

**THE CRISIS IN CHILDREN'S DENTAL HEALTH:
A SILENT EPIDEMIC**

HEARING
BEFORE THE
SUBCOMMITTEE ON PUBLIC HEALTH
OF THE
COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS
UNITED STATES SENATE
ONE HUNDRED SEVENTH CONGRESS
SECOND SESSION

ON

EXAMINING THE CRISIS IN CHILDREN'S DENTAL HEALTH, FOCUSING
ON CREATING AN EFFECTIVE ORAL HEALTH INFRASTRUCTURE, IN-
CREASE ACCESS TO DENTAL CARE, AND RELATED PROVISIONS OF S.
1626, TO PROVIDE DISADVANTAGED CHILDREN WITH ACCESS TO DEN-
TAL SERVICES

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JUNE 25, 2002
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THE CRISIS IN CHILDREN'S DENTAL HEALTH: A SILENT EPIDEMIC

TUESDAY, JUNE 25, 2002

U.S. SENATE,
SUBCOMMITTEE ON PUBLIC HEALTH,
OF THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND
PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:50 p.m., in room SD-430, Dirksen Senate Office Building, Senator Bingaman, presiding.

Present: Senators Bingaman, Sessions, and Hutchinson.

OPENING STATEMENT OF SENATOR BINGAMAN

Senator Bingaman [presiding]. The hearing will come to order.

Thank you all very much, and I apologize for starting a little late. We had a vote on the floor which delayed us a little bit.

This is a very important hearing on ways to improve access to and delivery of dental health services to our Nation's children. The oral health problems facing children were highlighted in a landmark report that was issued by the Surgeon General and the Department of Health and Human Services entitled, "Oral Health in America: A Report of the Surgeon General," in which Dr. Satcher, who is our first witness here today, observed that our Nation is facing what amounts to a "silent epidemic" of dental and oral diseases.

In fact, dental caries, which refers to both decayed teeth and filled cavities, is the most common childhood disease. According to the Surgeon General, among 5- to 17-year-olds, dental caries is more than five times as common as a reported history of asthma and seven times as common as hay fever. In short, dental care is, as the Surgeon General adds, the most prevalent unmet health need among America's children.

The severity of the problem is even greater among children in poverty. Poor children age 2 to 9 have twice the levels of untreated decayed teeth as nonpoor children. The problem is exacerbated in certain ethnic groups. For example, the Surgeon General found that poor Mexican American children have rates of untreated decayed teeth that exceed 70 percent, a rate of true epidemic proportions. In the case of American Indian and Alaskan Native children age 2 to 4, they have five times the rate of dental decay of other children.

For these children, their personal suffering is real. Many of the oral diseases and disorders can cause severe pain, undermine self-esteem, undermine self-image, discourage normal social interactions, cause other health problems, and compromise nutritional status, and lead to chronic stress and depression as well as, of course, cause substantial financial cost to the families involved.

Lack of treatment is estimated to result in a loss of 1.6 million school days annually according to the National Center for Health Statistics.

Incredibly, almost all of this could be prevented. As the Surgeon General's report notes, preventive programs in oral health that have been designed and evaluated for children using a variety of fluoride and dental sealant strategies have the potential of virtually eliminating dental caries in all children. Unfortunately, children do not get the dental services they need. For example, there are 23 million children who have no dental insurance. Even when children do have dental coverage, access to care is often sorely lacking. Medicaid is the largest insurer of dental coverage for children, yet despite the design of the Medicaid program to ensure access to comprehensive services for children, including dental care, the inspector general of the Department of Health and Human Services reported in 1996 that only 18 percent of children eligible for Medicaid received even a single preventive dental service. The factors are complex, but the primary one is due to limited dentist participation in Medicaid.

The good news is that many States including my home State are taking actions to improve the participation of dentists in the Medicaid program by raising the low payment rates and reducing the administrative requirements. Dr. Burt Edelstein of the Children's Dental Health Project has some important data with respect to these issues, and I look forward to hearing that today.

In addition, the Federal Government administers other health care programs providing dental services for providers for low-income children and their families, including services administered by community health centers and Indian Health Service. Unfortunately, both of these programs are underfunded. The GAO report found difficulty in meeting the dental needs of their target populations.

We are fortunate that Ed Martinez is here today to discuss the many challenges that community health centers such as the one he has in San Ysidro, CA face in delivering dental services to low-income children.

In addition to Dr. Satcher, Dr. Edelstein, and Mr. Martinez, I am pleased that we will also be hearing from Dr. Timothy Shriver, who is president and CEO of the Special Olympics, about the oral health issues confronting children with special health care needs; Dr. Gregory Chadwick, who is president of the American Dental Association; and Dr. Lynn Mouden, who is the State Dental Director from Arkansas.

We are glad to have all of them here to address the problems that we will hear about today.

We have put together some bipartisan legislation with Senator Cochran that has been cosponsored by Senators Dodd and Harkin and Collins and Hutchinson on our committee. S. 1626, the Chil-

dren's Dental Health Improvement Act, would improve access and delivery of dental health services to our Nation's children through the Medicaid program, through the State Children's Health Insurance Program, through the Indian Health Service, and through the Nation's safety net of community health centers.

These problems are well-documented, and they call out for congressional action as soon as possible.

In addition to the testimony of the witnesses which we will receive today, I want to insert in the record testimony from the American Dental Education Association, the American Dental Hygienists' Association, and the National Head Start Association.

Senator BINGAMAN. Before I actually introduce our first witness, Dr. Satcher, let me call on Senator Sessions for any comments he has, and then on Senator Hutchinson.

OPENING STATEMENT OF SENATOR SESSIONS

Senator SESSIONS. Thank you, Mr. Chairman.

I am very pleased that we are holding a hearing on this important issue. I thank you for chairing it, and I thank Senators Gregg and Frist for allowing me to serve as ranking member today. This is an issue that I have some real interest in and concern about.

I would like to extend a special welcome to Dr. Satcher, a native Alabamian. Thank you for your service to your country. We are glad that you are here today, Dr. Satcher.

As the witnesses today will testify, oral diseases are predictable and preventable. Thus, it really is inexcusable that so many children lack dental care and must suffer from oral diseases. We must do better.

I applaud Senator Collins for her efforts to improve access to dental health care with her bill, the Dental Health Improvement Act, which she introduced last year and which was included in the health care safety net legislation this committee passed and which is now awaiting final action by the House.

Alabama, like so many other States, is suffering from a dental health crisis. According to the Department of Public Health, we have 312,000 Alabama schoolchildren in need of some dental treatment, and as many as 10 percent of those have urgent needs. African American and rural children have the most dental diseases. Fifteen percent of rural African American children have five or more teeth with a cavity.

Alabama has 38 dentists per 100,000 population; that is compared to 54 per 100,000 throughout the United States. Most of Alabama has been designated as a dental professional shortage area.

Eighty-two percent of the water supply in the State is fluoridated, and Alabama is only one of 22 States that meet the national Healthy People 2000 objectives for fluoridation, which is good news. Five hundred out of approximately 1,700 practicing Alabama dentists are now treating Medicaid patients. That is up from only 135 a few years ago, thanks to improved reimbursement levels and an outreach to the dental community in Alabama by the Medicaid department.

In December of 2000, my home town newspaper, the Mobile Register, Mr. Chairman, ran a series called "The Dental Divide" that dealt with the problem of poverty and lack of dental care. In this

series, the reporter of Sam Hodges revealed the terrible condition of dental health in Alabama as well as the challenges of providing dental care in a rural State.

Although since the article was published, many improvements have been made, there is still much to be done, and indeed, one reason why we have gone from 135 Medicaid-accepting dentists to 500 is a direct result of that article; it was a tremendous series of articles that really would touch the heart of anybody who read them. There were photographs of young children with terrible dental problems, terrible problems, that had to have affected their ability to learn, their ability to be good students, as well as their self-esteem.

So Mr. Chairman, I think this is an important hearing. I intend to be a supporter of the legislation you just mentioned. It is something that I think we should focus on. We are almost there. As has been shown in Alabama, with some good, aggressive outreach, with a little better funding increases for dentists, we can get a real surge in the number of dentists willing to take Medicaid patients, and that would go a long way toward dealing with many of the more severe problems.

Thank you.

Senator BINGAMAN. Thank you very much.

Senator Hutchinson, did you have a statement that you would like to make?

OPENING STATEMENT OF SENATOR HUTCHINSON

Senator HUTCHINSON. Yes, Mr. Chairman.

Let me first thank you for holding the hearing today and for sponsoring S. 1626. I am pleased to cosponsor this legislation with you. Dental health is an important subject, and I want to welcome Dr. Satcher. It is good to see him again, and when I have the opportunity, I look forward to introducing Dr. Mouden, who is director of the Office of Oral Health in the Arkansas Department of Health. I am pleased to have him on the second panel.

As you have pointed out, Mr. Chairman, tooth decay is considered the most chronic disease of childhood, and even though advances have been made through the years in preventative dental procedures and techniques, untreated tooth decay and its consequences remain a significant and growing problem.

Children of low socioeconomic status make 37 percent fewer visits to the dentist's office than do those of higher socioeconomic groups. And actually, 25 percent of children under the age of 19 in the United States endure 80 percent of all tooth decay. Children in families with incomes below 200 percent of the Federal poverty level, although most of them are eligible for Medicaid and SCHIP, have significantly more unmet dental treatment needs than those from families with higher incomes. This is because of lack of access to adequate dental services, be it a lack of transportation, as we oftentimes see in rural areas, or a lack of dental professionals in a given area.

In Arkansas, approximately 139,000 children are eligible for dental care through either Medicaid or the SCHIP program, but only 77,000, or about 55 percent of these children, were seen by a dentist in 2001.

We are fortunate in Arkansas to have over 37 percent of our about 1,000 dentists who are willing to treat these children, while the national average is only about 32 percent.

This is a big problem, and it is one that I am pleased to see the committee addressing. We need to develop creative solutions that will engage the provider community and reduce the barriers for these low-income families.

Senator BINGAMAN. Our first witness is Dr. David Satcher, who is of course well-known to the committee for his outstanding service as the Nation's Surgeon General. He is now a Visiting Fellow at the Kaiser Family Foundation until he assumes the new post which I believe he is about to assume as director of the new National Center for Primary Care at Morehouse School of Medicine in Atlanta, GA this fall.

Dr. Satcher, thank you very much for being here.

STATEMENT OF DAVID SATCHER, M.D., SENIOR VISITING FELLOW, KAISER FAMILY FOUNDATION, AND DIRECTOR-DESIGNEE, NATIONAL CENTER FOR PRIMARY CARE, MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA

Dr. SATCHER. Thank you, Mr. Chairman and members of the subcommittee.

I am delighted to be able to join you and especially to support your efforts in the area of improving children's dental health.

Of all of the reports that I released as Surgeon General, this report has certainly stimulated more discussion and action at the local, State and Federal level than perhaps any other. The support that it has received from within Government and outside Government has certainly been outstanding, yet as you well know, there is room for so much more to be done.

This report was released in May of 2000, and it was entitled, "Oral Health in America: A Report of the Surgeon General." I also want to point out that a month later, we had a Surgeon General's workshop on children and oral health in June, and part of my remarks are based on that workshop.

A lot of other things have happened throughout the country in terms of activities surrounding the report, and I am very grateful for that, because it is one thing to release a report; it is another thing to really have people work to make the recommendations real.

I am especially pleased that this hearing today focuses on children's oral health, because one of my priorities as Surgeon General was to ensure that every child had an optimal opportunity for a healthy start in life, and my commitment to that issue continues today.

We also released a report on the special health needs of children with mental retardation, working very closely with Dr. Tim Shriver whom you will hear from later today. That was the last report that I released, and in that report, we pointed out the very severe dental and oral health needs of children with developmental disabilities, especially mental retardation.

Over one-third of the U.S. population has no access to community water fluoridation, despite all the evidence that CDC and others

have accumulated over the years about the potential of water fluoridation to prevent dental decay.

Over 108 million children and adults lack dental insurance, which is over two and a half times the number who lack medical insurance.

Expenditures for dental services alone make up 4.7 percent of the Nation's health expenditures as of 1998. That is about \$54 billion out of a budget of \$1.3 trillion. As you can see, there are many reasons why we need to pay more attention individually and collectively to our oral health, but there are also opportunities for action for health professionals, for individuals, and for communities to work together to improve health.

First, I would like to focus on some of the findings of the report. Let me say that there was some good news in this report. The good news was that we have had dramatic improvement in oral health over the last 50 years. Great progress has been made in understanding the common oral diseases such as tooth decay and gum disease, and today, most middle-aged and younger American expect to retain their natural teeth throughout their lifetime. That is significant progress.

But there was also very bad news in that report, and it was that we are experiencing a virtual "silent epidemic" of dental and oral diseases across the country. Many of us still experience needless pain and suffering, complications that devastate overall health and well-being, as well as high financial and social costs that diminish the quality of life at work, at school, and at home.

Oral and forensic cancers, for example, are diagnosed in about 30,000 Americans each year. In fact, 8,000 people die annually from these cancers, and that makes them the sixth-leading cancer cause of death in the country.

Nearly one in four Americans between the ages of 65 and 74 has very severe periodontal disease. Oral clefts are one of the most common birth defects in the United States, with a prevalence of about one per 1,000.

We tried to make some major points in the report, and the first one is that the mouth has a way of reflecting the general health and well-being of the entire body. By examining the mouth, we can detect problems in the circulatory system, nutritional problems, and infectious diseases. So in that sense, the mouth is sort of a mirror of the rest of the body.

Oral disease and disorders, however, in and of themselves affect health and well-being throughout life in so many ways—the ability to eat, to chew one's food, therefore influencing the type of foods selected; the ability to speak, the ability to smile and to relate to other people. Many things that determine growth and development for children are impacted if there is poor oral health.

Oral diseases and conditions are often associated with other health problems. For example, in people with periodontal disease, there is an increased risk of cardiovascular disease, diabetes, and adverse reproductive outcomes. And even though, as we pointed out in the report, we do not understand how periodontal disease relates specifically to these problems of heart disease, diabetes, and difficult reproductive outcomes, it is an association that needs more research.

But safe and effective measures exist to prevent the most common dental diseases, and those are dental caries and periodontal disease. If those methods were used—and some of them are at home, in terms of regular brushing and flossing, good nutrition; some of them are seeing a dentist and getting dental sealants and other things that can happen in that setting to prevent dental caries.

Lifestyle behaviors that affect general health—things like tobacco use and excessive alcohol use, poor dietary choices—also affect oral and craniofacial health.

There are profound and consequential oral health disparities within the U.S. population, as you have implied, but among the poor, among minorities, among persons with developmental disabilities, there are major oral health problems such that 20 to 25 percent of children experience over 80 percent of all of the oral health problems.

More information is needed, so I do want to make the point that scientific research is key to further reduction in the burden of diseases and disorders that affect the face, the mouth, and the teeth.

Now, specifically as it relates to children's oral health, dental caries are the single most common class of chronic disease among children, as you have heard, and that is something that is very important since children experience 51 million hours of lost school days because of tooth decay and toothache.

As one of the most common birth defects, cleft lip and palate is estimated to affect one in 1,000 births—one in 600 live births for whites, one in 1,850 live births for African Americans.

In addition, dental caries is the most frequently unmet health need of children in this country.

There are striking disparities in dental disease by income, so poverty is a major factor here, and that is why access is such a challenge. Unintentional injuries, many of which include head, mouth, and neck injuries, are common in children, but by the same token, intentional injuries commonly affect the craniofacial tissue.

Professional care is necessary for maintaining oral health, yet 25 percent of poor children have not seen a dentist before entering kindergarten. We pointed out in our report that medical insurance is a strong predictor of access to dental care. Uninsured children are 2.5 times less likely than insured children to receive dental care. Children from families without dental insurance are 3 times more likely to have dental needs than children with either public or private insurance.

For each child without medical insurance, there are at least 2.6 children without dental insurance.

Medicaid has not been able to fill the gap in providing dental care to poor children. In our report, we said that in the year before our report, only one in five children on Medicaid saw a dentist. So Medicaid for many reasons is not able to fill that gap, and as you point out, in many cases because many dentists do not see children on Medicaid. And when you talk with dentists about this, as I have throughout the country, many of them will point out that it really in some cases is not worth their while to accept Medicaid for seeing children, that the cost of the time that it would take to fill out the

forms is not adequately reimbursed in terms of Medicaid reimbursement.

I am very pleased that there are changes taking place. Several States have now increased their Medicaid reimbursement. It is not enough. We need to continue to push for improving the Medicaid reimbursement, because it really impacts upon children's access to dental health services.

Children with disabilities including mental retardation have more dental health problems, and you will hear more about this later from Dr. Shriver. I had an opportunity to attend the Special Olympics in Alaska last year, and they have some very interesting screening programs which you will hear about. But it had a tremendous impact on my perspective of the health care needs of the mentally retarded.

Let me close by sharing these recommendations for action. Everyone has a role in improving and promoting oral health. Through a collaborative process, we can develop a framework for action. We can change perceptions. We really need to educate the public, policymakers, and health providers regarding oral health and disease so that oral health becomes an accepted component of general health.

We need to accelerate the building of the science and evidence base and apply science effectively to improve oral health.

We need to build an effective oral health infrastructure that meets the oral health needs of all Americans and integrate oral health effectively into overall health.

We need to remove the known barriers between people and oral health services, especially children.

We need to use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral disease, and I must say there are some very impressive programs. The Kellogg Community Voices Program is one that I am familiar with, as well as the Healthy Smiles Program, the Bright Smile Program. Colgate Palmolive and Procter and Gamble both support programs for getting dental care to children who are poor and underserved. Rosie O'Donnell has set up a foundation to improve access to dental health care. So there are some very interesting public-private partnerships.

Mr. Chairman, in the past half-century, we have come to recognize that the mouth is in fact a mirror of the whole body. It is a sentinel of disease, and it is critical to overall health and well-being. The challenge facing us today—to help all Americans achieve oral health—demands the best efforts of the public and private agencies as well as individuals.

I am pleased to have this opportunity to present this overview. I have submitted a full written report for the record, and I will be happy to respond to any questions.

[The prepared statement of Dr. Satcher may be found in additional material.]

Senator BINGAMAN. Thank you very much, Dr. Satcher.

Let me give you a very uneducated view of this situation just to get your reaction, Dr. Satcher. In my home State of New Mexico, several of our schools make available to parents who want their

children to participate in it a dental sealant program. I believe is in the early grades, second or third grade, when they do that.

My impression is that that is been very successful in that it does reduce the incidence of dental caries, and it is very cost-effective. It does not cost much money. Everyone seems very pleased with it.

Based on that, I wonder why we cannot have as a goal trying to implement that kind of program in all the public schools in the country and, just as we have programs to immunize school-age children at certain ages, have this as part of what is expected by all parents and all children and all those involved with our public school system throughout the country.

As I said, that is an uneducated notion that I have had, but have you looked at anything like that, or did you have a chance to as part of the study that you did?

Dr. SATCHER. We have been involved in several studies, and let me just say that we tried to make very clear in the report that we are talking about problems that are preventable, and clearly, dental sealants play a major role in preventing tooth decay in children.

I am of the impression that it would be a very good investment in the long run and that we would prevent a lot of unnecessary oral health problems if we invested in things like access to dental sealants at a very early age. So we strongly recommend that.

I think it is an interesting issue, because here is something where there are things that must be done at home by parents and their children, where regular brushing and flossing, good nutrition are very important. But it is also critical that children have access to those kinds of dental health services very early, and if they had that, it would prevent a lot of problems later on.

I do believe very strongly that poor oral health negatively impacts upon children's growth and development in many ways—their ability to relate to their peers; their comfort in speaking in public. Of course, in our study, we found older people on Indian reservations who were shamed to speak in public because of their dental health problems, so you can image what children go through when they have very bad teeth.

So with toothaches, the pain and discomfort can interfere with learning, but also, at a very important stage of social development, children suffer needlessly, and I think we ought to invest in preventing that.

Senator BINGAMAN. One of the things that you alluded to in your testimony was the problem of inadequate fluoridation of our water systems. Do you have a plan or a proposal for us to consider on that? I know we have some things in this legislation that Senator Cochran and I and Senator Hutchinson and various others have introduced to try to move in that direction. But is there a clear role that you see for the Federal Government in trying to meet this need so that we have fluoridation of our water more generally available?

Dr. SATCHER. I think several local communities have struggled with this issue, and just in the last few years, several local communities have made the decision to go to fluoridation of water.

Unfortunately, there are a lot of misconceptions out there about fluoride. A lot of people paint pictures of danger. CDC has done years of research on the impact of fluoride and listed it as one of

the ten leading public health developments of the 20th century. No. 1, I think we really need to do a better job of educating the general public, because these decisions are made in local communities by vote. I think the Federal Government can help with that, but I also think we can provide incentive for communities to work toward water fluoridation.

Obviously, it is an issue of the role of the local government versus State versus Federal, but this is such a critical issue for the health of children that I think the Federal Government should provide all the support that it can to move local communities in that direction, including financial incentives for them to do so.

Senator BINGAMAN. I will not put you on the spot right now, but I would just urge that if you could look at this legislation that we have introduced and give us any comments you have about things we could add or improve in order to carry out some of the recommendations in your report and in your testimony today, I think that would be very helpful to us.

Dr. SATCHER. I would be happy to.

Senator BINGAMAN. And again, thank you very much for being here.

Dr. SATCHER. I would like to comment, because I did mention our concern about the growing shortage of dentists, and as you know, many dental schools in the country closed in the eighties and the nineties. I think we are at 26 now. So there is a growing concern about the shortage of dentists all over the country because the rate of enrollment now will not meet the needs. So that is also an issue that is going to need attention, and I know that the American Dental Education Association and many others have been struggling with this. We need to provide much more support for getting students into fields of oral health.

Senator SESSIONS. On that subject, Dr. Satcher, why is that? People get turned down at dental schools regularly. I hear about people trying to get in who might not be accepted unless they have the most exceedingly high test scores and that sort of thing.

What can we do to make sure we have the capacity for the dentists that we need?

Dr. SATCHER. I think dental education is expensive, and I think we need to invest in it. In some ways, when you compare it with medical education, for example, the cost of the tools and equipment to educate a dentist, and sometimes even access to patients, can be very difficult. So I think we need to really look critically at what we need to do as a nation to really foster access to dental education.

The dental schools are struggling themselves, because they have to provide funding for faculty and others, and it is not as easy to support that with clinical care and other things as some other health professions. So I think we need to look at the unique needs of dental education in this country and how we can target specific programs to enhance dental education and better support of dental schools so they can expand their enrollment.

It is no accident, of course, that all those dental schools closed, because dental education is expensive, and it became very difficult for some. Universities that have more than one health professions school, of course, tend to compare them in terms of what they bring

in in terms of resources and what they require to support faculty and others. But I think we really need to make a commitment to dental education and provide the support that it is going to take. It would be a good investment in the long run.

Senator SESSIONS. With regard to rural health care, generally, there is a higher level of poverty, compounded by the problem of dentists preferring to be in more urbanized areas.

What do you think are the impediments, and what can we do to improve dental care out there in the rural areas?

Dr. SATCHER. I think rural health in general is a major challenge in terms of getting people who have gone through health professions schools to live and work in rural communities. But part of the problem is in fact the poverty of rural areas—that is one of the problems, because there is also lack of transportation and so on—but poverty in and of itself means that a disproportionate number of people who live in rural communities rely on Medicaid or their completely uninsured.

So a dentist who is in another kind of community may be able to choose that he will see so many Medicaid patients, but he will also see a lot of patients who are private pay. But if you are in a community where the overwhelming majority of patients are poor, it becomes very difficult. We have to realize that it takes more support for people to practice in rural areas and in underserved inner city communities as well, for people to really be able to make a living. If you are relying on Medicaid, and Medicaid reimbursement is as low as we have all agreed that it is, you can imagine how difficult it is to make a go of it in a rural community when the majority of the patients are poor. If you talk to dentists throughout the country, that is what you hear.

Senator SESSIONS. And that is one reason why they are choosing to practice in the more urban environments.

Dr. SATCHER. Exactly; that is one of the major reasons. It is very hard to make a living practicing dentistry in a rural community where you are depending upon reimbursement or no pay for the care that you provide.

If Medicaid reimbursement is a problem for dentists even in established communities where a small percentage of their patients are Medicaid, you can imagine what it is like when you must rely upon that as your major source of pay.

Senator SESSIONS. Is the Medicaid reimbursement set by the States totally, or do you know the numbers on that?

Dr. SATCHER. As you know, Medicaid is a partnership between the Federal and State governments, but the States set the reimbursement. But I don't want to imply that it is just a State problem. Medicaid is a partnership between Federal and State governments, and it may well be that the Federal Government will need to provide some form of assistance to help get Medicaid reimbursement up.

States have to make that decision, and several States have made the decision, as you pointed out, to increase their Medicaid reimbursement. But when they do that, of course, they do it in the context of funding that is a partnership between the Federal and the State governments.

Senator SESSIONS. Mr. Chairman, I don't know exactly how it happened, but as you read the articles in the Mobile newspaper and talk to dentists, you get a little bit of an impression that dentists felt like they were so underappreciated and so underfunded that gradually, many of them just gave up Medicaid practice, and we ended up with a real crisis.

Dr. SATCHER. Exactly.

Senator SESSIONS. There has been an increase in Medicaid funding. The State Dental Association has worked hard to encourage dentists to get back into giving Medicaid patients, and we have had about a threefold increase in the last several years in the number of dentists who have been willing to do that. But I think this may be a bigger problem around the country than we like to think about.

Dr. SATCHER. I think it is a very big problem. Some of the same dentists who do not accept Medicaid patients and reimbursement, for example, provide free care. They join in programs to provide free care to poor children in certain communities. So it is an interesting paradox.

Senator SESSIONS. Thank you.

Senator BINGAMAN. Thank you.

Senator HUTCHINSON?

Senator HUTCHINSON. Thank you, Mr. Chairman.

I think you have covered the subject very well, but just help me to understand one thing. In your testimony, you mentioned that for every one person who does not have health insurance in our country, there are 2.5 persons who do not have dental coverage. So if there are 40 million Americans without health insurance, that equates to 100 million without dental coverage.

Why is it that health insurance plans do not typically cover dental health?

Dr. SATCHER. I am not sure that I can fully answer that question, but that is a major problem.

In the workplace, for example, we found that only 60 percent of baby boomers had dental care as a part of their insurance plans. So there are a lot of people who work every day who get their insurance from their employers, but do not get dental coverage.

