Statement of the
American Dental Education Association (ADEA)

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before the

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Introduction

The American Dental Education Association (ADEA)[1] welcomes the Committee's examination of issues related to the dental workforce and diversity of the profession. I am Dr. James Q. Swift, Professor and Director of the Division of Maxillofacial Surgery at the University of Minnesota School of Dentistry. I appear before you this morning as the President of ADEA and am honored to share my views with you.

Profound disparities in the oral health of the nation's population have resulted in a "silent epidemic" of dental and oral diseases affecting the most vulnerable among us. These disparities, in combination with the current shortage of dental school faculty, the scarcity of underrepresented minority dentists, and the need for targeted incentives to draw dentists to practice in rural and underserved communities, make this Committee's examination timely and necessary.

The challenge to Congress and the dental community is not only how to expand the capacity of the dental workforce, but also how to improve access to oral health care. According to Delta Dental Plans Association and the National Association of Dental Plans, 134 million Americans do not have dental insurance. The lack of insurance is a significant barrier to receiving needed preventive and restorative care. Having insurance, however, does not guarantee quick access to dental care; even insured Americans can wait weeks for appointments with their general dentists and/or specialists.

Despite concerted efforts by Congress and the dental community to address access to dental care, there has been little genuine progress made since the untimely death of 12-year old Deamonte Driver one year ago. Deamonte was a young Maryland boy who died from infection caused by an abscessed tooth that spread to his brain. All of us know this tragedy could have been avoided if his Medicaid coverage had not lapsed and if he had had better access to dental care. I do congratulate Congress for having approved a guaranteed dental benefit in the bill to reauthorize the State Children's Health Insurance Program (SCHIP), even though the bill was twice vetoed. ADEA and the entire oral health community pledge to work for passage of this important bill in the next Congress.

The Dental and Oral Disease Burden in the United States

It has been seven years since the first-ever U.S. Surgeon General's report[2] was published which comprehensively examined the status of the nation's oral health (Table 1 provides a summary of the report's major findings). The report identified oral health as integral to general health stating that "Oral health is a critical component of health and must be included in the provision of health care and the design of community programs." It also declared that "oral health is essential to the general health and well-being of all Americans." Unfortunately, millions are left wanting and needing dental care. There are "profound and consequential oral health disparities within the population," the Surgeon General concluded, particularly among its diverse

[1] The American Dental Education Association (ADEA) represents all 57 U.S. dental schools, 714 dental residency training programs, 285 dental hygiene programs, 271 dental assisting programs, and 21 dental laboratory technology programs, as well as the faculty, dental residents and dental and allied dental students at these institutions as well as 10 Canadian dental schools. It is at academic dental institutions that future practitioners and researchers gain their knowledge, the majority of dental research is conducted, and significant dental care is provided. Our member institutions serve as dental homes to thousands of patients, many of whom are underserved low-income patients covered by Medicaid and the State Children's Health Insurance Program.

[2] U.S. Department of Health and Human Services. Oral health in America: a report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

segments "including racial and ethnic minorities, rural populations, individuals with disabilities, the homeless, immigrants, migrant workers, the very young, and the frail elderly."

Over the past 55 years, discoveries stemming from dental research have reduced the burden of dental caries (tooth decay) for many Americans. However, the Surgeon General's report declared dental carries to be America's most prevalent infectious disease, five times more common than asthma and seven times more common than hay fever in school children. The burden of the disease, in terms of both extent and severity, has shifted dramatically to a subset of our population. About a quarter of the population now accounts for about 80 percent of the disease burden. Dental caries remains a significant problem for vulnerable populations of children and people who are economically disadvantaged, elderly, chronically ill, or institutionalized. This high-risk group includes nearly 20 million low-income children (nearly all are eligible for Medicaid or SCHIP). Early childhood caries is found in children less than five years of age. It is estimated that 2 percent of infants 12-23 months of age have at least 1 tooth with questionable decay whereas 19 percent of children 2-5 years of age have early childhood caries in the U.S.[3] It should be noted that the American Academy of Pediatric Dentistry recommends that all children visit a dentist in their first year of life and every 6 months thereafter, or as indicated by the individual child's risk status or susceptibility to disease. ADEA concurs with this recommendation.

Table 1: Major Findings of the U.S. Surgeon General's Report

- Oral diseases and disorders in and of themselves affect health and well-being throughout life.
- Safe and effective measures exist to prevent the most common dental diseases—dental caries and periodontal diseases.
- There are profound and consequential oral health disparities within the U.S. population.
- More information is needed to improve America's oral health and eliminate health disparities.
- The mouth reflects general health and well-being.
- Oral diseases and conditions are associated with other health problems.
- Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth and teeth.
- Each year, millions of productive hours are lost due to dental diseases. Children miss 51 million hours of school due to treatment problems. Workers lose 164 million work hours because of dental disease.
- Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health as well.

The U.S. Population and the Dental Workforce

The U.S. Bureau of Labor Statistics (BLS), which placed the number of practicing dentists at 161,000 in 2006,[4] projects a 9 percent growth in the number of dentists through 2016. This rate would bring the total number of practicing dentists to 176,000.

About 80 percent of dentists are solo practitioners in primary care general dentistry while the remaining dentists practice one of nine recognized specialty areas: 1) endodontics; 2) oral and maxillofacial surgery; 3) oral pathology; 4) oral and maxillofacial radiology; 5) orthodontics; 6) pediatric dentistry; 7) periodontics; 8) prosthodontics; and 9) public health dentistry.

[3] Savage MF, Lee JY, Kotch JB. Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs. Pediatrics 2004;(114)4.

[4] U.S. Bureau of Labor Statistics, http://www.bls.gov/oco/content/ocos072.stm, accessed February 5, 2008.

