Statement of
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Committee on Appropriations
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Good morning, Mr. Chairman and members of the Subcommittee.

My name is Dr. David Johnsen. I am the Dean of the University of Iowa College of Dentistry. Today, I am pleased to represent the American Dental Education Association (ADEA) as its President and to offer recommendations for Fiscal Year 2003 appropriations for dental education and research.

ADEA is the premier national organization that speaks for dental education. It is dedicated to serving the needs of all 55 U.S. dental schools, as well as hospital-based dental and advanced dental education programs, dental research institutions, and the faculty and students in these institutions. It is within these institutions that 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, including individuals covered by Medicaid and the State Children’s Health Insurance Program (SCHIP).

ADEA concurs with the Surgeon General’s report, Oral Health in America, released in 2000, which alerts Congress and the nation to the full meaning of oral health and its importance to general health and well-being. It makes clear too that there are profound disparities in the oral health of Americans, amounting to a “silent epidemic” of dental and oral diseases affecting our most vulnerable populations, i.e., low-income persons of all ages, but especially low-income children and seniors. The long-term consequences of this disparity deleteriously affect the school, work, and home activities of these individuals and, ultimately, their quality of life.

In addition to these alarming disparities, other significant challenges exist with regard to the infrastructure of dental education and the oral health delivery system. For instance,

- The dentist-to-population ratio is declining, creating concern as to the capability of the dental workforce to meet emerging demands of society and provide required services efficiently. In one-third of the counties in Iowa, 20 percent of the dentists are age 60 or more. Once these dentists retire, who will take their places? The need for dentists in Iowa may soon become urgent.

One indicator to measure the potential need for dentists is an increase in the designated dental health professions shortage areas (HPSAs). The number of dental HPSA’s in the United States in December 2000 was 1,233; in December 2001, there were 1,853. The population in these geographic areas is 38.5
million. In Iowa, the number of dental HPSAs jumped from 3 in December 2000 to 73 in June 2001, encompassing a population of 500,000. To meet the target ratio of dentists to patients, according to the Health Resources and Services Administration (HRSA) guidelines, Iowa would need an additional 131 dentists.

- Dental education debt has increased, affecting both career choices and practice locations. In 2000, 45 percent of individuals who had debt graduated with debt over $100,000 and 21 percent had debt greater than $150,000. The average debt was $106,000.

- Current and projected demand for dental school faculty positions and research scientists is not being met. Presently, there are 400 budgeted, but vacant, faculty positions in the 55 U.S. dental schools. The issue of access to care cannot be addressed successfully without first addressing (and increasing) the number of dentists entering academia and research. ADEA’s survey of dental students graduating in 2000 found that only 0.5 percent plan to seek careers in academia and research.

- A crisis in the number of faculty and researchers threatens the quality of dental education, oral, dental, and craniofacial research, and, ultimately, access to necessary oral health care. Access to care and faculty shortages are inextricably linked. And,

- Lack of diversity and the number of under-represented minorities in the oral health professions is disproportionate to their distribution in the population at large. Their low rate of enrollment in dental schools forebodes their continued under-representation in academia, research, and the dental workforce.

Mr. Chairman, ADEA’s funding requests for FY 2003 take into account many of the challenges I have just mentioned. Indeed, the federal programs being considered by this Subcommittee are playing a significant role in responding positively to the challenges of oral health disparities, dental education, and diversity in the workforce. Consequently, it is imperative that Congress appropriate adequate funding for the continuation and enhancement of these programs.

In particular, the American Dental Education Association urges the Subcommittee’s positive consideration for the following five programs that are of critical importance to dental education and research:

1) For General Dentistry and Pediatric Dentistry Residency Training programs, the American Dental Education Association recommends that the Subcommittee adequately fund the Primary Care Cluster to ensure an appropriation of $15 million for these two primary care dental programs.

