"Help us take care of the children."
~ Dr. Heber Simmons Jr.

2025 AAPD
PEDIATRIC ORAL HEALTH ADVOCACY ISSUES

LITTLE TEETH ARE A BIG DEAL

Tooth decay is the single most common **chronic childhood disease**, more common than asthma or childhood obesity. The actions identified here can help promote the oral and overall health of children in the U.S.

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STATUS OF CHILDREN'S ORAL HEALTH

Oral health is integral to overall health and well-being. Poor oral health triples the likelihood of **school absences** due to dental pain and increases the risk of lower academic performance for children. It also leads to **missed work** for parents and caregivers, lower quality of life, reduced productivity, and **additional expenses** for the family and community.

Oral health inequities persist for children living in the U.S. Children with public insurance are less likely than children with private insurance to be connected to dental care. The NIDCR reports: "American Indian and Alaska Native (AI/AN) children aged 6 to 8 years are twice as likely to have **untreated dental caries** in their primary teeth, and five times more likely to have untreated caries in their permanent teeth than their peers. Mexican American and non-Hispanic Black children are more than twice as likely to have untreated dental caries than non-Hispanic White children." One third of preschoolers living in poverty experience tooth decay, according to the CDC.

THE KIDS NEED YOUR HELP.

While "baby teeth" don't last forever, dental disease can. Children who have cavities in their primary teeth are 3 times more likely to get cavities in their adult teeth. Dental disease gets worse—and more expensive—with delay. When children do not get the preventive care they need and dental disease worsens, some will require extensive dental work to restore oral health. The cost of treatment for severe tooth decay in the most serious cases can reach **$10,000 per child.**

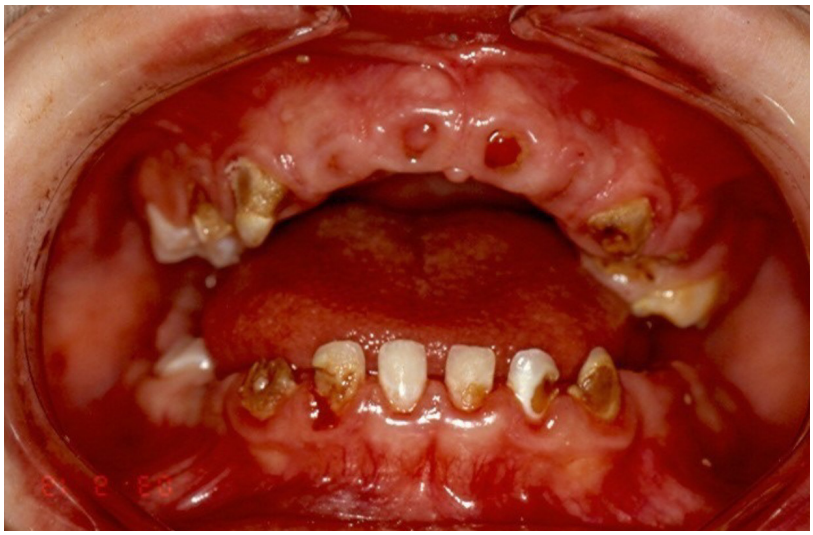
YOUR SUPPORT MATTERS.

More children—regardless of insurance status- are getting into dental care than in the early 2000s. According to the 2021 NIDCR report, *Oral Health in America: Advances and Challenges*, since 2000 untreated tooth decay in primary teeth among children aged 2-5 years in the U.S. has decreased from 19% to 10%. In children under 12, it has decreased from 23% to 15%. The pediatric dentistry community is more empowered than ever to improve the oral health of children in the United States.

