THE HONG KONG SOCIETY OF
FAMILY DENTISTRY
香港家庭牙醫學會

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Food and Health Bureau
The Government of the Hong Kong Special Administrative Region

Dear Sirs,

It is our greatest pleasure to voice out our views regarding the Consultation Document on Health Care Reform. After lengthy discussions among ourselves, as well as performing a questionnaire survey on patients attending various dental clinics, we have arrived in several recommendations for your Bureau to consider when formulating policies on promoting the health care services for the people of Hong Kong. I would be grateful if you could kindly acknowledge receipt of the attached document. Thank you very much.

Yours truly,

Dr. YIU Bun Ka
President, HKSFD

Introduction

In response to the consultative paper on health care reform and financing, the Hong Kong Society of Family Dentistry (HKSFD) is submitting this paper on the matters relating dental health service to the Bureau of Foods and Health for consideration.

The Hong Kong Society of Family Dentistry is a dental professional organization registered as a limited company by guarantee. It consists of dentist members and is accredited by both the Dental Council of Hong Kong and the College of Dental Surgeons of Hong Kong as a CME (Continuing Medical Education) provider. The main objectives of the society are to promote dental health to patient and continuing professional development to the profession.

This paper is divided into three parts. Part A is an excerpt of the Oral Health Survey conducted by Department of Health 2001. Together with Part B on patient questionnaires, the background information forms the basis on the recommendations on Part C.

Part A

Present oral health status

1. According to the oral Health survey conducted by Department of Health 2001, the oral health of the Hong Kong population showed improvement over the years. The level of tooth decay showed a definite downward trend among the 5 and 12-year olds, but had remained relatively stable among the adult and older persons groups. Hong Kong's 12 year-olds had one of the world's lowest decay experiences. Calculus deposits, however, were present in more than half of the 12 year old population. Hong Kong could boast the fact that none of its adults had total tooth loss (edentulous), and this condition among the NOP** showed a downward trend. For the adult and NOP groups, the gum conditions had generally improved over the years. However, calculus deposits and gum pockets remained prevalent, as almost half of the adults had calculus deposits and also close to half had gum pockets, while more than a third of NOP had calculus deposits and more than half had gum pockets. Although Hong Kong's standing compared to that of other developed countries was encouraging, the area of concern in this context, would be on the gum health of our population.

Since the introduction of water fluoridation in 1961, the prevalence and severity of tooth decay has declined in Hong Kong. Together with the wide availability of fluoride containing toothpastes and its use over the years, we have seen a further reduction in the level of tooth decay especially in the younger age population.

There were other significant milestones in the field of dentistry in Hong Kong, near and around the time the earlier sets of data were drawn from. In 1980, the Faculty of Dentistry, University of Hong Kong was established and took in its first batch of dental student trainees, who then became qualified dentists in 1985. Also in 1980, the then Medical and Health Department (now known as the Department of Health) started the School Dental Care Service to provide oral health care to the primary school children in Hong Kong. In 1989, the then Medical and Health Department set up an Oral Health Education Unit to fulfil Government's objective of promoting oral health to the community. Back in 1980, there were 638 registered dentists, and in 2001, the number increased to 1 663.

**NOP=Non-institutionalized old persons, IOP= institutionalized old persons

The effects from these important developments, no doubt, have collectively contributed to some of the positive changes over the years.

2. What is to be expected in the oral health of the Hong Kong population in the years to come?

The oral health indices in the age groups examined in this survey are shown in Table 8.7. Care should be taken not to view this as a definitive trend for future development. However, looking at the findings tabulated in Table 8.7, the future does appear somewhat promising. This optimistic note starts with the expected and continued improvement in prevalence of tooth decay, as the post-fluoridation generation with a lower level of tooth decay progressively lives through the sequential age spectrum. The fact that 99.2% of Hong Kong's adults were found to have ≥20 teeth in 2001, it would be most unlikely to expect a downward spiral to the 8.6% (the proportion of NOP with total tooth loss based on 2001 findings) with total tooth loss, for these adults who will become Hong Kong's future NOP in 30 years' time. It would also be hard to imagine having almost every adult affected by tooth decay 30 years down the road, when only 37.8% of the 12-year old students had experienced tooth decay in 2001.