These two programs provide dentists with the skills and clinical experiences needed to deliver a broad array of oral health services to the full community of patients. They are highly effective in improving access and availability to primary care dental services. The Bureau of Health Professions acknowledged the value of the General Dentistry Residency Training program in this way: “Considering the relatively modest investment of funds by the federal government, the impact on the growth and scope of General Dentistry programs and the subsequent effect on dental care has been substantial.”
A 2001 HRSA-funded study found that postdoctoral general dentistry training programs, because they are typically either dental school- or hospital-based, generally serve as safety net providers to underserved populations. General dentistry programs are important because they increase access to care while training dental residents to become competent in treating diverse populations, including economically disadvantaged and aged patients as well as those needing specialized care, i.e., mentally disabled, heart, hypertension, cancer and diabetes patients. According to the study, the Title VII, Section 747 grant program for general dentistry has been the dominant force for the creation and expansion of new programs and training positions. Between 1995 and 1999, first-year training positions in general dentistry programs increased by 169, while first-year training positions in pediatric dentistry programs increased by 24.

Pediatric dentistry is the dental counterpart to general medical pediatrics. Only recently has the program begun to expand after 20 years of little change, despite increased societal needs. Many applicants to pediatric dentistry residency training programs are turned away due to lack of positions. In 1999-2000, there were 3,528 applications for only 205 first-year positions. In the first two years of funding, FY 2000 and FY 2001, approximately $2.7 million was awarded to 14 dental education institutions to fund general and pediatric dental residencies. However, eight additional programs in FY 2000 and three programs in FY 2001 were approved, but un-funded. While preventive oral health care for children is one of the great successes in public health, there remains significant unmet need. For example, 25 percent of the pediatric population experiences 80 percent of the dental cavities, and these are concentrated in low-income and minority populations. Two-thirds of patients seen in pediatric dentistry programs are Medicaid recipients. Almost 52 million school hours, equivalent to more than 850,00 school days, are missed each year by children because of dental problems.

Residents trained in general dentistry and pediatric dentistry programs are necessary to meet the needs of Medicaid and SCHIP populations. These primary care training programs are requisite components of the Health Resources and Services Administration’s (HRSA) oral health initiative to improve access to oral health care.

2) For the Health Professions Education and Training Programs for Minority and Disadvantaged Students, the American Dental Education Association recommends $135 million, including $3 million for the Faculty Loan Repayment Program.

The Health Professions Education Training (Title VII) programs have been successful in creating the basic infrastructure for educating a primary care workforce to care for vulnerable populations. However, that infrastructure requires sustained and increased federal support to meet the challenges of diversifying the workforce, addressing student indebtedness, eliminating faculty shortages, and eliminating oral health care disparities in underserved communities.

Two federal programs, the Centers of Excellence (COE) and the Health Careers Opportunity Program (HCOP), play critical roles in preparing, recruiting and retaining disadvantaged students in predoctoral health professions schools. Recruiting and retaining under-represented minorities (Black/African Americans, Native Americans/Alaska Natives, and Hispanic) in dental education remains a serious challenge. As the U.S. population becomes increasingly multicultural, so must the faculties and students in academic dental institutions. The federally funded COE and HCOP programs are key in assisting health professions schools to prepare disadvantaged and minority students for entry into dental, medical, pharmacy, and other health professions. The federal government has a responsibility to help to develop a culturally competent workforce that will reduce health care disparities related to cultural factors.
Another Title VII diversity program, the Faculty Loan Repayment Program (FLRP), assists dentists and other qualified clinicians to enter academia. It is the only federal program that endeavors to increase the number of economically disadvantaged faculty members. The program takes on additional significance in light of current and predicted faculty shortages. As I have said previously, the issue of access to care cannot be addressed successfully without first addressing (and increasing) the number of dentists entering academia and research. In 2002, the Faculty Loan Repayment Program was funded at $1.3 million. While dentistry alone could use the entire appropriation, I should note that graduates from 23 different health care disciplines competed for this limited pool.

Unless Congress and the dental education community itself take action to develop, recruit, and retain faculty, access problems will surely worsen. Congress should increase funding and broaden eligibility for the Faculty Loan Repayment Program to faculty members with qualifying student loan debt, regardless of their background. And Congress should create a separate program directed at eliminating faculty shortages in the nation’s 55 dental schools. Furthermore, general and pediatric dentistry residents who are committed to academic careers should be eligible for FLRP awards.

ADEA strongly recommends that you reject the Administration’s decision to zero fund all of these critical Title VII diversity programs. On the contrary, this Subcommittee should expand the programs.

