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Senate Committee on Health, Education, Labor and Pensions (HELP)
Hearing Title: Examining Health Care Workforce Shortages: Where do we go from Here?

Thursday, Feb.16, 2023, 10:00 AM
Rm. 430, Dirksen Senate Office Building

On behalf of the American Dental Association's (ADA) more than 159,000 dentist members, thank you for the opportunity to submit testimony for the record for the Senate Committee on Health, Education, Labor and Pensions (HELP) hearing, "Examining Health Care Workforce Shortages: Where Do We Go From Here?" Addressing critical dental workforce shortages is one of the ADA's top priorities, and America's dentists thank you for your much needed efforts to highlight and solve this problem.

We would like to focus on four critical areas in which policy can improve dental workforce shortages: student debt, diversity, underserved areas, and the dental team, including dental hygienists and dental assistants.

Student Debt

The cost of dental education, and the subsequent debt borne by dental school graduates, is prohibitive for many potential dentists. Recent surveys of dental graduates show that the average new dentist will graduate with over $300,000 in student debt[1]. Unlike physicians, who get clinical training through a funded residency program, dentists' clinical training comes through their dental schools. As part of this clinical training, dental schools often provide care to their communities at a reduced cost. While dental schools and dental students are proud to provide these services to those in need, the structure of dental training forces many dental students to pay higher costs for their education than physicians, while at the same time accruing interest and making loan payments during residency.

[1] Appendix 1.

The ADA, along with many other dental professional groups seeking to increase access to dental care by decreasing the burden of student debt, has supported the following pieces of legislation:

- The Protecting Our Students by Terminating Graduate Rates that Add to Debt Act (POST GRAD Act) would reinstate eligibility for graduate and professional students with financial need to receive Direct Subsidized Stafford Loans, which are now only available to undergraduate students.
- The Resident Education Deferred Interest Act (REDI Act) would allow medical and dental residents to defer payments on their federal student loans—and delay the point at which interest begins to accrue—until after completing their residency.
- The Student Loan Refinancing Act would enable borrowers to refinance their federal student loans on multiple occasions to take advantage of lower interest rates.
- The Student Loan Refinancing and Recalculation Act would provide a chance for borrowers to refinance their federal student loans when interest rates are lower. It would also eliminate loan origination fees and allow medical and dental residents to defer payments until after completing their residency programs. Additionally, it would delay the accrual of interest for many low- and middle-income borrowers while they are in school.
- The Student Loan Interest Deduction Act would double the student loan interest deduction (from $2,500 to $5,000) and eliminate the income limits that prevent those with higher incomes from reaping the benefit.
- The Indian Health Service Health Professions Tax Fairness Act would allow dentists participating in the Indian Health Service Loan Repayment Program to exclude interest and principal payments from their federal income taxes, as well as certain benefits received by those in the Indian Health Professions Scholarships Program.
- The Dental Loan Repayment Assistance Act would allow full-time faculty members participating in the Dental Faculty Loan Repayment Program (DFLRP) to exclude the amount of the loan forgiveness from their federal income taxes.
- The HIV Epidemic Loan-Repayment Program Act (HELP Act) would offer up to $250,000 in educational loan repayment to dentists, physicians, and other health care professionals in exchange for up to five years of service at Ryan White-funded clinical sites and in health profession shortage areas

While the underlying high cost of higher education would remain, the passage of these bills could attract more low income and minority students to the dental profession by mitigating the burden of student debt upon graduation from dental school.

Diversity

This amount of debt is burdensome for anyone, but according to the ADA Health Policy Institute (HPI), black dentists graduate with far more student debt than other groups[2]. The burden of student debt may contribute to the lack of an increase in the number of black dentists over time, despite the overall increased diversity of the dental workforce. Because black dentists are the most likely group to participate as Medicaid providers and are far more likely to treat vulnerable populations[3], the disparity in student loan debt has implications for access to care, as Dr. Herbert also noted in his testimony.