Table 8.7
Oral health indices in 2001 according to age groups

	5	12	35-44	NOP	IOP
% With no teeth	N/A	N/A	0	8.6	27.2
% With ≥ 20 teeth	N/A	N/A	99.2	49.7	24.1
dmft / DMFT	2.3	0.8	7.4	17.6	24.5
% dmft / DMFT	51.0	37.8	97.5	99.4	99.8
dt / DT	2.1	0.1	0.7	1.3	2.6
% dt / DT	49.4	6.9	32.0	52.9	55.2
Mean number of teeth with untreated root decay	N/A	N/A	<0.05	0.3	0.4
% Untreated root decay	N/A	N/A	3.4	21.5	22.7
% with bleeding gum	N/A	35.0	3.4	1.7	0
% with calculus	N/A	59.5	49.9	43.0	49.8
% with gum pockets	N/A	N/A	46.0	55.3	49.9

N/A= not applicable

However, there is no room for complacency nor false sense of security either. From Table 8.7, it can be observed that as a whole, the level of tooth decay and gum disease had continued to increase with age. The presence of gum inflammation and calculus deposits found at age 12, was an early indication of risk detection in the development of gum disease, while tooth decay on the other hand, was of a lesser problem from age 12 to adulthood, judging from the low level of tooth decay at age 12 in 2001. There were also early warning signs on the emerging problem of root surface decay, as seen in the adult and older persons age groups. With the increasing trend of having teeth retained in the mouth for a longer span in the lifetime, such exposure of root surfaces due to loss of gum attachment, and its risks to tooth decay, make root surface decay a threat and problem to watch out for in the future adults and older persons groups. The fact remains that oral health problems detected early on in life would gradually progress and build-up, unless preventive efforts are enhanced, early intervention provided and maintenance care is sustained.

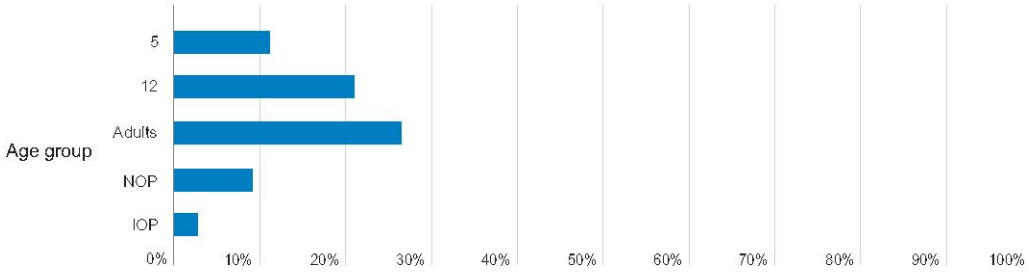
Although the oral health of the Hong Kong population compared with those of other

countries was relatively good, **both tooth decay and gum disease are still imminent threats to the oral health of the local population**. To reduce the undesirable consequence of tooth loss, it is essential to prevent the onset of new diseases, and to prevent the deterioration of existing diseases. **Prevention is the key to better oral health**.

3. Usage of oral health care services -regular dental checkup

The proportion of people who claimed to have the habit of regular dental checkup is shown in Figure 8.3. Regular checkup was not at all a common practice. Although adults had the highest proportion with reported checkup habit, there were almost three out of four adults who still did not seek regular dental checkup.

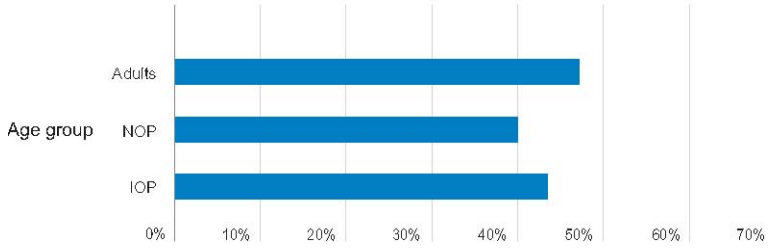
Figure 8.3
Reported habit of regular dental checkup of all age groups



4. Usage of oral health care services when there were perceived severe oral health problems

It was found that less than half of the adults and older persons with perceived severe oral health problems visited the dentist. (Figure 8.4) The proportion of people who did not seek attention was even higher for other "milder" perceived oral health problems.

Figure 8.4
Reported behaviour in seeking oral health care services when there were perceived severe oral health problems



Regular dental checkup is not just about screening to detect the presence of disease. Its primary aim is to fortify the preventive aspects of care to prevent the onset of oral diseases. During regular checkup, family dentists can make appropriate personal and customized advice on individual life-style and behaviour, give personal and individual instructions on the skill of teeth cleaning, and monitor the effectiveness of such home care behaviour, all in the name of improving oral health. It is evidence-based that one of the most effective ways to ensure proper dental plaque removal was for people to receive simple but individualized advice from dental personnel on a regular and repetitive basis. It has also been shown in a local exploratory study that the usage rate

of dental floss was significantly higher among regular dental visit attendees than among the irregular counterparts.

