



Association of State and Territorial Dental Directors

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Issue Brief – Health Reform

The Dental Public Health Infrastructure: Failing to meet the needs of the underserved.

As the nation debates the dual problems of the current economic crisis and the failure of the health care system to meet the needs of all Americans it need only look to the declining dental public health infrastructure to observe a prime example of how the two crises interface.

In 2000 the U.S. Surgeon General released *Oral Health in America*, which stated two major themes; that **“Oral Health means much more than healthy teeth”** and that **“Oral Health is integral to general health.”** The Surgeon General’s Report went on to note **“oral diseases are progressive and cumulative and become more complex over time.”** **These diseases can affect economic productivity and compromise our ability to work at home, at school, or on the job.”**

Currently, in 2009, the Centers for Medicare & Medicaid Services Office of the Actuary reported that **dental spending for 2007 had risen to \$95.2 billion**, an increase of \$35.2 billion since the Surgeon General’s report of 2000. In 2007 the Centers for Disease Control and Prevention (CDC) noted that tooth decay among pre-school children has risen from 24% to 28% in a five-year period, this despite the fact that dental caries (tooth decay) is a preventable disease.

The Surgeon General’s Report also noted that, **“The public health infrastructure for oral health is insufficient to address the needs of disadvantaged groups and the integration of oral and general health programs is lacking.”** That statement remains true in 2009. In the Winter 2006 issue of the *Journal of Public Health Dentistry*, Dr. Scott Tomar reported in: *An assessment of the Dental Public Health Infrastructure in the United States* that “Findings suggest that the US dental public health workforce is small, most state programs have scant funding, the field has minimal presence in academia, and dental public health has little role in the regulation of dentistry and dental hygiene. Successful efforts to enhance the many aspects of the US dental public health infrastructure will require substantial collaboration among many diverse partners.”

As noted in Dr. Tomar’s paper, broad-based partnerships will be required to improve the dental public health infrastructure. The latest data (National Health Interview Survey 1998) indicate that approximately 65% of the population have access to at least one dental visit per year; the “other” 35% of the population who do not have access to even one dental visit a year are those disadvantaged and underserved populations who are at the core of the discussion about the lack of access to care. This is one more indicator of a dwindling dental public health infrastructure.

Traditionally most state oral health activities were funded with federal Maternal and Child Health support. The *2008 ASTDD Synopsis of State and Territorial Dental Public Health Programs* reports that many states now have more diversified funding from HRSA, CDC, state general funds and foundations. Of the 44 states that provided information on source of funding, however, 28 (64%) reported receiving 75-100% of their funding from just one source. For 13 states (30%) this source was their state; for 10 states (23%) their main source was HRSA; and for 4 states (9%)

the source was the CDC. Reliance on one funding source can affect program sustainability. In the same survey, 23% of states reported decreases in their budget (primarily in federal funds) while 37% reported an increase in funding (primarily in state funds).

Grant programs through CDC and HRSA have attempted to build the infrastructure and capacity of state oral health programs. HRSA MCHB provided \$3.2 million per year in State Oral Health Collaborative Systems grants to most states from 2003 to 2007. A new cycle of Targeted State Oral Health Service System cooperative agreements started in late 2007 and provides a total of \$3.2 million per year in funds to 19 states and 1 territory through 2011. From 2003-08 the CDC Division of Oral Health provided \$3.8 million per year to 12 states and 1 territory for cooperative agreements to increase their oral health infrastructure; another round of funding for \$4.4 million for State-Based Oral Disease Prevention Programs provided funding for 16 states starting in July 2008.

To enhance the dental public health infrastructure the Association of State and Territorial Dental Directors (ASTDD) recommends the following:

- **A strong, well-trained, dental public health presence at all levels of government: federal, regional, state and local.**
- **Support for community-based participatory research, health care services research, and oral health disparities research.**
- **Increased support for community-based oral disease prevention and oral health promotion programs.**
- **Support for new models for an oral health/public health workforce that include a variety of professionals and career pathways with associated competencies, training, and leadership opportunities, incentives and continuing education.**
- **Policies that support evidence-based and cost-effective community focused oral disease prevention programs; require trained dental public health leadership in all programs intended to meet the oral health needs of the population, and sustainable program funding at all governmental levels to enhance the dental public health infrastructure.**

Recommendation #1: A strong, well-trained, dental public health presence at all levels of government: federal, regional, state and local.