Over the past 15 years, we have seen gradual improvement in the diversity of the dental workforce, suggesting that diversity can and will be improved in dentistry. More women are now graduating from dental schools than men, and the dental workforce has become increasingly less white. This diversification is largely because of the increase in Asian-American dentists[4]. There are numerous ways in which to increase diversification in the dental profession including: additional support for dental schools at Historically Black Colleges and Universities (HBCUs) or those seeking to expand their curriculum to include a dental degree, increased funding for career and technical training programs at community colleges and trade schools for other members of the dental team, and funding and support for programs at elementary and secondary schools in underserved or diverse communities to attract people to the profession at a young age. Dealing with the large amount of student debt that dental student and newly graduated dentists face is another important way to increase diversity in the dental workforce.

Underserved Areas

Student loan debt is also perhaps the biggest impediment to attracting new dentists to underserved and rural communities. Ensuring that loan forgiveness programs are well funded, easy to navigate and expanded to include shorter time commitments or fewer mandatory weekly

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[2] Appendix 2.
[3] Nasseh K, Fosse C, Vujicic M. Dentists Who Participate in Medicaid: Who They Are, Where They Locate, How They Practice. Medical Care Research and Review. 2022;0(0). doi:10.1177/10775587221108751; Appendix 2.
[4] Appendix 2.

hours worked could go far in attracting new dentists to these communities. Other incentives should also be considered, including tax incentives, small business grants and more attractive loan terms for purchasing or building a new dental practice in communities of need.

The ADA has championed the Action for Dental Health (ADH) program, which is intended to provide federal funding to address the dental health needs of underserved populations. ADH funding is directed towards dental disease prevention through improved oral health education, reduction of geographic and language barriers, and improved access to care, among other initiatives. Increased funding and agency support of ADH initiatives, which fall under section 340g grants, would help advance the ADA's and Health Resources and Services Administration's (HRSA) efforts towards health equity.

In order to allocate funding to areas where there are dental workforce shortages, HRSA uses a formula to measure geographic access to care, including access to dental hygienists and other allied dental health professionals. Areas in need are designated Health Professional Shortage Areas (HPSAs). When shortage areas are incorrectly defined, human and capital resources are improperly disbursed, policy is improperly focused, and bad proposals move forward. Thus, those most in need are likely left behind in favor of others who may not need as great a degree of help.

The current model of defining where the greatest needs lie in respect to number and distribution of providers is sorely outdated and inflexible[5]. With an updated, technology-driven approach, we can better allocate resources to enact responsive policy that meets the unique needs of each community, addressing the "maldistribution" of health care providers discussed in Dr. Herbert's testimony. The ADA has proposed a revised HPSA algorithm, like that used by the ADA HPI, that utilizes geomapping to locate beneficiaries, providers (with a particular focus on those accepting new patients), and travel options and times to care.

The Dental Team: Dental Hygienists and Dental Assistants

[5] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/advocacy/dental-coverage-and-benefits/200916_american_dental_association_response_to_hrsa.pdf. Retrieved February 14, 2023.

The cost of education and training also affects dental staff, whose work is not only essential to dental practice, but who also increase access by enabling dentists to see more patients[6]. Unfortunately, a large majority of dentists have reported that it is very difficult to find candidates to fill dental hygienist and dental assistant positions in their offices. The ADA strongly agrees with Dr. Herbert that "we must increase the number of doctors, nurses, and other healthcare professionals… to address our growing population, aging workforce, and many underserved communities."

To help dentists find candidates to fill these positions, the ADA has called for an increase in the authorized funding level for the Oral Health Workforce Development Program (42 U.S.C. 256g), which is part of the Public Health Service Act[7]. This program helps to build and train the oral health workforce, improving access to quality oral healthcare for those most in need. The Grants to States to Support Oral Health Workforce Activities program authorized under 42 U.S.C. 256g is also crucial to efforts to meet dental workforce needs according to each state's individual needs. This program provides assistance that is targeted to areas and populations where recruitment and retention is especially difficult and is well suited to take advantage of local knowledge that can be used in recruitment and retention efforts.

At the state level, there are also efforts to fill the need for dental hygienists and dental assistants through the authorization of incentives and grants that fund the recruitment, training, and retention of dental hygienists and assistants. In Oregon, nearly one-tenth of all dental assistant positions are vacant, and the number of job openings for dental assistants is nearly double the number of new certified assistants[8]. Oregon House Bill 2979 would provide $20 million to programs aimed at filling the surplus of open dental hygienist and dental assistant positions[9]. The ADA is strongly advocating for the passage of this bill, and others like it in other states.

