away the smell ... my husband says that my breath is not good.'
- ▶ 'Sometimes I get scared that this is how it's going to be. So I've decided that I'm going to get the rest of my teeth pulled out as I'm sick of the worry and the problems.'
- ▶ 'The GP [under the Medicare scheme] organised for me to go to a private dental clinic to get my broken tooth fixed. It was very easy and didn't cost me anything.'
- ▶ 'I was studying at TAFE and was able to get three appointments at the Royal Dental Hospital as a student.'
- ▶ 'I clean my teeth really well.'

Aldo (not his real name) was in his mid-seventies. He was born in Italy and left school when he was 15 years old. He came to Australia in his early 20s and became a bricklayer/builder.

When Aldo retired he couldn't afford private dental care so he went to the Royal Dental Hospital in the centre of Melbourne. It was a long way to go and a long wait in the hospital so they suggested he sign on for Dianella. Aldo has been coming to Dianella for some years now. When asked about having emergency care he explained:

I don't know about emergency care but I suppose I haven't had any trouble with my teeth in recent years. Once you get there the service in public is OK ... I can't go private as it's too expensive but I'm happy coming here ... I make sure I clean my teeth really well and I use a mouthwash too.

When asked about whether he would like any more information about dental services Aldo said:

I would like a brochure or something like that and then his daughter could read it for him.

Aldo will definitely keep his appointment.

Note: Aldo did keep his appointment

Elsie (not her real name) was born in Australia and is in her mid-sixties. She has been receiving dental care at Dianella since she and her husband retired. A few years ago they used another public dental service because they were concerned about waiting for such a long time at Dianella. Elsie and her husband explained:

We went along to another dental service and signed on there. That was nearly two years ago and we had an appointment within six months. It was really good because it has kept us pretty happy about the state of our teeth. We're back on the waiting list there again and maybe we'll have two appointments given us at the same time, which would be difficult.

When Elsie was asked which dental service she would prefer to attend, she said:

Oh Dianella 'cause it's much closer to where we live than the other one.

Note: Elsie did keep her appointment.

Health issues experienced

It seemed that many of the participants in this study experienced health issues either as a direct result of chronic tooth and gum problems or as issues that impacted directly on their dental health.

1. Chronic diseases

At least six participants reported that they had been diagnosed with diabetes, two with heart disease and two who reported a history of cancer. All but one of these did not realise that they may qualify for dental work under the Medicare Chronic Disease Dental Scheme.

One of those with diabetes stated her wish to avoid having continuing problems with her teeth. She said she wanted to 'have them all removed so I don't have to worry about them again'. Another woman, a retired Turkish school teacher, described how she would cover her mouth in embarrassment because she had such bad, infected teeth and 'I tried to get emergency treatment but I couldn't'. Though this woman had diabetes, she was not aware of the Medicare dental scheme and proposed to find out more about it from her GP. This lack of knowledge

about available services was common among participants and points to the underlying need for improved information about current and especially new, dental services.

However, one Turkish woman did know about Medicare dental services and had been referred to a private dentist by her GP. She was very pleased with her care. Ongoing problems with her teeth meant that she still intended to keep her appointment with Dianella.

One woman who had arthritis did not have a chronic disease as defined in the legislation. She had heard about the scheme but was told by the GP that the chronic illness of arthritis did not qualify her for the Medicare scheme.

Camilla (not her real name) came from Italy as a young woman. She went to school until about Form Four and was a hairdresser for many years. Now she was a single mother and was finding life very difficult.

A few years ago Camilla was diagnosed with breast cancer:

It was a very difficult year for me. Suddenly I was a single mother and then I had this diagnosis... After surgery I saw the oncologist. He told me I'd need chemotherapy treatment but that had side-effects which could result in problems with my teeth. He suggested I make an appointment to have my teeth and gums checked.

I came to Dianella to see if I could have an appointment but I was told that my case wasn't an emergency under the guidelines and that I'd have to go on the waiting list. I was told "you just have to wait".

Camilla soon had difficulties with her teeth and developed an abscess from her poor immune system. She phoned up Dianella to see if she could get an emergency appointment but as it was close to Christmas she was told she wouldn't be able to see anyone. Then:

My lovely family gave me an appointment with a private dentist for Christmas and he saw me on Christmas Eve.

Camilla considered the effect on her was 'massive'. She has been 'physically disabled and dysfunctional' with her teeth, 'constantly taking antibiotics and Panadol' to cope with the pain. She can't eat what she considered a 'normal diet' and she would like to see change happen:

No, I don't know enough. I don't understand how the system works and I've not seen a brochure – but then I'm usually thinking about other things when I'm there. I'd really like something sent to me, a letter or a phone call, anything.

Yes, of course I'll come to my appointment.

Note: Camilla did keep her appointment

2. Poor diet

The majority of participants had stories about how their dental health had deteriorated while they were waiting. One of their major issues was the inability to chew food. One man explained '...But things have got a lot worse whilst I've been waiting ... I can't eat fresh fruit and chewing meat, it's impossible.'

Another man said 'I think my problems have got a lot worse because I can't eat properly. It seems my gums are shrinking and my denture keeps breaking'.

An Italian woman explained how 'my GP has put me on iron tablets as he says I'm not eating enough meat – but it is too difficult ...'

Brenda (not her real name) was in her mid-forties. She had not completed school beyond Year 11 and worked previously as a supervisor of truck drivers. However, Brenda had been on a disability allowance for some time and was pleased to hear from friends about public dental services as she couldn't afford private dental care. She explained how:

I had lost a lot of my teeth at the top – they just seemed to crack and crumble – so I had my teeth taken out and then I was told that I'd be put on the waiting list and I'd have to wait for about eight months. Well, that was over two years ago. I can't go private as I just can't afford it. I've broken more teeth now and I've got having the roots being removed to look forward to ... so it seems that waiting this long means that I have to have a lot more work done.

