

Access to Oral Health Care

ADA Testimony on the Fiscal Year 2002 Appropriation for the Indian Health Service

April 16, 2001

The American Dental Association Dental (ADA) appreciates the opportunity to provide testimony on the fiscal year 2002 appropriations for the Indian Health Service (IHS). Over the past 35 years the ADA has worked in partnership with the IHS Dental Program to improve the oral health of American Indians and Alaska Natives (AI/AN).

The Association would like to thank the Committee for its continued support for oral health care and specifically for its significant actions on the FY 2001 IHS appropriations. We believe that those actions will help reverse some of the troubling trends we recently observed regarding declining access to oral health services among AI/AN people. However, the effectiveness of these funding increases will be lost under the President's FY 2002 funding for the IHS Dental Program. The request of \$94,908,000 only allows for increases in staffing at new facilities and mandatory pay increases. While these are important, several other dental components need to be funded to improve the oral health of Indian people.

Every 3 years members of the ADA's Council of Governmental Affairs conducts a program evaluation at selected IHS dental clinics. Last July, the Council had the opportunity to visit the Phoenix area. We discovered a significant gap between the oral health of Indian people and the people we see in our practices every day, especially very young children and the high percentage of patients with diabetes. The Council was astounded to learn that 95 percent of 4 year old Apache and Hopi children have dental caries. The reasons for this high decay rate are multi-faceted - lack of fluoridation, poor diet, excessive soft drinks and sugar consumption, and lack of good nutrition all degrade oral health.

Fluoridation

Community water fluoridation is one of the most effective ways to reduce the burden of dental decay before it starts and the ADA would like to see that all AI/AN people have access to fluoridated water. However, the ADA was dismayed to learn that the most recent IHS fluoridation monitoring program documents a dramatic reduction in the number of water systems monitoring fluoride levels and the number of these reporting systems with samples in compliance with standards. Through the late 1980's and early 1990's, about 700 water systems submitted samples for evaluation with about 500 within compliance levels each month. In FY 1999, only 192 water systems were delivering fluoride, with only 26 systems (about 14%) in compliance. Such a drop in coverage of one of public health's most cost-effective preventive tools is unequivocally resulting in higher rates of decay in the AI/AN population. This discouraging trend, coupled with the documented reduction in access to dental care, will rapidly wipe out the gains in oral health status that were achieved in the 1980's and early 1990's. We urge your support of an increase in \$1.5 million dollars budget to enhance training and technical assistance to tribes to improve community water fluoridation programs.

Adequate Workforce

For 46 years the IHS has strived to build a system of oral health care delivery for the AI/AN people. Included in this effort has been the development of structures to recruit highly qualified staff, and opportunities for training to enhance knowledge and skills in the treatment and prevention of oral diseases. Until very recently this system has resulted in progressive improvement in the oral health status of Indian people, but funding shortfalls have eroded that progress.

Probably the most compelling evidence that the IHS Dental Program is losing its capacity to serve the AI/AN population is that annual utilization of dental services dropped to approximately 25% since 1996 from a high of 33% in the early 1990s. The IHS Dental Program's infrastructure has

been eroded as a consequence of budget constraints and the reorganization of the IHS. Since 1992 the IHS has not received full mandatory cost increases to maintain services. This lack of funding has deprived the dental program of \$9 million and has significantly diminished the dental program's capacity. As a result, almost 60% of Area and Headquarters dental staff (including training and prevention positions) have been lost over the last six years. Presently, several Area offices have no staff assigned to support dental programs. At the Phoenix Indian Medical Center there are only 11 dentists to serve 65,000 people, allowing only 18% of the eligible population to receive care. These vacancies have directly affected the IHS' ability to recruit and retain clinical providers and oral health promotions/disease prevention coordinators. Vacancy rates for clinical dentists are now the highest in IHS history with one out of four positions vacant.

The ADA believes that Congress should take several steps to provide the IHS Dental Program with the resources necessary to maintain a capable dental public health infrastructure and the capacity to support both clinical care and community-based preventive activities. The ADA recommends that:

1. The IHS adopt an oral health goal of restoring access to dental services over the next three years to the 33% annual utilization rate that existed in the early 1990s. This goal is consistent with the Administration's goal to eliminate racial and ethnic disparities in health status.
2. An additional \$11 million be added to the IHS dental budget to increase access to oral health care. The Administration has embarked on an ambitious initiative to eliminate health disparities among disadvantaged populations by the year 2010. The Association supports this initiative as well as the Administration's request that \$11 million dollars be appropriated to increase access to oral health care in FY 2002. This funding will allow the IHS to hire approximately 115 dental professionals, which will extend basic dental services to about 50,000 additional Indian people.
3. Loan repayment for dentists be enhanced. The Association was very pleased that the Committee provided increased funding last year for loan repayment for dentists. The Loan Repayment Program has proven to be a powerful recruitment and retention tool for the IHS. The additional funding for FY 2001 has allowed the dental program to retain 85 dentists, who otherwise would have left, and to hire 10 new dentists. However, there are still 50 entry-level positions to fill. Furthermore, in recent years the IHS has experienced difficulties recruiting and retaining dentists because the average starting salary for an IHS dentist remains below a similar trained and experienced dentist in private practice. The lack of parity in pay has been lessened with recent legislation that improved pay for military and Commissioned Corps dentists, which the ADA effectively supported. However, the IHS has been required to absorb these pay increases at a cost of \$8 million. Therefore, the ADA recommends that \$7 million for loan repayment be earmarked for dentistry and \$8 million be provided to offset the cost of pay increases for Commissioned Corps dentists.
4. Contract Dental Care be expanded. Opportunities for enhancing AI/ANs' access to dental care in more populated regions could be immediately and significantly enhanced through the private sector if funding were available. We note that IHS expenditures for dental care through its Contract Health Services Program have declined in recent years from about \$12 million in 1992 to about \$7 million in FY 2000. In that same period the overall Contract Health Services budget has increased from \$309 million to \$406 million. This is a very disturbing trend since it occurred at a time when oral health status and access to dental care for Indian people were declining. The ADA recommends that a total of \$12 million be earmarked from within the contract medical services budget specifically for dental services.
5. Continue Congressional program to upgrade dental facilities. The ADA is disappointed that the Administration has not included funding to support modular dental units and we urge you to increase support of this critical item in FY 2002. Historically, the Congress has supported modular dental units at \$1 million annually. Due to the backlog of need, the ADA recommends that \$1.5 million be allocated for modular dental units in FY 2002.

6. Housing for staff be upgraded. In recent site visits to IHS facilities, we have observed many remote locations where dentists have substandard housing or must commute great distances because housing is unavailable near the clinic. We believe this housing situation contributes to the serious shortage of dentists. Providing basic housing for dentists and other health professionals must be made a priority if IHS is to recruit and retain an adequate health professional workforce. The ADA recommends that the Committee appropriate funds to provide staff quarters for dentists at those sites where housing is not currently available.

Rebuild the Dental Public Health Infrastructure

As mentioned above, reducing the dental decay rate of Indian children requires a multi-faceted approach. The Association's final recommendation is in response to the cumulative set of challenges facing the IHS Dental Program, which have been the result of continued loss of its public health infrastructure. We are concerned that the FY 2002 appropriation was level funded and hinders the IHS' ability to rebuild the dental public health capacity. In our visit to the Phoenix Area, we recommended that the IHS improve the capability of dental auxiliary personnel in expanded functions techniques and in educating the community. We recommend additional resources be allotted for dental auxiliary training in FY 2002. In FY 2000, the IHS established four Clinical and Preventive Support Centers to provide training and technical assistance in improving efficiency and effectiveness in preventive and clinical care. We encourage expansion of this effort to an additional four centers to meet the needs of IHS, Tribal and Urban dental clinics.

The IHS has only 15 pediatric dentists and they cannot begin to meet the needs of very young Indian children. The ADA recommends that resources be allocated toward support for training of all dental specialties, particularly in pediatric dentistry, to enhance access to specialty care. This training will ultimately increase access to specialty dental care as well as improving retention of dentists in IHS.

We recommend that resources be allocated for expenses incurred by dental student externs when they are hosted by IHS facilities. These collaborative efforts between the IHS and dental educational institutions have proven to be a valuable recruitment tool. However, most students have been unable to participate in the program due to financial constraints.

Enhancing community-based preventive efforts is critical to the huge oral health and treatment needs faced by Indian people. The ADA supports the efforts that the IHS has demonstrated for community water fluoridation and recommends that resources be provided for this effort. We are also supportive of school-based and clinic-based pit and fissure sealant programs.

The ADA believes that this request represents a relatively "bare bones" approach to rebuilding the dental public health infrastructure and is essential to accomplishing increased access to care as well as meeting the accountability requirements of the Government Performance and Results Act. The ADA recommends that \$6 million be appropriated to support the initiatives listed above.

From the Association's experience of working with the IHS dental program for over 35 years, we know that adequately funding dental care can make a difference. The 1991 Oral Health Survey shows in areas where dental care was accessible there was a:

- A 14% increase in the number of children 5-19 years with no decay;
- A 12% decrease in the number of children 5-19 years with high decay rates (7 or more cavities);
- A 9% decrease in the number of adults 35-44 years with periodontal disease; and
- A 21% increase in the number of adults 35-44 years who have never lost a tooth due to periodontal (gum) disease or dental caries (cavities).

The Association wants to see even greater trends in these areas because it is well documented that AI/AN people have among the highest oral disease rates reported in the world. The recently completed IHS survey of Oral Health Status and Treatment Needs indicate the following:

- 79% of children aged 2-4 years had a history of dental decay.
- 68% of adults and 61% of elders had untreated dental decay.
- 59% of adults 35-44 years and 61% of elders have periodontal (gum) disease.

Conclusion

The ADA recognizes the multitude of funding priorities Congress must reconcile. However, inadequate funding of the IHS Dental Program impairs its ability to meet the growing needs of the AI/AN population. The overall IHS budget as proposed represents only a modest commitment to reverse this trend, and must not be reduced. To do so at a time of national prosperity would represent an inexcusable broken promise to the "First Americans." The Association respectfully requests that this subcommittee support the program enhancements discussed above, as they offer an efficient and effective means of restoring access to dental services.