During dental checkup, family dentists can also provide preventive treatment such as fluoride application and fissure sealants. The diagnosis of diseases and the provision of curative treatment should not be the main thrust of the overall aim of regular dental checkup.

5. How did the people perceive the seeking of oral health care services?

In the evaluation of people's attitudes towards oral health care services, it was observed that a relatively large proportion (52.9% adults, 64.9% NOP & 42.3% IOP) of respondents chose the response that *dentists are more concerned on treatment than to teach people how to prevent dental disease*.

In general, the adult and older persons groups had a high confidence on the dental profession, in terms of *their competence at solving oral health problems*. However, there were still concerns among these two groups on issues like the *worry of contacting contagious disease* and *pain* and *discomfort in dental treatment*. Furthermore, 27.9% adults and 17.1% NOP worried that *dentist may perform treatment that was unnecessary*.

The *uncertainty of cost / worry of high cost* had always been mentioned as one of the reasons for not visiting the dentist. There was an apparent lack of knowledge on the cost of oral health care, especially among the NOP. 6.5% of adults and 29.5% of NOP could not give an estimate of the cost of a dental checkup and professional cleaning (scaling). Among those who could give an estimate, the median estimate cost in both the adult and NOP groups was $300.

There was an expression of doubt on the value of oral health care services compared with the cost as shown by 51.7% adults and 37.6% NOP. The problem of cost of oral health care services might be the lack of price information, or the affordability of services, or it might well be the lack of appreciation and value placed on the cost of care. More in-depth evaluation is required in this respect.

Dental schemes might be a consideration to remove the cost barrier by removing the uncertainty of cost or actually reducing the cost, as the coverage by dental schemes was found to be associated with better usage of oral health care services in all age groups. It should be noted that even with dental schemes coverage, around one-third of people in all age groups still did not seek oral health care services.

Many respondents did not perceive dentists as being associated with prevention.

Coverage by dental schemes was found to be associated with better usage of oral health care services. Whether the coverage by dental schemes was the cause of the more favorable usage of oral health care services could not be ascertained by this survey. Even with coverage, other barriers might still deter some people from seeking oral health care services.

Pain was found to be an important determining factor in the oral health care seeking behavior in all age groups. The absence of pain was often interpreted by students, parents, adults and older persons as a sign of good oral health and hence, did not warrant dental checkup. When their perceived dental treatment need was compared with the assessed

need based on the survey criteria, it was found in all age groups that most of the preventive and curative treatment needs had not been perceived.

There was the expected disparity between the perceived oral health care need and the assessed need. It was generally observed that the assessed oral health care need was higher than what was perceived. In other words, in the absence of pain or discomfort, people did not perceive that they had any oral health care needs, when in fact they needed preventive and/or curative treatment.

Even in the presence of discomfort, it was found that the seeking of care was often delayed. It was generally perceived that the discomfort would relieve by itself. People tended to ignore pain and discomfort, or attempted to manage the discomfort by themselves. Similar results were obtained from another study, where majority of the people who experienced various types of dental pain still did not visit the dentist. A lot of them had tried to use various alternative methods, including Chinese herbs, over-the-counter medication, acupuncture, homeotherapy, and aromatherapy, to control their pain, and these methods were reported to be effective by the majority.

Tooth decay and gum disease are usually described as **silent epidemics**, since they are progressively destructive without obvious symptoms during its early stages of development, nor are the conditions perceptible by the affected person. When oral health problem is perceived, the condition is usually in the moderate or advanced stage of tissue destruction. Thus, it has been advocated by the dental profession that individuals should seek regular dental checkup, to detect disease early, and to initiate intervention early, in order to minimize the extent of the damage.

Minor but perceptible signs are usually tell-tale signs of underlying problems. Tooth sensitivity may be a sign of tooth decay, or exposed root surfaces. Bleeding gums may be a sign of gum inflammation. More apparent signs and symptoms such as mobile teeth, abscess and severe pain are already an indication of advanced stages of tooth decay or gum destruction. When an individual has perceived oral health problems, professional care is already urgently required.

There were barriers to the demand for oral health care services. The problem of cost of oral health care services may be the lack of price information, or the affordability of services, or it may well be the lack of appreciation and value placed on the cost of care. More in-depth evaluation is required in this respect. Among adults and NOP, there were some who worried about issues like *contracting contagious disease and pain* and *discomfort in dental treatment.* It was not conclusive as to whether the problem of cost was the affordability factor or its perceived value.