3) For the Ryan White HIV/AIDS Dental Reimbursement Program of the Ryan White CARE Act, the American Dental Education Association recommends an appropriation of $19 million, a modest increase of $6 million over the FY 2002 level.

Federal support for this program increases access to oral health services for HIV/AIDS patients, while, at the same time, providing dental students and residents the education and training necessary to deliver oral health care to this population. Thus, two major and appropriate objectives of the federal government, that is, service to patients of limited means and education of future practitioners, are accomplished by this important, but very modest, federal program.

As a result of immune system breakdown, HIV/AIDS patients are more susceptible to oral diseases, such as oral lesions that cause significant pain and oral infection leading to fevers, weight loss, and difficulty in eating, speaking, or taking medication. In fact, many of the first physical manifestations of HIV infection are found in the oral cavity. A dentist is often the first health care professional to diagnose these patients.

Private insurance and Medicaid coverage for dental services is very limited or simply unavailable for adults. This lack of adequate reimbursement particularly affects those dental education clinics that serve as the safety net for a significant number of Medicaid and HIV/AIDS individuals. The Ryan White HIV/AIDS Dental Reimbursement Program encourages treatment of patients by alleviating some of the financial burden incurred by the dental education institutions that serve them.

In 2001, the program provided retrospective reimbursement to 85 dental education programs that treated more than 66,000 patients who could not pay for services rendered. The $10 million paid to these institutions represented approximately 64 percent of the direct costs incurred from providing dental services to low-income HIV and AIDS patients.
4) For the National Health Service Corps (NHSC) Scholarship and Loan Repayment Programs, the American Dental Education Association supports the President’s recommended funding level of $191 million and requests that the Subcommittee encourage the Corps to increase dental participation in these programs.

ADEA strongly supports the National Health Service Corps (NHSC) Scholarship and Loan Repayment Programs that assist students with the rising costs of financing their health professions education, while promoting primary care access to underserved areas. Over the last several years and, particularly in the FY 1999 appropriations report language, Congress instructed the Corps to increase dental participation in the loan repayment and scholarship awards programs. NHSC should open the scholarship program to dental students in all four years of dental school and increase the number of dental hygiene students receiving both scholarships and loan repayment. Currently, the dental scholarship program is open only to third-and fourth-year dental students.

It is critical that the National Health Service Corps’ commitment to dentistry be strengthened as the need for dental providers in underserved areas throughout the nation becomes more pronounced. Also, NHSC should continue to work with dental education institutions, dental organizations, and state and local public health departments to determine dental site readiness, especially in rural and border areas.

5) For the National Institute for Dental and Craniofacial Research (NIDCR), the American Dental Education Association endorses the recommendations of the American Association for Dental Research (AADR) regarding research priorities and joins AADR in requesting an appropriation of $420 million for NIDCR. Likewise, ADEA recommends that the Subcommittee encourage NIDCR to expand loan forgiveness programs for researchers and the National Institutes of Health (NIH) to collaborate with the Health Resources and Services Administration (HRSA) to integrate oral health care fully into the multidisciplinary research component of the Centers of Excellence in Women’s Health.

ADEA commends the Subcommittee for its leadership in the area of biomedical research, appropriately demonstrated by significant increases in NIH funding. The National Institute for Dental and Craniofacial Research also is deserving of enhanced federal funding. Past support has yielded significant results applicable not only to oral health, but to health in general. Through collaborative efforts with NIDCR, oral health researchers in U.S. dental schools have built a base of scientific and clinical knowledge that has been widely communicated and used to improve oral health. Research is advancing investigations in bone formation and craniofacial development, treatment of facial pain, salivary gland disorders, the link between periodontal diseases and pre-term low birth weight and arteriosclerosis, to name just a few.

In conclusion, Mr. Chairman, I thank you again, on behalf of ADEA and its membership, for the opportunity to present our views and budget requests for dental education and research programs in FY 2003. Continuing the federal investment in these programs is vital. So too is the development of a partnership between the federal government and dental education programs to implement a national oral health plan that guarantees access to dental care for everyone, ensures continued dental health research, eliminates disparities, and eliminates workforce shortages. In addition to being good public policy, such a plan is absolutely necessary for maintaining the oral health of our nation.