Table 2: Approximate Number of Dentists U.S. 2006	
General Dentists	136,000
Specialists	34,878
Orthodontists	9,400
Oral and Maxillofacial Surgeons	7,700
Pedodontists	4,978
Prosthodontists	3,300
Periodontists	5,100
Endodontists	4,400
Other dentists and specialists	5,756

The vast majority of the 176,634 professionally active dentists in the U.S. are White non-Hispanic. At the present time the U.S. population is 303,375,763.[5] At the time of the last census, when there were 22 million fewer people, the largest segment of the U.S. population was White (75 percent) but an increasing percentage was minority with 35.3 million (13 percent) Latino, and 34.6 million (12 percent) Black or African Americans (see Table 3).

Table 3: U.S. Population by Race and Hispanic Origin for the United States: 2000[6]

Race and Hispanic or Latino Number	Number	Percent of total population
RACE		
Total population	**281,421,906**	**100.0**
One race	274,595,678	97.6
White	211,460,626	75.1
Black or African American	34,658,190	12.3
American Indian and Alaska Native	2,475,956	0.9
Asian	10,242,998	3.6
Native Hawaiian and Other Pacific Islander	398,835	0.1
Some other race	15,359,073	5.5
Two or more races.	6,826,228	2.4
HISPANIC OR LATINO		
Total population	**281,421,906**	**100.0**
Hispanic or Latino	35,305,818	12.5
Not Hispanic or Latino	246,116,088	87.5

Dental Hygiene, Dental Assisting, Dental Laboratory Technology

The allied dental workforce, comprised of dental hygienists, dental assistants and dental laboratory technologists, is central to meeting increasing needs and demands for dental care. About 167,000[7] dental hygienists, 280,000[8] dental assistants and 53,000[9] dental laboratory technologists were in the U.S. workforce in 2006. Both dental hygiene and dental assisting are among the fastest growing occupations in the country with expected growth of 30 percent and 29 percent respectively through 2016 bringing the total numbers of dental hygienists to about 217,000 and dental assistants to 361,000. Only about 2,000 dental laboratory technologists will be added to the workforce by 2016. The ability to increase the number is limited. At the present time there are only 21 accredited training programs.

Dental hygienists are licensed professionals who perform a variety of clinical tasks while dental assistants work alongside dentists during dental procedures and provide assistance. However, both dental hygienists and assistants perform substantial routine preventive and certain other

[5] U.S. Bureau of the Census, http://www.census.gov/population/www/popclockus.html, February 5, 2008.
[6] Source: U.S. Census Bureau, Census 2000 Redistricting (PL 94-171) Summary File, Tables PL1 and PL2, http://www.census.gov/prod/2001pubs/c2kbr01-1.pdf, February 5, 2008
[7] U.S. Bureau of Labor Statistics, http://www.bls.gov/oco/pdf/ocos097.pdf, accessed February 5, 2008.
[8] U.S. Bureau of Labor Statistics, http://www.bls.gov/oco/ocos163.htm, accessed February 5, 2008.
[9] U.S. Bureau of Labor Statistics, http://www.bls.gov/oco/ocos238.htm, accessed February 5, 2008.

radiographic and treatment services in compliance with state practice acts. Dental laboratory technicians fill prescriptions from dentists for crowns, bridges, dentures, and other dental prosthetics and may specialize in one of five areas: orthodontic appliances, crowns and bridges, complete dentures, partial dentures, or ceramics.

Dentist Shortage or Maldistribution

Some say we have a dental shortage. Others say we have a maldistribution of dentists to meet the nation's oral health needs. No matter how one defines it, there can be no doubt that there is a significant access problem for millions of Americans. We must acknowledge that the current dental workforce is unable to meet present day demand and need for dental care.

If every man, woman and child were to have a dental home and were covered by dental insurance, then the nation would clearly have an insufficient number of dentists to care for the population. We are not close to being at this point but we aspire to get there as quickly as possible so everyone who needs and wants dental care is able to achieve optimal oral health. The need and demand for dental services continues to increase; in large measure this is due to the population explosion. Also, Baby Boomers as well as the geriatric population, are retaining more teeth and there is a growing focus on increasing access and preventative dental care.

Each year academic dental institutions (ADIs), including dental schools, allied dental programs and postdoctoral/advanced dental education programs), graduate thousands of new practitioners to join the dental workforce. About 4,500 predoctoral dental students graduate annually. About half of these new graduates immediately sit for a state licensure exam before beginning private practice as general dentists, or they join the military, the U.S. Public Health Service, or they advance their education in a dental specialty. Approximately 2,800 graduates along with hundreds of practicing dentists apply to residency training programs. Nearly 23,000 allied dental health professionals graduate from ADIs each year and join the dental workforce. Approximately 14,000 dental hygiene students, 8,000 dental assistants, and 800 dental laboratory technologists graduate annually.

According to the U.S. Surgeon General, the ratio of dentists to the total population has been steadily declining for the past 20 years, and at that rate, by 2021, there will not be enough active dentists to care for the population. The number of Dental Health Professions Shortage Areas (D-HPSAs) designated by the U.S. Health Resources and Services Administration (HRSA) has grown from 792 in 1993 to 3,527 in 2006. In 1993, HRSA estimated 1,400 dentists were needed in these areas; by 2006, the number grew to 9,164. Nearly 47 million people live in D-HPSAs across the country. Although it is unknown how many of these areas can financially support a dentist or attract a dentist by virtue of their infrastructure or location, it is clear that more dentists are needed in these areas.

