Testimony for the Health, Education, Labor and Pensions Committee

Hearing on

Children’s Dental Health Improvement Act of 2001

June 25, 2002
Mr. CHAIRMAN, my name is Lynn Mouden. I am an Arkansas dentist and Director of the Office of Oral Health in the Arkansas Department of Health. I have 27 years experience in both private practice and public health. As Arkansas State Dental Director, I am charged by Arkansas state law to plan, direct and coordinate all dental public health programs in the state.

I also serve as President of the Association of State and Territorial Dental Directors, whose mission is to increase awareness of oral health issues; to assist in the development of initiatives for the prevention and control of oral diseases; and to provide leadership on sound national oral health policy. On behalf of the Association and especially the citizens of Arkansas, I thank you for this opportunity to discuss the importance of improving oral health for all Americans.

I’d like to begin by answering a question posed earlier. The reason we have an oral health crisis in this country is because oral health has not been a national priority. Unfortunately, we live in a country where decision-makers and insurance companies have decided that health care ends at the neck. For some reason dental, mental and vision seem to be in a different category than the rest of the body. We will never achieve optimum oral health until we correct those beliefs.

Arkansas is often described as the unhealthiest state in the nation, based on a wide variety of health indicators. Arkansas also mirrors the nation in that oral disease remains pervasive among families with low income, those with limited education, the frail elderly, persons with disabilities, those who are under-
insured, and ethnic minorities.

Our recent statewide oral health assessment shows that on average Arkansas third-grade children suffer from three cavities each. Statewide, more than three-fourths of our children have had tooth decay. Obviously, the slogan from the 1960’s of “Look ma, no cavities” is not being realized across Arkansas. Worse yet is that Arkansas is not unique.

More than 40% of Arkansas children attend school with untreated cavities, and one-in-twelve have emergency dental needs. Such severe dental problems adversely affects how these children eat – or can’t eat; how they sleep – or can’t sleep; and how they succeed in school – or can’t succeed. These children also enter adult life with a mouth no one would hire to smile at a customer. Consider for a moment if these same dental statistics applied to the 100 members of the US Senate. We would wonder how well the Senate’s business would proceed if 40 Senators had untreated tooth decay and 8 of them tried to work with toothaches. I’ll leave it to the members of the committee to decide which of their colleagues should have the toothaches.

Problems are even worse in the underserved areas of Arkansas, specifically the Mississippi River Delta region and inner-city Little Rock, with 50% more of the children needing emergency dental care. These areas are predominantly poorer and with a higher percentage of ethnic minorities. The data point out once again that a minority of our children suffers with a majority of dental problems. A recent screening brought one particular child to our attention. The boy, when asked if he had a toothbrush responded, “Yes, but it doesn’t have any hairs on it anymore.” The toothbrush was so worn it no longer had even one bristle – but he was proud to have a toothbrush.

Insufficient funding of Medicaid continues to plague Arkansans. Arkansas Medicaid only pays approximately 50% of a participating dentist’s usual fees. In a profession where overhead typically is 70% of income, it is amazing that dentists are put into the unique position of having to subsidize their services by
providing dental care at less than cost.

And, increased funding for Medicaid is not the whole answer, because dentistry’s commitment to the underserved is well documented. In Arkansas alone, dentists donate more than eight million dollars each year in free dental care. It is often the bureaucratic barriers can make participation in Medicaid an administrative nightmare for dentists, most of whom are in solo private practice.

SB1626 provides several methods to ensure optimum oral health for all. The requirement that states provide adequate reimbursement to dentists will bolster our system. The requirement that state plans guarantee access for children equal to that available in the general population will ensure dental care for those children at highest risk.

SB1626 also provides an important initiative to support oral health promotion and disease prevention. Dentistry and state oral health programs have a long history of primary prevention activities. Community water fluoridation has long been heralded as the most effective, most economical and safest method for preventing tooth decay. However, without continued and increased funding to support fluoridation, communities working to balance difficult budgets often discontinue this important public health program. In addition, other proven prevention programs such as dental sealant initiatives, also rely on Federal support for success. Although fluoridation and dental sealants are proven prevention methods, Arkansas has only 59% of its citizens enjoying the benefits of water fluoridation and only one-fourth of our children have dental sealants. In our poorer areas of Arkansas, less than 2% of children have sealants.

Arkansas recently received a grant from the CDC Division of Oral Health to start programs. Through that grant, our state has made tremendous inroads in establishing oral health partnerships throughout Arkansas. The grant has helped us ensure effective prevention activities. We are now able to reach out to other health care professionals, educating them on the effect of oral health upon patients’ general health. We also have new programs to enhance oral health
services for our most vulnerable populations, especially those individuals with developmental disabilities.

However, only five states received this funding starting in 2001. SB1626 would greatly enhance support for state and local programs, allowing us to increase access for the underserved populations of Arkansas and the nation. In addition, I encourage you to support increased funding to the CDC to build upon the successful cooperative agreement initiative and to ensure that collaboration between state and Federal entities continues to address our most serious oral health problems.

In 2000, our Association published the study on Infrastructure and Capacity in State Oral Health Programs. The study identified the administrative and financial barriers to improving the nation’s oral health. Leadership from state dental directors is imperative to make dental public health programs succeed. However, Senators, just among the members of this committee, some of your own states don’t have dental directors, so you are already lacking in dental public health resources for your states.

Many Americans enjoy the highest quality of dentistry in the world. If a child lives in Maumelle, Arkansas and has plenty of money, access to dental care is no problem. However, if that child lives in poverty in the Arkansas Delta region, access to dental care is almost impossible. Eliminating disparities in oral health must be our goal.

In closing, I want to thank Senator Bingaman for recognizing the oral health crisis in this country and for his efforts to make a difference in our nation’s oral health. I applaud Arkansas’ Senators Hutchinson and Lincoln and the others that have supported this effort. I thank Senator Hutchinson and the Chairman for inviting us here today to champion the chance for all of America’s children to enjoy oral health – to eat, to be free from pain and to smile. I ask that you continue to work with us – those of us at the local, state and national level – to make optimum oral health for everyone in America a reality. Thank you.