Again, when we look at health comprehensively, we have to really think about oral health as a part of overall health and well-being. So you cannot segment it out and say we will take care of this part of the body, but we will not take care of that part. It makes no sense, and that is what we tried to point out in our report, that oral health is such a critical component of overall health and well-being that we have got to move to a point in this country where we incorporate it into overall health. That includes insurance programs.

Now, States set rules, I guess, for insurance coverage, and I know that there are guidelines set at the Federal level, but people really need to be educated as to the importance of oral health and the importance of it being part of the coverage.

Senator HUTCHINSON. So in fact this lack of emphasis on dental care is very shortsighted.

Dr. SATCHER. That is why I started off my recommendations with the first recommendation to really educate and change the percep-

tion of the general public and policymakers, because a lot of people do not realize how important oral health is. Some people say that it is just cosmetic. It is much more than that, even though I would not downplay the importance of the cosmetic part in terms of people feeling comfortable about themselves and relating to others. But beyond that, there are other major problems that stem from poor oral health.

Senator HUTCHINSON. From what Senator Sessions was saying, I would say that our most vulnerable population, our children, who are low-income, are faced with several barriers. We have a shortage of dentists. We also have a maldistribution of oral health care providers, and we have low participation of dental providers in the Medicaid program. And those three barriers are all interrelated as to what the reimbursement rate is, what kind of participation rate we get, and where dentists are going to locate to provide care.

Would you comment on that?

Dr. SATCHER. I think you are right. I think they are all interrelated. We are doing two things. Obviously, we have created a potentially major problem in terms of the shortage of dentists in this country, and that is looming over our heads as we speak. But also, I think we have programmed oral health services in such a way that we end up shunning people in certain areas and leaving large proportions of the population out in terms of access to oral health services. So I think they are all interrelated in terms of where dentists are—first, how many dentists there are and will be, where dentists practice, whether or not they see children who are on Medicaid. They are all interrelated in the extent to which we value oral health and the extent to which we reflect that in our reimbursement programs.

Senator HUTCHINSON. Thank you, Dr. Satcher.

Senator BINGAMAN. Thank you very much.

Let me just make one other comment and get any reaction that you may have. When I started hearing a lot about dental health problems was by visiting emergency rooms in my home State. In Albuquerque, for example, people would say, you know, you could take a lot of pressure off our emergency rooms if you could figure out some way to provide adequate dental care, particularly to kids. A lot of them are here because nobody is paying any attention to their dental health needs.

I do not know if that is true nationwide, but it is certainly something that I have encountered.

Dr. SATCHER. I do not think there is any question about the fact that emergency rooms treat a lot of problems that are not emergencies in the classical sense and would not be problems at all if people had access to primary dental health services in their communities.

In general, as you probably know, emergency rooms estimate that over half of the patients they see do not have emergencies in the classical sense.

Now, when somebody has a toothache because they have not gotten dental care, you have created an emergency. So we create a lot of emergencies by not providing primary care, if you will. So I know the American Academy of Pediatrics and the American Academy of Dentistry and the American Dental Association and others are

working very hard to increase awareness and develop models for solving these problems.

The Boys and Girls Clubs, for example—if you want to look at some of the programs around the country to try to improve access that represent private efforts, there are several Boys and Girls Club programs that are being supported. Some dental schools, for example, will send dentists in vans to Boys and Girls Clubs to provide dental health services, and some of the foundations are supporting that, like Procter and Gamble, Rosie O'Donnell, and others.

Senator BINGAMAN. Again, thank you very much, Dr. Satcher, for your testimony and your leadership on this issue. I do think the report that you issued as our Surgeon General has shined a light on the problem, and we are anxious to follow through with some actual legislation in this area. So thank you again for your help.

Dr. SATCHER. Thank you.

Senator SESSIONS. I would like to add my thanks, Dr. Satcher, for the report and for your service.

Dr. SATCHER. Thank you.

Senator BINGAMAN. We have a distinguished second panel consisting of five witness, and I will ask them to come forward now. I will introduce four of them, and Senator Hutchinson wishes to introduce one of the five.

Dr. Burt Edelstein is the founding director of the Children's Dental Health Project. He is director of the Division of Community Health at Columbia University School of Dental and Oral Surgery. I have known Dr. Edelstein for several years. He is one of our Nation's leading authorities on children's dental health, and we appreciate him being here.

Dr. Timothy Shriver is president and chief executive officer of the Special Olympics. He is a leading authority on children with special health care needs.

Dr. Gregory Chadwick is current president of the American Dental Association, operates a private dental practice in Charlotte, NC. I want to particularly thank him and the American Dental Association for their longstanding support and advocacy in improving our Nation's oral health.

Mr. Ed Martinez is chief executive officer of San Ysidro Health Center in California and a leader in addressing the needs of low-income Hispanic children along the U.S.-Mexico border.

Senator Hutchinson, did you want to go ahead with the introduction of Dr. Mouden?

Senator HUTCHINSON. Yes, I would be honored to. Thank you, Mr. Chairman.

It is a real pleasure to introduce Dr. Lynn Mouden. Dr. Mouden is director of the Office of Oral Health in the Arkansas Department of Health. He came to us from Missouri, where he had been in private dental practice and was later the associate chief of Missouri's Bureau of Dental Health.

Dr. Mouden is currently president of the National Association of State and Territorial Dental Directors. He serves on the External Review Panel at the Institute of Medicine, and he is a consultant to the American Dental Association's Council on Access, Prevention, and Interprofessional Relations.

Dr. Mouden is also very involved in my home State, where he is the State coordinator of the Arkansas Special Olympics, chairman-elect of the Arkansas section of the American College of Dentists, and is on the faculty of both the School of Public Health and the School of Dental Hygiene at the University of Arkansas for Medical Sciences. He has published numerous dental articles and lectured extensively on dental subjects, and I am very pleased that he is going to be testifying today.

I have made my apologies to him for having to excuse myself early, but I am very interested in this subject and look forward to reviewing the record.

Thank you, Mr. Chairman.

Senator BINGAMAN. Thank you very much, and thanks for being here and participating actively in the hearing.

Why don't we just start on my right with Dr. Edelstein and then go right across the table? Let me also say that we will include the entire testimony of each of you in the full record. I think the best way to proceed if you could is to make the main points or summarize the main points that you think we need to be focused on, and do that in 5 or 6 minutes each, and then we'll have time for a few questions.

Dr. Edelstein, thank you for being here.

STATEMENTS OF BURTON L. EDELSTEIN, DIRECTOR, CHILDREN'S HEALTH PROJECT, AND DIRECTOR, DIVISION OF COMMUNITY HEALTH, COLUMBIA UNIVERSITY SCHOOL OF DENTAL AND ORAL SURGERY, NEW YORK, NY; LYNN DOUGLAS MOUDEN, DIRECTOR, OFFICE OF ORAL HEALTH, ARKANSAS DEPARTMENT OF HEALTH, LITTLE ROCK, AR; GREGORY CHADWICK, CHARLOTTE, NC, PRESIDENT, AMERICAN DENTAL ASSOCIATION; ED MARTINEZ, CHIEF EXECUTIVE OFFICER, SAN YSIDRO HEALTH CENTER, SAN YSIDRO, CA, ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC; AND TIMOTHY SHRIVER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SPECIAL OLYMPICS, INC., WASHINGTON, DC

Mr. EDELSTEIN. Thank you, Senator Bingaman.

I very much appreciate the opportunity to speak before this group and to recognize the sophistication of the opening remarks and the questions that were asked of Dr. Satcher. My effort will be to put some of the facts and figures that you have heard today into context and to try to point out the opportunities that this subcommittee has to advance children's oral health.

I speak as the founding director of the Children's Dental Health Project. The Children's Dental Health Project is a not-for-profit policy shop that works exclusively to improve children's access to dental services and their oral health. I also speak as a member of two organizations—the American Dental Education Association and the American Academy of Pediatric Dentistry, the 4,800 pediatric dentists in the country who serve children with direct dental services.

My message is really quite simple, although the issue is indeed complex. The message is simply this. Far too many children suffer far too much disease that is consequential to their lives but overwhelmingly preventable. That is the irony of the entire problem.

It is wonderful that there is a hearing. It is terrible that it has to be called “The Crisis in Children’s Dental Health: A Silent Epidemic,” because indeed, it is a problem that should not exist.

The good news is that with the tremendous improvements we have had for the majority of the population, the residual problem is solvable, and there are specific actions that can be taken that can make a real difference.

How do we know that it is consequential, and how do we know it is important? I think that one of the most salient statistics, one that has not yet been featured today, is that when the National Health Interview Survey asks parents if their children have any unmet health care needs, three-quarters or 73 percent of all those who report that their children have an unmet health care need report that that need is for dental care.

So there is indeed a strong resonance with your constituencies, and there is a strong resonance in communities.

The press has become ever more engaged in this issue, reflecting the fact that the population at-large is recognizing that there is a problem. Whether we are talking about this week’s NPR story or last year’s front page, above-the-fold New York Times article, this is an issue that is getting ever more attention.

Foundations have become increasingly involved. State government has become increasingly involved. There are bits and pieces of voluntary efforts, some of which are sustainable, the majority of which are not, some of which are replicable, others that are idiosyncratic to their areas. But there are efforts underway that can lay the groundwork for Federal programs and Federal policies.

Let me consider for a moment the statistics that you have heard today but in a different context. Wrap them into a story that indeed explains what it is that we are talking about here.

In a very real sense, for those children who are still underserved, those children who still suffer significant disease, all the things that are problematic for child health care in this country are highlighted by oral health. Let me give you some examples.

You have already heard about coverage. For every child who lacks medical coverage, there are 2.6 children who lack dental coverage. Let us talk about disease burden. It was already mentioned that dental caries is five times more common than asthma. Senator Bingaman mentioned that in his opening remarks. To bring that down to a more personal level, one out of every five children between the ages of 2 and 4 has a visible cavity upon inspection. One out of every two children in second grade has experienced tooth decay.

If we are talking about access, we have a profound disparity where those children who have the greatest need have the least access, and those who have the least need have the greatest access.

If we are talking about disparities again, we have the Hispanic population, the fastest-growing population in the United States of subset of children, and these are the children who have markedly higher caries rates—kids who are putting greater pressure on the delivery system in order to be served, many of whom are also low-income and many of whom depend upon Medicaid, a program which has overwhelmingly failed in the majority of States. I think we should State clearly that Smile Alabama is a notable exception,

one of the six States that has made real progress in improving dental services.

And if we are talking about disability, I think it is important to mention that 5 percent, one in every 20 children, have disease severe enough that it impedes their normal function.

But having clearly described the problem and having heard about the problem, it is time to move along to solutions. And when we confront the solutions, the solutions themselves confront structural barriers. Some of them, you have already discussed today—work force. In work force, we have already heard about declining numbers of dentists and a maldistribution of dentists. But we also have a real profound problem with the diversity of dentists. The dentists of America do not reflect the composition of the American population. We also have an issue about the dentists' preparedness and comfort with treating those children with special health care needs, those children who are very young, those children who have the most advanced disease.

We have a safety net issue. Any child with a broken arm can find his or her way into any emergency room and obtain care for that broken arm; but any child with a toothache, as you heard Dr. Satcher say, can get to the emergency room but will walk out only with pain medication and perhaps a prescription for antibiotics—no definitive care.

We have a problem in education. Our dental schools are small in number—there are only 55—and we have a real crisis coming in the number of dental school faculty, with over 300 unfilled funded slots in dental education today.

Perhaps most important, NIH has done some tremendous research on the cause and progression of tooth decay. Some of that has simply not made it over to programs that identify children by risk and bring all the benefits of science to truly preventing disease in the first place.

What are those congressional opportunities? The first is oversight. There are tremendous programs out there already that simply require closer congressional oversight to ensure that when they are talking about children's health, they mean children's total health and not just their medical care.

The second is authorizing legislation like S. 1626—a bill that fills in some of the gaps that are missing because dental health had not in prior years been considered as important as your group now considers it.

The third is appropriations to appropriately empower and sustain programs that can make a real difference.

And of course, perhaps the most important is simple, straightforward leadership on your part, leadership that champions this problem and makes clear to the public that you hear them and that you understand what a problem it is for parents.

So on behalf of America's children, on behalf of America's parents, we thank you. We thank you for S. 1626. We thank you for the other efforts represented, and most of all for the tremendous bipartisanship that this issue has received. And we look forward to supporting your efforts to move this from a bill to a markup to legislation that becomes law to programs that really make a difference for children.

You see pictures here of the kinds of conditions that children are in. This committee, with its concern for education, works hard to make sure that there are school lunch programs, that children are well taken care of and prepared to learn. We have already heard that if they are in poor dental health, they are not prepared to learn. Not only do we provide them with lunch programs, but now, let us make sure that they are able to eat them.

Thanks very much.

Senator BINGAMAN. Thank you very much, Dr. Edelstein.

[The prepared statement of Mr. Edelstein may be found in additional material.]

Senator BINGAMAN. Dr. Mouden, thank you very much for being here. Please go right ahead.

Mr. MOUDEN. Thank you, Mr. Chairman.

As both Arkansas' State dental director and as president of the Association of State and Territorial Dental Directors, I thank you for the opportunity to talk about the importance of improving oral health for all of America.

I would like to start by answering a question you asked earlier about why we seem to have let oral health slide down the ladder of importance. I think it is a matter of national priorities. Quite frankly, we live in a country where even insurance companies are allowed to end their insurance coverage the neck. For reasons unknown, we do not cover, dental, mental, and vision in the same way that we cover other health problems.

I would like to give a little perspective on Arkansas and then reflect on the country as a whole. Arkansas is often described as the unhealthiest State in the Nation based on a wide variety of health indicators. It also mirrors the Nation in that oral disease remains pervasive among families with low income, those with limited education, the frail elderly, persons with disabilities, those who are underserved, and ethnic minorities.

Arkansas' recent Statewide oral health assessment showed that on average, Arkansas third grade children suffer from three cavities each, and Statewide, more than three-fourths of our children have had tooth decay.

Obviously, the slogan of the 1960's of "Look, Ma, no cavities," is not being realized in Arkansas. Worse yet, Arkansas is not unique.

More than 40 percent of Arkansas' children attend school with untreated cavities, and one in 12 has emergency dental needs. Such severe dental problems adversely affect how these children eat—or cannot eat—how they sleep—or cannot sleep—how they succeed in school—or cannot succeed. These children also enter adult life with a mouth that no one would hire to smile at a customer.

Consider for a moment if these same dental statistics applied to the 100 Members of the U.S. Senate. I wonder how well the Senate's business would proceed if 40 Senators had untreated tooth decay and 8 of them tried to work with a toothache. I will leave it to the members of the committee to decide which eight they would like to have a toothache. [Laughter.]

Senator BINGAMAN. That may be why we have such trouble getting along with some of our colleagues here. [Laughter.]

Senator SESSIONS. Some give me a headache. [Laughter.]

Mr. MOUDEN. Our problems are even worse in the Mississippi River Delta and in the inner city of Little Rock, with 50 percent more of the children needing emergency care. These areas are predominantly poor and with a higher percentage of ethnic minorities.

A recent screening brought one such child to our attention. The boy, when asked if he had a toothbrush, responded: "Yes, but it does not have any hairs on it anymore." The toothbrush was so worn that it no longer had even one bristle, but by the same token, he was proud to have a toothbrush.

Insufficient funding of Medicaid continues to plague Arkansans. Arkansas Medicaid only pays approximately 50 percent of a participating dentist's usual fees. In a profession where overhead is typically 70 percent of income, it is amazing that dentists are put into a unique position of having to subsidize their services by providing dental care at less than cost.

And increased funding for Medicaid is not the whole answer, because dentistry's commitment to the underserved is well-documented. In Arkansas alone, dentists donate more than \$8 million each year in free dental care. However, it is often the bureaucratic barriers that can make participation in Medicaid an administrative nightmare for dentists.

S. 1626 provides several methods to ensure optimum oral health for all. The requirement that States provide adequate reimbursement to dentists will bolster our system. The requirement that State plans guarantee access for children equal to that available in the general population will ensure dental care for those children at highest risk.

S. 1626 also provides an important initiative to support oral health promotion and disease prevention. Dentistry and State oral health programs have a long history of primary prevention activities. Community water fluoridation has long been heralded as the most effective, most economical and safest method for preventing tooth decay. However, without continued and increased funding to support fluoridation, communities working to balance difficult budgets often discontinue this important public health program.

In addition, other proven prevention programs such as dental sealant initiatives also rely on Federal support for success.

Although fluoridation and dental sealants are proven prevention methods, Arkansas has only 59 percent of its citizens enjoying the benefits of fluoridation, and only one-fourth of our children have dental sealants. In the poorer areas of Arkansas, less than 2 percent of our children have sealants.

Arkansas recently received a grant from the CDC Division of Oral Health—and I do ask that the written comments be corrected, that it is the "Division" of Oral Health. Through that grant, our State has made tremendous inroads in establishing rural health partnerships throughout Arkansas. The grant has helped us ensure effective preventive activities. We are now able to reach out to other professions, educating them on the effect of oral health upon a patient's general health. We also have new programs to enhance oral health services for our most vulnerable populations, especially those individuals with developmental disabilities.

However, only five States received this funding in 2001. S. 1626 would greatly enhance support for State and local programs, allow-

ing us to increase access for the underserved populations of Arkansas and the Nation.

In addition, I encourage you to support increased funding to the CDC to build upon the successful cooperative agreement initiative.

In 2000, our association published a study on infrastructure and capacity in State oral health programs. The study identified the administrative and financial barriers to improving the Nation's oral health. Leadership from State dental directors is imperative to make dental public health programs succeed. However, even among the members of this committee, some of these States do not have dental directors so are already lacking in dental public health resources.

Many Americans enjoy the highest quality of dentistry in the world. If a child lives in Maumelle, AR and has plenty of money, access to dental care is no problem. However, if that child lives in poverty in the Arkansas Delta, access to dental care is almost impossible. Eliminating disparities in oral health must be our goal.

In closing, I want to thank you, Mr. Chairman, for recognizing the oral health crisis in this country and for the efforts to make a difference.

I applaud Arkansas' Senators Hutchinson and Lincoln and the others who have supported this effort.

I thank you for giving us the chance to champion the chance for all American children to enjoy oral health—to eat, to be free from pain, and to smile. I ask that you continue to work with us, those of us at the local, State, and national levels, to make optimum oral health for everyone in America a reality.

Thank you.

Senator BINGAMAN. Thank you very much.

[The prepared statement of Mr. Mouden may be found in additional material.]

Senator BINGAMAN. Dr. Chadwick, please go right ahead.

Mr. CHADWICK. Thank you, Mr. Chairman.

I am Greg Chadwick, president of the American Dental Association, which represents over 70 percent of the dentists in this country. I speak today on behalf of the community of dental professionals.

We are sincerely grateful for this opportunity to present to you at this first ever hearing on oral health and children's health.

Dentists are proud that most Americans enjoy excellent oral health, but we also believe it is a national disgrace that in America today, thousands of children cannot sleep or eat properly, cannot pay attention in school, and do not smile because of untreated dental disease which is so easily preventable.

Dentists are fighting to bring these children into the system, but we cannot do it alone. Until we as a nation find the political will to make oral health a priority, our children will continue to suffer.

While we are making progress, our biggest challenge remains convincing legislators that oral health is just as important as medical care, and not simply a throwaway benefit or the easiest program to be cut from a tight budget.

We are committed to changing this. Next February, the ADA will join dental societies all across the country in a one-day campaign

to deliver free services to children who would not otherwise receive dental care.

Although the "Give Kids a Smile" project will help thousands of children, our larger purpose will be to deliver the message that we cannot solve this problem alone and that for every child that we care for that day, there are hundreds of thousands more that will continue to suffer until the Nation gets serious about oral health.

Charity alone will never fix the problem, because charity is not a health care system. The real irony is that preventive programs could effectively eliminate dental disease, and they do not cost a lot of money. Community water fluoridation and sealants can prevent pain and save billions, yet 100 million people in this country do not have access to fluoridated water.

Take a look at the posters that we have brought today. One of them shows a 4-year-old boy who was hospitalized for 5 days with a preventable facial infection, costing the taxpayers over \$20,000. Routine dental care would have prevented the pain, the emotional trauma, and the expense.

The problems are clear, and the solutions are not difficult. The missing element is committed leadership at the national and State levels.

The dental Medicaid program is broken. Some State Medicaid programs reimburse dentists at 30 cents or less for every dollar of care provided. The cost to provide the care is over twice that much, exclusive of any compensation to the provider.

Many States set fee structures that are inadequate and then leave them in place for as long as 15 or 20 years. Here in our Nation's capital, Medicaid rates have not increased, even to cover the cost of inflation, since 1985.

Federal law under Medicaid requires the States to cover and provide dental services to children, but States are struggling to make ends meet, and the Federal Government is not enforcing the law. All in all, government is not living up to the statutory obligation. The cost of this untreated childhood disease has far-reaching consequences. People who do not have teeth do not have good jobs.

Some States are testing innovative programs to improve Medicaid and SCHIP programs. Michigan, for example, has designed a program that functions very much like a private program, with rates and features that mirror the marketplace. Consequently, the number of children treated has increased from 18 to 45 percent.

There are other good States examples like, for example, the Smile Alabama program, which has been mentioned a couple of times today.

Another barrier to access is lack of dentists, particularly pediatric dentists, in underserved areas. Congress can help States establish programs to attract dentists to underserved areas, especially rural areas, through tax credits and student loan forgiveness.

This committee can also support HRSA dental training programs that have been targeted for severe cutbacks and sometimes even elimination.

We must also strengthen our dental schools, which are front-line and in some areas a main delivery system for care. Many dental schools face faculty shortages and lack of diversity among faculty and student bodies. Additional support is vitally needed to train a

future dental work force so that access problems are not exacerbated.

I want to take a moment to thank you, Mr. Chairman and also Senator Collins, for your leadership in introducing bills to help more States pursue innovative solutions to improve children's access to care. You and your cosponsors are taking action, and I urge all Senators to join you in passing these important bills.

I wish I could tell you that if Congress did a few simple things, the problem would be solved, but I cannot. And our profession does not expect Congress to solve the Nation's oral health crisis with a stroke of a pen. But we do expect you to join us in making this a national priority. Let us start with our children, our common future, and build outward from there.

Thank you, and we look forward to work with you, Mr. Chairman.

Senator BINGAMAN. Thank you very much for your testimony, Dr. Chadwick.

[The prepared statement of Mr. Chadwick may be found in additional material.]

Senator BINGAMAN. Mr. Martinez, please go right ahead.

Mr. MARTINEZ. Mr. Chairman, thank you very much.

My name is Ed Martinez, and I am the CEO of San Ysidro Health Center in San Ysidro, CA, which is a small community in the southern part of the City of San Diego adjacent to the U.S.-Mexico border.

It is my privilege this afternoon to testify in support of S. 1626 as a representative of the National Association of Community Health Centers and the millions of patients that we take care of every year.

Currently, there are nearly 800 federally-supported health centers operating nearly 3,400 community sites across the country. Together with more than 200 other health centers known as FQHC look-alikes, we treat approximately 12 million people annually. Out of this population, 5 million are children.

Our dental network consists of 402 dental clinics. We employ approximately 1,000 dentists. In the year 2000, we had 1.3 million dental patients. We have generated approximately 3 million dental visits.

Collectively, we have produced a model of health care that has demonstrated that this Nation can meet compelling health needs while containing health care costs. The health center legacy probably shows the value and vast potential of a community-based health system that is lifting the barriers to health care, safeguarding health, revitalizing communities, keeping people healthy at cost savings to the Nation.

A few words about my health center. It was started in 1969 by a local women's organization that was interested and concerned about the lack of dentists and doctors in their community in San Ysidro. The women went to the San Diego Medical Society and the University of California School of Medicine and were collectively successful in opening a free clinic in 1969.

Today, through the help of State and Federal resources and private foundations, we operate a network of nine neighborhood health centers, and we have approximately 40,000 registered pa-

tients. Last year, we generated 180,000 visits in medical, behavioral, and dental health services.

Our patient population is 80 percent from the Latino background of low-income households. Our services emphasize early screening and intervention which are key to oral health initiatives.

What has been our experience in terms of oral health? Since 1973, when our first dental clinic opened, we have been the primary dental safety net for the South Bay Region of San Diego County. Each month, we treat approximately 1,700 patients, adults and children. Out of this population, about 500 children are under the age of 10. Most of these children present at our dental clinic with advanced stages of dental disease. Most if not all come from families without medical and dental insurance.

At the urging of our dentists when I first arrived at the health center 4 years ago, we decided to perform an oral health needs assessment in our community. We did this in the year 2000. Our dentists spent 4 months in the community, going to preschools, Head Start programs, local school districts. We examined 2,000 children all under the age of 5. The statistics were alarming. Sixty-nine percent of the children surveyed had untreated dental disease. Forty percent had one to six caries. Twenty percent, or almost 200 children, had 12 or more caries.

We know from other studies that 5 percent of this population, or approximately 100 children, would eventually require restorative care in the operating room under anesthesia. In our State, this kind of procedure will cost Medicaid close to \$5,000 to \$7,000, something that we all pay for.

This information was very clear and explained why the dentists were so frustrated working at 100 percent capacity to keep up, or at least try to keep up, with the tidal wave of underserved children with dental disease. I think it is fair to say that collectively across this country, we are all caught in a frustrating cycle of running to keep up with this increasing demand for treatment, while recognizing the fact that over time, the only effective way to reduce the burden of children's dental disease is to implement community-based disease prevention and health promotion initiatives.

With limited program capacity and increasing dental disease among children, additional resources are desperately needed to effectively respond at the community level. I am here today to say that the health centers in America stand ready to work on improving children's care and oral health and on improving the implementation of S. 1626.

There are three primary reasons why I feel that we are up to it. No. 1, health centers are strategically positioned, uniquely positioned, to make S. 1626 successful. We are located in high-need underserved communities, and the communities trust us.

We have a nationwide care delivery system of 3,400 delivery sites in underserved communities. We are governed by community boards, and we have a legacy of organizational commitment to serving those who have no insurance or are underserved and in need of care.

Second, health centers are in a high State of readiness. Although our safety net is thin, and in some areas, it has holes in it, our commitment is strong. We have a multidisciplinary work force that

is committed to working in our community centers. They could work anywhere because of their background and experience, but they choose to serve the community.

We have the essential administrative infrastructure in place to manage service expansion initiatives in a cost-effective and timely manner.

I believe we have effective accountability systems in place that can manage and oversee the financial management and quality assurance of our services.

We have developed a history of effective community-based disease prevention programs and pediatric and prenatal programs—again, early screening and early intervention.

Finally, health centers can deliver much of what S. 1626 proposes. We work with the children in the communities that are at risk now. We can find the children who are at risk.