Modified and updated criteria for Dental HPSAs designation has been in "clearance" at the U.S. Department of Health and Human Services for more than two years. At the present time the HPSA criteria require three basic determinations for a geographic area request: (1) the geographic area involved must be rational for the delivery of health services, (2) a specified population-to-practitioner ratio representing shortage must be exceeded within the area, and (3) resources in contiguous areas must be shown to be over utilized, excessively distant, or

otherwise inaccessible. HPSA designation is used by a variety of purposes by federal programs.[10]

Need/Demand for Dental Care

Need for oral care is based on whether an individual requires clinical care or attention to maintain full functionality of the oral and craniofacial complex. The disproportionate burden of oral diseases and disorders indicates that specific population groups are in greater need of oral health care. Demand is generally understood as the amount of a product or service that users can and would buy at varying prices.

Americans spent roughly $91.5 billion on dental procedures in 2006, the vast majority of this amount was paid out of pocket ($40.6 billion) or through private insurance ($45.3 billion) while $5.5 billion was paid through public programs, Medicare ($0.1 billion) and Medicaid/State Children's Health Insurance Program ($5.3 billion).[11] Mostly this was spent on fillings, crowns, implants, and high-end restorative procedures. The extent of oral health care disparities clearly indicates that many of those in *need* of oral health care do not *demand* oral health care.

Unfortunately millions of Americans experience dental pain daily and cannot afford to buy dental insurance or pay for dental care out of pocket. Since few oral health problems in their early stages are life-threatening, people often delay treatment for long periods of time. Often, when they do seek care, it is hospital emergency rooms or others in the dental safety-net system – ADIs, community health centers, school-based clinics, and municipal clinics. This system of care is inadequate to effectively deal with the magnitude of the problem.

Additionally, charity dental care provided by dentists cannot solve the problem. Each year, ADIs eagerly join with dentists in the community and others to participate in Give Kids a Smile Day, a national initiative by the American Dental Association to focus attention on the epidemic of untreated oral disease among disadvantaged children. The 5th annual Give Kids A Smile Day held on February 1, 2007 provided care to 751,000 children at more than 2,000 locations across the country. Approximately $72 million in dentistry was provided at no charge to patients. Taking part were 14,315 volunteer dentists and 38,000 others including dental school faculty and students. While this event is noteworthy for all care it provides, it is not a cure for the problem. State dental societies regularly organize Missions of Mercy in which thousands of people receive free care in temporary dental "hospitals" and about 74 percent of dentists routinely provide free or discounted care to people who otherwise could not afford it. Charity has exceeded $1.5 billion annually.[12]

While dental care demands are higher than many other health care demands, many people in the U.S. do not receive basic preventive dental services and treatment. Most oral diseases are preventable if detected and treated promptly. Preventative care is essential to contain costs associated with oral health care treatment and delivery. Children who have early preventive dental care are more likely to continue using preventive services. Those who wait to visit a dentist are more likely to visit for a costly oral health problem or emergency.

[10] Several federal programs utilize the federal HPSA designation in the administration of their programs including the National Health Service Corps and the U.S. PHS Grant Programs administered by HRSA-BHPr gives funding preference to Title VII and VIII training programs in HPSAs.

[11] Catlin, Aaron, Cowan, Cathy et al., Health Spending in 2006, Health Affairs, 2008, 27 (1): page14-29.

[12] American Dental Association, "Insuring Bright Futures: Improving Access to Dental Care and Providing a Healthy State for Children" statement to Energy and Commerce Committee hearing March 27, 2007.

Access to Care and Academic Dental Institutions

U.S. academic dental institutions are the fundamental underpinning of the nation's oral health. As educational institutions, dental schools, allied dental education, and advanced dental education programs are the source of a qualified workforce, influencing both the number and type of oral health providers. U.S. academic dental institutions play an essential role in conducting research and educating and training the future oral health workforce. All U.S. dental schools operate dental clinics and most have affiliated satellite clinics where preventative and comprehensive oral health care is provided as part of the educational mission. All dental residency training programs provide care to patients through dental school clinics or hospital-based clinics. Additionally, all dental hygiene programs operate on-campus dental clinics where classic preventive oral health care (cleaning, radiographs, fluoride, sealants, nutritional and oral health instruction) can be provided 4-5 days per week under the supervision of a dentist. All care provided is supervised by licensed dentists as is required by state practice acts. All dental hygiene programs have established relationships with practicing dentists in the community for referral of patients.

As safety net providers, ADIs are the dental home to a broad array of vulnerable and underserved low-income patient populations including racially and ethnically diverse patients, elderly and homebound individuals; migrants; mentally, medically or physically disabled individuals; institutionalized individuals; HIV/AIDS patients; Medicaid and State Children's Health Insurance Program (SCHIP) children and uninsured individuals. These dental clinics serve as a key referral resource for specialty dental services not generally accessible to Medicaid, SCHIP, and other low-income uninsured patients. ADIs provide care at reduced fees and millions of dollars of uncompensated care is provided each year.

No Professors - No Profession: Strains on Academic Dentistry

The math is simple on this equation. There is an increasing need and demand for dental care. There is a current shortage of dental faculty to educate and train the future dental workforce. Several new dental schools are scheduled to open across the country to meet individual state workforce and access needs. We face a crisis if resources are not dedicated to help recruit and retain faculty for the nation's dental schools.

The number of vacant budgeted faculty positions at U.S. dental schools increased throughout the 1990s, with a peak of 358 positions in 2000. Following this peak, the number of vacancies declined, falling to 275 in 2004-2005. Since that time, there has been a rapid increase in the number of estimated vacancies, reaching 417 in 2005-2006, falling slightly to 406 in 2006-2007. Competition for this scare resource of faculty will be exacerbated by the opening of new academic dental institutions across the country.