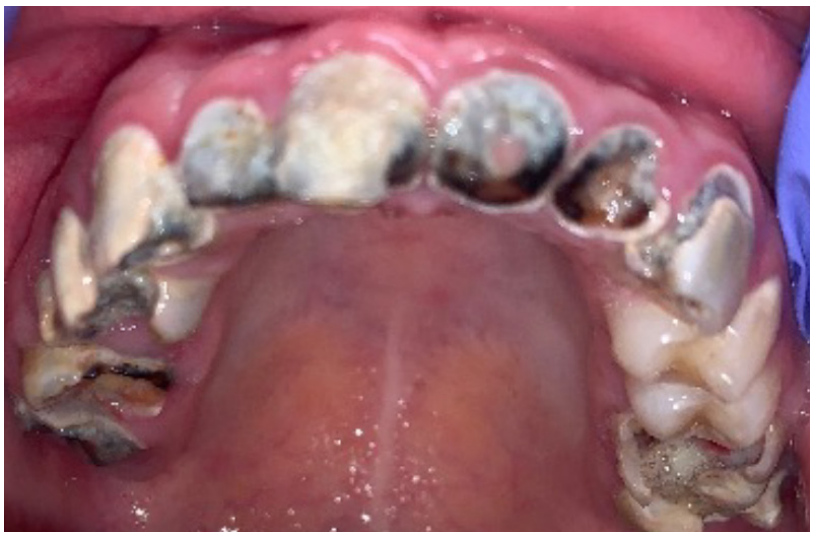
Help a child smile today!

The Reality Pediatric Dentists Face Every Day

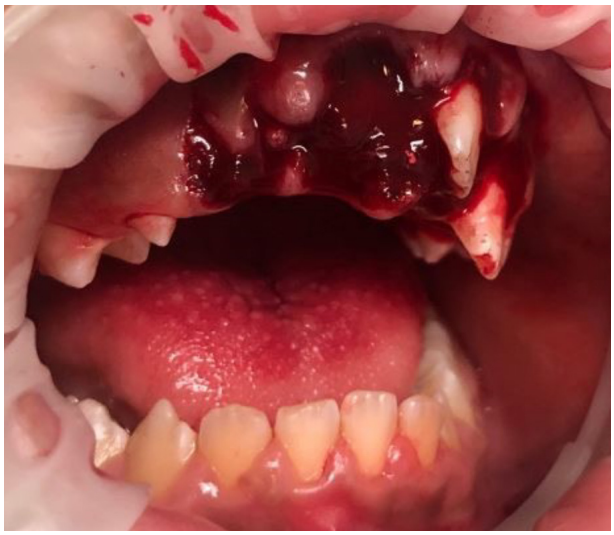
SEVERE DECAY – TRAUMA – PAIN



FOUR YEAR-OLD WITH **ENTIRE** *PRIMARY DENTITION AFFECTED*



YOUNG ADULT WITH *INTELLECTUAL DISABILITIES AND* **SEVERE** *DENTAL DISEASE*



SEVERE DENTAL TRAUMA

OUR CHILDREN DESERVE BETTER.

We Need Your Support to Protect Their Oral Health and Future

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SUPPORT THE HRSA PEDIATRIC DENTISTRY TRAINING PROGRAM

The House and Senate appropriate funds for dentistry training through Title VII of the Public Health Service Act (PHSA), with distinct resources for pediatric dentistry. The FY 2025 allocation within Title VII funding under the Continuing Resolution was $13 million each for general and pediatric dental residency training programs. Since FY 2000, funding has been used to support over 60 pediatric dentistry programs. These funds have been vital to meeting the nation's oral health care needs. Pediatric dentistry residency training programs provide a significant amount of care to underserved populations. Two-thirds of the patients treated in these programs are enrolled in Medicaid.

History of Program

Title VII, section 748 of the Public Health Service Act **(PHSA)** supports pediatric dentistry health care workforce education and training through grants to and contractual agreements with institutions to support predoctoral (dental school) education and postdoctoral residency programs, recruitment and retention initiatives in community-based educational settings, health workforce evaluation within state health departments, and individual assistance to those pursuing health professions education and training. This includes the highly successful Dental Faculty Loan Repayment Program **(DFLRP)**.

The two-to-three year Pediatric Dentistry Residency, taken after graduation from dental school as a specialty program, immerses the dentist in scientific study enhanced with clinical experience. The trainee learns advanced diagnostic and surgical procedures, along with unique care techniques and skills for treating children such as child psychology and behavior guidance; child development; and caring for patients with special health care needs. Since children's oral health is an important part of overall health, pediatric dentists often work collaboratively with pediatricians and other health care professionals.