We have treatment programs in place. We can connect the children to treatment services. We have essential enabling and support services such as translation, transportation, help with referrals. Once the children are in service, we can support their families in the maintenance and continuity of the care, which over time is really the secret to what we are talking about.

Finally, we have the passion and the commitment at the community level to develop innovative strategies and procedures for preventing disease, engaging parents, and long-term sustainable efforts to stop the cycle of disease.

For all of these reasons, I believe that health centers stand ready to support you in this very important initiative.

Thank you very much.

Senator BINGAMAN. Thank you very much for your testimony, Mr. Martinez.

[The prepared statement of Mr. Martinez may be found in additional material.]

Senator BINGAMAN. Dr. Shriver, please proceed.

Mr. SHRIVER. Mr. Chairman, Senator Sessions, distinguished guests, Special Olympics volunteers—among whom I gather I have a colleague on the panel—distinguished panelists, Special Olympics athletes and family members who are here, I am enormously grateful, like the other members of the panel, to be here.

I come representing a movement of a million athletes participating in the Special Olympics around the world, over 500,000 who participate in this country alone every year. It is a movement that is 35 years old and built on a simple concept. It is built on the concept that everyone deserves a chance and everyone when given a chance can make a difference.

Special Olympics just completed its first publication designed for and by athletes. I want to recognize Renee Deitz, a former athlete who is here, who helped in the design of this little booklet which you have in front of you. It brings sound health care advice to our athletes when they come to our events and enter our health screenings. It has a mirror on the cover which cost a few cents extra, but the athletes told us it was an important reminder. I encourage the possibility that we might think of the mirror in a different way than a toothache, as a mirror on our own responsive-

ness to this population as we proceed with this legislation and its important agenda.

I think that if we were to look in the mirror today and ask the question, are we responding to the health care needs of people with mental retardation, we would have to answer no.

I come today after several years of embarking on this work in the Healthy Athletes Program to say that the athletes of Special Olympics who are Americans, who deserve respect, who are heroes in some cases in their own communities, are reporting being shunned, discriminated against, overlooked and forgotten in the delivery of health care to them and to their families in this country. They are not, Senators, being given a chance in the way in which our movement would hope to embody.

We first learned this 7 year ago when, at the Special Olympics World Summer Games in Connecticut in 1995, we had 40,000 volunteers and for the first time set up health screening centers providing health screening in oral health and eye health and vision health. At the end of the week, I heard the results of the several thousand athletes who had passed through those screenings. On the oral health care front alone, 68 percent of the athletes had gingivitis; one in three athletes, untreated decay; 20 percent, one in five, reported pain in the oral cavity. Fifteen percent had to be referred to emergency rooms from the Special Olympics venues because of such severe pain or disease.

In the days that followed, we embarked on an attempt to understand this. We talked to several doctors, and I remember one explanation in particular. A doctor took me aside and said, "Tim, in most cases, doctors do not want to treat these patients. They either do not know how, or there are not adequate reimbursements, but often even when they do, it is not real care. It is a 'quick and dirty'—get them in, get them out."

Other doctors have reinforced this unfortunate situation. Just last month, one of our leading dentists, Dr. Steve Perlman, who has blue-chip credentials, talked about changes in the dental profession over the last 20 years. He said, and I quote: "Almost everyone has given up treating Medicaid patients, and it seems all have given up treating people with special needs. Many of us were told by our fellow professionals, Oh, you take care of people with special needs because you are not good enough to treat normal people; you can get away with anything."

When he makes referrals, he says he refers patients to other specialists, and he has met with: "If you let one in, you let them all in."

Over the last few years, we have tried to respond to this crisis. We have created this health program called Healthy Athletes which includes year-around community-based health screening, care, and referral efforts designed to reach people with mental retardation and closely-related developmental disabilities and their families. It is enormously successful, and it is growing. We are continuing to seek Federal support for its expansion. We believe that it is a model for a nontraditional public health delivery system using a sports program to deliver at least some basic information, care, and referral services at events like Special Olympics. But we just cannot continue to listen to parents, who tell us over and over

again: “I cannot find a dentist to treat my son” or daughter. I know you can imagine from your own work with your constituents how painful it is to hear that message—and sometimes it is transportation, but frequently, it is training or openness or willingness to care.

This bill holds great potential, and I support the statements of all the prior speakers including and especially former Surgeon General Satcher, who has been an advocate for the health care needs of people with mental disabilities.

However, Senator, you mentioned earlier the opportunity to have input and make suggestions. I would respectfully ask that you consider the possibility of specific mention of the oral health care needs of people with mental retardation and closely related developmental disabilities.

Our experience shows very simply that when they are not mentioned specifically in legislation, they are overlooked. I know there are thousands of special interest groups, but this is a population that is routinely and regularly overlooked in the delivery of these kinds of services, so specific mention of policies to affect reimbursements for the care of people with mental disabilities—specific mention of requirements for provider training in the care of people with mental disabilities—would be enormously valuable additions to this bill and would give us a sense that when it is enacted, as I’m sure it will be, our population will not once again be forgotten.

My time is up, but let me close with a short story that came to me last week from a mother of one of our athletes whose son graduated from high school in Vermont last week. She describes her son preparing to give a short, 2-minute speech. Her name is Kim Daniels, her son is Troy Daniels.

Troy’s speech was only 2 minutes long, but I want to quote from it here today. In part, he said in his speech—this is a young man with Down syndrome who often uses a communicative device because he is hard to understand—but speaking on his own, he said: “Not long ago, people with disabilities could not go to school with other kids, could not have real friends. Not long ago, they called people like me ‘a retard.’ That breaks my heart. When I came to school, there was a law that says all kids go to school in the place where they live. The law says that I can come to school, but no law can make me have friends. I want all people to know and to see that the students I call my friends are the real teachers in life. They are showing you how it should be. They are the teachers for all of you to follow their lead. Yes, I am a person with a disability, and the law says I am included—but it is my friends who say, ‘T.D., come sit by me.’”

At the end of Troy’s speech, there was a standing ovation, as you might guess. But today, I come with the simple message, really echoing his words, that I am asking on behalf of our athletes and their fellow citizens with mental disabilities, over 7 million in this country, that the U.S. Senate and the United States Congress, leading policymakers, the people on this panel and others, listen to Troy’s invitation and say to him: “Come sit by me. Come sit in my waiting room. Come and sit in a dental chair and receive the care that you need and the care that I will give you.”

This is a population that has its own special challenges; it needs special attention in order to receive the just care that it deserves.

Thank you.

[The prepared statement of Mr. Shriver may be found in additional material.]

Senator BINGAMAN. Thank you, and I thank all the witnesses. I think this has been very valuable testimony.

Let me ask a few questions, and I am sure Senator Sessions will have a few questions as well.

On the issue of work force shortages that we have all talked about and several of you discussed, what can we be doing proactively other than what we have in this legislation, if there are thoughts that any of you have, to deal with this growing problem?

In my State, we have never had a dental school. We have always depended on people in our State who wanted to become dentists going to some nearby State and getting their training and hopefully coming back. More often than not, they decided not to come back for financial reasons or whatever. I think we are 49 out of 50 States in the number of dentists that we have per capita in my State of New Mexico. So if the Nation overall has a shortage of dentists, we have a real shortage of dentists in my State.

What can we be doing to solve this problem? It seems to me like something does not fit here. The compensation levels are very high for dentists in my State—at least, that is what I am informed. It is a very good profession to pursue from a financial point of view. There are problems getting dentists to settle in rural parts of our State, but that does not explain to me why there is an overall shortage.

If any of you has some additional insight into this, I would be anxious to hear it.

Dr. Chadwick, you are in charge of the dentists in the country. Why don't you explain it first?

Mr. CHADWICK. I wish I were in charge of the dentists. If you will make me in charge of the dentists in this country, we can get some things solved.

Senator BINGAMAN. OK. Go ahead and tell us the answer.

Mr. CHADWICK. You started your comments by saying "other than what is in our bill"; I would say first of all, let us make sure that the things that are in the legislation—well, first of all that we get the bill passed, and then we begin to implement it. So I think you are off to a great start, and I think you have some of the more salient features.

I would point out two that jump out at me in your legislation. One is the loan repayment provisions, and the other is the \$1,000 per month stipend for those who see a significant number of Medicaid patients. According to the students, that is significant, so we certainly would not want to underestimate those.

In general, I think we need to make sure we are providing adequate financial incentives for advanced general dentistry programs, for residency programs in pediatrics, to treat some of the children in the rural and underserved areas.

You said the problem was overall. I suspect that in the more urban areas, you probably have an adequate number of dentists. It is when you go into those underserved areas, and therein lies the

challenge of beginning to get people to go to or back to an underserved area. I think Dr. Satcher put it very well. In poorer areas, there is often not enough to attract physicians and dentists to those areas. So I think we have to give them some special incentives.

I was speaking to a dentist in rural Kansas not long ago, and he said, "I do not have anybody to take over my practice, and I have lived here and practiced here all my life." And in the conversation, it turned out that he had a daughter who was in dental school, and he said that she was coming back to take his place, but she is marrying a physician, and they have decided to stay in Kansas City. So therein lies our challenge, which is providing adequate incentives to get people back to those rural areas.

Let us not discount the diversity issue, either. We need to attract more diverse students to our dental schools. We need to attract more diverse people into our profession. Certainly, our patients are a lot more diverse than our profession itself.

Last weekend at the ADA, for example, we had a conference on diversity, and we met with a number of these groups, and one of the main things that we were talking about in that afternoon was how can we work together to recruit minority dentists, racial and ethnic minorities, into dentistry. And I do not think the place to look is necessarily in the high school senior class or the folks who are in college. Maybe we need to go back even further; maybe we need to be talking about this in junior high and in early high school with guidance counselors to begin to get people to realize that there is a possibility for a profession in dentistry.

Senator BINGAMAN. Let me ask Dr. Edelstein or any of the other panelists, does it make sense to do what Dr. Shriver is recommending here and build into the training of dentists and dental hygienists and others some particular training related to individuals with mental disabilities? Is that something that is in the training now, and should it be in the training?

Mr. EDELSTEIN. Without doubt, it is essential, and it relates very closely to your former question about the number of dentists available, because the number of dentists available really matters at the level of the number of dentists available to those who most need services. So it is a complex issue that relates to productivity, accessibility, dentist preparation and comfort with the various patients who most need services—and not just numbers.

So that, for example, let us look at Michigan as an example of a State that has made a major reform. Overnight, by changing the administration of their Medicaid program, the Medicaid child became identical to the commercially insured child, and service rates begin to approach the commercial insured rates for children. There were no increased numbers of dentists in the demonstration counties. There was simply a change in the program so that the children on Medicaid looked identical to the children in the premium insurance program.

Senator BINGAMAN. And that was because they raised the reimbursement rate under Medicaid?

Mr. EDELSTEIN. Not only did they raise the reimbursement rate, but the State signed onto a commercial network using the standard methods that dentists use for filing claims, for having prior authorizations—all the paperwork that is involved in running a dental of-

office became identical for Medicaid as for the commercial program. So it just fit with and made sense to the private dental community.

The safety net is equally hampered by low Medicaid reimbursement, and it has tremendous capacity where private providers are not as available. But the overwhelming numbers of dentists today are still located in the private sector, so programs like Michigan's that bring in the private sector to people who would otherwise have no access become critically important.

Senator BINGAMAN. Let me ask one more question, and then I will defer to Senator Sessions.

Mr. Martinez, you indicated that there are 3,400 community health center delivery sites in the country.

Mr. MARTINEZ. Yes.

Senator BINGAMAN. And there are 402 dental clinics.

Mr. MARTINEZ. Yes.

Senator BINGAMAN. If I am understanding those numbers, the obvious conclusion is that there is a tremendous number of delivery sites that do not provide any kind of oral health care.

Mr. MARTINEZ. That is correct. One of the issues that we are dealing with is the capital required to buy the equipment, which is very expensive; it is about \$40,000 per operatory, to do the construction, recruit the staff. There is a scarcity of resources right now that we are all dealing with, and consequently, of the 800 federally-funded health centers, about 402 have dental clinics.

There is an expansion initiative that the Bureau of Primary Health Care has right now, and they are providing additional dollars to allow centers to add dental to their program.

If I could, I would like to talk a little bit about the pipeline of professionals, dentists. I think we can do more in the area of finding students early, in elementary school, and introducing them to the profession of dentistry.

We are affiliated with a local hospital at the University of California, and we have a family medicine residency training program. Next year, one of the first graduates will be a gentleman, a doctor, from San Ysidro. His mother brought him to the clinic for his shots when he was an infant. He graduated from Harvard Medical School and had the choice of different residencies to complete, and he selected our center. So we "grew our own," and I think this is what we have to do, partnering with dental schools. There are some high schools that have health career programs, and bringing the students in and showing them what the dental profession is all about, I think will do a lot.

Senator BINGAMAN. Thank you.

Senator Sessions?

Senator SESSIONS. Thank you, Mr. Chairman.

This has been extremely interesting, and I guess the question gets down to how can we actually make things work better, and Mr. Chairman, I believe that the legislation that you are proposing takes us a good step.

Dr. Chadwick, you are familiar with dental practice in America, the practical aspects of it. What can we do to identify at an earlier age, and are we doing enough through schools and other institutions to identify children with problems, to use sealants, as Senator Bingaman suggested? Could we, through management and with, all

things considered, a relatively small amount of money make some big progress in identifying and protecting children earlier?

Mr. CHADWICK. I think certainly we could, and I think prevention has to be our gold standard. You have got to appreciate that dental disease starts, it progresses, and it keeps on going. It is not like a common cold; you do not get rid of it. You have got to either restore it or, if it is in a primary tooth, that tooth comes out. It is completely progressive.

So prevention works if you can start at the beginning of the pipeline. It would be an interesting experiment if we could actually get a commitment from everybody in this country that oral health was important, and we agreed on that today. The first baby born right now would not have a tooth for 6 months, so we would have 6 months to get this thing under way and then, have every baby seen when their teeth first erupt by a dentist to diagnose any problems and then have the team begin to apply sealants and fluorides and so on. We could really curtail that common disease of childhood which is dental caries.

But yes, prevention works. It is a good investment, especially when you talk about sealants and why don't you just go ahead and put sealants on teeth—

Senator SESSIONS. Why don't we?

Mr. CHADWICK. One reason—let us do it, but let us do it in the right order. It is kind of like painting a house. If you have peeling paint, and you have problems in the wood, you do not just put a new coat of paint on it. It is the same thing with sealants. If we are going to do something like this, let us have those children see a dentist; let us diagnose the problems and see if there are any minor problems there to begin with, and let us go ahead and treat those and then put the sealants on—and then, let us see them periodically every couple of years or every year to see if those sealants are holding up and if one of them needs to be replaced.

And while we are talking about prevention, let us not forget fluoride. That does not require going to a dentist or anything. All you have to do is drink water that has been fluoridated. And as I said in my statement, we have 100 million people in this country right now who do not drink fluoridated water—and fluoride is about 60 percent effective in preventing decay.

Senator SESSIONS. Dr. Edelstein, in terms of investment—you have stated these numbers—it seems like this is a winnable war. It is an effort where, for a relatively small investment, we could get tremendous returns which would save larger costs and may even come close to paying for itself. Certainly, if it does not pay for itself financially, it does health-wise for the people that we treat.

Do you have any comments on that?

Mr. EDELSTEIN. Without forgetting about the children who already have disease that needs to be repaired—and that is an expensive bill—without forgetting about those children, the promise of comprehensive care that has an essential preventive component is tremendous. You have real potential cost savings.

Senator SESSIONS. But the ones who need care now will only get worse and become even more expensive with every week that goes by unless they are treated; isn't that true?

Mr. EDELSTEIN. Absolutely. As an expression of that, CMS was asked to estimate the cost of general anesthesia procedures just to have children treated under general anesthesia, because they are very young and their disease is severe. The estimate was that \$100 to \$300 million a year of Medicaid expenditure in the country go to general anesthetic services that make it possible to provide restorative care.

So there are some significant expenses. On the other hand, the cost of dental services in Medicaid across the country averages about 0.5 percent of total State Medicaid expenditures. If a significant increase were implemented, we would still be talking about a very marginal cost in a large program.

So the potential to spend little and have tremendous results as you suggest is absolutely the case.

Senator SESSIONS. Mr. Martinez and Dr. Edelstein, I recently visited with Claude Allen, Secretary Thompson's top assistant, five community health centers in rural areas in Alabama. I remember distinctly that one of them had a fully-equipped dentist's office with no dentist; others were having trouble getting dentists part-time. This is a real problem.

After that visit, I am inclined to believe that we need to enlist the private health care system more and work more effectively with the community health centers, but do you have any comments on how we can deal with this problem?

Mr. MARTINEZ. This is a problem. In our community, we have rural areas in East San Diego County and parts of the north county. All the clinics in San Diego came together as a consortium and approached a local foundation for some support to put together a dental safety net that would cover the country geographically. Our thought was that we would first build the primary care treatment with basic funding, and then go on to request other funding for a specialty pool where we could contract with specialists, dentists working as specialists who could go to different centers on a limited basis, maybe 1 day a week, and provide services needed in that community. We are looking at mobile services as well.

I think the key is that the health centers and the local dental society community, working together, can best solve this problem, because really, it is a community problem.

Senator SESSIONS. Dr. Edelstein and Dr. Chadwick, if you would like to comment on that, too, I would appreciate it.

Mr. EDELSTEIN. I would like to echo Ed's remarks and suggest that HRSA does allow the contracting of private dentists to community health centers, and that is a potential avenue for expanding the availability of services for the populations that seek care in community health centers and engage them in a situation where comprehensive dental care is available.

Senator SESSIONS. Dr. Chadwick?

Mr. CHADWICK. I would really just echo that, but I did want to bring up one point. When we were talking about the community centers, we talked about how prohibitive it could be to have a dental clinic in some of them because it was \$40,000 per operatory. That is why the dentist's overhead is so high, because the dentists have already put that capital investment out there.

So I am really encouraged to hear about the possibility of working with the community health centers, maybe on a contractual basis, to let some of those children be funded, and let them be seen in the dental offices. We have about 180,000 dentists out there, and most of them have dental offices that these children could be seen in, either contractually seen in a health center, or seen in the private dental office.

Senator SESSIONS. Thank you, Mr. Chairman, for this good hearing. I would just say that I would like to know why we are having so many people turned down for medical and dental schools when everybody is saying we need more doctors and dentists. I think that is a problem that we need to work on also.

Senator BINGAMAN. Again, thank you all very much for your testimony. I think it has been very useful. We will urge our colleagues to support our efforts to pass this legislation, and we will do our very best to get it passed with some of the suggestions that you have made; we will try to incorporate those in the legislation.

Thank you. That completes the hearing.
[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF DAVID SATCHER, M.D.

Mr. Chairman, Members of the Subcommittee, good afternoon. My name is David Satcher—I am currently a Senior Visiting Fellow at the Henry J. Kaiser Family Foundation and Director-Designee of the National Center for Primary Care at Morehouse School of Medicine. I also served as the 16th Surgeon General of the United States from February 1998 to February 2002.

I appreciate this opportunity to appear before you today to discuss the critical issue of children's oral health. As you may know, I reported on the state of oral health in this country in May 2000 in "Oral Health in America: A Report of the Surgeon General," which emphasized that good oral health and good general health are inseparable. The report noted the remarkable strides that have been made in improving the oral health of the American people and also illustrated the profound disparities that affect those without the knowledge or resources to achieve good oral care. It also called for a national partnership to provide opportunities for individuals, communities, and the health professions to work together to maintain and improve the nation's oral health.

I am especially pleased that this hearing today focuses on children's oral health because one of my priorities as Surgeon General was to ensure that every child has an optimal opportunity for a healthy start in life—and my commitment to this issue continues today. We held a Surgeon General's Workshop on Children and Oral Health in June 2000 to bring attention to the impact of oral health on children's overall health and well-being and to promote action steps to eliminate disparities in children's oral health.

Through our extensive study of this issue, we have found that oral diseases are progressive and cumulative and become more complex over time. They can affect our ability to eat, the foods we choose, how we look, and the way we communicate. These diseases can affect economic productivity and compromise our ability to work at home, at school or on the job. Health disparities exist across population groups at all ages. Over one third of the US population (100 million people) has no access to community water fluoridation. Over 108 million children and adults lack dental insurance, which is over 2.5 times the number who lack medical insurance. Expenditures for dental services alone made up 4.7 percent of the nation's health expenditures in 1998—\$53.8 billion out of \$1.1 trillion. As you can see, there are many reasons we need to pay more attention individually and collectively to our oral health. But there are also opportunities for action—for all health professions, individuals, and communities to work together to improve health. But first I'd like to discuss the actual findings of our report.

MAJOR FINDINGS OF THE SURGEON GENERAL'S REPORT ON ORAL HEALTH

For years Surgeon General's reports have helped frame the science on vital health issues in a way that has helped educate, motivate and mobilize the public to deal more effectively with those issues.

When we speak of oral health, we are talking about more than healthy teeth. We are talking about all of the mouth, including the gums, the hard and soft palates, the tongue, the lips, the chewing muscles, the jaws; in short, all of the oral tissues and structures that allow us to speak and smile, smell, taste, touch, chew and swallow, and convey a world of feelings through facial expressions.

With that in mind, oral health means being free of oral-facial pain conditions, oral and pharyngeal cancers, soft tissue lesions, birth defects such as cleft lip and palates, and a host of other conditions.

We also found that oral health is integral to overall health. Simply put, that means you cannot be healthy without oral health. New research is pointing to associations between chronic oral infections and heart and lung diseases, stroke, low birth-weight, and premature births. Associations between periodontal disease and diabetes have long been noted. Oral health must be a critical component in the provision of health care, and in the design of community programs.

Looking at the oral health of our country, there is good news and bad news. The good news is that there have been dramatic improvements in oral health over the last 50 years. Great progress has been made in understanding the common oral diseases, such as tooth decay and gum diseases. This has resulted in marked improvements in our oral health. Today, most middle-age and younger Americans expect to retain their natural teeth over their lifetimes.

Even so, the bad news is that we still see a "silent epidemic" of dental and oral diseases across the country. Many of us still experience needless pain and suffering,

complications that devastate overall health and well-being, as well as high financial and social costs that diminish the quality of life at work, at school, and at home.

Some examples: Tooth decay is currently the single most common chronic childhood disease—five times more common than asthma and seven times more common than hay fever; Oral and pharyngeal cancers are diagnosed in about 30,000 Americans each year, and 8,000 people die annually from these diseases. They are the 6th leading cancer cause of death; Nearly one in four Americans between the ages of 65 and 74 has severe periodontal disease; And, oral clefts are one of the most common birth defects in the United States, with a prevalence rate of about 1 per 1,000 births.

Another concern we found is that not all Americans are achieving the same degree of oral health. Although safe and effective means exist of maintaining oral health for a majority of Americans, this report illustrates profound disparities that affect those without the knowledge or resources to achieve good oral care. Those who suffer the worst oral health include poor Americans, especially children and the elderly. Members of racial and ethnic groups also experience a disproportionate level of oral health problems. And people with disabilities and complex health conditions are at greater risk for oral diseases that, in turn, further complicate their health.

Major barriers to oral health include socioeconomic factors, such as lack of dental insurance or the inability to pay out of pocket, and access problems including a lack of transportation or the ability to take time off work to seek care. While about 44 million Americans lack medical insurance, about 108 million lack dental insurance. Only 60 percent of baby boomers receive dental insurance through their employers, while most older workers lose their dental insurance at retirement. Meanwhile, uninsured children are 2.5 times less likely to receive dental care than insured children, and children from families without dental insurance are three times as likely to have dental needs compared to their insured peers.

We also found that, safe and effective measures for preventing oral disease exist, including water fluoridation, dental sealants, proper diet, and regular professional care, as well as tobacco cessation. However, they are underused. For example, 100 million Americans do not have fluoridated water. And the smoking rate in America remains at about 23 percent, even though every practically every Surgeon General's report on tobacco since 1964 has established the connection between tobacco use and oral diseases.

There were 8 major findings of the report:

- 1) Oral diseases and disorders in and of themselves affect health and well-being throughout life. The burden of oral problems is extensive and may be particularly severe in vulnerable populations. It includes common dental diseases and other oral infections (such as cold sores and candidiasis) that can occur at any stage of life, as well as birth defects in infancy, and the chronic facial pain conditions and oral cancers seen in later years. Many of these conditions may undermine self-image and self-esteem, discourage normal social interaction, and lead to chronic stress and depression as well as incur great financial cost. They may also interfere with vital functions such as breathing, eating, swallowing and speaking and with activities of daily living such as work, school, and family interactions.

- 2) Safe and effective measures exist to prevent the most common dental diseases—dental caries and periodontal diseases. Community water fluoridation is safe and effective in preventing dental caries in both children and adults. Water fluoridation benefits all residents served by community water supplies regardless of their social or economic status. Professional and individual measures, including the use of fluoride mouthrinses, gels, dentifrices, and dietary supplements and the application of dental sealants, are additional means of preventing dental caries. Gingivitis can be prevented by good personal oral hygiene practices, including brushing and flossing.

- 3) Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health as well. These individual behaviors are associated with increased risk for craniofacial birth defects, oral and pharyngeal cancers, periodontal disease, dental caries, and candidiasis, among other oral health problems. Opportunities exist to expand the oral disease prevention and health promotion knowledge and practices of the public through community programs and in health care settings. All health care providers can play a role in promoting healthy lifestyles by incorporating tobacco cessation programs, nutritional counseling, and other health-promotion efforts into their practices.

- 4) There are profound and consequential oral health disparities within the US population. Disparities for various oral conditions may relate to income, age, sex, race or ethnicity, or medical status. Although common dental diseases are preventable, not all members of society are informed about or able to avail themselves of appropriate oral health-promoting measures. Similarly, not all health providers may

be aware of the services needed to improve oral health. In addition, oral health care is not fully integrated into many care programs. Social, economic, and cultural factors and changing population demographics affect how health services are delivered and used, and how people care for themselves. Reducing disparities requires wide-ranging approaches that target populations at highest risk for specific oral diseases and involves improving access to existing care. One approach includes making dental insurance more available to Americans. Public coverage for dental care is minimal for adults, and programs for children have not reached the many eligible beneficiaries.

5) More information is needed to improve America's oral health and eliminate health disparities. We do not have adequate data on health, disease, and health practices and care use for the US population as a whole and its diverse segments, including racial and ethnic minorities, rural populations, individuals with disabilities, the homeless, immigrants, migrant workers, the very young, and the frail elderly. Nor are there sufficient data that explore health issues in relation to sex or sexual orientation. Data on state and local populations, essential for program planning and evaluation, are rare or unavailable and reflect the limited capacity of the US health infrastructure for oral health. Health services research, which could provide much needed information on the cost, cost-effectiveness, and outcomes of treatment, is also sorely lacking. Finally, measurement of disease and health outcomes is needed. Although progress has been made in measuring oral-health-related quality of life, more needs to be done, and measures of oral health per se do not exist.