Interpretations of Part A

- ***Prevention is the most important in maintaining dental health.***
- ***Good oral health status in the population sector with public funded services i.e. School Dental Service.***
- ***Dental condition deteriorates after students leaving primary school.***
- ***Perceived treatment needs in specific groups are high but accessibly to service is low.***
- ***Cost barrier to accessibility of dental services is high.***
- ***Dental insurance or plan helps.***

Part B

Questionnaires

Title:

Patient survey on the needs of dental services

Objectives:

To investigate the attitudes of patients towards the necessity of including dental services in the Healthcare Reform.

Methodology:

This is a cross-sectional observation study in form of sample survey.

Sampling:

The sample was taken from the patients who had attended dental treatment in the clinics operated by the members of Hong Kong Society of Family Dentistry from 1-6-2008 to 7-6-2008. In order to minimize the selection bias, two measures had been taken:-

- Geographic location – the chosen dental clinics are located in Hong Kong Island, Kowloon as well as New Territories.

- Types of Dental Clinic – Various types of dental clinics are included in this study i.e. clinic in commercial building, clinic in residential area, clinic in shopping center, and clinic in hospital.

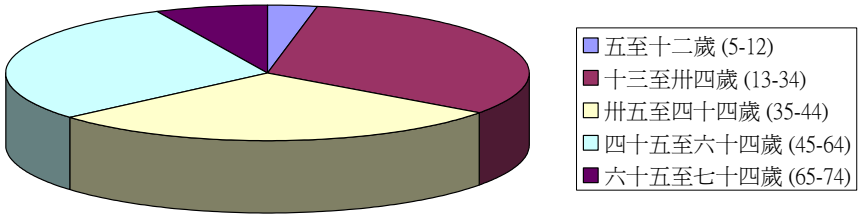
Results

Total number of respondents: 476

Question 1 - Age

Age of Patient	Number of Patient
5 - 12	14
13 - 34	152
35 - 44	137
45 - 64	140
65 - 74	33

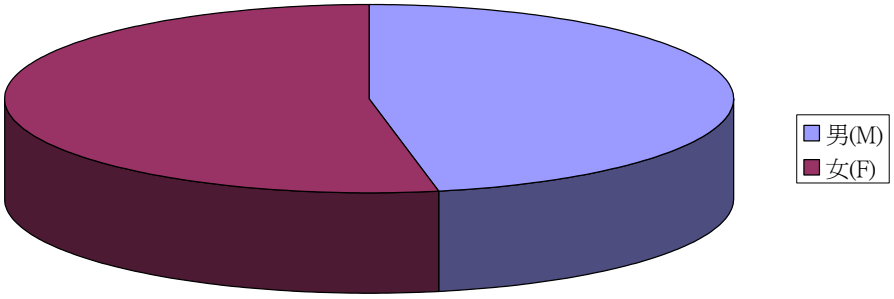
年齡 (AGE)



Question 2 – Sex

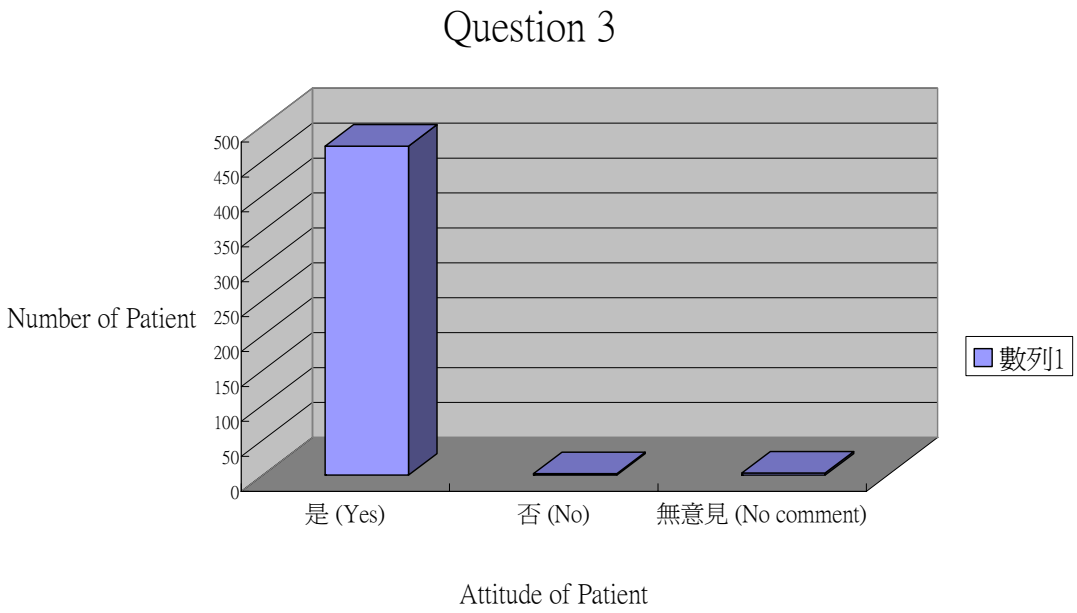
Sex of Patient	Male	Female
Number of Patient	224	252