Brenda told how she was anxious about getting the work done but knew that she had to go through it as she couldn't afford to go anywhere else. Particularly she considered:

I really think my health has gone to pieces in the last couple of years. I can't eat properly – I'm always getting aches and pains and it's embarrassing not being able to eat like other people and I really can't laugh without hiding my mouth so I try not to laugh ... and I used to laugh a lot.

Brenda felt she had learnt a lot about dental care in the last couple of years and 'knows pretty much through personal experience'. But she commented that:

You know I haven't got even a brochure whilst I've been waiting – I would have liked to get something like an update about what's happening [with the waiting list].

In response to the questions about whether Brenda would attend her appointment she said 'absolutely – I have to come as soon as possible – I won't like it but I have to come.' Brenda talked a lot about how her life had been become dominated by her teeth in recent times. How her state of mind depended on the level of pain she was experiencing but particularly how it affected her personality:

Before I was always smiling – but now I'm different. Teeth are very important you know.

Note: Brenda did keep her appointment.

Social issues

Those interviewed were considerably affected by dental ill-health in their social interactions while waiting for dental care. This happened in many ways, much of it in conjunction with other difficulties such as age, ethnicity, disability, education level and poverty. For instance, an elderly couple who had recently migrated to Australia from Iraq, had their social isolation compounded by unmet dental needs plus their lack of English language skills, together with an inability to understand the public transport system in Melbourne. They were reliant on their family for transport to appointments and suffered greatly when the need arose for emergency dental care. They described how they relied on their family if they were sick and, as their grand-daughter noted, this 'challenged their pride'.

Other social impacts revealed were embarrassment, unwillingness to go out socially, obligations to family who insisted on paying for their dental care, and difficulty functioning with chronic pain. Some indicative quotes are:

- ▶ 'I take a lot of painkillers to try to get rid of the pain ... but I don't feel like going out when I'm in pain. It feels as though I'm become a different person now...'
- ▶ 'I used to like going out a lot but now ... I tried to get into emergency but in the end I had to spend over a \$1000 on a private dentist – so I had to cut out going out and other expenses too. But my dental problems just got worse ...'
- ▶ 'I'm embarrassed that my breath smells – so I always put my hand over my mouth.'

- ▶ 'It seems my social life is dependent on what I still need done [to her teeth]... I depresses me knowing I have to wait and getting emergency is so hard.'
- ▶ 'My husband and I came from Cyprus. We had rotten teeth but we were waiting and waiting. We went back to Cyprus for a holiday and he died there suddenly. It was very upsetting ... when I got back I found I had missed my appointment ... well it's over four years now and I'm very embarrassed with my teeth, I have to cover my mouth when I'm speaking ... it's very difficult without my husband.'

Ideas from those interviewed

Many participants provided suggestions and ideas for service improvement. These have been collated and are presented here:

- ▶ One couple interviewed together suggested that information should be provided at CentreLink in different languages and given to different groups, and there should also be information points at hospitals and community health centres. The woman said: 'We have over 300 women at the Turkish Women's Association. We go walking together and have social get-togethers – we love have people coming to tell us about themselves.'
- ▶ One woman thought that she does not understand enough about public dental care. She said 'I would like to know more about public dental care – especially about emergency care.'
- ▶ 'People should be given letters that explains it simply.'
- ▶ 'I really didn't know whether I was still on the list. I thought that something must have happened so it would have been nice to get something in the post that explains what's happening.'
- ▶ 'I rang for an emergency appointment and heard about the Royal Dental Hospital on the recording. It helps and it told you about weekends.'
- ▶ 'I don't know much about what to do and I would like to know ... I used to have pain in my teeth all the time and then when I had an emergency and had to have my tooth out I heard about Sensodyne toothpaste and it's much better now.'
- ▶ An elderly gentleman from the Ukraine suggested: 'What you need is a very large poster, just where people are standing, that explains clearly what happens so that everyone understands. It's too complicated for the girls to answer the phone and look after people at the same time. It might help for the girls to have a lesson on how to manage difficult people as it's very difficult for them.'
- ▶ A young woman gave a perspective from that of the younger generation: 'Me and my friends we don't like to do much reading – so it's better if we hear it [about health services] at a social function or at TAFE 'cause then we talk about it.'
- ▶ 'I would really like to have a letter telling me about what's happening'. Several consumers said they would like a letter from Dianella with information about their services.
- ▶ A man from Iraq said 'if you reduce the waiting list it can be perfect.'

Bohdan (not his real name) had a university degree as an electrical engineer and was retired. For several years he attended the Royal Dental Hospital in the city and was recommended to go to Dianella from there, which he finds much more convenient.

Bohdan had experienced ongoing problems with his teeth as he waited for public dental care. He said that he was surprised that:

No one assesses your need whilst you're waiting, or categorises you and then when you really need some work done urgently you can't even get through on the phone to find out what to do... so what I did was to have to spend money I can't afford to spend on a private dentist – I didn't like to do that.

Bohdan found that although he originally used emergency care for a filling that had come out, in the end he had to pay for several visits to the private dentist which he did not like doing:

The expense is massive. If you have to pay out so much money for private care you don't have enough money left for other things like rates and insurance which are important. Having to pay for all these things means we have very little left just for living.

In response to the question as to whether he would attend his appointment Bohdan said 'yes of course I will.' But he was emphatic that:

I would have preferred to have more of an idea as to what was happening whilst I was waiting such about going to the dental hospital in the city, about recommended dentists in the area or even about preventative care – what the GP can do.