6) The mouth reflects general health and well-being. The mouth is a readily accessible and visible part of the body and provides health care providers and individuals with a window on their general health status. As the gateway of the body, the mouth senses and responds to the external world and at the same time reflects what is happening deep inside the body. The mouth may show signs of nutritional deficiencies and serve as an early warning system for diseases such as HIV infection and other immune system problems. The mouth can also show signs of general infection and stress. As the number of substances that can be reliably measured in saliva increases, it may well become the diagnostic fluid of choice, enabling the diagnosis of specific disease as well as the measurement of the concentration of a variety of drugs, hormones, and other molecules of interest. Cells and fluids in the mouth may also be used for genetic analysis to help uncover risks for disease and predict outcomes of medical treatments.

7) Oral diseases and conditions are associated with other health problems. Oral infections can be the source of systemic infections in people with weakened immune systems, and oral signs and symptoms often are part of a general health condition. Associations between chronic oral infections and other health problems, including diabetes, heart disease, and adverse pregnancy outcomes, have also been reported. Ongoing research may uncover mechanisms that strengthen the current findings and explain these relationships.

8) Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth, and teeth. The science base for dental diseases is broad and provides a strong foundation for further improvements in prevention; for other craniofacial and oral health conditions the base has not yet reached the same level of maturity. Scientific research has led to a variety of approaches to improve oral health through prevention, early diagnosis, and treatment. We are well positioned to take these prevention measures further by investigating how to develop more targeted and effective interventions and devising ways to enhance their appropriate adoption by the public and the health professions. The application of powerful new tools and techniques is important. Their employment in research in genetics and genomics, neuroscience, and cancer has allowed rapid progress in these fields. An intensified effort to understand the relationships between oral infections and their management and other illnesses and conditions is warranted, along with the development of oral-based diagnostics. These developments hold great promise for the health of the American people.

There are three major points I'd like to make today: 1) Disparities in oral health are profound, but with individual, professional, and community action we can work toward eliminating them, 2) There are limitations to how far providing access can go toward improving oral health, so we must adopt a balanced approach, and 3) Many opportunities for prevention exist and it is crucial that we take advantage of them.

DISPARITIES IN ORAL HEALTH

Eliminating disparities is not a zero-sum game—one person's gain does not mean another's loss. I believe that to the extent we care for the needs of the most vulner-

able among us, we do the most to promote the health of the nation. That's true of oral health, where we have seen some of the greatest health disparities.

Disparities in oral health are clearly evident from review of Healthy People 2010's goals and objectives. As the nation's health agenda for the decade, Healthy People 2010 contains 467 objectives that fall under 2 main goals. The first goal is to increase the years and quality of healthy life and is particularly relevant because it is clear quality of life can be enhanced significantly by improving oral health. In doing so, we must look across the lifespan, beginning to address oral health in early childhood and continuing all the way through the latter years.

The second goal of Healthy People 2010—eliminating racial and ethnic disparities in health—is well-illustrated by the problems in oral health. Not all Americans are experiencing the same degree of oral health. For example, African Americans are more likely than Whites to experience and die from cancer of the mouth and pharynx. Although most American children enjoy excellent oral health, a significant subset suffers a high level of oral disease. The most advanced disease is found primarily among children living in poverty, some racial and ethnic populations, disabled children, and children with HIV infection. And while dental caries have declined dramatically among school-aged children, they remain a significant problem, particularly among certain racial and ethnic groups and poor children.

The last report I released as Surgeon General, "Closing the Gap: A National Blueprint to Improve the Health of Persons with Mental Retardation," is a good illustration of oral health disparities. As many of you are aware, there's a real dearth of data on the health status of people with mental retardation, but of the data that is available, the Special Olympics may have some of the best. As part of their Special Olympics Healthy Athletes Program, they have conducted annual oral, vision, and hearing screenings and provided health assessments, health education, disease prevention and corrective health care to the athletes. One of the things they learned from those screenings is that people with mental retardation have worse health overall, including in the area of oral disease. Their findings are outlined in a joint report with Yale University. That report found that while dental services for many children are covered under Medicaid, only 1 in 5 eligible children receives any dental services each year. These data has been recently updated by the Centers for Medicare and Medicaid Services (CMS), whose statistics indicate that one million more Medicaid-eligible children now receive annual dental care than was the case when the report was published. Added to that is the fact that most states have limited dental care benefits for adults, so that individuals with mental retardation are no longer eligible for dental care coverage under Medicaid, once they reach the age of maturity.

ACCESS: NECESSARY BUT NOT SUFFICIENT

Access is a major issue when it comes to oral health. We have found people tend to pose two major reasons for not visiting the dentist: (1) denial that a problem exists, and (2) cost.

While 43 million Americans are without health insurance, 108 million are without dental insurance. Only 60 percent of baby boomers receive dental insurance through their employers, while most older workers lose their dental insurance at retirement. Meanwhile uninsured children from families without dental insurance are three times more likely than their peers to have dental needs.

But we know that addressing insurance alone, while certainly critical, is not enough. There are many barriers to oral health, and even when comprehensive dental coverage is available through states, use of dental care is low. A report by the Department's Inspector General revealed serious shortcomings in Medicaid dental programs in the United States and demonstrated that the level of reimbursement from Medicaid is a major concern.

We must also address issues surrounding socioeconomic status, such as education, income, and housing. Some poor children have limited access oral health care, as well as some nursing home residents. Low educational level has often been found to have the strongest and most consistent association with tooth loss, among all predisposing and enabling variables. We also must eliminate discrimination in quality by professionals.

OPPORTUNITIES FOR PREVENTION

In addition to raising awareness about oral health, changing perceptions about its significance, and removing barriers to oral health services, we must also encourage Americans to improve their health behaviors and practice a simple but often overlooked device: prevention.

One of my priorities as Surgeon General, and one that continues today, is moving the nation toward a balanced community health system. That means balancing health promotion, disease prevention, early detection and universal access to care.

As one of the components necessary to achieving a balanced community health system, we must encourage Americans to adopt good preventive general health practices and preventive oral health practices. We must increase the use of effective prevention measures such as water fluoridation, dental sealants, proper diet, tobacco cessation and regular professional care.

The report notes that general health risk factors, such as tobacco use and poor dietary practices, also affect oral and craniofacial health. The evidence for an association between tobacco use and oral diseases has been clearly delineated in every Surgeon General's report on tobacco since 1964. Tobacco use is a risk factor for oral disease, specifically periodontal disease and cancer of the oropharynx. The risk of oral cancer increases when tobacco use is combined or alcohol use. Poor nutrition is another risk factor for oral diseases. When coupled with dietary factors, physical inactivity is the second leading cause of preventable death, resulting in over 300,000 deaths each year. Also, when poor nutrition is coupled with physical inactivity, the risk of overweight and obesity is increased. So we must find ways to support better dietary choices. Moreover, recent research findings have pointed to possible associations between chronic oral infections and diabetes, heart and lung disease, stroke, and low-birth-weight premature births. The report assesses these emerging associations and explored possible mechanisms that may underlie these oral-systemic disease connections.

One of the biggest challenges we have as a nation is convincing people to adopt healthy lifestyles. The best science-based information on healthy habits is readily available but the will and commitment to good health do not always follow.

CHILDREN'S ORAL HEALTH

Unfortunately, children as a group illustrate the nation's oral health problems well. Dental and oral disorders are common in children and have a significant impact on children and families. Dental caries (tooth decay) is the single most common chronic childhood disease—5 times more common than asthma and 7 times more common than hay fever. As one of the most common birth defects, cleft/lip palate is estimated to affect 1 out of 600 live births for whites and 1 out of 1,850 live births for African Americans. In addition, dental care is the most frequent unmet health need of children.

Some highlights of oral health data on children from the report:

There are striking disparities in dental disease by income. Poor children suffer twice as much dental caries as their more affluent peers, and their disease is more likely to be untreated. These poor-nonpoor differences continue into adolescence. One out of four children in America is born into poverty, and children living below the poverty line (annual income of \$17,000 for a family of four) have more severe and untreated decay.

Other birth defects such as hereditary ectodermal dysplasias, where all or most teeth are missing or misshapen, cause lifetime problems that can be devastating to children and adults.

Unintentional injuries, many of which include head, mouth, and neck injuries, are common in children.

Intentional injuries commonly affect the craniofacial tissues.

Tobacco-related oral lesions are prevalent in adolescents who currently use smokeless (spit) tobacco.

Professional care is necessary for maintaining oral health, yet 25 percent of poor children have not seen a dentist before entering kindergarten.

Medical insurance is a strong predictor of access to dental care. Uninsured children are 2.5 times less likely than insured children to receive dental care. Children from families without dental insurance are 3 times more likely to have dental needs than children with either public or private insurance. For each child without medical insurance, there are at least 2.6 children without dental insurance.

Medicaid has not been able to fill the gap in providing dental care to poor children. Fewer than one in five Medicaid-covered children received a single dental visit in a recent year-long study period. While recent CMS data indicate progress in this area with one million more Medicaid-eligible children now receiving annual dental care than was the case in 1996, there is still a long way to go to ensuring greater access. Although new programs such as the State Children's Health Insurance Program (SCHIP) may increase the number of insured children, many will still be left without effective dental coverage.

The social impact of oral diseases in children is substantial. More than 51 million school hours are lost each year to dental-related illness. Poor children suffer nearly 12 times more restricted-activity days than children from higher-income families. Pain and suffering due to untreated diseases can lead to problems in eating, speaking, and attending to learning.

Over 50 percent of 5- to 9-year-old children have at least one cavity or filling, and that proportion increases to 78 percent among 17-year-olds. Nevertheless, these figures represent improvements in the oral health of children compared to a generation ago.

A FRAMEWORK FOR ACTION

Everyone has a role in improving and promoting oral health. Through a collaborative process, we developed a framework for action put forth in the report with the following principal components:

Change perceptions (of the public, policymakers and health providers) regarding oral health and disease so that oral health becomes an accepted component of general health.

Accelerate the building of the science and evidence base and apply science effectively to improve oral health.

Build an effective oral health infrastructure that meets the oral health needs of all Americans and integrates oral health effectively into overall health.

Remove known barriers between people and oral health services.

Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

With specific regard to the oral health infrastructure, as with the rest of public health, we need to focus on building an effective infrastructure. A key component of this is creating and enhancing state oral health programs—dental public health workers at the state level play a critical role in improving the oral health of children and families. We all also look forward to the appointment of a Chief Dental Officer for CMS.

Mr. Chairman, in the past half-century, we have come to recognize that the mouth is a mirror of the body, it is a sentinel of disease, and it is critical to overall health and well-being. The challenge facing us today—to help all Americans achieve oral health—demands the best efforts of public and private agencies as well as individuals.

I am pleased to have had this opportunity to present an overview of the state of America's oral health for you to consider as you proceed with the work of this subcommittee. I am happy to answer any questions you may have.

PREPARED STATEMENT OF BURTON L. EDELSTEIN

As Founding Director of the Children's Dental Health Project in Washington and a professor of dentistry and public health at Columbia University, I appreciate the Health Education Labor and Pension Committee's commitment to exploring the issues that underlie significant problems in access to dental care for our nation's children. I am pleased to submit this testimony also on behalf of the American Academy of Pediatric Dentistry and the American Dental Education Association.

My message is simple: far too many children suffer far too much dental disease that is consequential to their lives and overwhelmingly preventable. Access to essential dental services for our nation's children is too often promised but not delivered by federal and state programs. And, ironically, much of the disease that goes untreated—disease that results in pain and infection and dysfunction—could have been prevented if we had simply started early enough and used established science well enough. Finally, my message is that the U.S. Senate Subcommittee on Health holds tremendous opportunity to bring focus and action to this problem in ways that can solve it with only a small investment of your time and authority and only a small investment in dollars.

The Children's Dental Health Project is dedicated to assisting policymakers, health professionals, advocates, and parents improve children's oral health and increase their access to dental care. It was developed in 1998 through the cooperation of the American Academy of Pediatric Dentistry; the American Dental Education Association, and the American Academy of Pediatrics, all of which support this mission. Additionally, the DC-based child health coalition, representing over 40 groups that are familiar to federal policymakers has shown longstanding commitment to the inclusion of dental services, along with mental health services, in the very definition of child health care.

We are fully aware that many regard children's oral health as a trivial concern compared with other US healthcare, education, and social issues that this Commit-

tee deals with. Those unfamiliar with the problem may scoff at the title of today's hearing, not understanding that there is a crisis in oral health and that dental disease remains epidemic amid some of our child populations. But we are also fully aware that no one who hears out a constituent about their inability to provide essential care for their children, no one who examines the alarming statistics substantiating the problem, no one who understands that many of our children suffer from high disease levels and inadequate dental care, will long consider this issue trivial.

The Children's Dental Health Project greatly appreciates the many requests and opportunities that Members of Congress have extended to us to provide technical assistance in their work on oral health. In the current session of Congress, the Children's Dental Health Project has worked with staff on the Children's Dental Health Improvement Act introduced by Senator Bingaman and Senator Cochran and already receiving significant co-sponsorship; with Senator Collins and Senator Feingold on the Dental Health Improvement Act which has been incorporated into the safety-net reauthorization legislation by this Committee; and with Senator Edwards on the Perinatal Dental Health Improvement Act which the Committee Chairman recently included in his mark-up of the women's health bill, amongst others.

These actions build well on past years' GAO reports, the Surgeon General's report on Oral Health in America, and the efforts of so many child and health proponents, state and national foundations, associations of state officials, and professional groups who highlight this problem and have begun to tackle it effectively. Proposed legislation reflects an ever-increasing demand by your constituents that they obtain meaningful access to essential dental care for their children and an ever-growing press coverage of this issue by both print and broadcast media.

While I now serve children through policy advocacy and education, for 24 years I learned about children's oral health more immediately by caring for children at the dental chair. Since my first encounter with a child patient in 1970, I have been aware of the stark disconnect between perception and reality around children's oral health. The too-widespread belief that childhood dental disease has been vanquished stands in contrast to the thousands upon thousands of toothaches and acute abscesses experienced daily by America's children—many as young as two years of age. From clinical observation, I grew to recognize that while dental disease was declining in general, we are raising a new generation of low-income and minority children for whom this disease is both familiar and often devastating—interrupting their ability to eat, to sleep, to play, and to attend to learning. As managing partner of a growing pediatric dental practice, I came to share my colleagues' understanding that federal and state health and finance programs hold much promise but too often provide little in the way of performance. In particular, I did not see Medicaid deliver on its legal promise of comprehensive dental care for children through EPSDT. Rather, what I saw in my home town is what is true in nearly every home town across the nation—fewer dentists, more disease and less dental care for children with treatment needs. I also observed firsthand a cascade of missed opportunities for governmental programs to meaningfully attend to oral health.

Federal data substantiates the reality of significant pediatric dental disease among America's children. Whatever health concern may exist about children—their disease burden, insurance coverage, racial and income disparities, unmet need for healthcare, special considerations for children with special healthcare needs, or the prevention of functional impairments—children's dental care unfortunately too often stands in as the “poster-child” of problems. Examples derived from federal data include the following:

Disease burden: As reported by former Surgeon General Satcher, tooth decay is five times more prevalent than asthma. In fact, one-in-five two to four year olds (18%) has at least one visible cavity and one-in-two second graders (52%) has experienced tooth decay according to the third National Health and Nutrition Examination Survey. While disease is more prevalent among low-income and minority groups of children, many pediatric dentists are today reporting anecdotally an upsurge of disease among children from middle class and affluent families.

Insurance coverage. For every child without health insurance there are more than two (2.6) without dental coverage according to the National Health Interview Survey.

Disparities: Poor preschoolers in America are twice as likely to have tooth decay, have twice as many cavities when they do experience decay, have twice the pain experience, yet have only half the dental visits as their affluent peers. Very high prevalence of tooth decay among fast-growing Hispanic populations portends an upturn in future disease burden.

Unmet need: Three times as many parents report that their child has an unmet need for dental care as for medical care according analyses of the National Health

Interview Survey data. In fact, three-quarters (73%) of parents reporting unmet need for health care claim that the unmet need is for dental care.

Special needs: Fully one-in-four parents of a child with special healthcare needs claim that their child is in need of dental care.

Treatment: Medicaid-enrolled children are nearly four times more likely to obtain a medical visit in a year than a dental visit according to CMS data.

Costs: Dental care for children in the US accounts for 20-30% of child health expenditures while dental care for Medicaid children accounts for only an average of 2.3% of Medicaid child health expenditures.

Impairments. We have simply failed too many of our children throughout their years of growth—leaving too many of them as toddlers with an inability to eat and sleep, as school children with swollen faces, as teens with embarrassing appearances, and as young adults with oral dysfunctions. This lack of attention to children extends into dysfunctions for adult populations including our military personnel. During Desert Storm the most common reason for soldiers presenting to sick call was reportedly for dental pain. New recruits are often found to be in need of extensive dental treatment in order to become combat-ready.

Many are working hard to address these problems at the state and local levels. But some solutions require greater involvement and partnership with federal government. Multiple state policymaking organizations including the National Governors Association, National Conference of State Legislatures and associations of health officers are attentive to this issue and stand ready to build on federal programs and policies. Foundations, notably the WK Kellogg Foundation's Community Voices Programs, the Robert Wood Johnson Foundation, and number of state-level foundations provide strategic grantmaking that demonstrates both what can and cannot work. These foundations and their partners have pointed the way for formulating effective public policies and programs that can improve both oral health and access to dental care. Government has much to learn from their trials and their risk-taking.

Those who work daily to address remaining concentrations of poor oral health among US children have come to recognize the power of public-private partnerships and have come to understand that neither parents nor dentists are to blame for the current failures in oral health and dental care. But public-private-partnerships require the active interest and involvement of federal public health programs. We encourage the Committee to reinvigorate such partnerships and to stimulate public attention to this bellweather health problem.

In almost every one of the states, there have been public-private efforts to address inadequate dental access. But these efforts among your constituents have too-often hit against one or another structural wall—walls that federal interventions can break down. On the public insurance side, most Medicaid dental programs are dysfunctional with fewer than ten states now meeting federal provider-payment requirements under the "equal access provision." On the public health side, far too many programs that could include oral health have failed to do so and existing programs are unevenly evident across the country. Regular and ongoing Congressional oversight of federal agencies is essential if we are to deliver services already promised or potentially provided through federal programs.

The walls that stand between children and dental care are many. Many of them are complex Yet there are ample opportunities for this Committee to address these barriers.

Workforce issues include a declining number of dentists relative to population, an inadequate supply of pediatric dentists, a maldistribution of providers so that we now have a real and palpable loss of providers in many rural and inner city areas, and a profound dearth of minority dentists and hygienists.

Education and training issues include a paucity of dental school faculty; especially minority faculty, and difficulties ensuring that our new dental graduates are fully prepared to treat young children competently and confidently. Students are graduating with impressive debt that limits their willingness and ability to take lower-paying positions in public health or teaching than in private practice. In addition to dentists, we need to train all who work with young children to promote oral health. Pediatricians, day care workers, teachers, WIC nutritionists, Head Start personnel, and home health visitors can all incorporate oral health into their health-promotion work with young children.

The dental safety net is small, understaffed, and sparsely distributed. For example, if any child in the US has a broken arm, that child can obtain definitive care at almost any emergency room. If that same child has a face swollen from dental infection, he or she can typically obtain only a pain pill and prescription for an antibiotic.

States without effective dental public health infrastructure are hampered in any effort to address access. At this time nearly one-quarter of the states represented on the Public Health Subcommittee—like many states—have no full time state dental director. Without a director, fluoridation and prevention programs, surveillance, and direct service programs suffer.

Science that can be put to work to improve health but doesn't reach people at risk is sterile science. The most common pediatric dental disease, tooth decay, is now well understood as an infectious and transmissible disease that can be prevented or suppressed. We appreciate the National Institute for Dental and Craniofacial Research's Centers to Reduce Oral Health Disparities program, the Centers for Disease Control and Prevention's Oral Health Division's work, and many other Department of Health and Human Services efforts. We now look to the HELP Committee to further promote dental programs and to further empowering the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, Head Start, and many other agencies within its jurisdiction to attend to children's oral health in a more focused and robust way through specific programmatic authorizations and requirements.

We have provided staff with specific information on each of the states represented by Members of the Subcommittee on Public Health. Data provided include CMS reports on the percentage of children obtaining a dental visit in a year and their associated costs; dentist-to-population trends that occurred during the last decade, and information on the status of state dental directors. Because of the Committee's responsibility for education, we have also provided a fact sheet entitled, "Oral Health and Learning" issued by the National Center for Education in Maternal and Child Health. This fact sheet substantiates that learning impairments can arise from untreated dental disease.

I close with a specific request of the Committee. We at the Children's Dental Health Project join with the American Academy of Pediatric Dentistry and others concerned with improving children's oral health to ask that the HELP Committee commits to improving our children's oral health and access to dental care by featuring oral health when considering general pediatric health policies and programs, by stepping up oversight of existing programs and agencies, by monitoring the effectiveness and performance of public programs, by enacting legislation when needed to fill voids where children's dental care has been missed in the past, and by opening avenues to hear constituents tell their elected officials about their need to ensure dental care for their children.

PREPARED STATEMENT OF LYNN MOUDEN

Mr. CHAIRMAN, my name is Lynn Mouden. I am an Arkansas dentist and Director of the Office of Oral Health in the Arkansas Department of Health. I have 27 years experience in both private practice and public health. As Arkansas State Dental Director, I am charged by Arkansas state law to plan, direct and coordinate all dental public health programs in the state.

I also serve as President of the Association of State and Territorial Dental Directors, whose mission is to increase awareness of oral health issues; to assist in the development of initiatives for the prevention and control of oral diseases; and to provide leadership on sound national oral health policy. On behalf of the Association and especially the citizens of Arkansas, I thank you for this opportunity to discuss the importance of improving oral health for all Americans.

Arkansas is often described as the unhealthiest state in the nation, based on a wide variety of health indicators. Arkansas also mirrors the nation in that oral disease remains pervasive among families with low income, those with limited education, the frail elderly, persons with disabilities, those who are underinsured, and ethnic minorities.

Our recent statewide oral health assessment shows that on average Arkansas third-grade children suffer from three cavities each. Statewide, more than three fourths of these children have had tooth decay. Obviously, the slogan from the 1960's of "Look, Ma, no cavities" is not being realized across Arkansas.

More than 40% of Arkansas children attend school with untreated cavities, and 8% have emergency dental needs. Such severe dental need adversely affects how these children eat—or can't eat; how they sleep—or can't sleep; and how they succeed in school—or can't succeed. These children also enter adult life with a mouth no one would hire to smile at a customer. Consider for a moment if these same dental statistics applied to the 100 members of the US Senate. We would wonder how well the Senate's business would proceed if 40 Senators had untreated tooth decay and 8 of them tried to work with toothaches.

Problems are even worse in the underserved areas of Arkansas, specifically the Mississippi River Delta region and inner city Little Rock, with 50% more of the children needing emergency dental care. These areas are predominantly poorer and with a higher percentage of ethnic minorities. The data point out once again that a minority of our children suffers with a majority of dental problems. A recent screening brought one particular child to our attention. The boy, when asked if he had a toothbrush responded, "Yes, but it doesn't have any hairs on it anymore." The toothbrush was so worn it no longer had even one bristle—but he was proud to have a toothbrush.

Insufficient funding of Medicaid continues to plague Arkansans. Arkansas Medicaid only pays approximately 50% of a participating dentist's usual fees. In a profession where overhead typically is 70% of income, it is amazing that dentists are put into the unique position of having to subsidize their services by providing dental care at less than cost.

And, increased funding for Medicaid is not the whole answer, because dentistry's commitment to the underserved is well documented. In Arkansas alone, dentists donate more than eight million dollars each year in free dental care. It is often the bureaucratic barriers can make participation in Medicaid an administrative nightmare for dentists, most of whom are in solo private practice.

SB1626 provides several methods to ensure optimum oral health for all. The requirement that states provide adequate reimbursement to dentists will bolster our system. The requirement that state plans guarantee access for children equal to that available in the general population will ensure dental care for those children at highest risk.

SB1626 also provides an important initiative to support oral health promotion and disease prevention. Dentistry and state oral health programs have a long history of primary prevention activities. Community water fluoridation has long been heralded as the most effective, most economical and safest method for preventing tooth decay. However, without continued and increased funding to support fluoridation, communities working to balance difficult budgets often discontinue this important public health program. In addition, other proven prevention programs such as dental sealant initiatives, also rely on Federal support for success. Although fluoridation and dental sealants are proven prevention methods, Arkansas has only 59% of its citizens enjoying the benefits of water fluoridation and only one-fourth of our children have dental sealants. In our poorer areas of Arkansas, less than 2% of children have sealants.

Arkansas recently received a grant from the CDC Office of Oral Health to start programs. Through that grant, our state has made tremendous inroads in establishing oral health partnerships throughout Arkansas. The grant has helped us ensure effective prevention activities. We are now able to reach out to other health care professionals, educating them on the effect of oral health upon patients' general health. We also have new programs to enhance oral health services for our most vulnerable populations, especially those individuals with developmental disabilities.

However, only five states received this funding starting in 2001. SB1626 would greatly enhance support for state and local programs, allowing us to increase access for the underserved populations of Arkansas and the nation. In addition, I encourage you to support increased funding to the CDC to build upon the successful cooperative agreement initiative and to ensure that collaboration between state and Federal entities continues to address our most serious oral health problems.

In 2000, our Association published the study on Infrastructure and Capacity in State Oral Health Programs. The study identified the administrative and financial barriers to improving the nation's oral health. Leadership from state dental directors is imperative to make dental public health programs succeed. However, Senators, just among the members of this committee, some of your own states don't have dental directors, so you are already lacking in dental public health resources for your states.

Many Americans enjoy the highest quality of dentistry in the world. If a child lives in Maumelle, Arkansas and has plenty of money, access to dental care is no problem. However, if that child lives in poverty in the Arkansas Delta region, access to dental care is almost impossible. Eliminating disparities in oral health must be our goal.

In closing, I want to thank Senator Bingaman for recognizing the oral health crisis in this country and for his efforts to make a difference in our nation's oral health. I applaud Senator Hutchinson and the others that have supported this effort. I thank Senator Hutchinson and the Committee for inviting us here today to champion the chance for all of America's children to enjoy oral health—to eat, to be free from pain and to smile. I ask that you continue to work with us—those of

us at the local, state and national level—to make optimum oral health for everyone in America a reality. Thank you.