By nature of their training, pediatric dentists can provide comprehensive oral health care to children. They are the backbone of the pediatric oral health care delivery system, helping to ensure all children have access to high quality comprehensive dental services. Access to dentists is especially critical for Medicaid and Children's Health Insurance Program (CHIP) enrollees. Seventy percent of pediatric dentists treat children enrolled in Medicaid, CHIP or both, which represents on average 30 percent of their patients. Essentially all pediatric dentists care for patients with disabilities. Pediatric dentists also provide a significant amount of charity care and care at a reduced cost.

PEDIATRIC DENTISTRY'S ASK

Support the HRSA Title VII Primary Care Dental Training Cluster and related oral health programs by providing FY 2026 funding of $46 million for the HRSA Title VII Primary Care Dental Training Cluster and related oral health programs, with not less than $13.5 million for Pediatric Dentistry training programs. This is the level that was recommended by the House in 2024 for FY 2025.

Title VII has led to significant expansion of and quality improvement in pediatric dentistry residency programs. **More children are receiving dental care under Medicaid in recent years thanks in large part to an increase in the number of Pediatric Dentists spurred by Title VII funding.** Per a 2019 pediatric dentistry workforce report commissioned by the AAPD, Title VII's success essentially had helped address the national shortage of pediatric dentists, although there are still challenges with the geographic mal-distribution of dentists. According to the 2021 NIH-National Institute of Dental and Craniofacial Research report *Oral Health in America: Advances and Challenges*, oral health improvements for children over the past 20 years is the result of services being more widely available. **Title VII funding made this possible by supporting the growth of the pediatric dental workforce.**

There remains an increased need for pediatric dentists, particularly in rural and under-resourced communities. **Increased funding for pediatric dentistry training will help improve access to dentist services for the children who need it the most.**

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SUPPORT THE DENTAL FACULTY LOAN REPAYMENT ASSISTANCE ACT

Individual recipients of the Dental Faculty Loan Repayment Program (DFLRP) must pay income tax on award funds. Salaries for dental faculty are much lower than private practice, and this additional tax burden has been prohibitive for many highly qualified dentists to choose to go into faculty positions. Legislation was introduced in the past two Congresses to correct this problem. In the 119th Congress, the Dental Faculty Loan Repayment Assistance Act (DFLRAA) was re-introduced in the House as H.R. 1758 and a Senate companion bill is expected shortly. Reps. Jeff Van Drew (R-N.J. 2nd) and Yvette Clarke (D-N.Y. 9th) are the House leaders on H.R. 1758, demonstrating the bi-partisan support for this issue. This legislation would exclude from gross income DFLRP awards under Title VII of the Public Health Service Act.

The Need for Alleviating Taxation of DFLRP

The Dental Faculty Loan Repayment Program (DFLRP) was created to help accredited academic dental institutions recruit and retain qualified and diverse faculty in dental schools and advanced education programs in general, pediatric, and public health dentistry. To build the dentist workforce, there must be a pipeline of faculty to support new dentists and hygienists. Recruiting and retaining dental faculty is a significant challenge, given the staggering level of student loan debt and drastically lower salaries in academic dentistry.

Many pediatric dental residents accrue debt in the amount of over $300,000 as they complete four years of dental school and an additional two-to-three years of pediatric dental residency training.

The tax burden on dentist faculty members—who are committed to training the next generation of oral health professionals and willing to accept lower earnings than their peers—is counterproductive.

A 2024 HRSA evaluation of DFLRP found that:

- During academic years 2016-2022, 148 dentists and dental hygienists provided 424 years of service as full-time dental faculty.
- Most participants had primary care backgrounds: general dentistry (55%), pediatric dentistry (32%), public health dentistry (5%), and dental hygiene (3%).
- Over the six-year period, the program provided $12,202,108 in loan repayment, which relieved an average 43% of student loan debt for the programs' participants. This reduction helps address a key barrier to dental faculty careers.
- Without the programs, dental faculty vacancies could have grown by 113% during academic years 2016-2021; instead, they only grew by 78%. The programs' reduced national dental faculty vacancy rates from 5.4% to 5.2% in AY 2016-2017 and from 6.3% to 5.2% in AY 2017-2018.[1]

PEDIATRIC DENTISTRY'S ASK

Co-sponsor and support passage of the Dental Faculty Loan Repayment Assistance Act (H.R. 1758).