Note: Bohdan did keep his appointment

Responses given about intention to attend appointment

The majority of those interviewed considered that they would most certainly attend their appointments. However, there was a significant minority who were either not sure or were not going to attend.

'Yes' response

Forty-three out of 47 interview participants were emphatic in their response to whether they intended to keep their dental appointment. The majority used words such as: 'oh yes', 'of course', 'definitely' and 'I can't hardly wait' described an enthusiasm to attend. One Arabic lady explained through an interpreter 'of course I will – it is still very painful and my teeth are no good like this'.

One man had been experiencing ongoing pain and had made an appointment with a private dentist said 'I'm going to cancel my appointment [with private dentist] if I'm going to be called here. It's much cheaper and they give you good care.' Another said 'Of course I'll come. I'm desperate.' Yet another said 'I might as well I've waited so long.'

'No' response

Three consumers stated that they were not going to attend their appointment. Two gave the reason that they were receiving care at another centre. The third an elderly woman from Italy was emphatic: 'No. My daughter has helped me see a private dentist. I'm having all the rest of my teeth taken out and fitted with a full denture. It's very painful I can't wait any longer.'

One consumer was not sure. He was considering whether to have his treatment at Dianella or to wait until he visited his family in Lebanon.

In summary, the main qualitative themes from this study provide a profoundly complex and problematic picture of disadvantage for consumers who rely on public dental care. This presents

considerable difficulty for dental services that operate with substantial constraints upon their services. It becomes apparent therefore that public dental services are faced with significant challenges to address these problems.

5.4 Post-interview telephone calls

Monitoring records of consumers' responses to offers of appointments and subsequent attendance

The responses of all participating consumers, and the control group, were studied four to eight weeks after the letter of offer was posted to the last group of consumers on the recruitment list. Comparison of responses to offers of appointment and appointment attendances among consumers shows that those who had been engaged (by the study as well as the service) responded to the service at a much higher rate than those who were less engaged with the service.

The Control Group

Sixty consumers (the control group) chosen from the dental waiting list at the same time were not aware of the study and not were contacted by the researchers. One consumer was removed from the waiting list as he had recently completed his course of dental care. It was found that 22 out of 59 (37%) made an appointment, and all of them attended their appointments. This is roughly equivalent to the normal rate of response at Dianella to their letters of offer.

The Intervention Group

The intervention group comprised 150 consumers who were sent a letter about the study and were contacted by telephone to take part in the face-to-face interviews. These included 43 consumers who presumably received the letter but were not reached by telephone and 107 consumers who received the letter and were contacted by telephone.

Of the 43 consumers on the list who may or may not have received the letter and were not reached by phone, 10 (23%) made an appointment. **Eight people** (17%) kept their appointments, and two cancelled or did not show up for the appointment.

Of the 107 consumers reached by telephone, 60 did not consent to be interviewed and 47 were interviewed.

Of the 60 consumers contacted by telephone but were not interviewed, 31 (51%) made an appointment. **Twenty-six** (43%) kept their appointments and five failed to do so.

Of the 47 interviewed participants, 34 (72%) responded positively to Dianella's offer of dental appointments, and 32 (68%) had used the services. Two failed to attend his/her appointment.

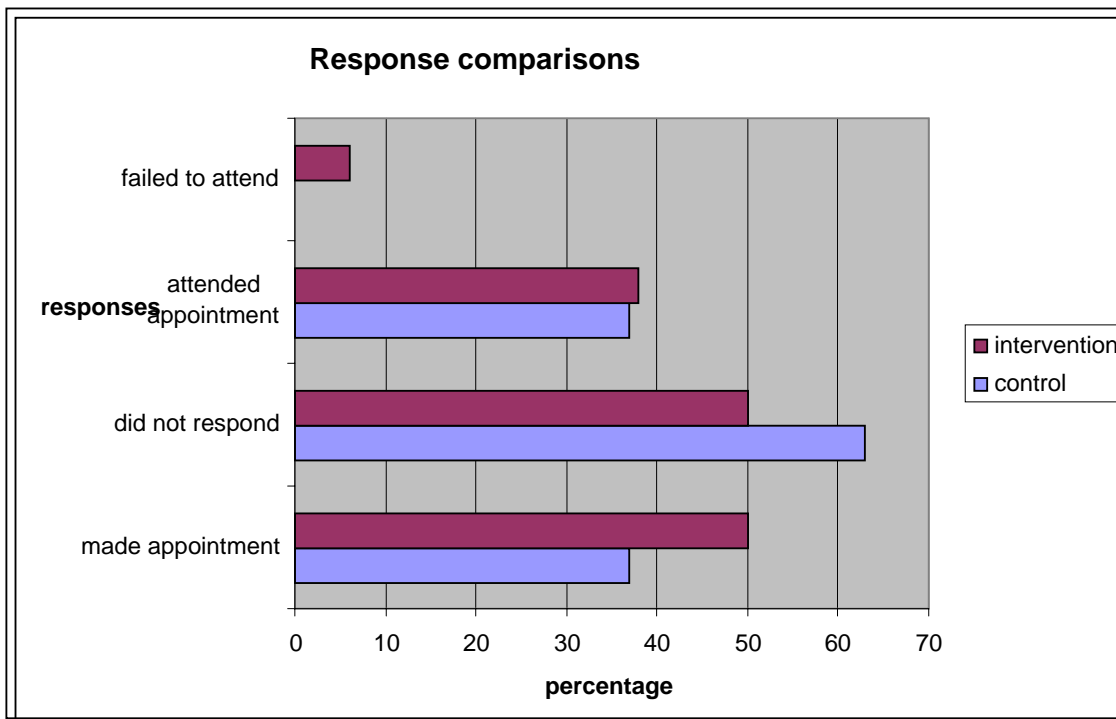
Table 4 shows a comparison of behaviours among consumers on the dental waiting list and Table 5 breaks down the actions of the intervention group alone.