BUILDING INFRASTRUCTURE & CAPACITY IN STATE AND TERRITORIAL ORAL HEALTH PROGRAMS

A SUMMARY OF THE APRIL 2000 REPORT PREPARED BY THE ASSOCIATION OF STATE AND TERRITORIAL DENTAL DIRECTORS

In 1999-2000, the Association of State and Territorial Dental Directors assessed the resources needed to achieve the oral health objectives of Healthy People 2010 (the nation's health promotion and disease prevention agenda). The study focused on the infrastructure and capacity of state and territorial oral health programs, the health agencies' oral health units. Infrastructure consists of the systems, people, relationships and resources that would enable state and territorial oral health programs to perform public health functions. Capacity describes the expertise and competence needed to implement strategies. Infrastructure and capacity provide the foundation to eliminate the "silent epidemic" of oral diseases and improve the oral health of all Americans.

For the study, state dental directors and lead dental consultants from health agencies in 43 states identified and reached a consensus on ten essential elements in building infrastructure and capacity for state and territorial oral health programs. These top elements are:

1. Provide leadership with a full-time state dental director and adequate staffing.
2. Establish and maintain a state-based oral health surveillance system.
3. Develop and maintain a state plan for oral health improvement.
4. Develop and promote policies for better oral health and to improve health systems.
5. Provide oral health communications and education to policymakers and the public.
6. Build linkages with partners interested in reducing the burden of oral diseases.
7. Integrate and implement population-based interventions for prevention of oral diseases.
8. Build community capacity to implement community-level interventions.
9. Develop health systems interventions to facilitate quality dental care services.
10. Leverage resources to adequately fund public health functions.

Not every state health agency has an oral health program. Not all state oral health programs have sufficient resources to address oral health needs. For example, at the time of the study, although 31 states and five territories have full time dental directors, 20 states (including the District of Columbia) have only part time or vacant dental director positions. About half of the states, with populations totaling 92 million people, have a budget of \$500,000 or less for each of their oral health programs. Furthermore, 43 states reported gaps in their dental public health infrastructure and capacity related to the ten essential elements listed above, including the need to develop comprehensive state-based oral health surveillance system. Currently no state has a comprehensive surveillance system and only 19% states have surveillance components. Only 38% of the states had an oral health improvement plan, and only 48% had an oral health advisory committee with partners representing a broad-based constituency.

The ASTDD Report recommends that states have sufficient funding to sustain effective oral health capacity and infrastructure. Recommendations are dependent on state population and other factors. In general, states with less than 3 million population require \$500,000 to \$700,000; states with 3 to 5 million residents require \$1 to \$1.6 million; states with more than 11 million residents need \$3 to \$5 million in funding to support effective oral health programs.

The Surgeon General's Report on Oral Health states that "the public health infrastructure for oral health is insufficient to address the needs of disadvantaged groups, and the integration of oral and general programs is lacking" (U.S. Department of Health and Human Services, 2000). Leadership within a strong oral health unit with sufficient infrastructure and capacity is critical when agencies and organizations are determining priorities, setting agendas, developing plans, making funding decision, and establishing policies that impacts the oral health of Americans.

THE ARKANSAS ORAL HEALTH COALITION

The Arkansas Oral Health Coalition began in 2001 as Arkansas' team at the National Governor's Association (NGA) Policy Academy on Improving Oral Health Ac-

cess for Children. The academy team consisted of seven individuals representing Governor Mike Huckabee's Office, the Arkansas General Assembly, the Office of Oral Health, the Division of Medical Services, the Arkansas State Dental Association, the Arkansas State Dental Hygienists' Association, and BHM International, Inc. The team worked with a faculty of national experts to develop Arkansas oral health goals in access, education, prevention and policy. To continue the academy efforts, the team invited other interested parties and expanded over the subsequent 10 months to what is now the Arkansas Oral Health Coalition. The Coalition has adopted the slogan "SMILES: AR, U.S."

The Coalition enjoys participation from a diverse set of organizations and agencies from across the state. Members of the Arkansas Oral Health Coalition are:

- Arkansas Academy of General Dentistry
- Arkansas Advocates for Children and Families (AACF)
- Arkansas Center for Health Improvement
- Arkansas Dental Assistants' Association (ASDAA)
- Arkansas Department of Education, Office of Comprehensive Health Education
- Arkansas Department of Health, Office of Oral Health (OOH)
- Arkansas Department of Health, Office of Rural Health and Primary Care
- Arkansas Department of Human Services, Division of Medical Services
- Arkansas Department of Higher Education
- Arkansas Head Start Association (AHSA)
- Arkansas Nurses Association (ANA)
- Arkansas School Nurses Association (ASNA)
- Arkansas State Dental Association (ASDA)
- Arkansas State Dental Hygienists' Association (ASDHA)
- BHM International, Inc.
- Community Dental Clinic
- Community Health Centers of Arkansas, Inc. (CHCA)
- Delta Dental Plan of Arkansas (DDPA)
- Healthy Connections, Inc.
- Partners for Inclusive Communities (PIC)
- Pulaski Technical College Dental Assisting Program
- UALR Share America
- UAMS College of Public Health
- UAMS Department of Dental Hygiene
- Vision 2010 Quality of Life Dental Committee

Activities of the Coalition have included the UALR Share America Future Smiles dental sealant project, the Health Connections dental sealant project, the Delta Oral Health Initiative, the Dental Services Project, and various assessment and program activities within the Office of Oral Health.

The Future Smiles project screened more than 2000 Head Start and Early Head Start children and elementary school students in the fall of 2001. Based on those screenings, students in 2nd and 6th grade were identified for dental sealants. During February and March of 2002, volunteer dentists and dental hygiene students from UAMS placed a total of 401 sealants for 109 students. The program was received so well that it is already planned in an expanded format in the upcoming school year.

Based on the success of the Future Smiles project, Healthy Connections in Mena, Arkansas replicated the project in elementary and middle schools in Mena. Using volunteer dentists and dental hygiene students from UAFS, 89 students received a total of 281 dental sealants.

The Delta Oral Health Initiative concentrates its efforts on increasing access to oral health services in the Mississippi River Delta region of Arkansas. While the Initiative members worked diligently beginning in mid-2001, no funding has yet been identified to move programs forward.

The Dental Services Project concentrates on oral health issues for the developmentally disabled population in Arkansas. Because of the Olmstead decision, dental services are required to be provided to developmentally disabled individuals that chose to live in the community instead of an institutional setting. No data has ever been collected on the dental needs of this population in Arkansas. Therefore, in November of 2001, volunteer dentists and dental hygienists screened 121 ambulatory adults with developmental disabilities, all living in community settings. Based on the screening, analysis showed that the patients screened required more than \$117,000.00 in immediate dental needs.

Along with current assessment and program activities within the Office of Oral Health, Coalition members are also currently pursuing additional grant opportunities for programs in increased oral health access and training for dental professionals in treating HIV+ patients.

Purpose

The Office of Oral Health, created in the Arkansas Department of Health in 1999, faces new challenges in assessment, policy development and assurance as it relates to dental public health in our state. Because little data has ever been collected on oral health needs within Arkansas, the first challenge was to collect baseline data on oral health. With an appropriate database, decisions can be made to guide dental public health policy. A survey with limited scope was conducted in 2000 and again in 2001. To increase the available data, during the spring of 2002, the Office of Oral Health conducted an expanded statewide oral health needs assessment under the CDC Cooperative Agreement on State Oral Disease Prevention Programs.

In addition, data is necessary for reporting to agencies of the federal government. The Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau provides leadership, partnership opportunities and resources to advance the health of the Nation's mothers, infants, children, adolescents and families through Title V of the Maternal and Child Health (MCH) Block Grant. The block grants provided to states create federal/state partnerships to develop community service systems to meet critical challenges in maternal and child health. These challenges include reducing infant mortality, providing comprehensive care for children and adolescents with special health care needs, reducing adolescent pregnancy and providing comprehensive prenatal care. As required by the block grant, Arkansas reports annually on eighteen national performance measures and eight state-selected performance measures related to maternal and child health.

One of the national performance measures is the percent of third-grade children who have received protective sealants on at least one permanent molar tooth. Dental caries (tooth decay) affects two-thirds of children by the time they are 15 years of age. Developmental irregularities, called pits and fissures, are the sites for 80-90% of childhood caries. Dental sealants selectively protect these vulnerable sites, which are found mostly in permanent molar teeth. Targeting dental sealants to those children at greatest risk for caries has been shown to increase their cost effectiveness. Although dental sealants in conjunction with community water fluoridation have the potential to prevent almost all childhood tooth decay, sealants have been underutilized.

Methods

Sealant utilization and assessment of oral health requires primary data collection or screening of a representative sample of school children. During 1999, the Arkansas Oral Health Advisory Committee developed a plan to collect data on sealant utilization. This plan was expanded for the 2000 and 2001 surveys to include data on decayed, missing and filled primary and permanent teeth; caries rates; and untreated caries along with sealant data. This data set was utilized for the expanded 2002 survey.

Elementary schools were randomly selected for the study. Letters of invitation to participate in the study were sent to twenty school principals across Arkansas. Of those, nineteen principals invited to participate agreed to assist with the survey.

An information sheet on dental sealants, explaining the survey, was sent to each student's home along with a permission slip for survey participation. Only students whose parents or guardians signed and returned permission forms were screened.

Only licensed dentists, and licensed dental hygienists under the supervision of a dentist, are allowed to perform dental examinations in Arkansas. Although the 2000 and 2001 study was conducted by the Director, Office of Oral Health, the 2002 survey utilized the services of seven contract dentists, paid a daily rate plus expenses. The Program Manager assisted with the surveys and provided screenings in most of the schools, alongside a contract dentist.

Examinations were conducted in the classroom utilizing a portable dental light, and sterile, single-use mirrors and explorers. Each school was asked to provide an adult to enter data as it was collected. Some schools provided adult volunteers while in other schools the teacher did the data entry. The newly created recording form allowed for easy data entry by non-dental personnel.

Following the examinations, each student was provided with a referral form to take home. The form stated that school-based screenings do not take the place of regular dental examinations in a dental office, but are to collect data on a large population. The form allowed the examiner to indicate to the parents that oral health conditions were adequate, conditions existed that needed attention when convenient, or that conditions existed that needed immediate attention. Referrals in the most serious category indicated that the child had apparent pulpal involvement, the child

already experienced pain or, in the examiner's clinical judgment, the conditions would soon cause abscess or pain. Referrals in the second or third categories were not made if, in the examiner's opinion, a carious primary tooth would be exfoliated before more adverse conditions presented.

An estimate of socio-economic level was made using the percentage of children participating or eligible for the free or reduced-cost lunch program. Free/reduced lunch data for each school was provided by the Arkansas Department of Education.

Findings

Survey Subjects:

A total of 698 children were examined.

Of the 698 children participating, 485 were White, non-Hispanic, 190 were African-American, 17 were Hispanic, 3 were of Asian or Pacific Islander heritage and 3 were listed as other.

Referrals:

167 children (23.9%) were referred for dental care with an additional 56 (8%) referred for immediate attention.

Sealant and Caries Rates:

24.4% of children examined had at least one dental sealant. Individual schools had a sealant rate of from 4.3% to 45.5%.

The 698 children examined had 2404 teeth that had been affected by decay, meaning that the tooth was decayed, had already been filled, or had been lost prematurely due to decay. This results in a DMF (decayed, missing or filled) rate of 3.44, meaning that on the average, each third-grade student in the survey has approximately three to four teeth that are decayed, or have been decayed.

Of the children examined, 698 children or 72.2% had teeth affected by caries.

Of the children examined, 294 children or 42.1 % had untreated dental caries.

Socio-economic Indicators:

55% of the children participate or are eligible for the free or reduced cost lunch program in their schools. The rate of eligibility in the individual schools ranged from a low of 10% to a high of 98%.

Discussion

According to the National Institutes of Health, the placement of sealants is a highly effective means of preventing pit and fissure caries. Sealants are safe and placed easily and painlessly. Sealants are currently underused in both private and public dental care delivery systems. Sealant usage in Arkansas is similar to the national rate (24.4% compared to 23.0% from NHANES III) while the Healthy People 2010 objective 9.9a calls for increasing the proportion of 8-year-old children who have received dental sealants on their first permanent molars to 50%.

The overall rate of 42.1% of all third-graders with untreated caries points out that access to quality dental care continues to be a problem for many children. This data shows that Arkansas lags seriously behind the Healthy People 2010 goal of 16% of 6-8 year olds with untreated caries on primary and permanent teeth.

The reasons for the underutilization of sealants are complex, but are affected in great part by the personal preferences of local dentists and their auxiliaries. Intensive efforts should be undertaken to increase sealant use through professional and lay education. Expanding the use of sealants would substantially reduce the occurrence of dental caries in this population.

The 1960's era of "Look mom, no cavities" has not yet arrived in Arkansas. Seven out of ten children are still affected by dental caries. Because Arkansas currently has only 59.9% of the population served by community water systems enjoying the benefits of water fluoridation (cp. Healthy People 2010 Objective of 75%) and no state-wide fluoride mouth rinse initiative, efforts to expand sealant usage along with these other proven preventive measures must be expanded to protect the oral health of our children.

SUMMARY:

The Year 2002 Arkansas Oral Health Needs Assessment Survey shows that only 24.4% of children surveyed had one or more dental sealants on permanent molars compared to the national Healthy People 2010 goal of 50%. The majority (72.2%) of all children surveyed had been affected by dental disease with an average of almost three decayed teeth per child (DMF = 3.44). Access to dental care is unattainable for many children, evidenced by the high number of children with untreated dental decay (42.1%). Efforts and resources must be targeted to increase the use of dental sealants, increase the percentage of Arkansans that enjoy the benefits of community water fluoridation, and assure that specific preventive and restorative dental services be provided to those children at greatest risk of oral disease.

PREPARED STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

The American Dental Association (ADA), applauds the committee for holding this hearing to address children's access to oral health care, and appreciates the opportunity to testify today.

As Surgeon General Satcher noted in his 2000 landmark report "Oral Health in America," while most Americans have access to the best oral health care in the world, the burden of oral disease continues to spread unevenly throughout the population directly affecting low-income children. In fact, what most public leaders do not understand is that dental decay is the most prevalent chronic disease of childhood, five times more common in children than asthma. According to the Surgeon General's report, overall utilization of dental services by underserved children is less than one in five. This is true despite the fact that federal law requires states to cover dental services for Medicaid-eligible children through the Early, Preventive, Screening, Diagnostic, and Treatment program (EPSDT). There is no shortage of shocking statistics or distressing anecdotes to describe the access problems faced by thousands of underserved children. It is critical for policymakers at the federal and state level to acknowledge that oral health is integral to general health and well-being; you are not healthy without good oral health.

FEDERAL SUPPORT AND RESPONSE

The dental community believes that Congress should assist and encourage states to develop their own individualized initiatives toward enhancing access to oral health care within their populations. Legislation has been introduced in this Congress that would help to do just that. Senators Susan Collins and Russ Feingold introduced The Dental Health Improvement Act (S. 998), which subsequently was incorporated into the Senate-passed Health Care Safety Net Amendments of 2001 (S. 1533). This legislation recognizes that for those individuals living in rural and inner city locations, obtaining dental care can be all too difficult. It provides for incentive-based programs to attract dentists to underserved areas and to help improve the oral health infrastructure and service delivery in these locations. Senator Jeff Bingaman introduced The Children's Dental Health Improvement Act (S. 1626), which would reward states that seek to enhance access to oral health care for children served by Medicaid, the State Children's Health Insurance Program (SCHIP), and our nation's safety net programs. This legislation has been endorsed by a bipartisan group of Senators and several private organizations. The groups representing organized dentistry strongly support both bills and are thankful to those Senators who have offered their endorsement.

DENTAL COMMUNITY RESPONSE

On behalf of the dental profession, the ADA wants to make clear that dentists find it unacceptable that in 21st century America there are children who cannot sleep or eat properly and cannot pay attention in school because they're suffering from untreated dental disease a disease that can be easily prevented. Dentists across the country, both as individuals and through their professional societies, are fighting for these children. But we can't do this alone.

As a nation, we must recognize how critical oral health is to overall health especially to the healthy development of a child and find the political will to do a better job of caring for the next generation of children. The dental community is committed to working with Congress, the federal agencies and the states to address and remedy this fixable problem.

The oral health community has come a long way these last few years in working to address issues affecting access to oral health care. Dental providers have joined with Governors, state legislators, Medicaid officials and many others to tackle barriers impeding children's access to care. As a result, some states have worked to make oral health a priority, but as a result of serious state budget cutbacks, several others have lost ground.

In the absence of effective public health financing programs, many state dental societies have sponsored voluntary programs to deliver free or discount oral health care to underserved children. Building on these efforts, next February, state dental societies and the ADA will sponsor a national program, hosting events around the country to reach out to underserved communities, providing a day of free oral health care services through a program called "Give Kids A Smile." This program will help to educate the public, state and local policymakers about the importance of oral health care while providing needed and overdue care to thousands of underserved children. Dentists are working to do what is necessary to reach out to these children; however, charity alone is not a permanent system. Congress and the states

must work with dentists to establish an improved health care system for the delivery of oral health care to our most needy and vulnerable citizens.

How can Congress work with states to help address the access problem? Let us examine some particular areas where there are recognized problems.

ORAL HEALTH PREVENTION PROGRAMS

First, states must continue to work with the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) to invest in successful cost-effective public health prevention programs, such as community water fluoridation and sealant programs. There are still an unacceptably high number of individuals and communities who do not have access to these necessary services. Prevention programs like fluoride and sealants are truly a cost-effective investment in the oral health of our nation's children and must continue to be expanded to ensure equal access for all populations.

States should also be encouraged to work with the dental community to continue promoting health prevention to adolescents through tobacco cessation and oral cancer detection. Last fall the ADA joined with the dental industry on a National Oral Cancer Awareness campaign. Billboards and subway signs went up across the country as a national alert. Many people question the value of campaigns like these. But, we have seen first hand how truly effective they can be. Earlier this year, the ADA received an email from a mother with heartfelt gratitude for the campaign. Her son made an appointment as a result of seeing the campaign information, and the appointment resulted in the removal of a malignant lesion. The "oral cancer information campaign has no boundaries," said the relieved mom, "information regarding oral cancer does save lives."

Prevention is one of the core precepts of oral health care. Most oral diseases are predictable and preventable with routine home care, regular check-ups, good nutrition and the assistance of public health prevention programs like community water fluoridation. Many patients who have not had the benefit of preventive care often end up in an emergency room, seeking attention for severe dental problems. The resulting cost of emergency room treatment for patients and taxpayers far exceeds the cost of preventive dental care. In addition, emergency room care is limited to pain management. The patient must still see a dentist for necessary restorative service. This year, Secretary Tommy Thompson began a prevention campaign to alert states and communities about the importance of focusing on preventable diseases as a way to reduce health care expenditures and enhance quality of life for our citizens. We ask that Congress help impress upon the Secretary the importance of incorporating oral health prevention into the Administration's health improvement initiatives, recognizing that good oral health must be a priority for all states and communities.

DENTAL MEDICAID PROGRAM

Dentists seek to work with members of Congress, the Centers for Medicare and Medicaid Services (CMS) and states to improve the Medicaid program in terms of financing and administration in order to increase dental participation. Over the last several years, dentists have joined with policymakers and stakeholders at national and state-based meetings to address why many dentists limit their participation in Medicaid, do not participate, or are leaving the program. Several problems affecting provider participation have been identified these problems include Medicaid reimbursement rates at less than what it costs dentists to provide care, excessive paperwork and other billing and administrative complexities, and lack of case management and other social barriers that result in a high rate of broken appointments.

There are several ways to address these recognized problems. One of the most critical strategies is for states to raise Medicaid rates to more closely mirror the marketplace, rather than allow dentists to be reimbursed for care at significantly less than what it costs them to provide it. In some states, inadequate fee increases set a standard in the state sometimes for as many as 15 or 20 years. Our nation's capital Washington, DC is an example of this situation, where Medicaid reimbursement rates for dental care have not been adjusted since the 1980's not even for cost-of-living adjustments. How can dentists effectively provide care to patients if the system will not afford that care?

Recent state budget cutbacks have escalated the problem of inadequate reimbursement rates. Dentists who have signed up to participate in the program are often punished as their legislature targets provider reimbursement rates as a means to reduce state Medicaid expenditures. In 2000, for example, the Iowa legislature increased reimbursement rates from 60 to 70 percent of a dentist's usual charges only to cut these rates to half that amount in 2002. It is impossible to achieve increased and consistent dental participation in such an inconsistent system. No mat-

ter how much dentists want to provide care to Medicaid beneficiaries, when typical office costs are about 65 to 70 percent of a dentist's earnings, it is impossible to provide care and keep the dental office doors open. Dentists should not have to accept 30 cents, or less, on every dollar spent to provide care.

The good news is that there are success stories. There are model states that have succeeded in increasing and stabilizing rates that at least 75 percent of dentists find acceptable such as Michigan, South Carolina and Delaware. The state of Michigan decided to creatively work to improve not only the financing structure of their Medicaid program, but also the delivery of the program. With the support of the dental community, the state contracted with Delta Dental to administer its Medicaid program within 37 counties, naming it the "Healthy Kids Dental" program. The result a Medicaid program that functions like a private program, with each Medicaid-eligible individual bearing a Delta Dental coverage card. The program offers reimbursement rates at market levels, has eliminated administrative complexities and functions like a private insurance benefit. Since this partnership, the number of Michigan Medicaid kids seen by a dentist has increased from 18 percent to 45 percent. Undoubtedly, this public-private model is a success story, and there are others. Through additional public-private partnerships, models like this can be achieved elsewhere.

Some officials express disagreement about the success increased reimbursement rates may have, but they do so by failing to look at the complexity of the issue. In September 2000, the U.S. General Accounting Office issued a report on the Medicaid dental program, titled "Factors Contributing to Low Use of Dental Services by Low-Income Populations." The report issued many legitimate findings regarding dental participation in Medicaid; however, its conclusions lacked significant insight. For example, the report stated that "raising Medicaid payment rates for dental services a step 40 states have taken recently appears to result in a marginal increase in use but not consistently." In that statement, the GAO oversimplifies a very complex issue and makes a conclusion without a proper assessment. The report does not explain that several states have raised rates to a level that continues to fall below dental overhead costs. The report fails to acknowledge the numerous factors affecting provider participation in Medicaid and fails to quantify their impact on utilization. To simply issue a conclusion that increased payment rates have an inconsistent impact on dentist participation is inappropriate and can have a devastating effect on state efforts to achieve needed improvements in reimbursement, particularly now when states are faced with increased budget cutbacks.

Where state fiscal situations impede increases in provider reimbursement, state dental societies are working to encourage improvements in the administration of the Medicaid program. Some examples are improved case management, transportation services to assist patients with scheduled appointments and public education on the importance of oral health. Many dentists have faced years of frustration with the Medicaid program, resulting in a great deal of mistrust. Too often the ADA and other dental organizations have heard their members outline the administrative hassles they face within these programs. Medicaid bureaucracy through lengthy provider applications, prior authorization requirements, and complex claims forms deter provider participation. Congress should ensure that the appropriate federal agencies work with states to help address this bureaucracy and improve the system.

There is certainly room for more public education on the importance of seeing a dentist at an early age mostly to educate parents or guardians. With some federal support through HRSA and the Administration for Children and Families (ACF), states have shown how this can be effectively done through Maternal and Child Health Departments, Women, Infants and Children (WIC) and Head Start programs but more support is necessary.

TRAINING AND WORKFORCE

Ensuring the development of a responsive, competent, diverse and "elastic" workforce is a key priority of the ADA, particularly as it relates to underserved locations many which are further limited by geographic location. We need programs and policies that ensure that an adequate network of providers is available in each state, including rural communities. We recognize that nationwide, a serious maldistribution of dentists exists within the states and that some states face a shortage of generalist dental providers and several face a shortage of pediatric dentists. Currently, there are only 3,800 pediatric dentists in the country; some states have fewer than 10. We must do more to fund additional training programs to meet the increasing need for pediatric oral health care services as 25 percent of the pediatric population experiences 80 percent of the dental disease, and this is concentrated in low-income, minority populations.

HRSA administers several programs to help bring providers to underserved communities in need of dental care through pediatric and general residency training programs and the National Health Service Corps program. These programs have been threatened by existing budget proposals, and dentistry is gravely concerned about their longevity and what affect such cuts will have on patient access to care. The population of underserved children served by both Medicaid and SCHIP experience disproportionately high levels of oral disease, increasing the need for pediatric dentists, as well as dentists with general residency dental training. Pediatric dentists treat a disproportionate percentage of those populations as well as medically compromised and disabled children. It is critical that the federal government support states in addressing this growing and persistent problem.

Together, we can do more to encourage the states to create incentives that will attract dentists and other dental team members to underserved areas. Senators Susan Collins and Russ Feingold provide for such incentives in their legislation, allowing for student loan repayment and forgiveness programs and tax credits for those who practice in underserved locations. With the level of debt many dental students face today when they graduate, those measures could be just what it takes to get a commitment from them to begin their years of practice in areas where they are needed most.

Dental schools and their satellite clinics are on the front lines of combating oral disease. For innumerable children, including many of the 23 million who have no dental insurance, these dental facilities are the sole source of oral health care. These facilities play an integral role in addressing access issues and working to eliminate disparities among Medicaid, SCHIP and uninsured populations where more than 65 percent are members of families with annual incomes of less than \$15,000. Yet, many schools are facing a shortage of dental faculty. During the 2001-2002 academic year, approximately 350 budgeted dental faculty positions were vacant. State and federal incentive programs are critical to curb this shortage and ensure that enough qualified faculty members are available to train future dental practitioners.

Congress can also do more to support additional funding for dental training programs, including programs to fund courses on caring for individuals with special health care needs. The ADA, Special Olympics and other concerned organizations participated in a Surgeon General's Conference last December to address the health concerns of people living with mental retardation. Access to oral health care was repeatedly mentioned as a key concern for this community. Dentistry pledges its support to partner and work toward developing solutions to this unacceptable problem.

FEDERAL/STATE ORAL HEALTH INFRASTRUCTURE

Dentistry is working at the federal level to ensure a strong oral health infrastructure within the agencies of the Department of Health and Human Services. Programs and positions must exist to address oral health issues concerning insurance coverage, prevention, research and outreach activities. Because dentistry is such a small percentage of nationwide health care expenditures, oral health sometimes ranks low on the list of critical issues agencies like CMS must address, and the focus of health care is generally on medical care. However, as Surgeon General Satcher and other Surgeon Generals before him have noted, oral health is integral to overall health and cannot be ignored.