At the present time there are 57 U.S. dental schools in 34 states, the District of Columbia and Puerto Rico. There are 714 dental residency training programs located in 44 states, the District of Columbia and Puerto Rico. There are 285 dental hygiene programs in all 50 states and the District of Columbia, 271 dental assisting programs located in 47 states and Puerto Rico and 21 accredited dental laboratory technology programs located in 21 states.

Growing demand for dental care in certain areas of the country has precipitated the opening of seven new dental schools. In 2003 the Arizona School of Health Sciences, the University of Nevada Las Vegas in 2002, and the Nova Southeastern University in Florida in 1997. Midwestern University in Glendale, Arizona will open a dental school in August 2008 with an enrollment of 100 students per class. The dental school is part of Midwestern's expansion plan to address the state of Arizona's health care workforce shortages. Western University of Health

Sciences in Pomona, California plans to open a dental school in 2009. The University is in the preliminary phase of the accreditation process. The North Carolina state legislature plans to open a dental school at East Carolina University in Greenville, North Carolina to focus on rural dentistry. The school plans to operate 10 student dental clinics in under-served communities throughout the state enrolling 50 students per class. Very recently New Mexico Governor Bill Richardson included funding in his FY 2009 budget for construction of a facility at the University of New Mexico for a dental residency program and to begin planning for a new dental school.

Academic Dental Institutions and Research

Oral health is an important, vital part of health throughout life, and through dental research and education, we can enhance the quality and scope of oral health. Despite tremendous improvements in the nation's oral health over the past decades, the benefits have not been equally shared by millions of low-income and underserved Americans. Dental research, the underpinning of the profession of dentistry, is needed to identify the factors that determine disparities in oral health and disease. Translational and clinical research is underway to analyze the prevalence, etiology, and impact of oral conditions on disadvantaged and underserved populations and on the systemic health of these populations. In addition, community- and practice-based disparities research, funded by the National Institute of Dental and Craniofacial Research (NIDCR) and the Centers for Disease Control and Prevention's Oral Health Programs, can help to identify and reduce risks, enhance oral health-promoting behaviors, and help integrate research findings directly into oral health care practice.

Applications, Diversity and the Dental Pipeline

Interest in the dental profession remains high and competition for first-year positions is robust. The application cycle for the 2008 is still in process but it appears that applicant to enrollee ratio is about 3:1. The number of applicants increased from 4,644 in 1960 to 15,734 in 1975, a dramatic increase of 239 percent. A precipitous decline followed that peak, falling to 4,996 in 1989. Applicants increased 97 percent between 1989 and 1997, to 9,829; falling again over the last two years to 9,010. First-year enrollments varied less during these time periods, increasing 76 percent between 1960 and 1978, from 3,573 to 6,301. First-year enrollments declined then through 1989 to 3,979. Since 1989, first year enrollment has increased nearly 20 percent.

The number of African American, Hispanic, and Native American students in dental schools remains disproportionate to their numbers in the U.S. population. In 2006, underrepresented minority (URM) students comprised 12.4 percent of the applicants and 11.6 percent of first-year enrollees. Asian/Pacific Islanders and whites comprised 69.7 percent of applicants and 71.1 percent of first-year enrollees. The proportion of URM applying and enrolling in U.S. dental schools is far less than the proportion of URM in the communities served by the dental school. For example, during the 2003-04 academic year, 7 percent of dental students enrolled at the University of California Los Angeles and the University of Southern California were Hispanic, while 46.5 percent of the Los Angeles population were Hispanic. Also in 2003-04, total African American enrollment at all U.S. dental schools was 5.41 percent, while 12.8 percent of the U.S. population were black. The proportion of URM dentists also remains significantly lower than the proportion of URM in the U.S. population. Currently, about 6.8 percent of professionally active dentists are URM, while 27.9 percent of the U.S. population are URM.

Increasing diversity in the dental profession is vital to the future of the profession and it is central to achieving optimal oral health for racial and ethnic minority groups, which experience a higher level of oral health problems and have limited access to dental care. Recognizing that enrollment of underrepresented minorities (URM) had remained largely stagnant, ADEA has become actively engaged in supporting programs that bolster underrepresented minority

recruitment and retention into dentistry and partnered with foundations and others to make headway:

- The "Pipeline, Profession, and Practice: Community-Based Dental Education" program sponsored by the Robert Wood Johnson Foundation (RWJF). This program has also been supported by the California Endowment and the W.K. Kellogg Foundation. The five-year initiative launched in 2003 to help increase access to oral health care. This program provided institutions with grants to link their schools to communities in need of dental care and to boost their URM and low-income (LI) student enrollment numbers. Dental Pipeline I successfully concluded with 15 dental schools participating. Dental students and residents in the program provided care to thousands of low-income patients through partnerships with 237 community-based clinics. The success of the first Pipeline has spurred the RWJF and the California Endowment to continue the program with Pipeline II, adding a mentoring portion to the curriculum. Awards will soon be announced.

- The "Summer Medical and Dental Education Program (SMDEP)" is a collaborative program administered by ADEA and the Association of American Medical Colleges and funded by the Robert Wood Johnson Foundation-RWJF. The program will run from summer 2006 through summer 2009 and offer academic enrichment for disadvantaged undergraduate freshmen/sophomores. The curriculum includes classes in organic chemistry, physics, biology and pre-calculus/calculus. Students gain learning and communication skills; get exposure to medicine and dentistry issues and get clinical exposure. Finally, students have a financial planning workshop to learn about financial strategies and issues. Nearly 1,900 students have participated (333 dental and 1,564 medical). Seventy-one percent of the participants have been women, 48 percent have been Black or African American, 21 percent have been Hispanic or Latino, and 2 percent have been American Indian.

