Written Testimony

of the

American Academy of Pediatric Dentistry

Submitted to the

Subcommittee on Labor, Health and Human Services, Education and Related Agencies

Committee on Appropriations
United States House of Representatives

April 29, 2004

Summary of FY 2005 AAPD Requests

1) Support $15 million in FY 2005 for the HRSA Title VII Pediatric and General Dentistry Training program, including $5.5 million for pediatric dentistry as provided by Congress in FY 2004.

2) Support an additional $5 million in FY 2005 for oral health activities under HRSA MCHB Special Projects of Regional and National Significance (SPRANS).

3) Support $10 million in FY 2005 to fund the Dental Health Improvement Act.
The American Academy of Pediatric Dentistry (AAPD) is the membership organization representing the specialty of pediatric dentistry. Our members are the “front line” providers of oral health care to America’s children and educators of health professionals about children’s oral health. The AAPD represents not only the nation’s pediatric dentists, but also general dentists who treat significant numbers of children in their practices.

The AAPD is the recognized authority on pediatric oral health care, and is a leader in several prominent areas, including: the development of pediatric dentistry oral health policies and clinical practice guidelines; the dissemination of information to parents and caregivers about pediatric oral health care; and partnership with the federal government on several key pediatric oral health initiatives targeted at pre-school children and adolescents.

The Oral Health Status of America’s Children

As thoroughly documented in the 2000 U.S. Surgeon General’s Report, “Oral Health in America,” tooth decay remains the single most prevalent disease of childhood —five times more common than asthma. Although the oral health of our nation’s children has improved dramatically over the past three decades, for millions of children severe dental disease and disability continue to exist in our country —despite tooth decay being overwhelmingly preventable. The Surgeon General reported that 80 percent of all dental disease occurs in only 25 percent of U.S. children. These children are more likely to live in low income and/or minority families and not only have increased dental disease, but more extensive disease and more treatment for pain. An estimated four to five million children are in acute dental need. Healthy People 2010 reports that nearly a fifth of preschoolers and over half of second graders already have experienced tooth decay. For every child in the U.S. that lacks medical insurance, 2.6 lack dental insurance.

1 The Academy’s 5,900 members serve as primary care providers for millions of children from infancy through adolescence; provide advanced, specialty-level care for infants, children, adolescents, and patients with special health care needs in private offices, clinics, and hospital settings; and are the primary contributors to professional education programs and scholarly works concerning dental care for children. Individuals trained in Pediatric Dentistry learn advanced, diagnostic, and surgical procedures; child psychology and clinical management; oral pathology; pharmacology related to the child; radiology; child development; management of oral-facial trauma; caring for patients with special health care needs; conscious sedation; and general anesthesia. Since children’s oral health is an important part of overall health, pediatric dentists often work with pediatricians, other physicians, and dental specialists.

Children in families with low incomes suffer more than twice the rate of tooth decay than children in middle and upper income families.\textsuperscript{3} This leads to serious consequences because good oral health is inextricably linked to a child’s overall health and well-being. Poor oral health is linked to slower growth rate for toddlers and poor nutrition in children. \textbf{Afflicted children experience pain and infection, which impacts their attentiveness, self-image, behavior, and readiness to learn.} Children suffering from untreated dental decay may be subject to complicating medical conditions, as well as inadequate diet and hygiene. Poor dental health in children is frequently a marker for poor overall health. Low income, low education, minority status and lack of private or public dental insurance coverage are all associated with lower odds of having dental visits.\textsuperscript{4}

\textbf{Underpinning these issues is the nationwide shortage of pediatric dentists.} There is approximately one pediatric dentist for every 12 pediatricians addressing the needs of the same number of children. Only three percent of all dentists are pediatric dentists, yet pediatric dentists provide approximately 30 percent of oral health care services for children in the U.S., and treat a disproportionate percentage of Medicaid, SCHIP, medically compromised, and disabled children.

**AAPD Recommendation 1**
**Support $15 million in FY 2005 for the HRSA Title VII Pediatric and General Dentistry Training program, including continuation of the FY 2004 funding level of $5.5 million for pediatric dentistry.**

This will help address the nationwide shortage of pediatric dentists, and is consistent with the recommendations of the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry in its November 2001 report. Children with more advanced disease are more likely to require the services of a specialist in pediatric dentistry. Pediatric dentists provide more complete and less sporadic care to Medicaid and SCHIP patients, and are especially successful with this population because of their advanced clinical training and expertise in behavior management.\textsuperscript{5} The two-year Pediatric Dentistry residency program, taken after graduation from dental school, immerses the dentist in scientific

\begin{itemize}
  \item \textsuperscript{3} The Third National Health and Nutrition Examination Survey (NHANES III) showed that dental decay is experienced by 30 percent of children 2-5 years old and 40 percent of children 6-12 years old from families with incomes below 100 percent of the federal poverty level.
  \item \textsuperscript{5} Cashion S: Children's utilization of dental care in the NC Medicaid program. Pediatric Dentistry 21:2 97-103, 1999.
\end{itemize}
study enhanced with clinical experience. This training is the dental counterpart to general pediatrics.