Table 4: Comparison between the control and intervention groups

Levels of intervention	No. in group	Made appointment	Did not respond	Attended appointment	Failed to attend
Control Group					
Never been contacted, not aware of study	59	22 (37%)	37 (63%)	22 (37%)	0
Intervention Group					
Sent recruitment letter	150	75 (50%)	75 (50%)	66 (44%)	9 (6%)

As can be seen, the intervention group responded considerably more positively to the offers (over 50%) than those on the control group (37%).

Figure 10: Response comparisons



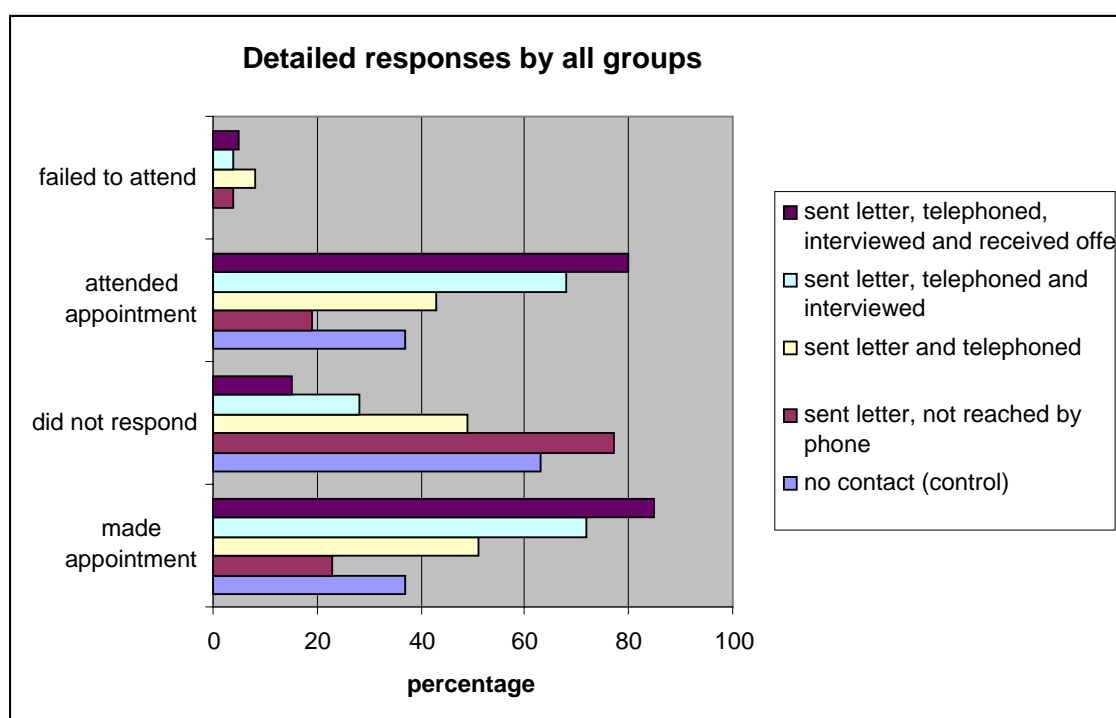
When we look at the Intervention Group in more detail, we see some clear differences in behaviour. Even the recruitment phone call itself had some impact, with 50% responding.

Table 5: Responses of the intervention group

Levels of intervention	No.	Made appointment	Did not respond	Attended appointment	Failed to attend
Intervention Group					
May have received a letter about the study, but not reached by telephone	43	10 (23%)	33 (77%)	8 (19%)	2 (4%)
Received a letter about the study, contacted by telephone but not interviewed	60	31 (51%)	29 (49%)	26 (43%)	5 (8%)
Received the letter about the study, contacted by telephone and were interviewed	47	34 (72%)	13 (28%)	32 (68%)	2 (4%)
Received the letter about the study, contacted by telephone, were interviewed and likely to receive a letter offering an appointment *	40	34 (85%)	6 (15%)	32 (80%)	2 (5%)
Control Group					
Never been contacted, not aware of study (n=59)	59	22 (37%)	37 (63%)	22 (37%)	0

* Excluding seven of the interviewed participants who were followed up by telephone after the interview and reported that they had not received a letter offering a dental appointment from Dianella.

Figure 11: Detailed responses by all groups



It is clear there are some key differences between the groups associated with the degree of contact made. The trend is for higher appointment rates relative to increased contact with the client.

Who changed their mind?

Among interview participants, 10 people behaved differently from their statement in the interviews. One of them was unsure as to whether he would take up the invitation and *made no response to the letter offering an appointment*. Nine had indicated that they would make an appointment when it was available to them but they had not done so. However, on follow-up, seven of these nine reported they had not received an invitation.

The rest of the interviewees acted according to their stated intention, including three who did not respond to the offer of appointment and 34 who made an appointment.

Why did they change their mind?

A brief telephone call was made to all those above who changed their minds.

Reasons for not making a dental appointment:

- ▶ Seven reported that they did not receive a letter of invitation.
- ▶ One woman would have liked to make an appointment but had been unable to make one at a time in the middle of the day to suit her two casual jobs and her commitment to her three children—one of whom has a disability—as a single parent.
- ▶ One man was overseas with his elderly parents. His wife explained that his offer had arrived and as soon as he returned he would make an appointment.
- ▶ One young woman who had a disability lived with her grandmother. Her grandmother was away when her offer arrived and so she waited until her grandmother had returned to make her appointment.