性別(SEX)



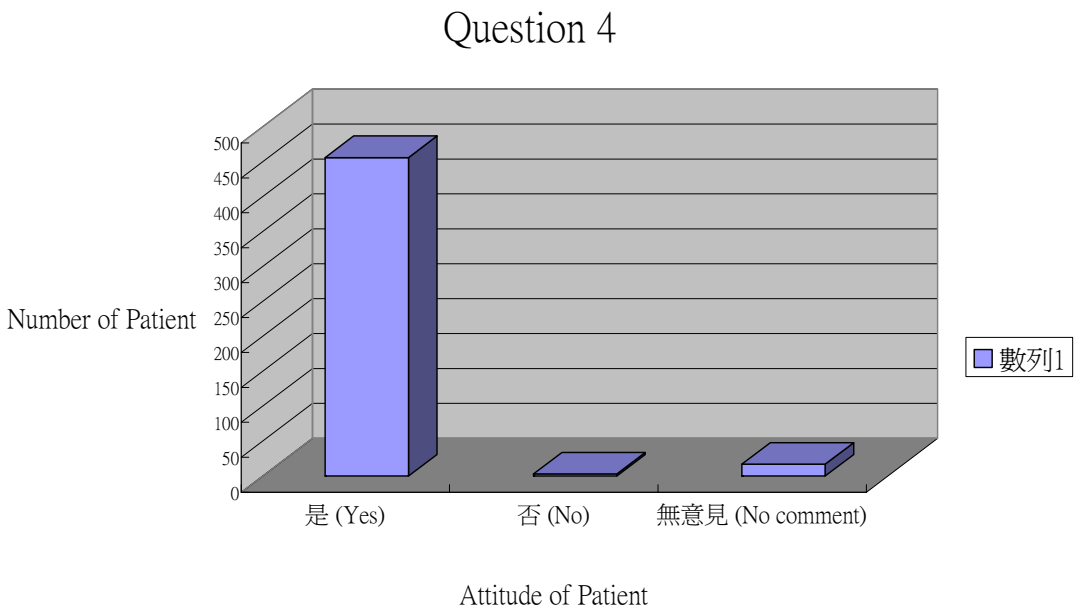
Question 3 – Do you think “Preventive Care” is the key to maintain good dental health?

Response Type	Yes	No	No Comment
Number of Patient	471 (99%)	2 (0.4%)	3 (0.6%)



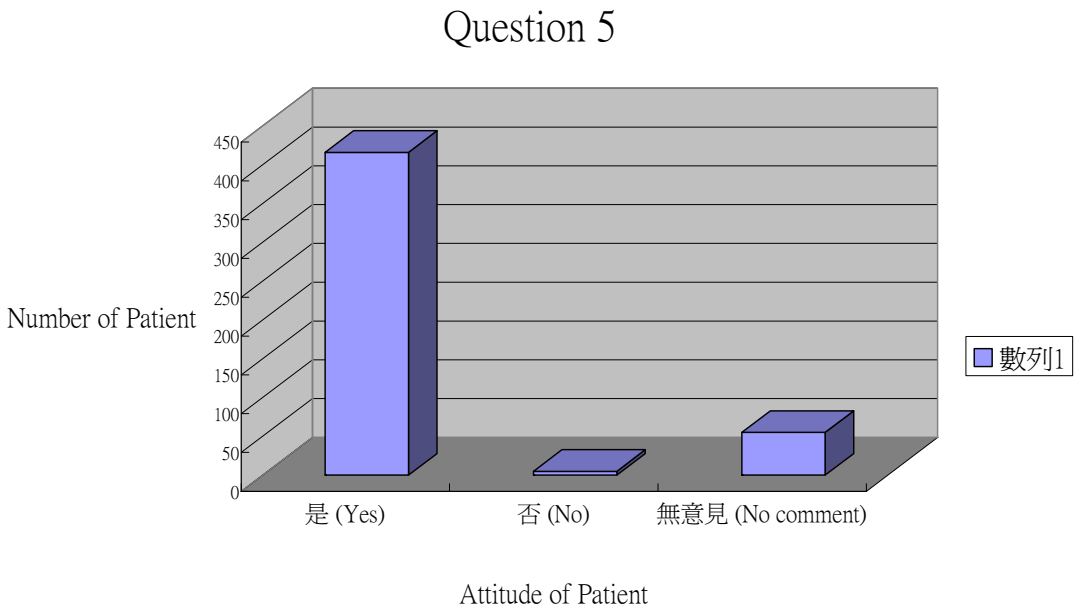
Question 4 – Do you think the government should promote and subsidize low-income and underprivileged groups to receive oral health preventive care?