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[6] "The Value of Dental Assistants to the Dental Practice." https://danbsfprodassets.azureedge.net/assets/docs/dalelibraries/research/value-visual-report.pdf. Retrieved February 14, 2023.

[7] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/advocacy/220222_ada_letterondentalworkforceshortages_nosigs.pdf. Retrieved February 14, 2023.

[8] "2022 Oregon Talent Assessment," ECONorthwest, Program and Policy Insight. https://www.oregon.gov/workforceboard/data-and-reports/Documents/2022%20Talent%20Assessment%20FINAL%2006-09-22.pdf.

[9] Botkin, Ben. "Legislative proposal seeks to help dental industry recruit and retain sorely needed staff." *Oregon Capital Chronicle,* February 13, 2023. https://oregoncapitalchronicle.com/2023/02/13/legislative-proposal-seeks-to-help-dental-industry-recruit-and-retain-sorely-needed-staff/.

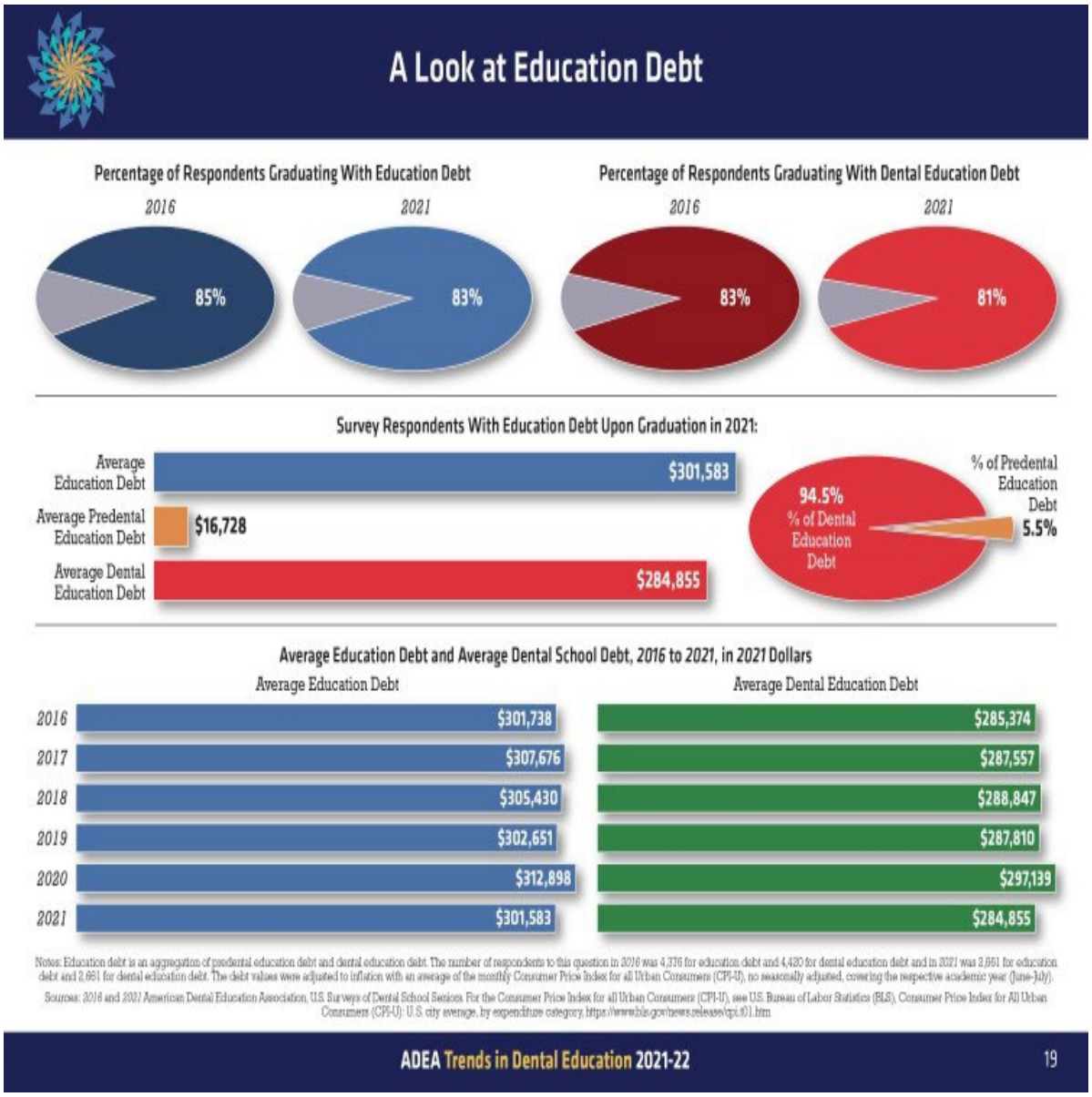
In conclusion, the ADA would like to reiterate its gratitude for your prioritization of health workforce issues. Dental workforce issues should always be included in discussions of general health workforce issues, remembering both the unique aspects of dental practice and that oral health is health. The ADA's top legislative and policy priorities for addressing workforce shortages are:

- Decreasing the burden of student debt, which has broad deleterious effects on the dental health workforce, including discouraging students from entering dental schools, distorting the geographic distribution of dentists, and falling disproportionately on black dentists. Policy should be focused on those providers locating in underserved areas.
- Continuing to work towards a more diverse dental work force by attracting people of diverse backgrounds to the dental profession.
- Increasing access for underserved populations, including increasing the pipeline to dental schools among underrepresented communities, as we work towards a more diverse dental workforce[10]. The ADA stands for oral health equity, including optimal oral health for underserved areas which are not currently being properly identified.
- Finally, training for dental hygienists and dental assistants needs increased support, especially designating dental assistants as primary care dental trainees for purposes of HRSA Title VII grants.

The ADA looks forward to working with the HELP Committee on health workforce issues in the future. If you have any questions, please contact Chris Tampio at tampioc@ada.org.

[10] Wright, Tim J, Vujicic, Marko, Frazier-Bowers, Sylvia. "Elevating Dentistry Through Diversity." *Journal of the American Dental Association*, Volume 152, Issue 4, P253-255, April 2021.

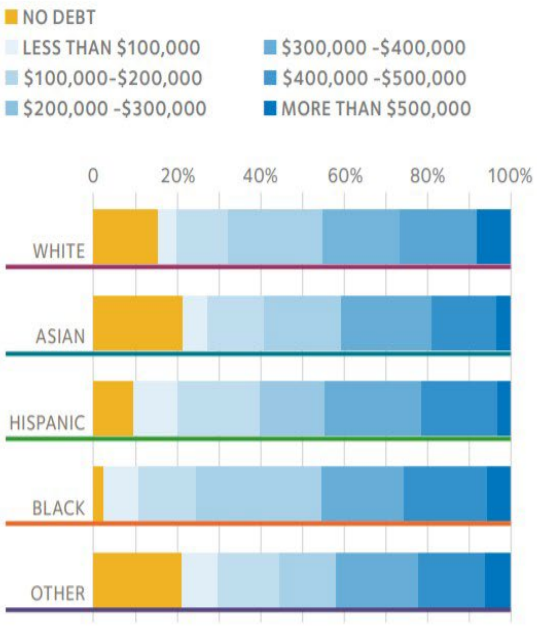
Appendix 1


A Look at Education Debt
Percentage of Respondents Graduating With Education Debt
2016
85%
2021
83%
Percentage of Respondents Graduating With Dental Education Debt
2016
83%
2021
81%
Survey Respondents With Education Debt Upon Graduation in 2021:
Average Education Debt
$301,583
Average Predental Education Debt
$16,728
Average Dental Education Debt
$284,855
94.5% % of Dental Education Debt
% of Predental Education Debt
5.5%
Average Education Debt and Average Dental School Debt, 2016 to 2021, in 2021 Dollars
Average Education Debt
Average Dental Education Debt
2016 $301,738 $285,374
2017 $307,676 $287,557
2018 $305,430 $288,847
2019 $302,651 $287,810
2020 $312,898 $297,139
2021 $301,583 $284,855
Notes: Education debt is an aggregation of predental education debt and dental education debt. The number of respondents to this question in 2016 was 4,376 for education debt and 4,430 for dental education debt and in 2021 was 2,661 for education debt and 2,661 for dental education debt. The debt values were adjusted to inflation with an average of the monthly Consumer Price Index for all Urban Consumers (CPI-U), no seasonally adjusted, covering the respective academic year (June-July).
Sources: 2016 and 2021 American Dental Education Association, U.S. Surveys of Dental School Seniors. For the Consumer Price Index for all Urban Consumers (CPI-U), see U.S. Bureau of Labor Statistics (BLS), Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, by expenditure category, https://www.bls.gov/news.release/cpi.t01.htm
ADEA Trends in Dental Education 2021-22
19