- ADEA has received a grant from the Josiah Macy, Jr. Foundation to increase the diversity of the dental workforce in the United States. ADEA is serving as the host organization and coordinating committee of the program entitled *Moving Forward: Bridging the Gap*. The grant funds the planning process to implement a flexible seven-year dental curriculum, modeled after one currently used in medicine, to prepare a new cadre of underrepresented minority and low-income (URM/LI) students for the practice of dentistry. The program aims to move toward the implementation of a seven-year curriculum that will significantly increase the number of URM students that receive a dental education and then enter the workforce as dental school graduates.

RECOMMENDATIONS TO ADDRESS DENTAL WORKFORCE CHALLENGES

There are several straightforward steps that Congress can take to immediately address the challenges we face. The answer lies in prioritizing resources both in terms of manpower and funding to tackle these challenges. Some are fairly simple and pragmatic while others, admittedly, will require coordination among multiple interested parties and compromise. ADEA stands ready to work with Congress and our colleagues in the dental community to ameliorate the access to dental care problems the nation faces and to meet the needs for the future dental workforce. Specifically, we recommend:

1. Strengthen and Improve Medicaid

Early intervention is the key to assuring that children have good oral health. While children enrolled in Medicaid have a Federal guarantee for access to dental services through the Early

Periodic Screening Diagnosis and Treatment program (EPSDT)[13], accessing services is often difficult due to low reimbursement rates and the number of participating dentists. Other barriers include a lack of community based oral health projects and public outreach. Unfortunately millions of children covered by Medicaid are not getting regular dental care. Many dentists decline Medicaid patients because of low reimbursement levels and complain about Medicaid paperwork. We urge Congress to work with states to increase reimbursement rates and to simplify and streamline the application, enrollment and recertification process for Medicaid, and lessen the administrative burden associated with this program. These actions would significantly increase access to care for children insured by Medicaid.

Children covered by Medicaid have access to excellent and care. Medicaid regulations[14] define dental as diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of (1) the teeth and associated structures of the oral cavity and (2) disease, injury or impairment that may affect the oral or general health of the recipient.

2. Include Dental Guarantee in SCHIP

Congress can improve the nation's oral health and increase access to dental care for vulnerable children covered by the State Children's Health Insurance Program (SCHIP) by establishing a 1) Establishing a federal guarantee for dental coverage in SCHIP; 2) Developing a dental wrap-around benefit in SCHIP; 3) Facilitating ongoing outreach efforts to enroll all eligible children in SCHIP and Medicaid; and 4) Ensuring reliable data reporting on dental care in SCHIP and Medicaid. These objectives are supported by ADEA and the entire dental community and were strongly advocated during the recent Congressional action on the Children's Health and Medicare Protection Act (H.R. 3162 - CHAMP Act).

Presently dental coverage is an optional benefit in SCHIP. Dental care sits atop the list of parent reported unmet needs. For children with special needs dental care is the most prevalent unmet health care need surpassing mental health, home health, and all other services. Dental coverage is often the first benefit cut when states seek budgetary savings. SCHIP lacks a stable and consistent dental benefit that would provide a comprehensive approach to children's health while reducing costly treatments caused from advanced dental disease. Congress can help stabilize access to oral health care services by improving funding for the SCHIP program.

3. Establish Dental Homes for Everyone

Ideally everyone should have a continuous and accessible source of oral health care–a dental home–established early in childhood and maintained throughout one's life. Having an established dental home makes oral health care accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective. The dental home should be able to provide the following 1) An accurate risk assessment for oral diseases and conditions; 2) An individualized preventive dental health program based on risk assessment; 3) Anticipatory guidance about growth and development issues; 4) A plan for emergency dental trauma; 5) Information about proper care of patients', infants' or children's teeth and soft tissues; 6) Information about proper nutrition and dietary practices; 7) Comprehensive dental care in accordance with accepted guidelines and periodicity schedules for general and pediatric dental

[13] Medicaid statutes, PL 101-239, Section 6403, require that dental services for children shall at a minimum, include relief of pain and infection, restoration of teeth, and maintenance of dental health. Medicaid guarantees medically necessary services, including preventive dental care, under its EPSDT provision.
[14] 42 CFR 440.100

health; and 8) Referrals to other dental specialists when care cannot be provided directly within the dental home.

4. Reauthorize and Fund the Dental Health Improvement Act
The Dental Health Improvement Act (DHIA), championed by Senators Susan Collins and Russ Feingold, is up for reauthorization. The program assists states in developing innovative dental workforce programs. The first grants were awarded to states last Fall 2006 and are being used to increase hours of operation at clinics caring for underserved populations, to recruit and retain dentists to work in these clinics, for prevention programs including water fluoridation, dental sealants, nutritional counseling, and augmenting the state dental offices to coordinate oral health and access issues. Eighteen states were among the inaugural cohort awarded.

5. Establish a Dental Disproportionate Share (DDS) Program
The capacity of ADI clinics to meet the needs of publicly insured and uninsured patients is compromised by inadequate payments from Medicaid and other Federal and state programs which threaten their financial viability as critical dental safety net providers. ADEA urges Congress to establish a Medicaid allotment for each state and territory that would be distributed in quarterly payments to qualified dental clinics operated directly by ADIs or those with an affiliation agreement with an ADI. Federal payments made to qualified clinics should require state matching funds. Qualified dental clinics would be required to have a pediatric Medicaid, SCHIP, and uninsured dental patient load equal to or more than a specified threshold compared to the total of their pediatric patients. Payments from the allotment would be based on a specified percentage of Medicaid payments for children's dental services in the previous quarter. ADEA is eager to explore this proposal with the Committee.