The woman who did make an appointment explained that that she wasn't good at remembering dates. 'I've written it down and put it in a drawer somewhere' she said. 'I'll find it and check it and if I've forgotten I'll phone up and make another appointment as I really need my teeth fixed'. This woman added that she had expected someone to phone her to remind her.

It seems that these consumers did not change their minds, but due to circumstances were either unable to keep their appointments or had not received an invitation to make an appointment.

SUMMARY OF FINDINGS

The following summary sets out findings from this study into the dental waiting list for public dental care. It is followed in the next section by an in-depth discussion about the impact of findings for public dental in general and for Dianella Community Health in particular.

These findings paint a complex picture of vulnerability, disadvantage, confusion and anger among those on the public dental waiting list. The oral health difficulties experienced by the consumers interviewed were seen to spread into their lives, making already taxing life situations more arduous. Coping with dental health problems seemed to affect many, impacting on their general health and social wellbeing. It can be supposed that delivering public dental health services with severely constrained budgets to such a needy population provides considerable challenges.

Key findings

A main objective for this study was to investigate the factors that influence decisions made by people on public dental waiting lists to attend dental clinics. We expected that the factors might include:

- ▶ Being ineligible for public dental care while waiting
- ▶ Having sought dental care elsewhere, either through emergency care or from private dentists
- ▶ Ill-health or family commitments
- ▶ Poor English literacy
- ▶ Low levels of health literacy.

Findings from the study indicate that all the above are barriers to people responding to and attending dental appointments. We also anticipated, but could not demonstrate, that other barriers might include the fact that people have moved away from the catchment area or are so frustrated by the waiting time that they ignored communication from the service.

To answer the overall question 'why do people registered on the waiting list at Dianella decide to keep or not to keep their appointment' is far more complex than simply the factors above. A fuller explanation involved a range of inter-related effects, as presented below.

Key findings from this study are as follows:

1. There was a dramatic increase in the number of consumers attending their dental appointment following their participation in this study. The more contact the researcher had with consumers resulted in a greater likelihood of consumers making and keeping their appointment, and this finding is similar to that of the Dental Costs Study (Horey et al. 2008). In this study, 30% of the control group attended, whereas 50% of those who only received a letter of invitation to participate attended; 72% of those who also had an interview attended; and 85% of those who received a second letter attended.
2. The system of ongoing communication, based around use of the database, does not seem to support ongoing engagement with consumers. For instance, about one-third of the database records were either out of date or incorrect and therefore people on the waiting list could not easily be contacted. Two to three years' waiting means that many consumers' contact details change. They become hard to reach by the service. This is a major barrier to service use despite their needs for dental care.
3. People who spend long periods of time on the waiting list face many difficulties. Their need for dental treatment becomes greater. They are more likely to have emergency-type occurrences. They can also experience deterioration in their overall dental, general and social health. For instance, the OHIP questionnaire into general health and quality of life found that, in the previous month, over 40% of the people

interviewed frequently found eating to be uncomfortable and 38% were in pain often to very often.

4. Access to emergency care was seen by consumers on the dental waiting list as an essential component of public dental care. Emergency care that is both responsive and adequate was not necessarily experienced by people in this study. For instance, sixty per cent of participants interviewed needed emergency treatment while on the waiting list. Of these, fewer than half (46%) did manage to access public emergency care, while 43% were treated privately. The rest (11%) either found another public facility for treatment or lived and coped with the pain.
5. People on the public dental waiting list at Dianella are culturally and linguistically diverse and have a low level of English literacy; they tend to move house frequently with the consequent risk of losing contact with dental services; are from a low socio-economic background, female, and often engaged in unpaid work including caring for young and sick family members with an associated busyness that precludes time for self-care. These are major barriers to service use and for communication.
6. Those on the waiting list lack knowledge about public dental care in particular and the health system as a whole. When faced with the need to negotiate the dental health system they are surprised and confronted by its intricacies and are challenged by this complexity and the expectations of them. Situations such as: understanding the notion of being on a 'waiting list' and when to make an appointment; the notion of preventive dental care; dealing with the need for interim emergency care; managing chronic illness integral to their dental care and knowing their GP can include a management plan to include dental care; and even taking public transport to attend a variety of appointments. All these present as barriers to dental service use and to the ability of consumers to navigate health and dental health systems, including emergency care and their rights to and eligibility for such care.
7. Information about public dental care is not readily available to members of the Dianella community. For instance, many did not know about the Medicare dental scheme for those affected by a chronic illness.
8. There was a level of anger, frustration and unhappiness that impacted on participants' attitudes towards public dental service and those providing it. The dissatisfaction was not about the quality of care they received but about having to wait so long for an appointment, and about difficulties accessing emergency care when it was needed. This is perhaps indicative of a lack of client engagement and their inability to access dental care when they needed it most.
9. Preliminary telephone calls for recruitment provided a voice for those who did not wish or could not be interviewed. Many were confused and frustrated they had waited so long and could not understand why this had happened.
10. Study participants provided some excellent suggestions and alternative ways of managing some of the above issues. Many considered that they received excellent services and were complimentary about Dianella staff. Together with the high morale reported by dental staff, these factors suggest there are considerable opportunities to develop more effective systems.

A discussion on these findings is presented in the next section.

DISCUSSION

Findings from the dental waiting study describe how the barriers experienced by consumers, coupled with their long wait for a dental appointment, result in a relatively poor level of attendance at the dental clinic, despite the evident high need. The following discussion will contextualise these findings with the review of the literature. It will consider the challenges for Dianella Community Health and the issues facing consumers of public dental services.