Most recently, the dental community successfully worked with CMS to establish a full time dental officer position to represent the oral health-related programs and policies of the agency. The posting for this position was released just last month. The dental community would like to recognize the agency for this support and looks forward to working with the new dental officer on several key issues, most importantly access to oral health care for children served by Medicaid and the SCHIP Program.

Likewise, we seek to work with HRSA to ensure similar oral health representation exists within the agency's national and regional offices. States depend on the information relayed through technical assistance and the funding support received from these agencies in order to operate effective oral health programs. An inadequate federal infrastructure is detrimental to the existence of strong oral health programs in the states, significantly affecting access to care.

At the same time, building an oral health infrastructure within each state is critical if we are to ensure that oral health is treated as a health care priority. We need recognized dental directors within each state who have access to Governors' offices, Medicaid officials, and public and private practitioners to propose access ideas and solutions. One way to build this infrastructure is through improved funding for HRSA's Maternal and Child Health Bureau, which provides support to state oral health programs through its Block and Discretionary Grant programs.

States also need support and guidance to improve data collection and surveillance within their communities to best identify where the most serious oral health access problems exist. Congress should encourage continued collaboration between the CDC and states to develop databases that monitor and help analyze the public's oral health needs.

CONCLUSION

Dentists are justifiably proud of the overall state of the nation's oral health, which, for most Americans, is excellent. But we cannot forget the fact that millions of people in this country particularly children aren't getting even basic preventive and restorative dental care. These children are out there suffering. There are dentists out there who want to end that suffering. Working with Congress and the states, together we must find the will to break down the barriers that separate them.

PREPARED STATEMENT OF ED MARTINEZ

Mr. Chairman and members of the Committee, my name is Ed Martinez and I'm the CEO of San Ysidro Health Center in San Ysidro, California, a neighborhood of the City of San Diego that is located adjacent to the U.S.—Mexico border crossing. It is my privilege to testify today in support of Senate Bill 1626 as a representative of the National Association of Community Health Centers, Inc. and the millions of patients that America's health centers serve every year.

OVERVIEW OF AMERICA'S HEALTH CENTERS

Currently there are nearly 800 federally supported health centers operating nearly 3,400 community sites across the country. Together with more than 200 other health centers known as FQHC "look-alikes," these centers have produced a model of health care that has demonstrated this nation can meet compelling health needs while containing health care costs. The health center legacy proudly shows the value and vast potential of a community-based health system that is lifting the barriers to health care—safeguarding health—revitalizing communities—keeping people health at cost savings for the nation.

Key to the success of health centers over the years has been the four core program elements that today still define each community-based, non-profit health center—these include:

1. Services are located in high-need communities;
2. Programs deliver comprehensive health and related services (e.g., "enabling" services such as translation, case management, transportation, etc.);
3. Services are open to all residents, regardless of ability to pay, with sliding fee scale charges based on income; and
4. Health centers are governed by community boards to assure responsiveness to local needs and aspirations.

Today, health centers are the family doctor and health care home for almost 12 million Americans, including substantial percentages of key groups of uninsured and underserved, including:

- 1 of 9 Uninsured Persons (4.9 million)
- 1 of 8 Medicaid Recipients (4.1 million)
- 1 of 6 Low-Income Children (4.9 million)
- 1 of 5 Low-Income Births (400,000 annually)
- 1 of 10 Rural Americans (5.4 million)
- 8 million of People of Color; 600,000 Migrant Farmworkers; 600,000 Homeless Persons

San Ysidro Health Center (SYHC), the program I have the privilege to represent, was established in 1969 out of the efforts of a community women's organization that had a vision for addressing the unmet medical and oral health needs of thousands of underserved residents in the San Ysidro community. Through developmental resources provided by the federal government and other public agencies, our health center has grown over the years in response to community needs. We now provide medical, dental, behavioral, as well as enabling services through a network of nine neighborhood service centers. Each year SYHC provides services to approximately 40,000 registered patients. Last year, SYHC generated 180,000 patient visits in the areas of medical, dental, and behavioral services. Approximately 75% of the families utilizing our services have household incomes equal to or below the Federal Poverty Level.

San Ysidro Health Center, like many other health centers, relies not on one—or even a few—but on a variety of funding sources to support ongoing programs—the following represents the typical mix of funding sources:

- 35% Medicaid and other public payors
- 26% Federal grants
- 19% State/Local/Other
- 7% Patient Income
- 6% Medicare

Our health center programs maintain a very delicate balance between the adequacy of revenues from these many sources and the capacity to serve the patient populations that need our services and support. Like all core safety net providers, health centers also face many challenges, any of which could upset that delicate balance, and a combination could have severe and profound consequences.

The biggest challenge all health centers face today is the continued rise in the overall number of persons without health insurance. This significant trend has been further compounded by cutbacks from local and state funding agencies—and private charitable organizations—all of whom have been squeezed by unexpected budgetary shortfalls. As a result, health centers and other core safety net providers have experienced high concentrations of uninsured patients unmatched by any other provider types. This might help to explain why, with barely one percent of the nation's practicing physicians, health centers now provide one-fifth of all ambulatory care for uninsured people in the country.

DENTAL CARIES (TOOTH DECAY) IS A PUBLIC HEALTH PROBLEM

Tooth decay is the most common chronic disease of childhood, affecting 5-8 times as many children as does asthma. Early childhood caries (ECC) is an aggressive form of the disease that can begin as soon as the teeth emerge into the mouth at about 6 months of age. Among 2-4 year-olds nationally, 17% had experienced dental caries in their primary (baby) teeth. Depending on the criteria used, Mexican-American children in the national study were 3.5-4.6 times more likely to have early childhood caries than white non-Hispanic and black non-Hispanic children. Among preschool children in California, in a 1993-94 statewide survey by the Dental Health Foundation, 40% of Head Start programs have higher decay rates than children in other preschool settings. Children from poor families with incomes below 200% of the federal poverty level (FPL) are 5 times as likely to have unmet dental care needs as children from families above 200% FPL. While some risk factors for ECC have been identified (e.g., prolonged bottle feeding with sweetened beverages, use of sweetened pacifier, untreated dental decay in mothers), their effects on specific ethnic groups or on very young preschool children have not been adequately investigated.

WHAT HAS BEEN SAN YSIDRO HEALTH CENTER'S EXPERIENCE WITH CHILDREN'S ORAL HEALTH PROBLEMS?

Since 1973, SYHC's oral health program has functioned as the principal dental safety net provider in the South Bay Region of San Diego County. Our health center currently operates two dental clinics with a total of 19 operatories—our dental workforce consists of seven full time dentists—one pediatric dentist and six general dentists. Each month our dentists provide comprehensive oral health services to approximately 1,700 adults and children. Of this population, approximately 500 are children under the age of 10 years; many of these children present with advanced stages of dental disease requiring extensive restorative services. These are children of families who do not have dental insurance, or who are underinsured, who generally come to us requiring urgent or emergency care.

Over the past several years, our dentists have reported difficulties in responding to an increasing rate of untreated oral diseases, primarily among children living in poverty and of racial and ethnic minorities. To clearly define the magnitude of the dental disease problem our health center was experiencing, our health center implemented a scientifically designed oral health needs assessment of 2,000 preschool children. This scientific study documented the fact that 69 percent of the surveyed preschool-age population (under 5 years) had untreated dental disease. This incidence of dental disease significantly exceeds both state and national disease rates.

As front-line providers of dental care services, it is quite evident that our health center is dealing with an epidemic of dental disease that is currently sweeping through our community, and—unless checked—threatens to overwhelm our community's limited treatment resources. Although our dental staff works at 100% capacity in providing urgent/emergency restorative dental care to underserved children, we are only able to scratch the surface, relative to arresting the epidemic of tooth decay

that is now sweeping our community. By necessity, our dental program concentrates on short-term, “drill and fill” services that serve to relieve the pain and suffering associated with acute and chronic dental disease. Health centers across the country report similar experiences in responding to the tidal wave of children suffering from rampant dental disease. Collectively, we are all caught in a frustrating cycle of running to keep up with the spiraling (upward) demand for urgent treatment services, while recognizing the fact that over time, the only effective strategy to reduce the burden of children’s dental disease is to implement community-based, disease prevention/health promotion initiatives. With limited program capacity and increasing dental disease among children, additional resources are needed to effectively treat and prevent oral disease.

USING THE STRENGTHS OF COMMUNITY HEALTH CENTERS TO IMPROVE CHILDREN’S
ORAL HEALTH

Since the beginning of the community health center movement in the early 1960’s, community health centers have clearly demonstrated their effectiveness in delivering affordable, high quality, and culturally competent services to low-income, traditionally underserved populations. To provide the full scope of program services required for federal funding (pediatrics, ob/gyn, medicine, social services, and case management), CHCs have pioneered a number of innovative strategies for delivering services to high risk, traditionally underserved populations. Conceptually, these well-established service delivery strategies are ideally suited to effectively address ECC in high-risk communities. Four strategies we have used to improve the health of our community can be readily applied to young children with early childhood caries:

1. Targeting high-risk populations with early intervention initiatives. Federally funded CHCs operate within designated “Medically Underserved Areas,” as well as “Health Professional Shortage Areas.” By definition, these geographic areas are populated by high-risk populations experiencing significant access-to-care barriers. Therefore, CHCs have the capacity to deliver early screening and health promotion programs to high-risk populations that include low-income women, children and adolescents.

2. To address ECC effectively for high-risk children, it is understood that primary prevention measures must begin between the ages of 1-2 years. SYHC as well as hundreds of other CHCs operate, and collaborate with, WIC and Headstart programs to reach high-risk children in a timely way. Over the past 3-6 months, SYHC’s WIC program has provided services to an average of 4,000 preschoolers per month. Through our ongoing WIC program, SYHC has established personal relationships with mothers and families that will facilitate the implementation of early dental intervention initiatives.

3. In the work of early childhood development, it is a well-established fact that a multidisciplinary approach is essential to optimize a child’s overall health and welfare. SYHC and many other CHCs are moving towards an integrated approach to delivering pediatric, prenatal, mental health, and WIC services to high-risk mothers, children, and families. Discussions are in progress to collaborate with agencies offering family-support services such as early child development counseling, parenting skills, and home visitation services. This comprehensive services approach represents an expansion of SYHC’s traditional model of care and builds on the goal of developing a more holistic approach to improving the quality of life for our community.

4. Historically, case management techniques have been well established in CHC programs. High-risk populations (e.g., diabetics, homeless, emotionally disturbed, HIV/AIDS) require focused attention, individualized treatment plans, and care coordination. Given the psychosocial and cultural characteristics of our community, this case management expertise is an essential piece to developing effective intervention programs for children at high risk for dental disease.

S. 1626, “CHILDREN’S DENTAL HEALTH IMPROVEMENT ACT OF 2001”

As a front-line provider of dental safety-net services, S. 1626 represents a bold, comprehensive vision for improving the oral health status of America’s children. The Children’s Dental Health Improvement Act of 2001 provides much needed public resources that will help create a stable economic platform that has the potential to stimulate and fund community-based innovations in the areas of service delivery, health promotion and disease prevention. New public resources will make it possible for health centers to design, organize and implement children’s oral health initiatives that have the potential to significantly reduce the incidence of dental disease, while responding to our community’s urgent need for treatment services.

As we consider passage of this bill, I believe it is appropriate to highlight the strategic role America's health centers could play in implementing a nationwide oral health improvement initiative:

1. Health centers are well positioned/poised to implement S. 1626 because health centers: represent a nationwide care delivery system made up of approximately 1000 centers and 3,400 delivery sites; have a tradition of organizational commitment to serving poor and underserved communities, as well as advocating for improvements in the public health services; provide a continuum of prevention and primary care services to millions of low-income, underserved children—we approach the oral health problems of children as a “pediatric health” issue vs. strictly a “dental” problem; have demonstrated effectiveness in building broad-based community partnerships to advance important public health initiatives, and throughout the country, health centers are now working to increase the public's awareness regarding children's oral health issues.

2. Health centers are in a high state of readiness to act in support of S. 1626 because health centers: have the essential administrative infrastructure to manage service expansion initiatives in a cost-effective and timely manner; have effective accountability systems in place for monitoring a broad range of clinical and operational performance standards; have successfully developed public-private partnerships that are now formulating community-based strategies for improving access to care and reducing disparities in oral health status; are experienced in leveraging public resources with other funding programs in order to optimize service delivery.

3. Health centers can help deliver much of what S. 1626 proposes because health centers: currently provide services to millions of children at-risk for dental disease—we can find the high-risk children; currently provide dental treatment services to millions of high-risk children—we can connect the children to treatment services; currently provide essential support services for high-risk children and their families—we can support ongoing professional management of a child's oral health maintenance; will take the lead in developing community-based strategies for developing effective oral health promotion and disease prevention programs.

Looking forward, America's community health centers stand ready to implement the bold dental health vision presented by S. 1626. Through the program resources provided by S. 1626 and the collective efforts of all child health advocates, we envision the day in the not too distant future where all children, regardless of financial background, have access to comprehensive, quality oral health services.

Thank you for the opportunity to express my comments on the important issue of children's oral health. I would be happy to answer your questions at this time.

PREPARED STATEMENT OF TIMOTHY SHRIVER

Mr. Chairman and esteemed Committee members, I am thankful for the invitation and eager to present testimony to you today concerning the oral health needs of persons with mental retardation. I commend you for conducting this hearing that focuses on a critical health issue for children and that certainly impacts a population that Special Olympics strives to serve every hour, every day, around the world. I had the good fortune in March of 2001, to present testimony before a Field Hearing of the Subcommittee of the Committee on Appropriations of the United States Senate. At that time, I stated to the best of my knowledge, that was the first time that a Federal legislative hearing had ever been dedicated to the health needs of persons with mental retardation. I can similarly state that in the 34 years of its existence, this is the first time that Special Olympics has ever been called to a hearing in Washington, D.C. to speak to the health concerns of persons with mental retardation.

I am sure that you are aware that Special Olympics is dedicated to providing year round training and competition for children and adults with mental retardation in Olympic type sports. We have effectively used sport as a vehicle to provide life opportunities to persons with mental retardation and to educate the public and policy makers about what people with mental retardation can accomplish when unnecessary, unfair, and sometimes illegal barriers, that are too often placed in their way, are reduced or eliminated. We currently serve one million athletes in 150 countries through more than 200 franchised Special Olympics programs at state and national levels that put on nearly 20,000 sports competitions each year. We are aggressively working to increase our service delivery to 2 million athletes worldwide by 2005. With continued persistence and support from a broad array of advocates and partners, including private citizens, corporations, academic entities, non-profit organizations, and governments around the world, we expect to reach that goal.

There is, however, a challenge that greatly affects our athletes, their families, and Special Olympics' ability to provide a quality sports experience; that is, the health

needs of our athletes. A little over a decade ago, we became aware that many of our athletes had health problems that caused them pain, limited their ability to perform in Special Olympics and compete in life, and that actually put them at risk. I personally experienced this in 1995 during our World Summer Games in Connecticut. When I looked at the data from our health screenings, I was appalled at what I saw: 50% of the athletes screened had ocular pathology; 25% had muscle disorders of the eyes; nearly 30% had general untreated visual problems; 23% had failed a test for visual acuity; 68% had gingival infection; and, one-third had obvious untreated dental decay. Most frightening, almost 15% of the Special Olympics athletes who chanced into our clinic suffered from acute pain or disease, necessitating immediate referral for care.

When I asked one of our senior clinical volunteers how such situations could exist, he did not seem surprised. Basically, he said, providers have low expectations for what such patients need or could possibly be expected to accomplish. Those that do get into the care system, get a “quick and dirty”, meaning just good enough to get by.

From that point, I knew that even though Special Olympics is a sports organization, we could not go forward assuming that the unmet health needs of our athletes would be taken care of or that flawed policies and discriminatory behaviors on the part of the health care system would resolve on their own. We have been forced to take steps to identify the scope and nature of the problems using objective scientific approaches, to communicate our findings broadly to the public and policy makers, and to take the lead in demonstrating models that can facilitate improved health and access to needed health services for our athletes and others with mental retardation. Make no mistake, we did not take on this challenge because we did not have enough to do promoting our sports initiatives. We simply had no choice.

I place before you two Special Olympics reports that document the health needs, including dental care needs, of persons with mental retardation. While there is not the abundance of data available that we would like, there clearly is enough to indicate that there is a big problem. The Health Status and Needs of Persons with Mental Retardation is a comprehensive literature review prepared by Dr. Sarah Horwitz and colleagues at Yale University. Promoting the Health of Persons with Mental Retardation: A Critical Journey Barely Begun is a policy oriented document created by Special Olympics that cites our own findings of the health needs of Special Olympics athletes and describes our efforts to address those needs through our Healthy Athletes initiative and research. Additionally, there is the Special Olympics Report of the field hearing conducted before a Subcommittee of the Committee on Appropriations of the United States Senate.

Let me also acknowledge and commend Dr. David Satcher, former U.S. Surgeon General and Assistant Secretary for Health, for the leadership he demonstrated in convening the first Surgeon General’s Conference on the health needs of persons with mental retardation in December 2001 and for producing the report Closing the Gap: A National Blueprint to Improve the Health of Persons with Mental Retardation. Special Olympics is working hard to address the key issues raised in this report and we anxiously await to see how governmental agencies and private professional, education and advocacy organizations will seriously take up the baton of responsibility to pursue actions to address the findings in the report. Special Olympics is in the process of entering into a grant relationship through the U.S. Centers for Disease Control and Prevention to implement the Healthy Athletes Initiative as called for in the FY 2002 Federal Appropriations Act.

In focusing in on the oral health issues specifically, consider the following facts from our 2001 Healthy Athletes screening data, collected through 31 U.S. screening sites and involving over 9,000 athletes: 30% of the athletes we screen have active tooth decay (infection) that is apparent without the use of x-rays or highly sensitive examination methods; 30% are missing one or more permanent teeth, likely the result of extractions due to tooth decay or periodontal infection. Could this be another example of “quick and dirty”?; 38% need care of a more pressing nature than “routine”; 14% report to be in pain from a tooth or other oral cause at the time of the screening; 44% show obvious signs of gingival infection; 4% have no natural teeth left in their mouth.

Data for non-U.S. athletes are even more alarming and we must assume that our athletes who participate in state level Games are likely to be the ones with better skills and more involved caregivers who are able to either provide or direct good oral health habits. The conclusion is that the unmet oral health needs among Special Olympics athletes and the larger population with mental retardation are high and care is difficult to obtain for this population.

While I have shared some hard data with you about the oral health needs of persons with mental retardation, let me also share some hard personal stories. Be-

cause, underneath the sterile dispassion of data tables are human lives—people who day-to-day, hour-by-hour have to deal with compounding challenges just to get through the basic functions of life. I want to share this with you through the lens of the person with mental retardation and through the lens of the concerned health care professional who is overwhelmed with what it's like to face the challenges of oral diseases without adequate support. This information comes from two people “on the ground”. Dr. Steven Perlman is the founder and Global Clinical Advisor for Special Olympics Special Smiles. His private practice in the Boston area is dedicated almost exclusively to treating Medicaid patients, including many, many persons with mental retardation and other disabilities. JoAnn Simons is the Executive Director of EMARC, a former Special Olympics Board member, and parent of a child with mental retardation.

Accessibility to dental care is a major issue for individuals with mental retardation because of both the funding issues and the unwillingness of many dentists to provide care to this patient group. In Massachusetts, Medicaid eligible children, and both children and adults with special needs, face a most difficult task in obtaining dental care. Only around 10% of the dentists in the state accept MassHealth (Medicaid) and about a fifth of pediatric specialists. I am not sure that any periodontists, endodontists or prosthodontists in the state accept patients with Medicaid. Medicaid serves as the principal payment mechanism for health care for persons with mental retardation in every state throughout the country.

As of March 15, 2002, the fees for the children's Medicaid program in Massachusetts were raised by 38%, but indications are that it did not induce many new providers to accept patients. Numerous other states have noted similar findings over the past several years.

For adults (over age 21 years) with disabilities, it is even more difficult to obtain care. The criteria are very strict; the dentist must have a note from a physician and a prior approval in order to provide any treatment. In addition, Massachusetts did not raise the adult fees when they raised fees for children's dental care services and, therefore, the provider must accept fees that are approximately 20-30% of usual and customary (UCR) for their most difficult and time consuming patients. There are only six or so dental practices in the state that are willing to treat adults with disabilities. Practitioners who are willing to step up and treat this population often find that they are overwhelmed by desperate parents and caregivers seeking a willing dental provider and scores of dentists seeking a willing dental provider to refer the case to.

Families and providers of mental retardation services in Massachusetts report that they must often travel great distances to either find a willing community dentist or they must receive care in a state funded, Medicaid eligible facility. Often, willing providers even tell parents of patients with mental retardation, “I will treat your child, but don't let anyone know or I'll be overwhelmed”.

Families and caregivers recognize the importance of maintaining good oral health; however, the reality is that many individuals with mental retardation go without daily oral hygiene care simply because it is too difficult to get the necessary compliance. This makes the access to reliable dental care even more essential.

Medicaid administrators, when confronted with these issues, point to institutional care provided through the Tufts program as the appropriate care provider for people with disabilities. Isn't it amazing, after decades of enlightened efforts to move people out of repressive institutional settings and into the larger community, that we would look to drive them back to institutions even for routine care.

The system does not have any incentives for dentists to treat this population; in fact, incentives exist for dentists not to treat. Most are able to fill their practices with private paying patients who do not require special attention.

Recently, Special Olympics published an important booklet for our athletes that was actually designed by our athletes. The title is provocative: *Are You A Healthy Athlete?* The cover shows two athletes, one of whom is holding up a hand mirror. Clearly, we are challenging the athletes to take a look in the mirror and to take their health seriously. This booklet contains simple sound advice for how our athletes can take actions to improve and protect their health and presents real athletes as role models for these behaviors. I am extremely proud that two of our athletes will be presenting a poster session on this work at a national health meeting in November.

I must say, though, that it is unfair and unrealistic to expect that our athletes and others with mental retardation will have enough personal resources and influence to deal with all of their health care needs. The mirror that the athlete is holding should really be for those who are in a position to make a difference—health policy experts, public officials, administrators of health systems, and leaders in the health field, as well as rank and file health care providers at the community level.

To date, our athletes and others with mental retardation have gotten short shrift. This must change.

Special Olympics, for its part, has implemented the Healthy Athletes program. We conduct health screenings, provide health education, deliver some definitive care (e.g., prescription eyeglasses), and make referrals for follow-up care. Currently, Healthy Athletes includes, Special Smiles, Opening Eyes, Healthy Hearing, and Athlete Health Promotion. We are developing new screening protocols on a continuing basis where we think that our athletes can benefit.

Many individuals and organizations have assisted us in this effort, including the Lions Clubs International, Grottoes Humanitarian Foundation, Patterson Dental Supply, Colgate Oral Pharmaceuticals, Oral Health America, American Dental Association Health Foundation, Sultan Chemists, Biologic, Essilor, Luxotica, Liberty Optical, and many more. Additionally, many health professional and allied health professional schools and associations have provided faculty, students and leadership to make the Healthy Athletes program accessible to athletes. And, thousands of health professionals have volunteered their time and talents to bring needed services to our athletes.

As I said earlier, we at Special Olympics are not a health care system, nor do we intend to be. We are committed, however, to compel others to take up these responsibilities even as we demonstrate effective ways to serve our athletes. We were fortunate, in 2002, to receive our first Federal assistance in support of Healthy Athletes. We are hopeful that leaders in Congress, including yourselves, will view our efforts as exceptional and important and worthy of your continued support in 2003 and beyond.

Senator Bingaman, your proposed legislation has the potential to redress many of the shortcomings in the current health care system so that millions of additional children will receive the dental care that they need in order to be healthy. I do wish to point out to you some additional considerations for your bill that would help assure that those with intellectual disabilities do not fall through the cracks as your bill becomes law. We have lived with the challenges of getting needed health care, including dental care, for our athletes for decades. While enhanced reimbursement levels and salary supplements for dental providers are important, they are not, in themselves, enough to assure that persons with mental retardation will receive the care that they need. Our experience is that few dentists and hygienists have received any significant training or experience in dealing with this population during professional school, in post-graduate work, or through continuing professional education. Actual teaching hours in dealing with these types of patients has declined in dental schools over the last decade. You would be hard pressed, in reviewing listings of current continuing dental professional education opportunities, to find offerings that deal with treating this population. We find that when we orient, train and provide hands-on experience for our Special Smiles volunteers, wondrous things happen. Dental providers gain confidence, new skills, improved attitudes and a commitment to serve our population. I recommend that you give consideration to adding provisions to your bill to address these concerns.

I recommend that your bill, in Title II, specifically challenge all of those institutions, providers and government agencies that would receive funding toward its implementation to address specifically the oral health care needs of those with disabilities, including mental retardation, and to explicitly establish baselines of need using objective criteria and scientific methods. Further, they should be required to explicitly plan approaches to address the special needs of individuals with mental retardation, wherever they live, and to establish quantitative and qualitative goals for improving their oral health status and access to care, and to monitor progress toward their improvement.

It is also important to recognize that utilization of traditional dental health professional shortage area criteria could still leave persons with disabilities and other Medicaid eligibles without accessible care. There are many geographic areas with an abundance of trained health professionals, but with inadequate access to care for persons such as those with mental retardation. A shortage should be viewed from the perspective of the patient needing and seeking care, rather than the perspective of just provider count. If trained, licensed health professionals choose not to treat persons with mental retardation, regardless of the number of providers, then surely there is a shortage. I recommend that any dentist willing to serve a significant number of Medicaid eligible individuals, whether as an employee or as an independent practitioner, be included as eligible for supplemental remuneration. Each of our athletes and others with mental retardation need a "dental home" where qualified, willing dental providers will commit to handling their oral health needs from prevention through rehabilitation on a continuing basis.

Consistent with this, I recommend that persons with mental retardation be regarded as a specific catchment group for which efforts should be targeted. Further, given the role that reimbursement plays in people not getting the dental care that they need, serious consideration needs to be given to market rational reimbursement policies that would reflect the additional care and time that patients with mental retardation may require. This would include reimbursement rates for oral health services comparable in market index to reimbursement rates for medical services under Medicare and additionally adjusted for case intensity.

I recommend that additional organizations, beyond those listed in Title II, be eligible to receive grants for purposes of improving oral health care access for underserved populations, including those with mental retardation. And, finally, I find it ludicrous that across the country, youth with a chronological age of 21 years, even while having a mental age well below this, age out of reasonable dental care under the Medicaid program as it now stands. While it is reasonable that, at some point, young people on Medicaid should become self sufficient adults, how could such logic be applied straight across to persons with mental retardation. In many cases, adults with mental retardation become more needy of support as their caregivers age, become infirm, dependent themselves, or pass away. To abandon their oral health care needs at age 21 is cruel and unscientific. I believe that age restrictions on Medicaid dental care services for those with mental retardation, who are otherwise eligible, should be waived the 23-year-old person with mental retardation and unmet dental care needs or who is in pain is no less vulnerable or deserving of care than the 17-year-old.

