INVITED EDITORIAL

Improving Dental Public Health Services through Advancement of a Workforce Agenda

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The dental public health workforce in the United States presently is inadequate to meet the needs of the nation, and the situation is getting worse. Only through significant and novel interventions will we be able to reverse this steady decline in the number of people entering the field with appropriate training. These notions are widely accepted within the specialty and, in my opinion, likely true. However, to date, we have had scant evidence to point to that would allow us to quantify this problem and direct interventions. In 1998, Shulman *et al.* (1) provided several recommendations on the needed roles and responsibilities within dental public health in their report, "Dental public health for the 21st century: implications for specialty education and practice," which appeared in 1998 in the *Journal of Public Health Dentistry*. They also provided recommendations for novel training models aimed at improving the supply of adequately trained dental public health practitioners. This report provided an important perspective by acknowledging that many, if not most, of the dental public health workforce is not and need not be "fully trained" diplomates of the American Board of Dental Public Health under the current standards. By suggesting that many of the dental public health activities required are likely to be carried out in field settings by clinical dentists, hygienists, or non-dental trained public health workers, Shulman *et al.* provided a broader perspective of the concept of "need" to inform our discussion of workforce issues.

A second necessary piece of information required to address the workforce issue is the assessment of "supply." Only by accurately quantifying the size, composition and distribution of the current workforce and by characterizing the nature and capacity of the current training programs can we understand where we are and begin to map out a strategy for getting to where we believe we should go. To that end, Scott Tomar provides in this issue an excellent overview of the dental public health infrastructure (2) in the United States. ("An Assessment of the Dental Public Health Infrastructure in the United States," pp15-16).

Under a commission from NIDCR, Dr. Tomar conducted, via original data collection and reviews of existing data, a comprehensive assessment of "what is" with regard to the dental public health infrastructure of the United States. Tomar's characteristically thorough and thoughtful review concludes with a rather pessimistic finding that things are, indeed, bad. The current workforce is small and the current training programs may not be optimally designed to accomplish our specialty's *de facto* mission of improving the public's oral health. I would strongly encourage all dental public health practitioners to read Tomar's article carefully. He provides some excellent recommendations for ways to begin to improve infrastructure.

We now have what I consider to be overwhelming evidence documenting the scope of the problem. Moreover, if we combine Tomar's recommendations with the Shulman *et al.* findings and the recommendations from the several workshops on dental public health (3), we have a rather comprehensive strategy for moving forward. Our next challenge is implementing these recommendations in a sensible and coherent manner. This will require a steady source of funding, policy changes at the state and national levels, and possibly most importantly, a willingness within the specialty to embrace new approaches to training and the concept of "specialist."

The challenges are many. We need to acknowledge that for the foreseeable future, the United States will continue to operate a decentralized fee-for-service dental care delivery system funded primarily by non-public funds. This model will continue to result in low visibility for dental public health activities and a low premium on improvements in population health. The overall lack of any central control of professional training or the care delivery system will mean that dental public health will continue to exert its influence on the public's health by working at the margins. Armed with this knowledge, it should be clear that we will need to be creative in devising new approaches to the recruitment and training of the next generation of dental public health professionals.

To fully operationalize these various recommendations and realize our goal of improving the quality and quantity of dental public health services available to the public several things must happen. First, a sponsoring organization is needed to coordinate the advancement of our workforce agenda. This will require the sustained efforts of dedicated and talented individuals with a broad view of the issues and who know how to impact policy at many levels. The American Association of Public Health Dentistry is well positioned to sponsor this activity. I would urge the Association to move forward with a plan to do so. Following that, a steady

source of funding needs to be developed to sustain essential recruitment and training activities. HRSA is, of course, a most likely candidate for this role. Significant advocacy from the (entire) profession, including the "big guns" at the ADA, will likely be necessary to create significant and sustained federal support for dental public health workforce development. Therefore, we need to assure that we continue to work in partnership with all segments of organized dentistry. It seems to me that we help the dental profession fulfill its responsibility to the public, and in so doing the profession and the public should eagerly seek to sustain our specialty's good health, for dental public health is truly a national resource that asks for very little while returning a great deal.

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References

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