Response Type	Yes	No	No Comment
Number of Patient	456 (95.8%)	3 (0.6%)	17 (3.6%)



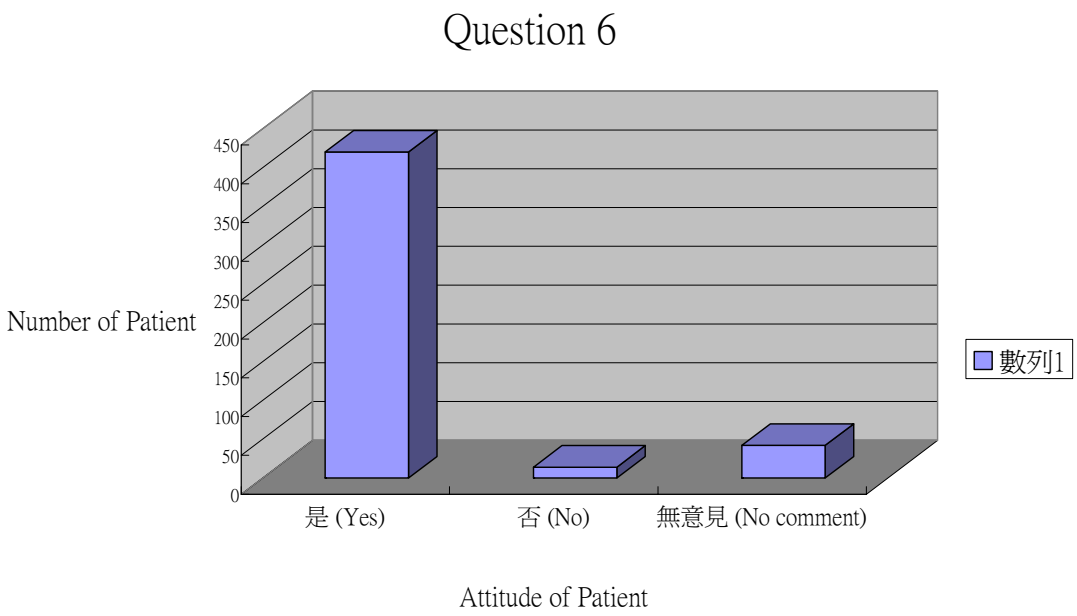
Question 5 – Do you think the government should extend the School Dental Service to secondary schools?

Response Type	Yes	No	No Comment
Number of Patient	416 (87.4%)	5 (1%)	55 (11.6%)



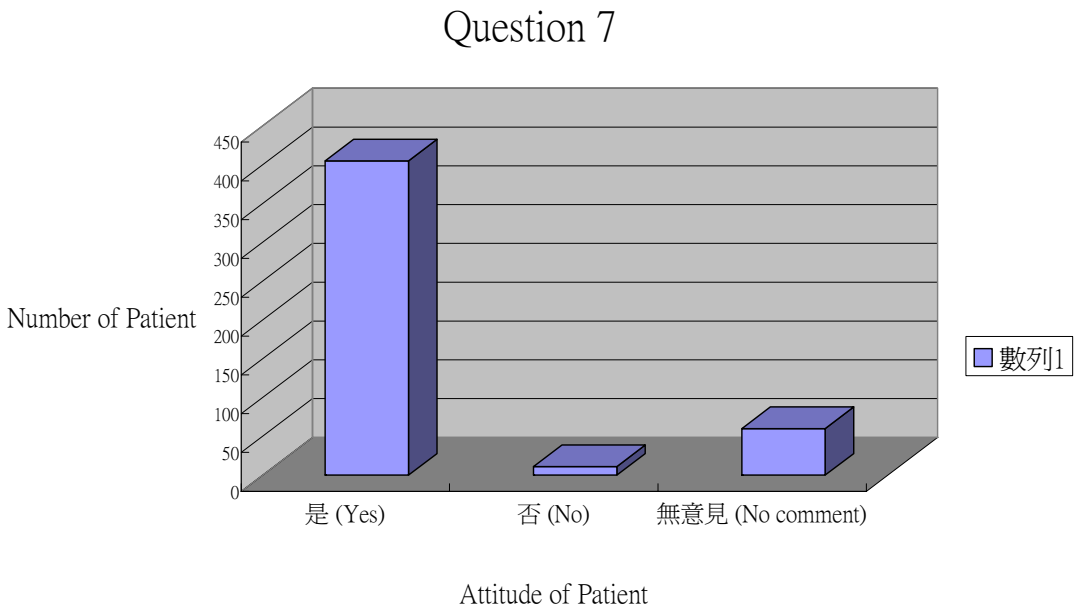
Question 6 – Do you think the government should include dental insurance when considering reform?