While there is a clear need to increase Pediatric Dentistry Residency Training positions, the U.S. is not training enough pediatric dental health care providers to meet the increasing need for pediatric oral health care services. Due to a lack of positions, 46 percent of all applicants to Pediatric Dentistry training positions for 2004-2005 were turned away. Some training programs have 25 times the number of applicants that can be accommodated. Because of increased attention to this problem, there has been a 37 percent increase in first year positions over eight years, but this is just a small dent in the overall need. The shortage of pediatric dentists is adversely impacting both private practice and academics. **Our nation must increase the number of practicing pediatric dentists dramatically in order to have any hope of improving the oral health status of underserved children.**

The authority to fund Pediatric Dentistry Residency training under Title VII was enacted under the Health Professions Education Partnerships Act of 1998. This expanded the existing General Dentistry training authority, providing three year “start up” funds to either increase Pediatric Dentistry positions at existing programs or initiate new programs. In the first four years of funding, approximately $8.1 million has been allocated to 29 Pediatric Dentistry programs, including six new programs. Every program that can be funded is critical, as Pediatric Dentistry residency programs provide a significant amount of care to under-served populations. **Two-thirds of the patients treated in our programs are Medicaid recipients.**

**Pediatric Dentistry Title VII grantees are also meeting stated federal goals.** Results from a study completed in 2003 by the Children’s Dental Health Project (funded by the AAPD Foundation) indicate that 30 percent of residents in Title VII pediatric dentistry programs are under-represented minorities (URM), far above the 11 percent URM that graduate from dental schools. Residents in these programs spend an average of 20 percent of their training time delivering care in under-served communities. Upon graduation, 40 percent of trainees with established career plans anticipate entering “non-traditional” areas such as public health, academics, or clinics focused on serving low-income populations. Of the remainder planning to enter private practice exclusively, the majority indicate that they will serve Medicaid, SCHIP and other low-income populations in their practices because of the experience gained through their pediatric dentistry residency training programs.

Dental education is experiencing a faculty shortage crisis, with approximately 280 current vacant faculty positions at U.S. dental schools. One of the most critical factors is economic, with the combination of staggering student loan debt and a “buyer’s market” for private practice opportunities that make it difficult
for dental education institutions to recruit new faculty. **HRSA should be directed to develop a primary care dental faculty loan repayment pilot program under Title VII.**

Another important way that Congress can assist academic dental institutions in meeting their missions is to put dental schools on an equal footing with medical schools by allowing them to compete for some Title VII program grants that at present only medical schools are eligible: specifically, Academic Administrative Units in Primary Care, Faculty Development in Primary Care, and Predoctoral Training.

Congress wisely provided $5.5 million for pediatric dentistry under Title VII in FY 2004. This important step will enable an increase in the number of pediatric dentistry training positions that will expand the pool of dentists to take care of the children. This funding level should again be included in the FY 2005 appropriations bill.

**AAPD Recommendation 2**

**Support an additional $5 million in FY 2005 for oral health activities under HRSA MCHB Special Projects of Regional and National Significance (SPRANS).**

This will allow the continuation and expansion of oral health efforts initiated at this funding level in FY 2003 and FY 2004. Programs will include grants to reduce the incidence of early childhood caries and baby bottle tooth decay, and support community water fluoridation and school-linked dental sealant\(^6\) programs, and implement state-identified objectives for improving oral health. This funding should also be directed to provide greater support of current programs such as the **MCHB Centers for Leadership in Pediatric Dentistry Education.** These centers are responsible for the development of leading educators and researchers in our field by providing dual training in pediatric dentistry and dental public health, and offering challenging research opportunities to trainees. Currently, only three centers are supported, at the University of Iowa, University of North Carolina, and University of Washington. However, centers are needed in each federal region of the country, requiring at a minimum seven more centers.

---

\(^6\) A sealant is a thin plastic layer placed on the chewing surfaces of teeth, preventing bacteria from getting trapped in small fissures. Sealants usually last from five to ten years and are most efficacious when applied to teeth at a young age before decay can begin. They are safe and effective and when coupled with fluoride can prevent the need for cavity fillings and other dental procedures, thereby saving time, money, and the pain associated with these procedures.
AAPD Recommendation 3
Support $10 million in FY 2005 for funding of the Dental Health Improvement Act.

The Dental Health Improvement Act was authorized by Congress under the Health Care Safety Net Amendments Act (HCSNAA) of 2002 (P.L. 107-251), and will help to eliminate the disparities in oral health status and assure access to oral health services for low-income children.

Under section 340G of the HCSNAA, $50 million was authorized over 5 years for innovative state oral health care grants. In light of current budget constraints but cognizant of the significant need for this program, we urge the subcommittee to provide $10 million for this program in FY 2005. The American Dental Association, the American Dental Education Association, the Academy of General Dentistry, and the Children’s Dental Health Project also support this request.

States will be able to use these grant funds for a variety of purposes, including: loan forgiveness and repayment programs for dentists serving in dental health professions shortage areas (HPSAs); grants or low- or no-interest loans for dentists participating in Medicaid who establish or expand practice in dental HPSAs; establishment of faculty recruitment programs at accredited dental training institutions whose mission includes community outreach and service, and that have a demonstrated record of serving underserved states; and development of a state dental officer position or augmentation of a state dental office to coordinate oral health and access issues in the state. This is a true federal–state partnership, as states must agree to match at least 40 percent of any federal contributions under this grant.

Conclusion

The AAPD thanks the subcommittee for the opportunity to present these recommendations to improve children’s oral health.