Appendix 2

The Pipeline

DISTRIBUTION OF EDUCATION DEBT LEVELS AT GRADUATION, 2019 GRADS



EDUCATIONAL DEBT LEVELS FOR DENTAL SCHOOL GRADUATES VARY SIGNIFICANTLY BY RACE. For example, more than 20% of Asian dentists graduate with no student debt compared to less than 1% of Black dentists. Black dentists, by far, graduate with the highest levels of educational debt.

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Key Take-Aways

- There are racial disparities in oral health outcomes, dental care use, and cost barriers to dental care. But the magnitude of these disparities as well as the trends over time differ significantly by age group and racial group.
  - Among children, racial disparities are narrowing over time and, for some outcomes, have actually been erased.
  - For adults and seniors, racial disparities are generally stable over time. They are much larger than for children.

- The dentist workforce is not representative of the U.S. population in terms of racial composition. However, over time, the dentist workforce has become more non -white, with the diversification driven almost entirely by increases in the number of Asian dentists.

- There has been no change in the number of Black dentists over time. Black dentists have the highest levels of student debt, are most likely to participate as Medicaid providers, and are far more likely to treat vulnerable populations. There are access to care implications of a diversified dentist workforce.

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The Dental Workforce -Gender

Total US Dental School Graduates by Gender 2016 -2021

Source: American Dental Association, Health Policy Institute, Surveys of Dental Education (Student Roster and Group II).

Health Policy Institute
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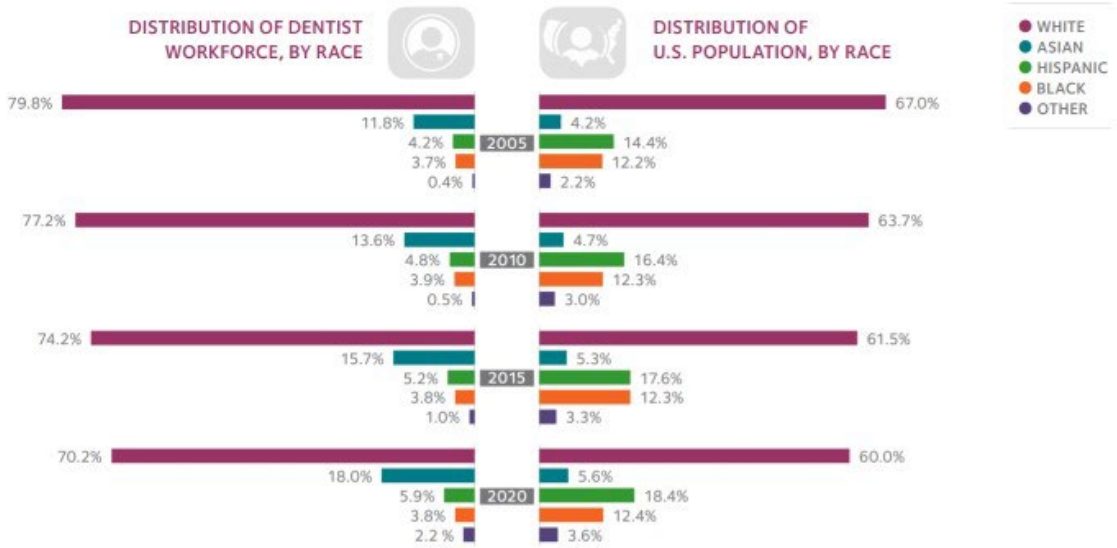
The Dentist Workforce –Race and Ethnicity



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