6. Pass Deamonte's Law, H.R. 2371
This legislation would authorize $10 million for two pilot programs that would greatly assist academic dental institutions and community health centers to address access issues. The bill calls for $5 million for grants to accredited dental education programs to support training that enhances and strengthens skills of dental students, dental residents and dental hygiene students in the provision of oral health care to children. Funding could be used to support continuing education for practicing dentists and dental hygienists in pediatric dentistry. Additionally, the bill would authorize $5 million for grants to federally qualified community health centers (CHC) to increase access to oral health care for patients seeking treatment. Funding could be used to hire dentists, purchase of dental equipment and construction of dental facilities. Also, funding could be used to support contractual relationships between CHCs and surrounding private practice dentists.

7. Pass the Essential Oral Health Act, H.R. 2472
The legislation aims to improve the delivery of dental services through a variety of measures. It would provide each State an option to accept an increase in its Federal Medical Assistance Percentage rate for its dental Medicaid and SCHIP programs provided certain access to care provisions are met. States that increase the percentage of plan users and participating dentists will continue to receive the enhanced match. It would authorize grants to pilot the Community Dental Health Coordinator (CDHC) position which will work in underserved communities, in collaboration with health and community organizations and schools to provide community-focused oral health promotion. The CDHC will also connect residents with limited dental care access to dentists. The bill would authorize grants for volunteer dental programs by community-based organizations, state dental associations, dental schools, and hospitals with postdoctoral dental education programs to provide free dental care to underserved populations. Finally, the

legislation would encourage dentists to provide additional donated dental services by providing a $5,000 tax credit for free and discounted services provided.

8. Pass the Special Care Dentistry Act
This legislation introduced in previous Congresses aims to provide dental care to the most vulnerable citizens, poor children, aged, blind and disabled. This includes developmentally disabled and mentally retarded, disabled, the aged frail elderly and medically compromised elderly as well as medically compromised patients. Across the country there are approximately 31 million such patients. The bill would permit flexibility for states allowing them to either make provision for special care dentistry coverage through a state's existing EPSDT program or by creating a separate program for Aged, Blind or Disabled Adults.

9. Restore Dental Graduate Medical Education for Programs in Non-Hospital Settings
Congress should bolster support for dental residency training in both hospitals and non-hospital sites through Medicare Graduate Medical Education (GME). While all medical residency training positions are supported by Medicare GME only some dental residencies are. No dentist may practice a specialty without having first successfully completed residency training. The current number of positions and funding is woefully insufficient for all dental graduates to participate in a year of service and learning in an accredited program. ADEA encourages dental graduates to pursue postdoctoral dental education in either general dentistry, advanced dental education program or a dental specialty. To accommodate advanced education in general dentistry and specialties additional supported training positions are needed. Meeting this challenge would help to strengthen the dental workforce and would help provide access to care.

10. Make Dentistry Eligible for Title VII Administrative Academic Units, Predoctoral Training, Faculty Development
At the present time academic dental institutions are ineligible to compete for three important programs within the Title VII primary care medicine and dentistry cluster; namely the Academic Administrative Units in Primary Care (AAU), Faculty Development in Primary Care (FD), and Predoctoral Training (PDTP) Programs. Congress should broaden eligibility to include dentistry and increase funding to accommodate this eligibility. In its November 2001 report to Congress, the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) also recommended this modification.

- Academic Administrative Units in Primary Care grants establish and improve primary care units so that they are equal to other departments or divisions in the medical school. Resources may be used to enhance the ability of the primary care unit to significantly expand their primary care mission in teaching, research and faculty development. ADEA suggests general and pediatric dentistry and dental public health units be added within the dental school.
- Faculty Development in Primary Care grants help to plan, develop, and operate programs, and pay stipends, for training of physicians who plan to teach in family medicine, general internal medicine and general pediatrics training programs. Four grant types: Type I Primary Care Clinician Researchers; Type II Primary Care Master Educators; Type III Primary Care Community Faculty Leaders; and Type IV Community Preceptors. ADEA suggests training for dentists who plan to teach in general and pediatric dentistry and public health dentistry be added.
- The Predoctoral Training grants help to plan, develop, and operate or participate in predoctoral programs in family medicine, general internal medicine and general pediatrics. ADEA suggests that both general and pediatric dentistry and public health dentistry be added.

11. Maintain Support for Title VII General and Pediatric Dentistry

Support for Title VII programs is essential to expanding existing or establishing new general dentistry and pediatric dentistry residency programs. Title VII general and pediatric dental residency training programs have shown to be effective in increasing access to care and enhancing dentists' expertise and clinical experiences to deliver a wide range of oral health services to a broad patient pool, including geriatric, pediatric, medically compromised patients, and special needs patients. Title VII support increases access to care for Medicaid and SCHIP populations. The value of these programs is underscored by reports of the Advisory Committee on Training in Primary Care Medicine and Dentistry and the Institute of Medicine. Without adequate funding for general dentistry and pediatric dentistry training programs it is anticipated that access to dental care for underserved populations will worsen.

General Dentistry and Pediatric Dentistry Residency Training programs are essential to building the primary care dental workforce are effective in increasing access to care for vulnerable populations including patients with developmental disabilities, children and geriatric patients. These programs are safety net providers of oral health care and generally include outpatient and inpatient care and afford residents with an excellent opportunity to learn and practice all phases of dentistry including trauma and emergency care, comprehensive ambulatory dental care for adults and children under the direction of experienced and accomplished practitioners.

12. Restore Funding for Title VII Diversity Programs

The only federal programs whose goal it is to strengthen and diversify the health professions are the Title VII Centers of Excellence (COE) and Health Careers Opportunity Program (HCOP). These programs work in diverse communities to achieve this national goal. After several years of cuts to these programs saw small increases; however, they remain woefully under funded. Congress should restore their funding to FY 2005 levels.