Loretta Claiborne, a highly accomplished Special Olympics athlete from Pennsylvania, offered the following riveting testimony before the U.S. Senate hearing last year in Anchorage: "We do more in this country to give health care to people in prison than we do for people like me who have done nothing wrong". Senator Bingaman, I believe that the legislation you have proposed could go a long way toward redressing this scandal. I am hopeful that we can see it passed and that the issues I have raised for your consideration can be reflected.

I would be happy to try and answer any questions that you may have.

PREPARED STATEMENT OF SPECIAL OLYMPICS, INC.

SUMMARY

As the largest organization in the world promoting acceptance through sport, Special Olympics has a 32 year track record of demonstrated success in providing year-round sports training and competition opportunities for children and adults with mental retardation. Founded in 1968 by Eunice Kennedy Shriver, Special Olympics, Inc. (SOI) is incorporated in the District of Columbia as a not-for-profit corporation focused on international sports.

Special Olympics flourishes in 150 nations and in each of the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and American Samoa. One million people with mental retardation annually participate in Special Olympics training and competition programs globally. One million volunteers and 250,000 coaches around the world support these efforts, training athletes in 22 Olympic-type sports and organizing more than 20,000 local, regional, national and international sporting events annually. Through regular sports training programs, Special Olympics athletes enhance their athletic skills, improve their overall physical fitness, and develop increased self-confidence and self-esteem. In fact, published research indicates that for people with mental retardation, regular participation in Special Olympics sports training and competition activities yields all of these benefits and often leads to sustained improvement in overall physical fitness and emotional well-being (1).

PREVALENCE/CAUSES OF MENTAL RETARDATION

The World Health Organization estimates that there are approximately 170 million people with mental retardation worldwide (2). In other words, nearly 3% of the world's population has some form of mental retardation. Accordingly, mental retardation is 50 times more prevalent than deafness; 28 times more prevalent than neural tube disorders like spina bifida; and 25 times more prevalent than blindness.

A person is diagnosed as having mental retardation based on three generally accepted criteria: intellectual functioning level (IQ) is below 70-75; significant limitations exist in two or more adaptive skills areas (e.g., communication, self-care, functional academics, home living); and the condition manifests before age 18. Mental retardation can be caused by any condition that impairs development of the brain before birth, during birth, or in childhood years. Genetic abnormalities, malnutri-

tion, premature birth, environmental health hazards, fetal alcohol syndrome, prenatal HIV infection, and physical abnormalities of the brain are just some of the known causes of mental retardation.

This report is the result of an analysis that was undertaken to identify and highlight the health status and needs of persons with mental retardation and to suggest approaches that could be implemented, given current knowledge and technology, to improve both the length and quality of their lives over the coming decade. Length and quality of life are central concerns of numerous high-level policy initiatives in many countries, including the United States. The recent launch of the Healthy People 2010 (3) initiative marks the third decade of a national commitment to improving the health and wellbeing of Americans. Major goals of the initiative include increasing the quantity and quality of life and reducing health disparities among various groups. However, if one focuses on the health status, needs and opportunities for persons with disabilities, the public policy record is much more Spartan. The previous Healthy People 2000 initiative (4), launched by the U.S. Department of Health and Human Services in 1990, included little direct focus on the health status and needs of persons with disabilities.

To its credit, the Healthy People 2010 report (3) dedicates a chapter and a number of objectives and “developmental objectives” to persons with disabilities. Yet, the chapter does not address specifically the health status, needs and access issues confronting millions of Americans with mental retardation or other specific disability groups. Further, there are notations of “no available data”, “inadequate data”, or “unanalyzed data” concerning persons with disabilities throughout the document. Similarly, several recent highly visible federal reports addressing oral health challenges and lack of access to oral health services for several special needs populations barely mentioned the population with disabilities, including individuals with mental retardation (5-7).

This is the central reason why Special Olympics is taking a leadership role with respect to the health status and needs of persons with mental retardation. While Special Olympics is not a health organization per se, it recognizes that individuals can not effectively or safely participate in sports training and competition at any level if they are constantly challenged by health liabilities and disparities.

Special Olympics is exerting leadership in the area of health for persons with mental retardation because, to date, adequate leadership has not emerged from the health care and public policy communities. Moreover, while there has been some welcome progress in terms of increased life expectancy and quality of life for persons with mental retardation over the past several decades, major health gaps remain and health improvement opportunities remain widely underaddressed. Healthy People 2010 (3) makes a clear statement that is rationale enough for this report:

“ . . . the principle—that regardless of age gender, race, ethnicity, income, education, geographic location, disability (emphasis added), and sexual orientation—every person in every community across the Nation deserves equal access to comprehensive, culturally competent, community-based health care systems that are committed to serving the needs of individuals and promoting community health” .

The major findings, conclusions and recommendations of this report are drawn from several sources, including: an independent, comprehensive review of the literature undertaken by scholars at Yale University (8); learned opinions from health and disability experts from various countries; administrative data derived from Special Olympics programs; and direct experiences of Special Olympics athletes, their families, program staff, and volunteers. Consistent with policies of Special Olympics, the findings, conclusions and recommendations in this report have been shared with a number of Special Olympics athletes.

MAJOR FINDINGS

Individuals with mental retardation suffer from a wide range of chronic and acute diseases and conditions. In many instances, they experience more frequent and severe symptoms than the general population. This is not solely a result of the primary disability of mental retardation, but reflects more fully the totality of risk factors and risk reduction opportunities made available to or denied to them. Importantly, their life and health experiences can not be adequately explained or rationalized solely by the fact that they have mental retardation, since they are impacted by secondary conditions and persisting environmental factors (social, economic, physical, etc.) that fail to ameliorate or actually exacerbate their risks.

Evaluating isolated categorical health deficits or conditions in persons with mental retardation through simple disease/condition comparisons with the general population is not, in itself, adequate for assessing health status or the need for health improvement. Even where there is evidence that the prevalence of a specific disease

or condition may be similar between the general population and those with mental retardation, the adverse impacts can be greater on those with mental retardation. Health must be seen in overall functional terms, especially for populations with disabilities and including the aspect of meaningful social participation.

Numerous measures indicate that persons with mental retardation experience lower life expectancy and lower quality of life than the population in general. The magnitude of these gaps can not be explained solely by the existence of the mental retardation condition.

Notwithstanding the increasing focus on personal and population health promotion and disease prevention, both in the United States and elsewhere, persons with mental retardation have received little consideration in terms of health improvements that they may be able to realize. Consistent with this finding, the information concerning the health status and needs of persons with mental retardation is entirely inadequate. Further, there is a dearth of information as to specific disease prevention and health promotion interventions that could improve the quality and length of life for persons with mental retardation.

Even in situations where persons with mental retardation experience similar levels of disease to persons without mental retardation, access to timely and appropriate health care often is not adequate and generally poorer than for the overall population. This leads to unnecessary suffering, functional compromise, and costs to individuals, families and society.

Although persons with mental retardation need health and health financing programs that are responsive to their particular needs, too often they are forced into general programs that actually can compromise their health. The most recent example of this is the movement toward managed care in Medicaid.

Families have served as principal advocates for the health care of their children with mental retardation. While many families are fortunate to have private health insurance and/or personal resources to help cover health care expenses, too many families and individuals face substantial health care costs on their own. While a large percentage of the population with mental retardation is covered under state Medicaid programs, many of these programs are plagued by a variety of problems, including poor reimbursement rates to providers, excessive paperwork and delays, limitations and exclusions in benefits, and a generally poor reputation among providers.

As an example, while dental services for many children are covered under Medicaid, only one-in-five eligible children receive any dental services each year (9). In most states, there are limited dental care benefits for adults, so that children with mental retardation are no longer eligible for dental care coverage under Medicaid, once they reach the age of maturity. Also, it should be noted that dental care is essentially unavailable under Medicare.

The majority of health professionals who are otherwise qualified to treat persons with mental retardation fail to do so. This is largely the result of a lack of appropriate, specific training, inadequate reimbursement policies, fear, and prejudice.

Existing federal, state and voluntary programs to meet the health needs of persons with mental retardation are inadequate. Enhanced and new efforts with supplemented and targeted resources will be required. Coordinated and integrated rather than piecemeal efforts must be a priority.

Significant additional targeted research is needed to more fully characterize and understand the health status and needs of persons with mental retardation and to test models for improving health. Still, existing data are adequate to conclude that persons with mental retardation are woefully under addressed in terms of national (virtually every nation's) health priorities. The Special Olympics Strategic Research Plan (10) can serve as a blueprint for many research efforts. However, strong research partners, including funders, will be necessary.

RECOMMENDATIONS

All public and private programs, initiatives and reports that address the health needs of the public should explicitly examine the unique needs of persons with mental retardation. Because of the complex constellation of physical, mental, and social variables that combine to challenge the health and wellbeing of this population, general conclusions based on individual demographic or risk factors are inadequate for designing effective policies and programs to help persons with mental retardation. "One size fits all" solutions to the financing and delivery of services will assure that persons with mental retardation will continue to be underserved and/or receive inappropriate services.

An expert working group should be convened by the Secretary, U.S. Department of Health and Human Services to address equity gaps and opportunities that exist

to better characterize the health needs of persons with mental retardation. If necessary, to stimulate action, public hearings should be convened by Congress to garner necessary focus and priority.

The goals of the Healthy People initiative only can be achieved when the health status and needs of specific populations are well documented, effective community and clinical education programs exist, prevention and treatment programs are designed, and adequate resources are made available.

Specific health objectives for persons with mental retardation should be established, consistent with the overall goals of Healthy People 2010 (3)—namely, to increase quality life years and to reduce the gaps in health status. Leadership should come from the U.S. Department of Health and Human Services through the Administration on Developmental Disabilities, Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), in conjunction with the Department of Education.

The CDC should conduct a comprehensive review of the degree to which data collection and analysis regarding the health and wellbeing of persons with mental retardation have positively or negatively impacted the lives of persons with mental retardation and what opportunities exist to redress past shortcomings.

Substantially enhanced documentation of the health status and needs of persons with mental retardation is needed. Currently, too many surveillance processes fail to collect adequate information on this population and fail to perform relevant data analyses in a timely fashion, which then could inform policy development and program design.

A diverse expert working group should be convened to examine the health and wellbeing for persons with mental retardation from the perspective of what could be achieved to enhance health opportunities, if existing disparities and conflicts in policies and organizational priorities could be resolved. This will directly impact the health of persons with mental retardation and the costs to society.

Too often, efforts to describe the scope of health and social challenges for persons with mental retardation have focused on the magnitude of disability and the cost of long-term and respite care. Policy makers and health organizations need to frame appropriately the opportunities that exist to facilitate skill development and independence for persons with mental retardation. They need to identify, in qualitative and in quantitative terms, the benefits to society for investing in the potential of persons with mental retardation.

Special Olympics should convene a blue ribbon corporate health advisory group for persons with mental retardation to develop a strategic and integrated corporate strategy for maximizing the impact of corporate contributions (intellectual, technical assistance, in-kind, cash) for the betterment of persons with mental retardation.

Given the inadequate resources and attention to the health needs and possibilities for persons with mental retardation, it is time for leading health organizations, including pharmaceutical companies, health equipment and supply companies, health insurers, and government and philanthropic organizations to commit resources to promoting health and preventing disease in this population, so that by 2010, clear health gains and realistic health promotion opportunities are created for persons with mental retardation.

Likewise, leading philanthropic organizations need to undertake a critical self-examination of the degree to which they have addressed the health needs of persons with mental retardation. Organizations with weak records of support in this area should make concrete commitments to funding programs and projects to improve the health of persons with mental retardation.

A focused effort to create health literacy enhancement opportunities for persons with mental retardation needs to be undertaken. Closing the gap in health literacy has been identified in the Healthy People initiative (3) as a principal strategy for reducing health disparities. Persons with mental retardation also need to have health information presented to them in ways that may empower and motivate them toward seeking higher levels of health. While this will not be possible universally, there are tens of millions of persons with mental retardation globally who can not simply be categorized as unable of taking an active role in their own healthcare. Further, caretakers will be more motivated to act in the best health interests of persons with mental retardation if they are aware of what appropriate standards are.

The Inspector General, of the U.S. Department of Health and Human Services, as well as the Association of State Attorneys General, should evaluate whether the provisions of publicly funded and private health programs are providing equal or equitable protection to persons with disabilities, including those with mental retardation.

A broad public health assessment of mental retardation needs to be undertaken by leading public health and professional organizations that can lead to formula-

tions of effective organizational policies and programs. The new National Center on Birth Defects and Developmental Disabilities at CDC should have an explicit program focus and adequate resources to fund research, surveillance, and assessments on the prevention of secondary disabilities among persons with mental retardation.

The public health community needs to reassess and reprioritize mental retardation as an important public health challenge that goes beyond simply primary prevention of diseases and conditions that result in mental retardation.

The NIH and other federal agencies with a health research mission should allocate increased levels of research funds to issues critical to understanding all dimensions of mental retardation and where research opportunities exist to pursue the prevention and rectification of the primary and secondary effects of mental retardation. Special Olympics should formally transmit its strategic research agenda to these agencies as a basis for consensus development around the strategic role of federal agencies in such research.

ADDITIONAL PERSPECTIVES

The findings and recommendations in this report have as their principal basis the comprehensive literature review conducted by Horwitz et. al. at Yale University (8), data and perspectives from Special Olympics program offerings and services delivery, and responses from key informants from a number of countries who are knowledgeable of and work in areas related to mental retardation.

Dr. Stephen Corbin and Dr. Donald Lollar asked professional colleagues in several countries to respond to a survey instrument (available from Special Olympics upon request) containing items addressing the existence of data, policies, laws, and programs for individuals with mental retardation, and their health status and needs. The key informant responses were solicited after completion of the other portions of the report so that they might serve a validation function. Responses came from individuals in Kenya, India, Australia, and the Czech Republic. As it turned out, these responses validated the findings and recommendations that had been articulated.

To date, health data collection and analysis for the population with mental retardation has not been a priority in these countries. Representative country data were not available to characterize in any comprehensive way the health status and needs of persons with mental retardation. Data that are available are not collected on an ongoing or periodic, scheduled basis. The tendency is for official data collection sources to seek data on disability in general or to rely on general population data which are of limited utility for understanding the health needs of persons with mental retardation.

Some institutional data are available (Czech Republic), but the depth of information varies significantly. It was noted that in Australia, de-institutionalization of persons with mental retardation has interrupted not only the availability of health services to these persons, but also negatively impacted the collection of information about the health needs and health service access for much of this population.

All respondents indicated that access to necessary health care services for individuals with mental retardation is a problem. Even in countries where medical care is made available by law to all citizens, persons with mental retardation have difficulty receiving needed care from qualified providers. Children with mental retardation tend to fare better than do adults with mental retardation. Those living in cities generally receive inadequate care and those in villages are even worse off. NGOs provide some assistance (Kenya), but this is not sufficient. It was pointed out that in Australia, many conditions could be ameliorated and or prevented by early intervention, but periodic screening is not a well-established part of the system. Disease prevention and health promotion services for persons with mental retardation do not appear in any systematic way through government or private sources and are not a public priority.

Further, bias against persons with mental retardation is reported to exist still, even among health care providers, and most persons with mental retardation are not in a strong position to communicate their health needs and desires. Several respondents indicated that individuals with mental retardation may be eligible for a level of services similar to those provided to individuals with other disabilities, but, in actuality, they usually end up with poorer access to care. For example, in India individuals with visual impairments and individuals who are orthopedically challenged have better access to health services than do individuals with mental retardation. Lack of adequate resources to pay for needed care is a consistent problem and, in the case of institutions (Czech Republic), adequate resources to provide appropriate staffing levels is a challenge.

The greatest barriers to the improvement in health status for persons with mental retardation include attitudes by the public, governments, service providers, and, in some instances, even family members. The health needs of persons with mental retardation do not register high enough on the priority scale to attract the resources and attention that they merit. Even where policies and laws exist that should provide a basis for needed services for persons with mental retardation, there is little attention to surveillance and enforcement.

Informants made a number of suggestions as to the most important actions that could be taken over the next decade in order to increase life expectancy and quality of life for persons with mental retardation. These include: Earlier, more adequate and frequent health screening; A more responsive general health system; Additional training and strong encouragement for health professionals to meet the needs of people with mental retardation; The development of a network of specialized tertiary referral health clinics to support the general health services and to provide a base for research and training; Adequate national data bases; Implementation of existing laws; Implementation of a mass awareness program through print and electronic media, including the internet, to better sensitize the public as to the nature and needs of persons with mental retardation; A firm stabilized health insurance system with adequate financing; Standardized, periodic screening targeting prevention and needed care; Better communication about the lives and personalities of persons with mental retardation, coupled with training in communications and ethics for care providers; Governments recognizing mental retardation as a special entity and enacting policies favorable to this group; and, Popularization of the idea of Special Olympics through which governments, the general public, professionals, and organizations can assist in health promotion and disease prevention efforts on behalf of persons with mental retardation.

SPECIAL OLYMPICS HEALTHY ATHLETES—AN INITIAL APPROACH TO ADDRESSING THE HEALTH NEEDS OF PERSONS WITH MENTAL RETARDATION

Special Olympics has provided year round sports training and competition opportunities for persons with mental retardation for more than three decades. Over a million athletes of all ages participate in a variety of summer and winter Olympic-type sports. Special Olympics was started by Eunice Kennedy Shriver in 1968 because persons with mental retardation consistently were excluded from societal opportunities, including sports and recreation. She recognized that persons with mental retardation could accomplish significant things through sport, while, at the same time, finding meaning in their lives. Since that time, the public record of service and opportunity provided to persons with mental retardation through Special Olympics has been well documented, through extensive print and electronic media and a continuing stream of highly visible public events.

In recent years, Special Olympics has expanded its interest in the health of its athletes by supporting research activities, organizing medical symposia, and collaborating with international organizations on prevention issues.

Beginning in 1989, the health needs of persons with mental retardation were highlighted as a result of vision screenings initiated through the Sports Vision Section of the American Optometric Association. These initial screenings demonstrated that Special Olympics athletes had significant and highly prevalent vision impairments and that they were woefully lacking in quality vision care opportunities.

In the early 1990s, an additional program, Special Olympics Special Smiles, was created to address the unmet oral health needs of Special Olympics athletes. Like Special Olympics Opening Eyes, Special Olympics Special Smiles demonstrated that Special Olympics athletes had a significant unmet need for oral health care. Boston University's Goldman School of Graduate Dentistry provided the founding institutional home for Special Smiles and enabled the program to grow quickly.

WHAT IS SPECIAL OLYMPICS HEALTHY ATHLETES?

Special Olympics Healthy Athletes is a diverse program of health assessment, professional training, service provision, and referral for Special Olympics athletes. Special Olympics Healthy Athletes screening venues are conducted in conjunction with sports competitions at local, state, national, regional, and global levels. These programs are elective for Special Olympics Programs and Games Organizing Committees. Despite the non-mandatory aspect, Special Olympics Healthy Athletes Programs have been expanding rapidly, based on the recognition that they bring a new and valuable range of services and resources to Special Olympics athletes. Special Olympics Healthy Athletes is not intended to be a comprehensive health care system, but rather is a short-term, limited, yet practical means for bringing a range

of health services closer and more convenient to Special Olympics athletes and in a welcoming, respectful, and non-discriminatory setting.

Special Olympics Healthy Athletes programming includes: Direct health services delivery to Special Olympics athletes; Health education services for athletes; Athlete referral for needed follow-up care; Documentation of the health status and needs of athletes; Recruitment and training of health personnel in treating people with mental retardation; Advocacy for improved public policies in support of the health needs of people with mental retardation; and, Advancing knowledge about the delivery of health care to persons with mental retardation.

RANGE OF SERVICES PROVIDED

Special Olympics Healthy Athletes program components offer the following range of personal health services, varying by discipline and specific screening protocols: Screening assessment, Clinical examination, Health education/counseling, Preventive services, Corrective services, Personal preventive supplies, Referral for follow-up care, Interaction between athletes and specially trained and motivated health care providers.

Qualified experts from the health disciplines within Special Olympics Healthy Athletes determine the appropriate contents and standards for their screening and service offerings, based on the state of science and clinical practice, with adaptations for the special population that is being served. Special Olympics program leaders along with the Special Olympics Global Medical Advisory Committee and legal staff monitor and approve overall program scope and practices.

In 2001, more than 100 Special Olympics Healthy Athletes screening clinics will be conducted. This includes screening events at local, state, national, and international levels. Also, beginning in 1999, several additional health disciplines were pilot tested for the first time as Special Olympics Healthy Athletes components. They include: hearing; physical therapy; dermatology; and orthopedics. Screening clinics in these disciplines have been conducted at a number of Games in the U.S. and abroad, and further growth in these and other medical disciplines is anticipated.

SPECIAL OLYMPICS HEALTHY ATHLETES PROGRAM FINDINGS

In addition to the health services that Special Olympics athletes receive through the Special Olympics Healthy Athletes Program, valuable insights have been gained as to the health status and needs for this population group. As reflected in the Yale University literature review (8), Healthy People 2010 (3), and feedback by key informants from different countries, there is a general lack of information as to the health status and needs of persons with mental retardation. Further, available data generally are from small institutionally based studies or administrative records of public agencies.

Specific advantages of the data derived from Special Olympics programs is that the population served is substantial and includes athletes of all ages from around the world. Literally tens of thousands of Special Olympics athletes have been screened through the Healthy Athletes Program to date. Further, the data have been collected using standardized protocols developed by experts in the field (e.g., U.S. Centers for Disease Control and Prevention).

Limitations in the data that must be recognized include the large number of examiners involved, the limited sensitivity of the survey instrument in some cases to detect quantitative differences in levels of disease (e.g. oral health screening instrument), and the convenience aspects of the population being reported on—i.e., athletes participating in Special Olympics events are not fully reflective of the larger community of institutionalized and non-institutionalized persons with mental retardation worldwide. As pointed out in the Yale University literature review, there appear to be certain health advantages or disadvantages to individuals based on their residential status. A number of disease conditions may be more prevalent among individuals with milder retardation living in freer environments where they must make conscious choices to avoid health risks (e.g. tobacco use) or to practice healthy habits on their own (e.g. oral hygiene, physical exercise, etc.). Nevertheless, there is little doubt that that Special Olympics Healthy Athletes data make a valuable contribution toward understanding the health status and needs of persons with mental retardation and planning programs and policies to address unmet needs.

VISION HEALTH OF SPECIAL OLYMPICS ATHLETES

Nearly 10,000 athletes have received vision assessments through the Special Olympics Opening Eyes Program since its inception. It is anticipated that in 2001, due to a program expansion facilitated by a major, multi-year grant from the Lions

Clubs International Foundation, an additional 6,000-7,000 athletes will directly receive such screenings. Findings have been fairly consistent over several years of assessments. Special Olympics athletes had not received adequate vision care in terms of timeliness and many require corrective services. Over 60% had not received a vision assessment in the past three years. Between one-fifth and one-third of athletes required glasses for the first time or replacement glasses. In many instances, athletes were wearing prescriptions that were found to be grossly inaccurate. The prevalence of astigmatism (44.2%) and strabismus (17.8%) were high. A high percentage of athletes examined would be classified as legally blind according to World Health Organization criteria.

Many anecdotal reports identified athletes who, after receiving eyewear through the Special Olympics Opening Eyes Program, could, for the first time, see the finish line, their friends and families cheering for them. In a number of instances, coaches and family members reported that the new eyewear literally changed the personality of individual athletes and immediately enhanced their quality of life, while reducing certain risks (e.g. injury from falls or collisions). Many athletes additionally have received prescription swim goggles or prescription or plano safety sports glasses intended to prevent sports injuries.

ORAL HEALTH OF SPECIAL OLYMPICS ATHLETES

Oral health assessments have been provided to approximately 20,000 athletes through the Special Olympics Special Smiles Program over the past seven years. Most screening clinics have been conducted in the United States, although it is anticipated that major program growth, starting in 2001, will take place outside the United States. Special Olympics Special Smiles utilizes an assessment instrument developed by CDC especially for Special Olympics. The instrument was designed to be reliable when used by a variety of trained examiners under varying conditions. This comes at the expense of providing great quantitative detail. Thus, as an example, an athlete would be assessed for obvious dental decay in at least one tooth. If such were the case, the assessment form would be marked "yes". However, if several teeth for an athlete had obvious decay, the "yes" category likewise would be marked. Thus, there would be no apparent distinction when examining data as to the extent of dental disease in an individual athlete. This protocol differs from more sophisticated epidemiological studies conducted periodically by federal and state governments that precisely quantify the presence of dental disease down to relatively small caries lesions on individual tooth surfaces. The limitations of government studies, however, is that they fail to include an adequate number of individuals with mental retardation to provide meaningful results or they fail to identify individuals by disability category.

Notwithstanding the limitations in data derived from the Special Olympics Special Smiles screenings, a good overall picture emerges of the oral health status and needs of Special Olympics athletes. The 1999 Special Olympics World Summer Games in Raleigh, North Carolina are representative. For the over 2,200 athletes of all ages examined, nearly 20% reported pain in the oral cavity, the vast majority attributed to tooth pain. Much untreated dental decay exists in Special Olympics athletes. Nearly one-in-three had active dental decay (untreated) in molar teeth and more than one-in-ten had active decay in pre-molar or anterior (front) teeth. Less than one-in-ten screened athletes had preventive dental sealants present on any molar teeth.

There is a clear need for more professional care to be made available to this population. More than 40% of screened athletes were in need of professional care beyond the level of routine, maintenance care, and more than one-third of these needed urgent care. There were substantial differences between U.S. and non-U.S. athletes in terms of needed professional care. Nearly half of non-U.S. athletes were in need of care beyond routine maintenance care compared to 28.4% of U.S. athletes. Urgent care was required nearly three times as often (19.9%) for non-U.S. athletes as for U.S. athletes (7.1%).

During 2000, 35 Special Olympics Special Smiles screening clinics were conducted, serving nearly 10,000 athletes. While the results from site to site demonstrated some variations in individual measurement categories, overall the data were consistent with the athlete data gathered at the 1999 Special Olympics World Summer Games.

HEARING HEALTH OF SPECIAL OLYMPICS ATHLETES

The Special Olympics Healthy Hearing Program is much newer than the Special Olympics Opening Eyes or Special Smiles Programs. The first hearing screening was conducted as part of the Special Olympics World Summer Games in 1999. A

second large-scale event was conducted at the 2000 Special Olympics European Games in Groningen, Netherlands.

