THE CHANGING FACE OF ORAL CARE FOR DISABLED PEOPLE IN THE NETHERLANDS OVER THE LAST 30 YEARS

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INTRODUCTION

Recent policies for disabled people in the Netherlands have strongly focused, in the footsteps of the Scandinavian Countries and the United Kingdom, on the principle of equal opportunities. This has led to a changing perspective for the disabled, specifically for mentally disabled persons. People with a disability became individuals in their own right . In oral health care we now aim for normalized care where possible, and special oral health care when needed. In this article, I will describe on two levels the changing face of oral care for the disabled : first, as a member of committees and working parties in the field, and, second as a dentist, dedicated to this care for more than 30 years.

ORAL CARE FOR DISABLED PEOPLE IN THE NETHERLANDS: CARE POLICY AND COSTS.

In 1970, a general concern by the professional organisation (Dutch Dental Association) and Health Authorities led to the full coverage of costs for children's dentistry. It took a much longer time to acquire comparable care provision for the disabled. At last, in 1976 a comprehensive oral care programme was incorporated within the coverage scheme of [1]*the Exceptional Medical Expenses Act*. The alteration meant that, from then on, all institutionalised people with (severe) cognitive and physically impairments, the chronically sick, and psychiatric patients could be provided with comprehensive oral care.
Since 1976, subsequent generations of dentists in the Netherlands have been enabled to provide oral health care of good quality for institutionalised patients with cognitive and physical disabilities.

DE-INSTITUTIONISATION

Since the 1980s, over a period of some years, de-institutionalisation of the disabled of all categories became the policy. Large residential institutions have their own medical and dental services "in-house" (financed by the Exceptional Medical Expenses Act), with an efficient recall system. However, during the 80s, the majority of the mentally disabled were moved to smaller residential settings where they have to rely on regular dental care in the community. Carers/parents were often not aware of the Special Care Dentistry Regulation, and even if they were, transport problems and shortage of personnel often meant they were unable or unwilling to bring the special needs patients for dental check-ups. This led to an overall *reduction* in the take-up of oral care. As a result, in 1990, the Special Care Dentistry Regulation (within the Social Health Insurance Act) was passed by the Dutch Ministry of Health.

The availability of comprehensive oral care for patients with clearly defined special dental needs is firmly secured by this Regulation. If the dentist can argue that oral care is needed in relation to the specific impairment or disability of the patient, costs will be fully compensated by the Social Health Insurance. Oral care, according to this Special Care Dentistry Regulation, can be provided by the general practitioner as well as by Centres for Special Care Dentistry (SCD). In practice, it is mainly provided by better skilled dentists in the SCD Centres, where a multi-disciplinary approach (e.g. with psychologists, anaesthesiologists) can provide high quality care for the tailored for individual patients with complex needs.

Despite this legislation, the mildly mentally disabled living with relative independence still run a significantly higher risk of caries as they can chose their own life-style. Special attention will have to be focused on programme of prevention for them.

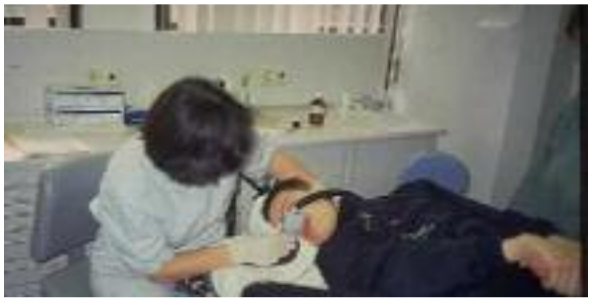
ORAL CARE AND DISABILITY: A PERSONAL CAREER

Retrospectively, my career in this specific field of dentistry reflects the changing views and development of oral health care for the mentally and physically disabled.

As a young dentist at The University of Amsterdam, in 1968-1970, I treated disabled children at the paedodontic department. Following my husband to the Rotterdam-region, I was asked to provide oral care in a new Residential Institution for the mentally disabled, "Craeyenburch" at Nootdorp (near Delft). Here I learned "by trial and error" ! When I left Craeyenburch in 1997, after 23 years of service, this initially residential home for 400 inhabitants, had turned into a client-care organisation and a residential home for less than 200 severely mentally retarded

In addition, from 1982 on, I also provided oral care in a Rehabilitation Centre for Children in Rotterdam. Here, in the densely populated Rotterdam region of 1.3 million inhabitants and financed by the Local Health Authorities, the modest dental department of the Rehabilitation Centre developed into the first Centre for Special Care Dentistry, based on the above mentioned Regulation. This Centre "BIJTER", the acronym of "Bijzondere Tandheelkunde Rijnmond" , started in 1987 with three part-time dentists in two dental surgeries.

Two children of a family of 7 from Morocco, of which 5 are severely mentally disabled. The youngest child, the boy in the picture, is healthy but has "rampant caries". The 5 disabled children are seen at SCD Bijter twice a year by the dental hygienist and dentist. If necessary dental care is provided with general anaesthesia.



Elinor Bouvy-Berends providing nitrous-oxide sedation to a midly mentally disabled boy with a generalised dystonia – The patient is on a stretcher as he is unable to sit in a chair.

At present 13 dentists, 2 dental hygienists, 2 consultant-psychologists and 3 consultant anaesthesiologists provide, all on part-time basis, top-clinical care in their respective fields (in five dental surgeries). The main asset of BIJTER is the office-based dental anaesthesia service provided by anaesthesiologists from the Erasmus University Hospital, specialising in the care of severely disabled persons with challenging behaviour.

Among the 1.3 million inhabitants of Rotterdam, there are 8,100 persons with a cognitive impairment, 48% mildly so, 58% moderate to severe. 10.500 people in the area present with moderate physical disability, 4,500 with severe disability and 1,200 with non-congenital cerebral damage.

In the year 2002, the SCD Stichting Bijiter provided 4,580 hours of dental care in total for 2,390 patients, including 1, 441 disabled (60%). This serious under-consumption of dental care by the special needs population has led to a planned major expansion of the Centre, within the next 5 years. The aim is to double the provision of special dental care, in a new centre with ultimately 8 surgeries. This centre will also aim to provide care for the young and the adult anxious patient, the medically compromised and the patient in need of maxillo-facial rehabilitation. The biggest problem will be finding dental professionals willing to work in this field and prepared to acquire the necessary skills.

A FINAL REMARK.

In the Netherlands, a small group of dedicated dentists, favoured by adequate legislation, is able to provide oral care of exceptionally good quality for the special needs patient. However, two factors place the continuity of this care is at risk: first, a lack of evidence-based information, education and research among the dental profession which can lead to "personally-biased" treatment planning, not suited to the special needs patient, and second, a lack of awareness among the public that this specialised care is available at no cost to families. Therefore I consider it a privilege and a challenge, by invitation recently of the University of Nijmegen, to lecture and to coach , at the end of my professional career, students interested in oral care for the disabled.

In the Netherlands as a whole there are about 120.000 children and adults with a cognitive disability. About 30.000 of them still live in large-scale residential institutions.

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