Response Type	Yes	No	No Comment
Number of Patient	416 (87.4%)	5 (1%)	55 (11.6%)



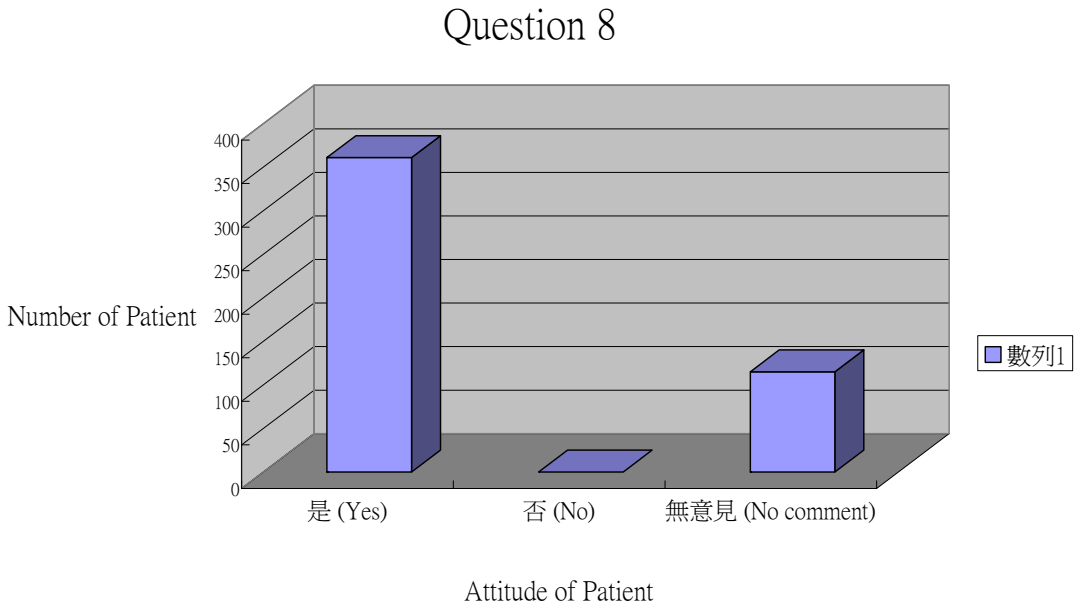
Question 7 – Do you think the government should promote public-private partnership in dental care?

Response Type	Yes	No	No Comment
Number of Patient	405 (85.1%)	11 (2.3%)	60 (12.6%)



Question 8 – Do you think the government should establish a Family Dentist Register?

Response Type	Yes	No	No Comment
Number of Patient	361 (75.8%)	0	115 (24.2%)



Part C

Recommendations

As evident in the consultative paper, we are glad to know the proposed health care reform is heading to a direction that is coherent with the recommendations of our Society. It has been mentioned in the Healthcare Reform Proposals that

The government plans to undertake the following reform –

(a) Enhance primary care to put greater emphasis on preventive care, reduce the need for hospital care, improve the health of our community, and contain the overall healthcare needs and expenditure of our community in the long run.

(b) Promote public private partnership (PPP) in healthcare to provide more choice of quality, efficient and cost-effective services and promote further healthy competition and collaboration between the public and private sectors in providing healthcare services.

(c) Develop electronic health record sharing to allow individuals' health records to follow them wherever they go for healthcare to improve the quality of healthcare for the public and provide the necessary infrastructure to support the healthcare reform.

(d) Strengthen public healthcare safety net to retain and improve the current public healthcare safety net for the low income families and underprivileged groups, while strengthening the safety net for patients struck by illnesses requiring costly healthcare.

(e) Reform healthcare financing arrangements to provide supplementary financing, apart from increased government funding, to ensure the sustainable development of the healthcare system and support the reform of the healthcare market.

Although there is no specific plan regarding dental services, we can see there are multiple portals of entry that the dental services can be part of the healthcare system.

It is the purpose of this paper to recommend to the government the financially sustainable initiatives that can benefit the public and the profession. While dental services can be costly, the Society thinks the public should not be deprived of the rights to assess dental services.