By alleviating taxation of such payments, this legislation will make the program even more effective in recruiting and retaining pediatric dental faculty.

AAPD asks your office to cosponsor and work to pass the Dental Faculty Loan Repayment Assistance Act in 2025.

[1] *https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/dental-faculty-lrp-outcomes.pdf*

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ENHANCE CHILDREN'S ORAL HEALTH THROUGH PREVENTION AND REDUCE A LEADING CHRONIC DISEASE AND ASSOCIATED EXPENDITURES

Two of the most cost-effective ways to prevent dental disease and promote oral health are:

1. Maintaining safe and effective levels of fluoride in community water systems; and
2. Promoting healthy food and beverages to limit sugar intake.

Community Water Fluoridation

The American Academy of Pediatric Dentistry (AAPD) relies on community water fluoridation to prevent and control dental disease in children. The AAPD aligns with colleagues at the American Academy of Pediatrics (AAP) and American Dental Association (ADA) in affirming its safety and effectiveness.

Top Reasons Why Fluoride in Water is Good for Communities

(American Dental Association, abridged):

1. **Prevents tooth decay.** One study has shown that children who live in communities without fluoridation are three times more likely to end up in the hospital to undergo dental surgery.
2. **Protects all ages against cavities.** Studies show that fluoride in community water systems prevents at least 25 percent of tooth decay in children and adults.
3. **Safe and effective.** For more than 70 years, the best available scientific evidence consistently has indicated that community water fluoridation at scientifically-proven levels is safe and effective. It has been endorsed by numerous U.S. Surgeons General, and more than 100 health organizations recognize [its] benefits.
4. **Save money.** When it comes to the cost of treating dental disease, everyone pays. Not just those who need treatment, but the entire community- through higher health insurance premiums and higher taxes. **The average lifetime cost per person to fluoridate a water supply is less than the cost of one dental filling.**
5. **It's natural.** Fluoride in naturally present in groundwater and oceans. Water fluoridation is the **adjustment of fluoride to a recommended level for preventing tooth decay.** It's similar to fortifying other foods and beverages, like fortifying salt with iodine, milk with vitamin D, orange juice with calcium, and bread with folic acid.

PEDIATRIC DENTISTRY'S ASK

Support federal efforts to support states in maintaining and expanding community water fluoridation and promote healthy childhood nutrition.

Recent concerns surrounding community water fluoridation have been driven by sensationalized reports of studies that are largely irrelevant to community water fluoridation practices in the U.S. Most of these studies were based internationally in countries that have much higher fluoride concentrations in water, while others had significant research flaws. The U.S. Public Health Service recommends a level of 0.7 mg of fluoride per liter of water. Pediatric dentists and other dental professionals, health care providers, and public health officials can work with parents/caregivers to optimize total fluoride exposures in a way that maximizes remineralization and minimizes the potential for any negative effects.

The U.S. experienced massive reductions in the prevalence of tooth decay in the years that followed its introduction in the 1950 and 1960s. **Most people in the U.S. today have never seen nor personally experienced the severity of tooth decay that occurs without fluoride. With an abrupt departure from community water fluoridation, our nation would undoubtedly experience a rapidly rising incidence of decay.**

Community water fluoridation remains the only way to ensure that all people—especially those at the greatest risk for dental disease and who have the fewest resources to maintain their oral health—can reap its cavity-preventing benefits.