The debate

This study has investigated matters arising from the recent Dental Costs study (Horey et al. 2008), which noted a large number of people on the public dental waiting list who ended up not using the service. In the Horey et al. study 511 letters were sent to people who had been on the public dental waiting list at Dianella Community Health. Only 246 (49%) took part in the interview and dental examination despite incentives offered by the study. This was similar to a normal rate of response to offers of a dental appointment by people on the waiting list at Dianella. This current study has demonstrated new findings, has confirmed others, and has revealed some additional results.

The Dental Costs study (Horey et al. 2008) described how long waiting times translate into higher needs of care. The estimated costs of care provided to public patients were three and a half times higher than the state average (\$924 per person, per course of care vs. the state average of \$271). The needs are so high that most treatment is acute and there is little opportunity to provide preventive care. This study confirms those findings and supports the literature, which suggests increased funding is needed to support services to better manage long waiting lists.

One answer to the core question about why many consumers do not respond to their offer of an appointment was found in the fact that the dental service had lost physical contact with many of them. In addition, social and cultural factors also impeded use of the service and understanding on both sides. For example, several consumers had changed contact details and could not be reached. Some had become ineligible for public dental care while waiting. Some had sought dental care through emergency treatment, private services, overseas dentistry and other providers. Family commitments and health status prevented some consumers from attending their appointments. Frustration caused by long waiting times and coping with poor oral health conditions were apparent, but nevertheless, all participants in this study who expressed such feelings said they would definitely use this service.

This study also found that a low level of English was a likely barrier to understanding the offers made by the service and that a low level of health literacy caused much confusion and anxiety among some consumers, making this a major barrier to service use.

Such findings pose challenges to public dental services. These are described and discussed in turn below. It is realised that the current system operates within more stringent constraints than most other areas of the health system. Dianella is more constrained than many other metropolitan services, given the limited number of dental chairs currently funded, relative to their level and complexity of demand. The following discussion points are therefore offered in a constructive way, conscious of current constraints. Some may be of immediate value to Dianella, while others may become opportunities if federal funding becomes available. Some ideas may also be of value to other public dental services in their particular contexts, whereas others may realistically require a state-wide initiative by the Dental Health Services Victoria.

Rethinking emergency care

Throughout this study, feedback from consumers suggested that emergency care provides some considerable challenges for Dianella as well as for consumers themselves. Many consumers reached out to emergency care during their long wait for dental treatment, yet were often unable to access information about emergency care options, which led to high levels of anxiety. Many consumers considered that once their emergency care was complete they did not need further follow-up treatment when their invitation to make an appointment arrived. Others

found accessing emergency treatment so stressful that they did not want to have any further dealings with that dental service. Yet some were only too happy to return as they understood the need to complete their course of dental care.

The challenge is to consider strategies to improve emergency care that reduces the anxiety and/or anger that consumers feel when they are uncertain about what to do in an emergency. This could include the development of a brochure and other means of communication (e.g. DVDs) in a language that consumers understand in combination with a streamlined system, as detailed in the recommendations.

Reducing the wait

Clearly, from this study (and supported in the literature) the long waiting times for dental care in the public system leads to the loss of contact with consumers. The loss of contact with consumers directly impacts on the low level of service use when appointments are offered. Long wait times also indirectly lead to a reduction in consumers' dental and general health, as well as impacting on consumers' social and mental wellbeing.

Further, longer wait times resulted in a greater need for emergency care and in turn to less capacity to deliver preventive and restorative care. Such a cycle of care increases the stress on the service's capacity to deliver timely dental care and to reduce the waiting times.

An obvious solution to some of the issues identified is a shorter waiting time. Increased funding for more dental chairs will relieve this pressure and it remains a priority to meet the high dental needs of the population in this disadvantaged area.

In the meantime, increased liaison with GPs to raise awareness of the need to access the Medicare dental health rebate for Dianella clients, along with more information for consumers so that they can initiate such discussions with GPs, would be valuable. Furthermore, effective engagement strategies are needed to maintain communication with clients and enable them to advise of any change of address and telephone numbers.

Maximising responses to appointments

A key finding is how those interviewed and contacted by the study were more likely to make and to attend their appointment and indeed the greater the contact, the higher the attendance rate. This shows how simple engagement with consumers on the waiting list can be of benefit. Of note is how this effect increased with each further contact. For example, given the constraints on dental funding, other opportunities for combining this engagement with other Dianella strategies, (e.g. health promotion work), could be explored.

Delivery of information – improving health literacy

It seems there is little understanding in the community of the pressures that the provision of a public dental service places on funding; service provision is generally seen only from a personal perspective.

Opportunities therefore exist that could include development of partnerships with other public dental providers and the Dental Health Services Victoria to raise community awareness of the need for change. Such partnerships could also consider collaborative measures between services.

Information delivery about public dental services appears to be haphazard. It was apparent from their puzzled responses that many consumers did not understand public dental care. This is not unusual in the wider health system (Australia has one of the most complicated health systems in the world) but it is especially so in dental services where a highly fragmented system has evolved.

Consumers seem to have found out about dental services at Dianella largely through word of mouth, and hence their understanding of dental services' availability was incomplete and information open to personal interpretation. Although some of those interviewed considered they had learnt how to navigate through dental health services over the years, many felt they

did not really understand what to do. One man said 'I have learnt a lot by this discussion we are having'.

The challenge is to be able to deliver information in a way that is appropriate for consumers from a culturally and linguistically diverse population. This suggests using a broader variety of information strategies and mediums, including visual ones. At a state-wide level, more varied information in various relevant languages would be useful, but strategies using other Dianella services, general practitioners, as well as community organisations and consumer networks would also be worth exploring.

The impact of ongoing engagement on service use, as well as the proposals recommended in the previous report (Horey et al. 2008)—about ongoing dental health education and assistance with oral health hygiene work—suggest the need for an approach to dental services that is broader than clinic-based care. An inclusion of community engagement strategies might assist consumers in comprehending and addressing their own dental health needs, with perhaps some consequent reductions in frustration and anxiety among consumers.