Under constraint resources, we understand the priority should always goes to the needed groups for relief of dental pain and basic rehabilitative treatment to improve the quality of life.

Based on the summary of Part A and Part B, the Society recommends

BFH suggestion:
Develop basic models for primary care services: as the basic standard for different age/gender groups with emphasis on preventive care, for reference by both healthcare professionals and individuals.

HKSFD Recommendations:
HKSFD believes the importance of continuing care. While the School Dental Services are doing well in the population of 6-12, the main workforce is still in the private sector. There

is an urgent need of a ***TRANSFERAL MECHANISM*** so as to ensure good oral health status can be maintained after students leave their primary schools.

BFH suggestion:
Establish a family doctor register: to register private doctors who serve as family doctors and provide comprehensive primary care to patients, for reference by individuals who wish to receive such care.

HKSFD Recommendations:
Quality assurance in delivering any form of healthcare is always the concern of the government who allocates the resources, the profession who requires trust from patients and the patients who are the end users of the services. Numerically there are not less than four hundred (i.e. 1/4 of the total dental workforce) general dental practitioners (GDP) possessing some form of post-graduate qualifications. The College of Dental Surgeons of Hong Kong has also introduced pathways for GDP for specialist and further training. In a nutshell, the training and accreditation system exists in Hong Kong for GDP. Therefore, the HKSFD believes a ***FAMILY DENTIST REGISTER*** can also be established to ensure any participants in the PPP can be quality assured.

BFH suggestion:
Subsidize individuals for preventive care: to subsidize individuals of different target age/gender groups to undertake preventive care through private family doctors. The basic models developed above could serve as a reference for these family doctors.
Improve public primary care: to purchase primary care services from the private sector and incorporate preventive care in the public clinics for low-income families and under-privileged.

HKSFD Recommendations:
With an establishment of a Family Dentist Register, subsidized patients can access to quality assured GDP under a ***DENTAL HEALTH MAINTENANCE SYSTEM*** with mutually agreed fee, scope and standards of services.

BFH suggestion:
To promote PPP, we will explore the following initiatives through pilot projects progressively – Set up multi-partite medical centers of excellence to draw together top expertise of the relevant specialties locally and overseas, and participation of experts both in the public and private sectors.

HKSFD Recommendations:
For an operational and cost effective dental health maintenance system, HKSFD suggests government to establish some ***REGIONAL PUBLIC DENTAL SERVICE AND VOCATIONAL TRAINING CENTERS*** for low-income families and under-privileged. The centers can be the vocational training center for fresh dental graduates under supervisions. Not only can it further assure the quality of new graduates, it also provides a financially favorable workforce to maximize the cost to benefit ratio of the resource allocated to these specific group of patients.

BFH suggestion:
Engage private sector doctors to practice in public hospitals, particularly in tertiary and specialized services, on a part-time basis, to facilitate cross-fertilization of expertise and experience.

HKSFD Recommendations:
HKSFD understands the existing government dentals service are mainly for the contractual service of civil servants and private dental practitioner practicing in government clinics will be less relevant. However, if the concept of Regional Dental Center is workable, the participation of private practitioners in form of ***VOCATIONAL TRAINERS*** can be valuable in service delivering, supervising, training and administration.

BFH suggestion:
The development of a territory-wide electronic health record (eHR) infrastructure is essential to enhancing continuity of care as well as better integration of different healthcare services for the benefits of individual patients. It also provides the infrastructure to support the healthcare reform especially in the areas of primary care and public-private partnership.

HKSFD Recommendations:
The flow of information is of particular importance for accuracy and efficiency. HKSFD recommends a ***DENTAL PORTAL*** that the dentist can access to the medical history of patients, can refer patients to government hospitals and can record / bill any transaction.

BFH suggestion:
Personal healthcare reserve: to require a specified group of the population to deposit part of their income into a personal account, both for subscribing to a mandatory regulated medical insurance before and after retirement, and for accruing savings (with the option to invest) to meet their own healthcare expenses including insurance premium after retirement.

HKSFD Recommendations:
HKSFD supports the concepts of personal healthcare reserve and mandatory regulated medical insurance. It provides a pooling effect on any ***OPTIONAL DENTAL INSURANCE*** for tertiary care which may sometime be financially less feasible for the low to median income groups.

Conclusions:

Through recommending the transferal mechanism, dental health maintenance system, public dental service and vocational training centers, vocational trainers, dental portal and optional dental insurance, HKSFD sincerely hopes it could be a possible blueprint for the better service to the public, quality assurance and business opportunities for the dental profession and the best allocation of resources from the government.

Submitted by the Hong Kong Society of Family Dentistry