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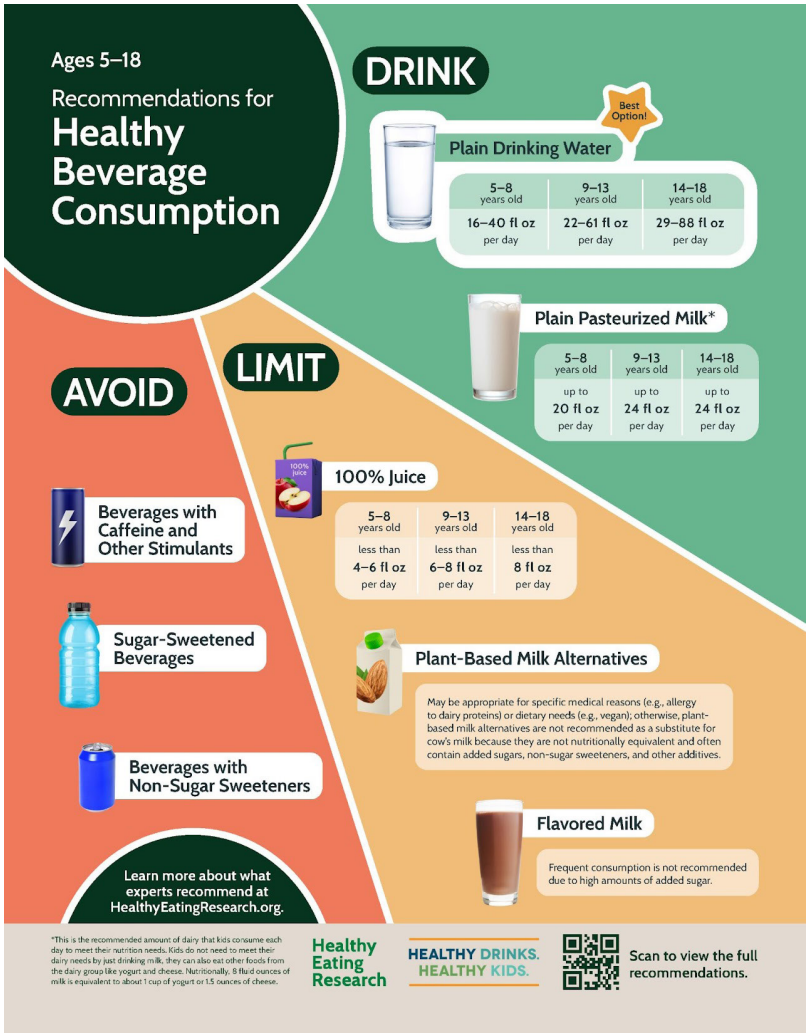
HEALTHY DIET/NUTRITION

The AAPD supports federal efforts to reduce intake of added sugar in children's diets, per the Dietary Guidelines of America (DGA) and consistent with the healthy beverage recommendations of the AAPD, Academy of Nutrition and Dietetics, American Academy of Pediatrics, and American Heart Association.[2]

Recent AAPD efforts in this area include:

- Supported the addition of water as the beverage of choice to the 2025-2030 DGA and its inclusion on MyPlate for nutrition education.
- Hosted a webinar on Reducing Consumption of Added Sugars as part of The Healthy People 2030 Oral Health Promotional Series, in partnership with the American Academy of Pediatrics.
- Supported the reduction of juice allotment in the Women, Infants, and Children (WIC) program.



[2]The Consensus statement
Healthy Beverage Consumption in Early Childhood Recommendations from Key National Health and Nutrition Organizations is available at: *https://www.aapd.org/globalassets/media/policies_guidelines/r_healthybev.pdf*
https://healthyeatingresearch.org/wp-content/uploads/2019/09/HER-HealthyBeverage-ConsensusStatement.pdf

WHAT IS PEDIATRIC DENTISTRY DOING TO HELP?

Over 70% of pediatric dentists accept **Medicaid** or **CHIP**, and publicly insured patients make up more than 30% of the typical pediatric dental practice.

AAPD's advocacy efforts advance **optimal oral health for all children**. Children from low-income families have improved access to care, thanks to a more than doubling of the pediatric dental workforce made possible by HRSA Title VII funding, an increase in Medicaid and CHIP enrollment, and advances in delivery of care.

The AAPD Foundation, the nation's largest dentist-led charity dedicated to child oral health, promotes healthy smiles for all children. Since 2010, the Foundation has issued more than **$10.3 million** in grants and commitments to 161 organizations in 36 states and the District of Columbia. Foundation grantees have helped provide healthy smiles to more than **800,000 children**.

71% of AAPD members report providing some type of **pro bono or non-compensated care** in 2021, amounting to more than $60 million in care for more than 500,000 children.

AAPD strongly promotes establishment of a **Dental Home by age 1**, which studies show reduces subsequent dental disease and treatment as well as related hospital costs.

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