Consumer feedback

Many consumers interviewed for this study were happy to provide their ideas to improve dental care at Dianella. It is highly probable that other consumers would also like to provide similar suggestions and contribute towards service development. There seemed few opportunities for people to contribute feedback in this way. However, the experience of this study suggests that some exploration of ways in which to include consumer feedback into dental care delivery, using simple but effective strategies, may be valuable. A wide range of these are available and in use in some other services. These are discussed in a 2005 paper published by the department of Human Services and which can be found at:

<http://www.health.vic.gov.au/consumer/downloads/participate.pdf>.

It has been noted how some organisations hold informal discussion groups to obtain feedback or identify key consumers and discuss issues at an individual level (this could happen via telephone calls). Some community health organisations have volunteers working at their centre, which provides an opportunity to engage volunteers who also use the dental service in a discussion about dental issues. These and other issues concerning consumer participation are also addressed by Health Issues Centre <http://www.healthissuescentre.org.au/>.

The challenge is to consider ways to include consumer feedback into dental care delivery, at the local level, using simple, inexpensive but effective strategies similar to those suggested above, and in the recommendations.

Database management

A number of key issues arose about managing the waiting list efficiently. It seems that the database for the waiting list for Dianella is both useful and highly complex. It was not the purpose of this study to examine the database's function, nor its management. However, the study did find a significant number of service problems that stemmed from database error. These included missing, incorrect and out-of-date consumer details and inaccurate waiting list status data. There seemed to be difficulties in systematically managing such changes, as well as some malfunction issues.

These certainly created consumer angst and inconvenience, but they probably also hindered the staff team more broadly in their ability to work efficiently and to their own satisfaction. Rectifying the issues and inconsistencies with management and updating of the waiting list database is a matter of urgency.

The challenge exists for developing strategies that manage the database in a way which minimises the negative effects of database malfunction. Therefore, a collaborative policy for database management needs to be developed.

Organisational barriers

It is not the brief of this study to investigate how dental services are organised. However, the National Health and Hospitals Reform Commission (2009) suggests that organisational change for public dental services is imminent, with the possibility of increased Medicare services. Therefore, it may well be appropriate to propose that ways are considered to facilitate and meet such a challenge.

As demonstrated in this study and in the literature, extended waiting times for public dental visits could have a number of important consequences for both the dental service and for consumers. With extended waiting lists, consumers' oral health is likely to deteriorate, leading to the need for more extensive restorative treatment or increased risk of tooth loss, anxiety, possible anger, social and general health costs. Delayed treatment is likely to increase demand for emergency dental services. This pattern of care shifts costs and service stress from preventive to emergency treatments. It also seems that the community at large does not understand the pressures on funding for public dental service provision, seeing and understanding the situation of service provision purely from a personal perspective.

Opportunities therefore exist that could include the development of partnerships with other public dental providers to raise community awareness of the need for change. Such partnerships could also consider collaborative measures between services to provide better coordination of dental services across the public domain.

RECOMMENDATIONS

These recommendations have been developed with the input of the Reference Group, their deliberation of the 'Discussion' section and the implications arising. It is anticipated that these suggestions can be further modified in an ongoing dialogue between dental services, the users of this service, as well as with DHSV. Of interest is how some of the recommendations, such as a dialogue with GPs about the Medicare scheme, are already happening.

The recommendations are listed as follows:

At the service level

1. When people are registered and put on the waiting list:

- ▶ Record additional contact details including next of kin, mobile phone numbers and email addresses
- ▶ Consider a needs assessment (a more sophisticated triage) that can indicate how long people can wait before their condition deteriorates
- ▶ Give written as well as verbal information in the form of a brochure (as described below)
- ▶ Recommend to clients they inform the service of any change in contact details.

2. Develop a strategy for engagement:

- ▶ Brochure
Develop and make available a brochure for people who are about to go on the waiting list, or posted out to those already on the waiting list, but who are still some way from the head of the list, with the letter of offer. An explanation of the brochure's contents should be available in key languages. This brochure should include:
 - How to inform Dianella of a change of address
 - How to access emergency treatment
 - What to do while on the waiting list regarding managing dental conditions and keeping in touch with the service and what to expect
 - Information about the Medicare scheme for people with a chronic disease
 - Information about other services at Dianella; for example, financial counselling
 - Any other important information that consumers of public dental care may need.
- ▶ Develop a large poster in key CALD languages that would be placed at the waiting area of the dental clinic and which could be read by those waiting for service at the dental desk.
- ▶ Produce a DVD in key CALD languages that can be offered to people to watch on appropriate occasions.
- ▶ Use Dianella health promotion services as a guide to develop peer connections with Dianella groups, external groups and community organisations. Using these links develop a health literacy campaign to inform consumers about the health service system, public dental services and how to navigate through the system.
- ▶ Adopt a collaborative approach with local community organisations, ethnic media and small community groups promoting services at Dianella. Such engagement can increase the amount of community knowledge and encourage the sharing of information.
- ▶ Develop culturally appropriate services with input from community organisations.
- ▶ Consider engaging family members through the school dental service.
- ▶ Develop a set of protocols with dental reception staff for handling complex or problematic situations; that is, for staff to deal with the waiting list data and for dealing with anxious patients.

3. While people are on the waiting list:

- ▶ Make regular contact by phone and/or letters to provide information about the progression of the waiting list.

- ▶ Enable a two-way communication with consumers that facilitates telephone contact. Perhaps offer casual group discussions and/or random contact by telephone with consumers who are on the waiting list to ensure innovations are being targeted correctly; to learn about ways to improve public dental services at Dianella, including the development of prevention strategies.