Table 4: COE and HCOP Funding by FY

	FY05	FY06	FY07	FY08
COE	$35 million	$12 million	$11.88 million	$12.77 million
HCOP	$33 million	$4 million	$3.9 million	$9.8 million

These programs assist institutions in developing a more diverse applicant pool, establishing and strengthening the academic performance of under-represented minority students enrolled in health professions schools, improving institutional academic, research and library capacity, and enhancing pipeline efforts to undergraduate and pre-college students. Also, HCOP makes grants to community-based health and educational entities to support student pipeline and other academic activities.

13. Limit Graduating Student Loan Debt Is Key to Access and Career Choice

Students are graduating from dental school with increasing amounts of educational debt In 2007 the average for all graduates with debt averaged $172,627, those graduating from a public school averaged $148,777 while those graduating from private/State-related schools averaged $206,956. This level of debt places a great deal of pressure on new dentists. Many new graduates who wish to further their education in a specialty or general dentistry forgo the option. New dentists who might otherwise choose a career in the U.S. Public Health Service or Armed Forces shun the option. By virtue of the staggering debt new dentists have upon graduating, many seek practice opportunities in relatively affluent areas where they are likely to earn higher salaries. This cycle has repeated itself year after year leaving underserved areas chronically understaffed. Congress can alleviate the debt burden new dentists face upon graduating by doing the following:

1. Restore nearly $50 million taken through rescissions from the Title VII and VIII revolving health professions student loan programs[15]. These low-interest loan programs designed and authorized by Congress to address shortages in the health professions workforce help limit borrowing from higher cost private loan programs. No federal funds are required to maintain these programs and they receive no annual appropriation, thereby posing no burden on taxpayers. They are funded with the interest from student/graduate repayment, creating a self-sustaining revolving fund designed by Congress to address shortages in the health professions workforce.
2) Increase the aggregate unsubsidized Stafford Loan limits[16] that dental and medical students. The current annual cap is $38,500 while the aggregate is limited to $189,125. The cap forces dental and medical students into less favorable loan options such as the GradPLUS or private student loans. This needlessly drives up graduating debt.
3) Congress should immediately and permanently restore the Economic Hardship Deferment option that was eliminated when Congress passed the College Cost Reduction and Access Act[17].

14. Increase Access for Native American and Alaska Native Populations

Congress should increase the award size for the Indian Health Service (IHS) loan repayment program and make both the loan repayment and the IHS scholarship programs tax free. By taking this action Congress would help to boost the number of dentists and other health care providers in Indian country. Eliminating taxation of IHS scholarship and loan repayment programs would be equivalent to increasing the programs' appropriations substantially without

[15] As part of the Labor-HHS-Education Appropriations for FY 2005 and FY 2006, Congress rescinded the "unobligated balances" from the Title VII and VIII student loan programs. Consequently, HRSA returned $21 million to the U.S. treasury in 2005 and $26.5 million in 2006. HRSA administers the loan programs authorized under Titles VII and VIII of the Public Health Service Act: 1) the Health Professions Student Loan (HPSL) program awards funds to accredited schools of dentistry, optometry, pharmacy, podiatric medicine, and veterinary medicine; 2) The Loans for Disadvantaged Students (LDS) program awards funds to HPSL and Primary Care Loan eligible students who are from a disadvantaged background as defined by HHS; 3) The Primary Care Loan (PCL) program awards funds to accredited schools of allopathic and osteopathic medicine for medical students who agree to enter and complete residency training in primary care within four years after graduation and practice in primary care for the life of the loan; and 4) The Nursing Student Loan (NSL) program awards funds to accredited schools of nursing under Title VIII.

[16] The aggregate combined Stafford Loan limit for health professions should be adjusted to reflect the annual unsubsidized Stafford Loan limits. The aggregate combined Stafford Loan limit for health professions students has remained stagnant for over a decade, does not account for increases in annual unsubsidized Stafford Loan limits or reflect programs of different duration, and is not defined in regulation. The "Deficit Reduction Act of 2005" (DRA) increased the annual unsubsidized Stafford Loan limit for graduate/professional students from $10,000 to $12,000 (effective July 1, 2007). This increased the annual combined Stafford Loan limit from $18,500 to $20,500. Certain health professions students in 9 month and 12 month programs are eligible for an additional $20,000 and $26,667 in unsubsidized Stafford Loans per year, respectively. The current aggregate combined Stafford Loan limit for health professions is $189,125. The justification for this figure is defined in the Federal Student Aid handbook as: *This increased aggregate loan limit would permit a student to receive the current maximum Stafford annual loan limits for four years of undergraduate study ($6,625 + $7,500 +$10,500 + $10,500) and four years of graduate/professional study ($18,500 x 4), plus the maximum increased unsubsidized loan limit for an academic year covering nine months for four years of graduate/professional study ($20,000 x 4).* However, this current aggregate limit does not reflect the increased annual unsubsidized loan limits mandated by the DRA nor does it recognize the annual increases allowed for health professions students in 12 month programs.

