Statement
of the
American Dental Education Association

On behalf of
The “Children’s Dental Health Improvement Act”

Before
The Public Health Subcommittee
of the
U.S. Senate Committee on Health, Education, Labor and Pensions

June 25, 2002
The American Dental Education Association (ADEA) is pleased to submit testimony in support of the “Children’s Dental Health Improvement Act” (S. 1626). Chairman Kennedy, ADEA applauds you for conducting this hearing and Senator Bingaman for his determined leadership in championing this critical issue.

S. 1626 is an essential and laudable effort in response to what the Surgeon General has identified as the most prevalent health need among American children – dental care. As such, the proposal is critical to developing a needed infrastructure to maintain coordinated dental services and eliminate existing disparities in oral health, especially among low-income children. ADEA urges Congress to enact S. 1626 before it adjourns.

ADEA is the primary national organization dedicated to serving the needs of all 55 U.S. and 10 Canadian dental schools, as well as hospital-based dental and advanced dental education programs, allied dental programs, and dental research institutions. Within these institutions future practitioners and researchers are educated; the majority of dental research is conducted; and significant dental care is provided to many underserved low-income populations.

The need to improve the oral health of America’s children is well documented. The National Health and Nutrition Interview Survey reports that the unmet dental need for children is three times greater than their unmet need for medical care; four times greater than their unmet need for prescription drugs; and five times greater than their unmet need for vision care.

The U.S. General Accounting Office’s April 2000 report entitled, “Dental Disease is a Chronic Problem Among Low-Income Populations,” documents the profound and unacceptable disparities in oral health that exist among low-income populations, especially poor children. In particular, these children suffer nearly 12 times more restricted-activity days, such as missed school, than higher-income children as a result of dental problems.

The 2000 comprehensive Surgeon General’s report: Oral Health in America declares that our nation is facing a “silent epidemic of dental and oral diseases.” The report performs the invaluable service of alerting all Americans to the reality that oral health is integral to general health and well-being. Independent of this government report, dental research institutions have collected scientific evidence that suggests infections in the oral cavity trigger or exacerbate disease elsewhere in the body.

With a collection of indisputable data that cry out for an immediate remedy, the Surgeon General has called public attention to the disturbing and unacceptable oral health status of American children in general, and of poor children in particular:

- Tooth decay is the most prevalent chronic childhood disease, affecting nearly 60 percent of 5-17 year olds. It is five times more common than asthma and seven times more common than hay fever;
• Children miss over 52 million hours of school annually due to dental conditions;

• Low-income children suffer twice as much tooth decay as other children, and children living below the poverty line have more severe and untreated decay;

• A cleft lip/palate, one of the most common birth defects, is estimated to affect 1 out of 600 live births for Caucasians and 1 out of 1,850 live births for African Americans;

• Tobacco-related oral lesions, a precursor to oral cancer, are prevalent in adolescents who currently use smokeless spit tobacco;

• For each child without medical insurance there are almost three children without dental coverage;

• Fewer than one in five Medicaid-eligible children received a single dental visit in a recent year long study; and

• State Medicaid agencies contribute only 2.3 percent of their child health expenditures to dental care. Even though the State Children’s Heath Insurance Program (SCHIP) has decreased the number of uninsured children, many still lack effective dental coverage because states that offer dental coverage provide only minimal dental care benefits.

In the formidable battle to reverse poor oral health among children, dental education institutions act as safety net providers and are invaluable resources in local, state, and regional communities with regard to patient care. Schools of dentistry provide comprehensive oral health care in settings that offer the benefits of both generalists and specialists, in combination with active education programs, and research components. This environment affords exceptional opportunities for a broad array of patients, including children who otherwise may not have access to oral health services.

Dental schools and their community-based dental clinics are on the front lines of combating oral disease. For innumerable children among the 23 million who have no dental insurance, these dental facilities are the sole source of oral health care and play key roles in addressing access issues and working to eliminate disparities among Medicaid, the State Children’s Health Insurance Program (SCHIP), and uninsured populations.

This reality is corroborated in a 1998 report conducted by the American Dental Association (ADA). Among the report’s findings is a description of the patients who seek and receive treatment at dental school satellite clinics:

• Nearly 57 percent of the satellite clinics are located in community health centers and hospitals;
• 50 percent are covered by public assistance programs, i.e., Medicaid and Medicare;

• 32 percent have no dental insurance coverage;

• About 25 percent are members of families with annual incomes between $15,000 and $35,000; and

• More than 65 percent are members of families with annual incomes of less than $15,000.

If enacted, S. 1626 would go a long way to combat the “silent epidemic of dental and oral diseases” by:

• Granting states flexibility to provide dental coverage to poor children through the State Children’s Health Insurance Program (SCHIP), just as states currently are able to do through Medicaid;

• Assisting states to enhance the dental workforce and alleviate workforce shortages within federally funded health programs, such as community health centers and the Indian Health Service, by providing funds to hire additional dental health professionals to serve low-income populations and by offering retention bonuses to dental providers in these programs; and

• Improving the federal-state public health infrastructure for oral health promotion and disease prevention and encouraging collaboration among health care providers, states, and communities to ensure that existing and future preventative, diagnostic, and treatment measures for oral diseases are available to all low-income children.

Mr. Chairman and members of the Subcommittee, in addition to voicing our support for S. 1626, ADEA would like to take this opportunity to alert you to two critical workforce challenges confronting dental education that have direct bearing on issues of access to dental care and oral health disparities. If state and national public policy makers do not respond effectively to these challenges, the nation’s access and disparities problems will surely worsen and intensify.

The first challenge relates to the crisis that exists in our community with regard to recruiting and retaining dental school faculty. Currently, 350 budgeted faculty positions in the 55 U.S. dental schools remain unfilled. The strong attraction of private practice and the substantial educational debt of graduates are significant deterrents to a career in academia and research. The trend portends continued faculty shortages in the institutions that educate the future dental workforce. Ultimately, faculty shortages threaten the health of the public. Without adequate numbers of qualified faculty, dental
schools simply cannot educate sufficient numbers of qualified practitioners to meet the oral health needs either of the general public or unserved and underserved groups.

The second challenge relates to the fact that underrepresented minorities (URM) comprise less than 6 percent of professionally active dentists and on average less than 10 percent of current dental school enrollments. URM student enrollment is less than half of the 25.3 percent representation of URMs in the U.S. population. Success in increasing minority representation in the dental profession and within the education and research community would have the benefit of enriching the talent pool of faculty and ensuring a geographic distribution of URM practitioners who traditionally provide services in minority communities throughout the nation. We need to increase our efforts so that, at the very least, minorities in dentistry match their representation in the general population.

Both challenges, therefore, have the potential to seriously impact the capacity of unserved and underserved populations to access necessary oral health care. Two critically important dental residency programs, one in general dentistry and the other in pediatric dentistry, act as catalysts for dental institutions to train residents who provide access to primary oral health care. Other federal programs such as the Scholarships for Disadvantaged Students (SDS) and Health Career Opportunities Program (HCOP) help to diversify the applicant pool in dentistry and other health professions. President Bush’s FY 2003 budget proposal, however, eliminates or severely underfunds these and other programs that focus on access to care and training. It is imperative that Congress continues to support these programs.

Mr. Chairman, Congress must remove the barriers that prevent America’s children, especially its poor children, from receiving the oral health care they must have to ensure their health, development, and happiness. Passage of the Children’s Dental Health Improvement Act would be a significant step in achieving that admirable goal.

Thank you for the opportunity to submit this statement.