4. When people have reached the top of the waiting list:

- ▶ Letter of offer is to be made to appear friendlier, with perhaps a colourful envelope, and followed up with a telephone reminder.
- ▶ Letter of offer is to be made simple, in plain English with a summary in key CALD languages.
- ▶ Give a reminder by telephone or message once the appointment is made.
- ▶ Ask for simple feedback with a follow-up telephone call after the appointment and ask for suggestions for service improvements.

At the community level

5. Institute service delivery changes:

- ▶ Liaise and collaborate with primary care providers such as GPs about providing a care plan to people with chronic conditions care plan to enable them to receive dental treatment under the Medicare dental scheme.
- ▶ Liaise and collaborate with DHSV with the implementation of workforce changes.

At the system level

6. Explore the feasibility of a centralised emergency referral

- ▶ In collaboration with other local dental providers, consider the feasibility of developing a centralised emergency service that would direct people in need to a convenient and accessible emergency service. This should be considered in association with the delivery of information about local community and public transport availability.
- ▶ A telephone system be installed that supports a centralised emergency service. This system would have the capacity to manage a high volume of calls in a short timeframe. System functionalities should include advanced queuing and 'on hold' message features that remind clients to stay on line, so as to keep their place in the queue.
- ▶ Adequate staffing to ensure that calls are answered as quickly as possible to reduce the stress on the clients.

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APPENDIX 1: MANAGEMENT OF WAITING LISTS

Agencies providing public dental care are required to manage waiting lists in accordance with DHS policies. The average waiting time has been a key performance measure in the dental program and DHS has recently reviewed the drivers and possible solutions of waiting list management (DHS, 2007a).

The effectiveness of managing a dental waiting list is a function of the number of dental chairs and dental staff available at the service (the supply), and the number of public dental patients in the catchment areas, their needs and the complexity of needs (the demand).

These factors can have a considerable effect on the waiting time for services. For example, Dianella Community Health has six dental chairs (four adult and two school dental service chairs). In this catchment area the number of eligible people per chair is 7,610 and the waiting time for general treatment is 30.9 months (Victorian Minister for Health, 2006; DHS, 2007b). The nearby Darebin Community Health Service (PANCH), which provides services in the north central metropolitan area, has seven adult dental chairs. The number of eligible people in its catchment area is 4,095 per chair and the waiting time for general dental care is 6.3 months (DHS, 2007; Victorian Minister for Health, 2006). This is significantly higher capacity than Dianella, and hence waiting times are very much lower.

Table 1 presents the catchment areas for public dental services in the north and west metropolitan region. The eligible population per chair, the dental services in the catchment area, the number of dental chairs, and the waiting time for general treatment at each service are reported in the table. Please note that figures on the number of dental chairs include school dental services, which are not a focus of this study.

Table 2 shows the demand and supply emergency dental services at Dianella. Due to limited number of dental chairs, Dianella can only provide emergency services to up to 55% of the requests during the month of November 2008 to January 2009.

Appendix 1 - Table 1: Reported number of dental chairs and waiting times in North and West metropolitan region (2007)

Catchment area	Eligible population per chair ¹	Dental clinics in catchment area	Number of dental chairs ²	Waiting time for general dental treatment (mths) ³
Moonee Valley - Melbourne	4,360	Doutta Galla CH Kensington	4	14.5
		Doutta Galla CH Niddrie	7	14.5
		Ozanam Day Centre	1	n.a.
West Bay	4,812	Altona SDS	2	n.a.
		Footscray SDS	5	n.a.
		Isis Primary Care Wyndham	8	n.a.
		Western Region Health Centre	6	41.7
Banyule-Nillumbik	5,155	Banyule Community HS	8	16.0
		Nillumbik Community HS	3	38.0
North Central	4,095	Darebin Community HS East Preston	4	9.3
		Darebin Community HS Northcote	2	6.3
		Darebin Community HS PANCH	7 (all adults)	7.5
		North Richmond Community HC North Yarra	2	36.9
		North Richmond Community HC Richmond	7	11.8
		Plenty Valley Community HS	9	35.7
Hume-Moreland	7,610	Dianella Community Health	6 (only 4 for adults)	30.9
		Moreland Community HS	3	30.0
		Moomba Park SDS	2	n.a.
		Sunbury Community HC	5	15.5
Melton-Brimbank	4,425	Isis Primary Care Brimbank	10	29.3
		Melton Latrobe Site	12	n.a.
		Melton Mobile Dental Van	2	n.a.
TOTAL	4,915		114	23.51

¹ (DHS, 2007)

² (DHS, 2007)

³ (Victorian Minister for Health, 2006)

Appendix 1- Table 2: Demand and supply of Emergency services at Dianella during November 2008 -January 2009

	November 2008	December 2008	January 2009	Total
Total requests for emergency service	445	261	227	933
Appointments given	245 (55%)	145 (55%)	99 (44%)	489 (52%)
Non-eligible clients re-directed to other services	51 (11%)	23 (9%)	3 (1%)	77 (8%)
Unable to provide appointments	149 (34%)	93 (36%)	125 (55%)	367 (40%)

APPENDIX 2: FURTHER DATA

1. Country of birth of interview participants:

Country of Birth	No (%)
Australia	13 (27.6)
Turkey	5 (10.6)
Italy	7 (15)
Iraq	8 (17)
Lebanon	3 (6.4)
Others	11 (23.4)
Total	47 (100)

2. Age range of interview participants

Age range	No (%)
Below 25	3 (6.4)
From 26 to 45	12 (25.5)
From 46 to 65	14 (29.8)
From 66 to 85	18 (38.3)
Total	47 (100)

Appendix 2 - Figure 1: Contact by telephone