As noted in the 2003 Surgeons General's report: *A National Call to Action to Promote Oral Health*, a critical action item to enhance the nation's oral health is to "Work to ensure oral health expertise is available to health departments and to federal, state and local government programs." Such expertise is necessary to assist in the development of sound policies, program planning and evaluation, and administration of complex public health programs. All dental public health programs require a competent workforce with training in public health as well as oral health.

For there to be strong dental public health programs, it is imperative that adequate funding for these oral health programs be assured. ASTDD requests a:

- \$26 million increase to the Centers for Disease Control and Prevention (CDC), Division of Oral Health to allow for the funding of a dental public health program in every state.
- \$15 million increase to the Health Resources and Services Administration (HRSA) for Title V block grant program to allow for funding of each states Oral Health Program to provide oral health services for Maternal and Child Health (MCH) Programs and to increase funding for special projects of regional and national significance (SPRANS) and targeted MCH oral health service systems grants (TOHSS).

Recommendation #2: Support for community-based participatory research, health care services research, and oral health disparities research.

It had been highlighted in *A National Call to Action to Promote Oral Health* that “Implementation strategies to build a balanced science base and accelerate science transfer should benefit all consumers, especially those in poorest oral health or at greatest risk.” To accomplish this goal ASTDD recommends an:

- Increase in funding for the National Institutes of Health (NIH), National Institute of Dental and Craniofacial Research (NIDCR) to support research on the effectiveness of community-based prevention programs, risk assessment for individuals and communities, increased population-based studies of at-risk populations and effective transfer of science into public health and private practice.
- Increase in funding to the CDC Division of Oral Health to expand the National Oral Health Surveillance System and monitoring of community water fluoridation programs.

Recommendation #3: Increased support for community-based oral disease prevention and oral health promotion programs.

Prevention pays. The \$95.2 billion spent on oral health care in 2007 was primarily spent on treating preventable diseases. ASTDD recommends an:

- Increase in funding to the CDC, Division of Oral Health to increase support for community water fluoridation programs and dental sealant programs in all states and territories.
- Increase funding to support collaborative programs between federal, state and local governments, key professional associations and consumer advocacy groups to improve the oral health literacy of disadvantaged populations and communities.

Recommendation #4: Support for new models for an oral health/public health workforce that include a variety of professionals and career pathways with associated competencies, training, and leadership opportunities, incentives and continuing education.

The Surgeon General's Report: *Oral Health in America* found that: "There is also a lack of available trained public health practitioners knowledgeable about oral health. As a result, existing disease prevention programs are not being implemented in many communities, creating gaps in prevention and care that affect the nation's neediest populations." The report went on to note, "There is a lack of racial and ethnic diversity in the oral health workforce," and there is a "worrisome shortfall in the numbers of men and women choosing careers in oral health education and research." ASTDD recommends:

- Increased funding for loan repayment programs and other assistance/incentives to oral health workers willing to serve in designated health professional shortage areas.
- Increased funding to support dental public health residency programs and other postgraduate fellowships in dental public health.
- Increased funding to support innovative workforce models designed to increase access to care for vulnerable populations.
- Assure the maximum availability of public health resources in a crisis response by amending the Public Health Service Act to include dental public health workers in the Federal definition of "public health worker" and "emergency response provider".

Conclusion:

The dental public health system in the US is responsible for community-based disease prevention programs affecting all Americans and for provision of care to the over 35% of the population unable to access the private practice care network. As the infrastructure supporting the dental public health system deteriorates, more people live with untreated oral diseases and experience needless suffering and disability. The failure of community based prevention programs to provide optimal disease prevention services cost all Americans by increasing treatment requirements. Only by strengthening the dental public health infrastructure can we as a nation reduce the costs associated with dental and oral diseases and prevent the pain and suffering of the most vulnerable among us.

A more robust dental public health infrastructure will provide improvements in oral health oral for all Americans while increasing access to care for underserved groups. Well-funded state oral health programs are critical to the coordination of community-based disease prevention programs and the leadership required to address the provision of care to the underserved, supporting public health surveillance and research as well as assuring a competent dental public health workforce.