EDITORIAL

Gaps in the Front Lines of Dental Public Health: HRSA Helps with the Need for Dental Public Health Specialists

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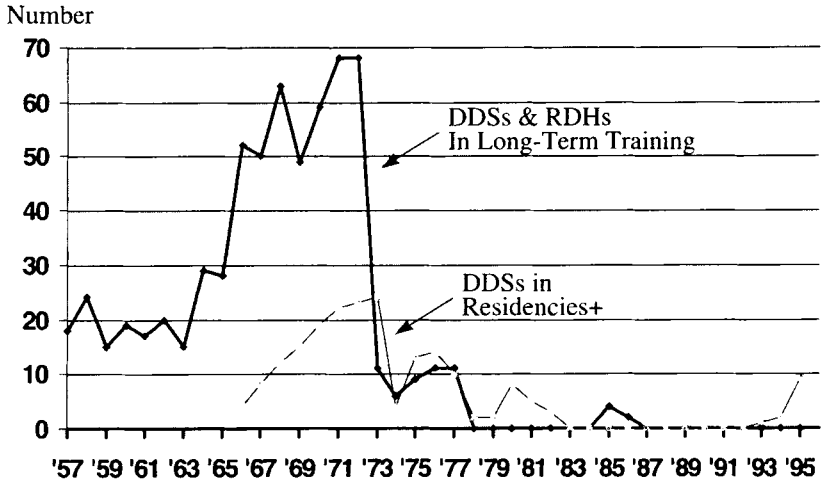
In the spring of this year, the Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), held its first competitive grant cycle for postdoctoral training programs in public health dentistry in 20 years. The BHPr awarded a total of about $500,000 for program enhancements and resident stipends for fiscal year 1997 to seven of 11 competing applications. The residency programs funded are those at Baylor VA Medical Center, Ohio State University, University of California San Francisco, University of Iowa, University of Texas at Houston, and the New York and North Carolina State Health Departments. Information on these programs and the other accredited educational programs in dental public health are listed on the AAPHD home page (URL:http://www.pitt.edu/~aaphd/).

This funding reverses a long-standing lack of federal support for dental public health training and is in direct response to growing evidence that we do not have sufficient dental public health professionals in the workforce (1-7). This shortage can reach seriousness proportions in the next 10 to 15 years as those dental professionals who are the products of the "Great Society" programs of the 1960s leave the workforce.

Trends in stipend support for dental professionals in public health training provided by the Department of Health and Human Services (DHHS) are shown in Figure 1 (8). The number of dentists and dental hygienists in long-term training supported with federal funds peaked at close to 70 in 1972, and thereafter rapidly declined. More dental professionals were in training in this single year than in all other years in the remaining two and one-half decades. The number of dentists in dental public health residencies supported with DHHS funds declined from a high of 24 in 1973 to 0 in 1983 when dentists were no longer eligible for this funding. During the period that dental public health programs were not eligible for federal funds, some residency directors were able to secure stipends from other sources; however, many residents were forced to support themselves using their own funds.

FIGURE 1
Dental Professionals in Public Health Training Supported by DHHS, 1957–95



+Estimates for 1966-68

Gaps in the front lines of dental public health practice are readily apparent. Several states are without a dental director, leaving whole populations without their own "community dentist" to look after them. Fewer than 10 percent of county or city health departments have dental programs.

The need for dental public health practitioners is expanding beyond traditional settings. Because of changes in the health care system, skills once needed mostly in the public sector now are needed in the private sector. Historically, public health meant organized, government-supported, community activities performed by federal, state, and local health authorities, whereas the private sector provided most all of the clinical care. Now, the movement is toward shared responsibilities, with public and private entities jointly deciding on the services that a population will receive, who will provide these services, and then holding each accountable for the different aspects of the overall health of this population (9,10). Some of the responsibilities being assumed by the private sector are those traditionally limited to public health. The public health worker of the future probably will be defined less by the practice setting or source of financing, and more by the knowledge, skills, and competencies required of them. As recently defined, the public health practitioner is anyone who has a population and prevention perspective, and works to improve the health status of a given population, regardless of the setting (11).

Needs for dental public health specialists also exist in dental education. Achieving the vision for dental education outlined in the goals of the 1995 Institute of Medicine study of dental education will require more dental public health expertise than is now available to dental education. Its goals are community oriented, calling for

generation of knowledge of what works and what does not work in the prevention and treatment of diseases, reduction of disparities in oral health status and services experienced by disadvantaged groups, prevention at the individual and community levels, and promotion of the awareness of oral health issues among health care providers and public officials other than just dental professionals. The AAPHD has recommended that every dental school have at least one dentist who is board certified in dental public health, as schools do for most other specialties. Far fewer than one-half of the nation's dental schools now have a specialist in dental public health on their faculties. Minimally staffing the needs in dental education would mean that almost one-half of the current active supply of dental public health specialists would be consumed by dental schools alone.

While the needs for dental public health professionals in practice and education are obvious, the number of actual opportunities are less so. Dental public health education and practice have several features that make them difficult to sustain. Demand for most public health services are not generated directly by the public as they are for personal health services, but by the politics, policy making, regulations, and every-day maneuvering of large bureaucracies. More often than not, decisions about the need for individuals with public health training are personal ones, often political and value laden, and always in competition with other needs, whether it be in a public health agency or in dental education.

Because of an erosion of governmental support, the infrastructure for public health has decreased over the last two decades. In turn, the decline in job prospects affects the number seeking training in dental public health. The applicant pool for graduate training in dental public health also has been affected by declining numbers of graduates from dental schools and the increasing attractiveness of private practice because of a perceived excess in demand for dental services.

The already small pool from which graduate programs draw has been fragmented further by the growth in training programs in oral epidemiology, health services research, and the behavioral sciences. At least seven schools have federal institutional training grants that provide stipends for up to three years of research training for dental professionals. Graduates of these programs are making important contributions to the country's overall research capacity; at the same time, the programs have further eroded the nation's capacity to produce an adequate and qualified dental public health workforce.

Avoiding an undersupply of dental public health professionals is in the national interest. The oral health of the public requires an adequate and appropriately trained dental public health workforce, one that in turn is supported by an educational enterprise that provides necessary practitioners from which to draw, and a research effort that provides the science base to sustain practice. Shortages of dental public health professionals affect the need for dental health services, access to care, the quality and cost of services provided, and the quality of life for the American public.

This recent HRSA funding will enhance the efforts of dental public health programs to provide training for dentists; however, other initiatives to overcome the shortage of dental public health practitioners are needed, many of which have been outlined in recent studies of dental public health scheduled to be published in a supplement to the *JPHD*. Funds still are not available for MPH or DrPH training for dentists and dental hygienists, or for the first year of two-year specialty programs. Because training funds provided by the BHPr support only the residency year of training, our ability to recruit dentists into the first year of training is severely limited, and no funds are provided for dental hygienists.

Awareness of career and training opportunities in public health dentistry is low among dental students and those already in practice. The DHHS and public health professional organizations regularly should make available information on dental public health supply and requirements and on career opportunities to policy makers, educators, professional associations, students, and the public. Full implementation of this recommendation will require research on the supply and requirements of the dental public health workforce, an endeavor that will need the ongoing support of the BHPr or other agencies.

Finally, dental public health practitioners of the highest caliber can be trained; however, without career opportunities, they quickly are siphoned off into other positions in dentistry or even other professions. The ultimate success of efforts to improve the oral health of the public rests on our efforts to revitalize dental public health. The demand for dental public health must be created by those of us who know and believe in its value and are committed to seeing it flourish.

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