[17] On September 27, 2007, President Bush signed the "College Cost Reduction and Access Act" (CCRAA, H.R. 2669, H. Rpt. 110-317). The measure included a change to the definition of economic hardship deferment, which has the potential to eliminate the pathway that most hospital-based dental residents as well as most medical residents use to qualify for the program. CCRAA changed the definition of economic hardship deferment. The new definition does not include the debt-to-income pathway, which is the most common means by which hospital-based dental residents and most medical residents obtained eligibility. Under the new definition, a borrower's income cannot exceed the greater of either the minimum wage rate or 150 percent of the poverty line applicable to the borrower's family size. For an independent single student the maximum qualifying monthly income will be $1,276.

costing any additional money. Equalizing the programs will enhance the IHS competitiveness for health care providers seeking loan repayment in exchange for service in eligible sites. The current playing field between IHS and the National Health Service Corps and Department of Defense scholarship and loan repayment programs[18] are not competitive. Also, unlike other federal scholarship and loan repayment programs, IHS scholarship stipends are subject to income and FICA taxation so the IHS pays up to 20% of Federal taxes directly to the Internal Revenue Service (IRS). As a result in FY 2006 IHS withheld 27.65 percent of each scholarship recipient's stipend to pay taxes. An additional 7.65 percent of the IHS contribution to the FICA tax also comes from the scholarship program funds. IHS had to use $2.3 million (17.5 percent) of its FY 2006 appropriation to pay taxes rather than award scholarships to deserving NA/IA health professions students.

15. Prioritize Dental Access in Rural Health Clinics

Delivery of health care in rural America is changing rapidly; however, one thing remains constant: rural communities across America rely on rural health clinics to provide care to everyone including those who are uninsured or underinsured. Full-service community hospitals in rural areas are safety net providers providing basic health services but often oral health care is unavailable. To improve the oral health status of rural America, Congress should incentive rural health clinics to add preventive and restorative dental services to the list of core services they provide on-site or under arrangement.

16. Increase Funding for Dental and Craniofacial Research and Disparities Research

Funding for dental research must be both reliable and increased. Oral health researchers funded by the National Institute of Dental and Craniofacial Research (NIDCR) have built a base of scientific and clinical knowledge that has been used to improve oral health. NIDCR is the only Institute within the NIH that is committed to oral health research and training. Institute-sponsored research continues to link oral infection to such systemic diseases as diabetes, cardiovascular disease (heart attack and stroke) and adverse pregnancy outcomes (preterm birth and low birth weight). Dental research is advancing investigations in bone formation and craniofacial development, treatment of facial pain, salivary gland disorders. The Institute remains the primary public agency that supports dental behavioral, biomedical, clinical, and translational research. Research is needed to identify the factors that determine disparities in oral health and disease. These factors may include proteomic, genetic, environmental, social, and behavioral aspects and how they influence oral health singly or in combination. Translational and clinical research is underway to analyze the prevalence, etiology, and impact of oral conditions on disadvantaged and underserved populations and on the systemic health of these populations. In addition, community- and practice-based disparities research, funded by the NIDCR and the Centers for Disease Control and Prevention's Oral Health Programs, can help to identify and reduce risks, enhance oral health-promoting behaviors, and help integrate research findings directly into oral health care practice.

17. Bolster Prevention to Eradicate Dental Caries

Congress could make great strides in reducing dental caries if they focused on preventive strategies that can save millions of dollars. The cost of providing restorative treatment is much higher than providing preventive services. Among the most immediate and effective strategies would be to establish a national water fluoridation standard. This is the best and safest public health measure to prevent dental disease. The CDC reports that approximately one-third of

[18] P.L. 107-16, Section 413, the Economic Growth and Tax Relief Reconciliation Act of 2001, which provides for the scholarship programs, and P.L. 108-357, Section 320, the American Jobs Creation Act of 2004, provides for the loan repayment programs.

Americans lack access to a community fluoridated water supply. Other strategies to reduce dental caries include: 1) applying pit and fissure sealants (plastic coating that are applied to the grooves and fissures of primary and permanent teeth) to patients at high-risk for dental caries. Only 18.5% of children have at least one sealed tooth. A nationally based dental sealant program in the public schools is an ideal way to deliver cost-effective services to children; 2) increasing dietary and hygiene counseling for patients at high-risk for dental caries; and 3) professionally applying topical fluoride 1-2 times per annually for patients at high-risk for dental caries.

The Centers for Disease Control and Prevention (CDC) found that delivering sealants to all children attending low-income schools was the most cost-effective strategy in significantly reducing as child's risk of having untreated dental disease. Combining oral health promotion and education with prevention strategies will improve the oral health of children who are at a higher risk for dental disease. Almost as importantly, these program save money. Delta Dental, a private dental insurer estimates that preventive care, early detection, and treatment of oral health conditions save $4 billion annually in the U.S. According to the Children's Dental Health Project, dental costs for children who receive preventative dental care early in life are 40 percent lower than costs for children whose oral health is neglected. The American Dental Hygienists Association estimates that for every $1 spent on prevention in oral health care, $8 to $50 are saved on restorative and emergency dental procedures.

18. Adequately Fund the Centers for Disease Control and Prevention (CDC) Division of Oral Health

Congress should continue to support this important program. The Centers for Disease Control and Prevention Oral Health Program expands the coverage of effective prevention programs by building basic capacity of state oral health programs to accurately assess the needs in their state, organize and evaluate prevention programs, develop coalitions, address oral health in state health plans, and effect allocation of resources to the programs. CDC's funding and technical assistance to states is essential to help oral health programs build capacity.

Conclusion

In conclusion, I thank the Committee for considering ADEA's recommendations with regard to addressing access to dental care and dental workforce issues. A sustained federal commitment is needed to meet the challenges oral disease poses to our nation's citizens including children, the vulnerable and disadvantaged. Congress must address the growing needs in educating and training the oral health care and health professions workforce to meet the growing and diverse needs of the future. ADEA stands ready to partner with you to develop and implement a national oral health plan that guarantees access to dental care for everyone, eliminates oral health disparities, bolsters the nation's oral health infrastructure, eliminates academic and dental workforce shortages, and ensures continued dental health research. I am happy to answer any questions you may have.