During the European Games, 529 athletes were screened at the Special Olympics Healthy Hearing venue. The athletes were from 61 countries. Screenings including otoscopic examination of external ear canals, otoacoustic emissions (OAE) hearing tests, pure tone audiometry, and tympanometry to screen middle ear function. Twenty-six percent (26%) of the athletes failed the hearing screening as compared to a general population rate expected to be under 5%. Of this group, 52% did not pass tympanometric screening, suggesting the presence of a conductive (probably medically correctable) hearing loss. Conversely, 48% passed the tympanometric screen, which implies that they failed the hearing screening due to a sensorineural (permanent) hearing loss.

Of the nearly three-quarters of the screened athletes who passed the screening protocol, one-in-five had ear canals blocked or partially blocked with cerumen (ear wax), reflecting a lack of ear hygiene and professional care. The results from the Groningen screening were similar to those compiled at the 1999 Special Olympics World Summer Games.

OVERWEIGHT AS A RISK FACTOR FOR SPECIAL OLYMPICS ATHLETES

According to Healthy People 2010 (3), the prevalence of overweight individuals is on the rise with 11% of school age children and 23% of adults being classified as obese. The prevalence of obesity in the population with mental retardation has been reported as more common than in the general population. Obesity has been implicated as a major preventable health risk factor for the general population. These risks include a higher prevalence for these individuals of cardiovascular disease, cerebrovascular disease, diabetes mellitus, and certain types of cancer.

For the first time during a World Special Olympics Games, in Raleigh, North Carolina in 1999, nutritional assessment and education were included in the Healthy Athletes Program. This was stimulated by the increasing focus on the nutritional status of both under and over nutrition in the general population. For Special Olympics athletes who train and enter athletic competition, under or over weight, representing poor nutritional status, may affect general wellbeing and performance. Ten hundred and sixty six (1066) Special Olympic athletes were assessed by anthropometric measurements. These included height and weight used to calculate Body Mass Index (weight (Kg) / ht (m²)) for each athlete. There were 421 athletes from the United States and 645 from other areas of the world.

The Body Mass Index (BMI) measurements were standardized for age using the NHANES III BMI values. BMI values for children and adults have been standardized in the U.S., but there are presently no available established reference ranges for BMI for children and adults with mental retardation. Each athlete who volunteered was evaluated anthropometrically by obtaining height and weight. BMI percentile ranges across ages were then compared. BMI below the 5th percentile represented malnutrition and between the 5th and 15th percentile a risk of under nutrition. BMI greater than 85th percentile represented obesity and greater than 95th super obesity with significant health risk factors.

For U.S. athletes, 3.3% were below the 5th percentile compared to 5.2% of athletes from other countries. The 5th to 15th percentile included 5% of U.S. athletes and 7.1% of athletes from other countries. There were 11.2% of U.S. athletes between the 15th and 50th percentile and 30.9% from other countries. For the 50th to 85th percentiles, there were 27.6% of athletes from the U.S. and 36.6% of other athletes. Fifty three percent (53%) of U.S. athletes and 20% of athletes from other countries were greater than the 85th percentile BMI, with 33% of American athletes and 7% of athletes from other countries greater than 95th percentile.

These findings reflect that the majority of U.S. athletes at the World Summer Special Olympics in 1999 were above the 85th percentile and, thus, were obese and 33% would be considered in a group with significant health risk because of super obesity. Whether these data represent all individuals with mental retardation, it is apparent the BMI values obtained from a majority of individuals who represent the Special Olympics athletes from the U.S. are at significant risk. More data for specific age, sex, living condition and diagnoses for nutritional status in the population with mental retardation need to be obtained. Also, the percentage of patients with Down syndrome relative to the general population with mental retardation is known to be more obese and may need to be studied separately. This large sample of Special Olympic athletes, although not representing the general mental retardation population, particularly for those from the U.S., indicated that these individuals may be at significantly increased health risk.

Thus, it is apparent that greatly increased efforts to work with athletes, coaches, families, teachers, health care providers, and program administrators in the area of diet, nutrition, weight control, and fitness are needed.

TRAINING HEALTH PROFESSIONALS TO TREAT PERSONS WITH MENTAL RETARDATION

It stands to reason that for individuals with mental retardation to have their health needs met, there must be trained, willing health care providers available. As reflected in the Yale University literature review, a number of reports indicate that health care providers overall feel ill prepared and minimally motivated to treat persons with mental retardation, even for conditions found routinely in the general patient population. Health professional students receive little didactic exposure to the health needs of persons with mental retardation during their training and even fewer have meaningful clinical experiences with such patients.

Accordingly, Special Olympics has made it a priority to train health professional volunteers and to provide them with hands-on experience in serving persons with mental retardation. Typically, health professional volunteers for the Special Olympics Healthy Athletes Program receive didactic training as to the nature of mental retardation, special health and social challenges faced by persons with mental retardation, special aspects of their own discipline relating to mental retardation, and effective techniques for rendering quality clinical services to this population. Volunteers additionally receive actual experience, lasting from several hours to several days, depending on the nature of the event, to provide service to and interact with Special Olympics athletes. They are accorded continuing professional education credit for this experience.

Consistently, health professional volunteers report their Special Olympics Healthy Athletes experience in extremely positive terms. Many individuals characterize the experience as the most meaningful professional encounter of their careers. Students typically become highly motivated to seek additional experience with special populations. Research conducted by Special Olympics clinical consultants on health professional volunteers indicates that volunteer optometrists have a reasonably high expectation for the capabilities of persons with mental retardation prior to their Special Olympics Healthy Athletes experience, and, that after their experience, they report even more positively in terms of what persons with mental retardation can accomplish in life and contribute to society. Oral health providers (dentists, dental students, dental hygienists) evaluated using the same instrument showed similar, albeit less consistent, results.

While the health services provided to Special Olympics athletes in conjunction with Special Olympics Games are valuable in their own right, they are minimal in the context of the overall health needs of persons with mental retardation on a year round basis. The ultimate goal of the Special Olympics Healthy Athletes program is to create a legacy of care for persons with mental retardation. The practicality of such a goal will only be apparent after additional research is conducted to determine whether, in addition to improved health professional attitudes, active commitments to outreach and the care of persons with mental retardation can be realized in providers' home clinics, hospitals and practices. Another important question is whether health professionals who have had such experiences subsequently reach out and encourage colleagues to become providers of care to persons with mental retardation. Only when this happens to a significant degree can the goals espoused in Healthy People 2010 (3) be achieved for all people.

PREPARED STATEMENT OF STANLEY B. PECK

INTRODUCTION

The American Dental Hygienists' Association (ADHA) appreciates this opportunity to submit testimony regarding "The Crisis in Children's Dental Health: A Silent Epidemic." ADHA applauds the Senate Committee on Health, Education, Labor and Pensions for holding this important Public Health Subcommittee hearing on children's oral health. ADHA is hopeful that henceforth, whenever Senators think of general health, they will also think of oral health. As today's lead-off witness, former Surgeon General David Satcher, will confirm, oral health is a fundamental part of overall health and well-being.

ADHA is the largest national organization representing the professional interests of the more than 120,000 dental hygienists across the country. Dental hygienists are preventive oral health professionals who are licensed in each of the fifty states.

As prevention specialists, dental hygienists understand that recognizing the connection between oral health and total health can prevent disease, treat problems while they are still manageable and conserve critical health care dollars. Dental hy-

gienists are committed to improving the nation's oral health, an integral part of total health. Indeed, all Americans can enjoy good oral health because the principal oral maladies (caries, gingivitis and periodontitis) are fully preventable with the provision of regular preventive oral health services such as those provided by dental hygienists. Regrettably, the experience, education and expertise of dental hygienists are now dramatically underutilized. ADHA wants to be part of the solution to the current problems of oral health disparities and inadequate access to oral health services and ADHA believes that increased utilization of dental hygienists is an important part of that solution.

ADHA SUPPORTS SENATE LEGISLATIVE EFFORTS TO ADDRESS THE NATION'S ORAL HEALTH CRISIS

ADHA is pleased that legislation has been introduced by members of the Senate Health Committee to address the national epidemic of oral disease among our nation's children. In particular, the strong leadership of Senator Jeff Bingaman on oral health issues is greatly appreciated by ADHA and by the New Mexico Dental Hygienists Association. Senator Bingaman's devotion to improving the oral health of children is inspiring and ADHA is proud to support S. 1626, the Children's Dental Health Improvement Act, introduced in November 2001 by Senator Bingaman.

ADHA also supports companion legislation in the House of Representatives, H.R. 3659, introduced by Representatives John Murtha and Fred Upton in January 2002. More than 40 organizations have endorsed S. 1626 and H.R. 3659, including non-dental groups such as the American Public Health Association, the Association of Maternal and Child Health Programs and the March of Dimes. This legislation is designed to improve the access and delivery of oral health services to the nation's children through Medicaid, the State Children's Health Insurance Program (CHIP), the Indian Health Service and the nation's safety net of community health centers.

ADHA also supports S. 2202, the Perinatal Dental Health Improvement Act of 2002. Introduced in April 2002 by Senator John Edwards and Senator Bingaman, this legislation recognizes the link between severe periodontal disease in pregnant women and pre-term low birth weight babies.

ADHA additionally supports S. 998, the Dental Health Improvement Act, introduced in June 2001 by Senators Susan Collins and Russ Feingold. This legislation would expand the availability of oral health services by strengthening the dental workforce in designated underserved areas. The Senate passed S. 998 in March 2002 as part of the Health Care Safety Net Amendments. ADHA is hopeful that this important legislation will be enacted into law before Congress recesses for the August district work period.

ADHA applauds this Committee for its increasing interest in oral health issues and pledges to work with members of this Committee and all lawmakers to enact the above-mentioned oral health efforts into law.

U.S. SURGEON GENERAL'S MAY 2000 REPORT ON ORAL HEALTH IN AMERICA

Former U.S. Surgeon General David Satcher issued *Oral Health in America: A Report of the Surgeon General* in May 2000. This landmark report confirms what dental hygienists have long known: that oral health is an integral part of total health and that good oral health can be achieved. Key findings enumerated in the Report include:

1. Oral diseases and disorders in and of themselves affect health and well-being throughout life.
2. Safe and effective measures exist to prevent the most common dental diseases—dental caries (tooth decay) and periodontal (gum) diseases.
3. Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health as well.
4. There are profound and consequential oral health disparities within the U.S. population.
5. More information is needed to improve America's oral health and eliminate health disparities.
6. The mouth reflects general health and well-being.
7. Oral diseases and conditions are associated with other health problems.
8. Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth and teeth.

ADDRESSING THE SILENT EPIDEMIC OF ORAL DISEASE

The Surgeon General's Report on Oral Health challenges all of us—in both the public and private sectors—to address the compelling evidence that not all Ameri-

cans have achieved the same level of oral health and well-being. The Report describes a “silent epidemic” of oral disease, which disproportionately affects our most vulnerable citizens—poor children, the elderly, and many members of racial and ethnic minority groups.

This nation must address the inequality in oral health status that is pervasive across America. All Americans, regardless of economic status or geographic location, should enjoy the benefits of good oral health. Indeed, ADHA maintains that “oral health care—a fundamental part of total health care—is the right of all people.” Please see Attachment A, the ADHA Access to Care Position Paper, in which this belief is enunciated.

ADHA is committed to working in partnerships at all levels with policymakers, parents, advocates, additional health care providers—both dental and non-dental—and others in order to improve general health and well-being through the promotion of optimal oral health. Fundamental to this goal is work to promote awareness of the fact that oral health is an integral part of total health and work to increase access to oral health care services.

ADHA further believes that we must focus first on our nation’s most precious resource—our children. That is why it is vital that we buttress the innovations states are pioneering with respect to Medicaid and SCRIP, such as the recent trend toward recognition of dental hygienists as Medicaid providers.

IMPROVING THE NATION’S “ORAL HEALTH IQ”

This U.S. Senate hearing today is a critically important step forward in the effort to change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health. Indeed, the perceptions of the public, policymakers and health providers must be changed in order to ensure acceptance of oral health as an integral component of general health. ADHA urges members of the Senate Health Committee to work to educate their colleagues in Congress with respect to the importance of oral health to total health and general well-being. This hearing is an important signal to the public that oral health is important. ADHA hopes that further signals will be forthcoming.

The national oral health consciousness will not change overnight, but working together we can heighten the nation’s “oral health IQ.” ADHA is already working hard to change perceptions so that oral health is rightly recognized as a vital component of overall health and general well being. For example, ADHA has launched a public relations campaign to highlight the link between oral health and overall health. Our slogan is “Want Some Lifesaving Advice? Ask Your Dental Hygienist.”

This ADHA campaign builds on the Surgeon General’s report, which notes that signs and symptoms of many potentially life-threatening diseases appear first in the mouth, precisely when they are most treatable. Dental hygienists routinely look for such signs and symptoms. For example, most dental hygienists conduct a screening for oral cancer at every visit and can advise patients of suspicious conditions. Other diseases with oral manifestations are diabetes, HIV and osteoporosis. Bulimia nervosa and anorexia nervosa also exhibit oral manifestations, such as localized enamel erosion. Scientific evidence is now building which demonstrates that periodontal (gum) disease also may be a risk factor for pre-mature, low birthweight babies. Pregnant women who have periodontal disease may be seven times more likely to have a baby that is born too early and too small. Caring for low birthweight babies and their mothers is extremely expensive. If the public, policymakers and health providers are educated about these links, their appreciation for the importance of oral health will be heightened.

ADDITIONAL ENTRY POINTS INTO THE ORAL HEALTH CARE DELIVERY SYSTEM ARE NEEDED

The current oral health care system is not meeting the oral health care needs of all Americans. Additional access points must be added, particularly for those who are economically disadvantaged. Indeed, despite the proven benefits of preventive oral health measures, less than one in five Medicaid-eligible children (4.2 million out of 21.2 million) actually received preventive oral health services in 1993, according to a 1996 U.S. Department of Health and Human Services report entitled Children’s Dental Services Under Medicaid. And only one in four Native American children received any dental care in a recent one-year period according to the Indian Health Service. Moreover, only 41% of adults (25 years and older) with less than a high school education had an annual dental visit while only 74% of adults with at least some college had an annual dental visit (NHIS 1997).

Clearly, the current structure of the oral health care system needs to change. ADHA believes that additional access points to oral health care must be utilized.

The vast majority of dental hygienists currently work in a dentist's private practice. Others work, for example, in public health settings, educational institutions, as well as in research, and in business. Interestingly, in 1948 only approximately 50% of dental hygienists worked in private dental offices. Others worked in schools, hospitals, public health facilities and other settings. Clearly, dental hygienists have lost significant outreach avenues over the years. Reversing this trend would no doubt help address the serious access to care problems confronted by too many Americans. ADHA urges policymakers to facilitate additional access points to the oral health care delivery system.

LACK OF ORAL HEALTH INSURANCE

The failure to integrate oral health effectively into overall health is seen in the distinction between oral health insurance and medical insurance. While 43 million Americans lack medical insurance, a whopping 108 million—or 45% of all Americans—lack oral health insurance coverage. Studies show that those without dental insurance are less likely to see an oral health care provider than those with insurance. Moreover, the uninsured tend to visit an oral health care provider only when they have a problem and are less likely to have a regular provider, to use preventive care or to have all their dental needs met. ADHA urges that the Senate Health Committee work to strengthen and enhance Medicaid and SCHIP dental benefits and ADHA looks forward to a future in which all Americans have dental health insurance coverage.

Even those who have dental insurance coverage, particularly Medicaid-eligible children, are not assured of access to care. ADHA is committed to increasing the percentage of Medicaid and SCHIP-eligible children who receive oral health services. One way to promote this goal is to facilitate state recognition of dental hygienists as Medicaid providers of oral health services. Indeed, states are increasingly recognizing dental hygienists as Medicaid providers and providing direct reimbursement for their services.

SUPPORTING THE WORK OF ENTITIES WITHIN THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The federal oral health infrastructure must be strengthened. Oral health must be fully integrated into overall health. ADHA urges this Committee to actively promote oral health programs within the Department of Health and Human Services (HHS). ADHA is very pleased that the position of Chief Dental Officer at the Centers for Medicare and Medicaid Services (CMS) has apparently been made permanent. Given the increasing recognition of the importance of oral health and the key role of CMS's Chief Dental Officer, it is imperative that this position be institutionalized. In addition, ADHA urges that this Committee encourage each state to name a Dental Director.

ADHA further encourages this Committee to buttress the important oral health work of the Oral Health Division of the Centers for Disease Control and Prevention, the Maternal and Child Health Bureau and the Oral Health Initiative of the Health Resources and Services Administration (HRSA).

An increased federal focus on oral health will yield positive results for the nation. To illustrate, the work of the National Institute on Dental and Craniofacial Research (NIDCR) in dental research has not only resulted in better oral health for the nation, it has also helped curb increases in oral health care costs. Americans save nearly \$4 billion annually in dental bills because of advances in dental research and an increased emphasis on preventive oral health care, such as the widespread use of fluoride. To enable NIDCR to continue and to build upon its important research mission, ADHA urges that NIDCR be maintained as an independent institute at the National Institutes of Health.

WORKFORCE ISSUES

As the General Accounting Office (GAO) confirmed in two separate reports to Congress, "dental disease is a chronic problem among many low-income and vulnerable populations" and "poor children have five times more untreated dental caries (cavities) than children in higher-income families. The GAO further found that the major factor contributing to the low use of dental services among low-income persons who have coverage for dental services is "finding dentists to treat them."

Increased utilization of dental hygienists in non-traditional settings such as schools, medical clinics, after school programs and nursing homes etc. would promote increased use of dental services among low income persons. These dental hygienists can serve as a pipeline that can refer patients to dentists. Increased utiliza-

tion of dental hygiene services is critical to addressing the nation's crisis in access to oral health care for vulnerable populations.

Dental hygienists are prevention specialists who are licensed in each of the fifty states and the District of Columbia. In order to be eligible for a license, prospective practitioners must graduate from one of the 260 dental hygiene education programs accredited by the American Dental Association Commission on Dental Accreditation. The accreditation standards for dental hygiene education programs require graduates to be competent in conducting thorough periodontal and dental examinations, developing a dental hygiene diagnosis and treatment plan, and making appropriate referrals for additional treatment needs. Further, candidates for dental hygiene licensure must pass a national written examination and a regional or state clinical examination. In addition, 48 states require continuing education for licensure renewal.

Since 1990, the number of dentists per 100,000 U.S. population has continued to decline. This decline is predicted to continue so that by the year 2020 the number of dentists per 100,000 U.S. population will fall to 52.7. By contrast, since 1990, the number of dental hygiene programs has increased by 27% and, from 1985-1995, the number of dental hygiene graduates increased by 20%, while the number of dentist graduates declined by 23%.

Some states have begun to examine dental workforce issues. The WWAMI Center for Health Workforce Studies at the University of Washington assessed the patterns and consequences of the distribution of the dental workforce in Washington state. This November 2000 study revealed that Washington state "does not have a dental workforce sufficient to meet Healthy People 2010 goals." The study found that "gaps in the state dental workforce will be difficult to fill with dentists because the nationwide per capita supply of dentists is decreasing; specialization is increasing, and programs to encourage dentists to practice in underserved areas are limited." The study recommended that "policymakers should consider expanding the role of hygienists . . . to deliver some oral health services in shortage areas."

In Washington state, policymakers have enacted a school sealant program for underserved populations where dental hygienists provide the services without any requirement for authorization from a dentist.

ADHA urges that the Committee work to facilitate increased utilization of the experience, education and expertise of dental hygienists.

INCREASED ACCESS TO PREVENTIVE ORAL HEALTH SERVICES IS KEY TO IMPROVING THE NATION'S ORAL HEALTH

Unlike most medical conditions, the three most common oral diseases—dental caries (tooth decay), gingivitis (gum disease) and periodontitis (advanced gum and bone disease)—are proven to be preventable with the provision of regular oral health care. Despite this prevention capability, tooth decay—which is an infectious transmissible disease—still affects more than half of all children by second grade. Clearly, more must be done to increase children's access to oral health care services.

While the profession of dental hygiene was founded in 1923 as a school-based profession, today the provision of dental hygiene services is largely tied to the private dental office. Increased utilization of dental hygienists in schools, nursing homes, and other sites—with appropriate referral mechanisms in place to dentists—will improve access to needed preventive oral health services. This increased access to preventive oral health services will likely result in decreased oral health care costs per capita and, more important, improvements in oral and total health.

ADHA feels strongly that restrictive dental hygiene supervision laws constitute one of the most significant barriers to oral health care services. Indeed, ADHA is committed to lessening such barriers, which restrict the outreach abilities of dental hygienists and tie oral health care delivery to the fee-for-service private dental office, where only a fraction of the population is served. To illustrate, here are a few examples of limitations on practice settings outside of the private dental office. In West Virginia, dental hygienists are limited to industrial clinics and schools; in Illinois, dental hygienists are limited to mental health institutions and nursing homes and in Arkansas, dental hygienists are limited to prisons.

Some states are pioneering less restrictive supervision and practice setting requirements. These innovations facilitate increased access to oral health services. Maine and New Hampshire, for example, have what is called public health supervision, which is less restrictive than general supervision. Oregon and California have expanded dental hygiene practice through the use of limited access permits and special license designations like the Registered Dental Hygienist in Alternative Practice (RDHAP).

Other states have unsupervised practice, which means that a dental hygienist can initiate treatment based on his or her assessment of patient needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and maintain a provider-patient relationship without the participation of the patient's dentist of record.

By the early 1990s, California and Washington recognized dental hygienists as Medicaid providers of oral health services and provided direct reimbursement for their services. Over the last several years, an additional five states followed: Oregon in 1999; Colorado, Connecticut, and Missouri in 2001; and Maine in 2002. Other states should adopt this approach, which appropriately recognizes the experience, education and expertise of dental hygienists and fosters increased access to much needed Medicaid oral health services.

States should heed the recommendations of organizations such as the Illinois Center for Health Workforce Studies which called for "new solutions" to the problem of limited access to oral health care services for Medicaid and SCHIP children. In February 2001, the Center called for "modifying the [Illinois] state practice act to allow dental hygienists to provide preventive care in public health settings without a dentist on-site."

ADHA encourages policymakers to recognize and encourage these innovations, which improve access to oral health care services and work to reduce the tremendous disparities in oral health in America. Rest assured that ADHA will continue to work to expand the practice settings of dental hygienists so that additional people may access needed oral health services. Dental hygienists should be viewed as essential entry points into the oral health care system. Physicians and dental hygienists should partner to ensure patients receive oral health care services. ADHA also will work to ensure that this dental hygiene outreach is linked appropriately with the restorative services of dentists.

PUBLIC-PRIVATE PARTNERSHIPS ARE CRITICAL TO ADDRESSING THE NATION'S SILENT
EPIDEMIC OF DENTAL DISEASE

An innovative public-private partnership in South Carolina called Health Promotion Specialists (HPS) provides a shining example of the effectiveness of public-private partnerships. This partnership has performed dental screenings for over 33,000 children during the past year and has delivered preventive dental hygiene care to over 12,000 children. Further, many thousands of children have been linked to dentists for the provision of restorative care.

This school-based oral health program is a collaborative effort between school health officials, community support services, dentists, dental hygienists and the state health agency. In fact, in February 2002 both the South Carolina Dental Association and the South Carolina Dental Hygiene Association joined with the South Carolina Department of Education and the South Carolina Department of Health and Environmental Control to endorse this type of public/private partnership. Upon return of a signed parental consent form, HPS provides oral hygiene instructions and preventive services that include cleanings, the application of fluoride and the application of dental sealants on permanent back teeth.

HPS provides these services at regular intervals as part of a continuing care program. HPS works to refer children who need restorative services to local dentists, clinics and available mobile dental vans. Public-private partnerships such as the school-based oral health program administered by HPS are vital to the oral health of America.

To illustrate the effectiveness of such partnerships and the dramatic impact these partnerships can make in the life of a child, ADHA wishes to share one of the many success stories realized through this program. A child in Marlboro County had been in dental pain for more than three months before HPS arrived. The school nurse and the school principal had been unable to get dental care for him. HPS arranged for a mobile dental van to go to Marlboro County to see this first grader. On the day the dental hygienist was to leave the school, the student saw her in the school hallway, hugged her, and gave her a big smile, and said "I don't hurt anymore." Because of this public-private partnership, that first grader is now able to focus on first grade instead of pain in the oral cavity. That's what makes it all worthwhile and ADHA hopes that lawmakers, educators, public health officials, dentists, dental hygienists, advocates, families and all those who care about the nation's oral health to come together in order to improve the health of the American people.

Another example of a public-private partnership that successfully increased access to care occurred recently in Oregon. This partnership is particularly heartening in that it involved both the Oregon Dental Association and the Oregon Dental Hygienists' Association. At the suggestion of the Oregon state legislature, these two asso-

ciations came together to develop a proposal to increase access to care by relieving certain dental hygiene supervision requirements.

A Task Force created by the two associations proposed the creation of a Limited Access Permit for experienced dental hygienists. This proposal was subsequently passed, without a single dissenting vote, by the Oregon legislature in 1997. Currently, approximately 20 dental hygienists hold a Limited Access Permit, which enables a dental hygienist to provide preventive oral health services in certain settings without a prior dental visit. Permit holders must have completed at least 5,000 hours of supervised dental hygiene clinical practice in the five years previous to receiving their permit; they also must complete forty classroom hours in specified courses. Twelve hours of continuing education are required to maintain the permit; this is in addition to the twenty-four hours required to maintain the dental hygiene license. Further, a Limited Access Permit Dental Hygienist must refer a patient annually to a dentist who is available to treat the patient. There are approximately 100 dental hygienists currently in the process of qualifying for the Limited Access Permit. The oral health of Oregonians will be better served when these candidates obtain their permits.

To illustrate, one dental hygienist holding a Limited Access Permit works weekly in an extended care facility with an on-site dental clinic. Depending on their dental hygiene treatment needs, she sees six to ten patients a day. Her services are appropriately linked to the services of a dentist, who visits the extended care facility at least once monthly to provide needed services. Over a given year, this hygienist provides care to approximately 400 patients in their place of residence. The resident and/or guardian's private insurance or Medicaid pays for the cost of their care. Importantly, the large majority of these patients are unable to leave the facility to access dental care.

Initially, provision of dental hygiene services under the Limited Access Permit was largely restricted to extended care facilities, including adult foster care and assisted living. In 2001, however, the Oregon legislature broadened the range of facilities in which Limited Access Permit holders could provide services to include public and private schools (grades kindergarten through twelve), pre-schools, correctional facilities and job training sites. This confirms the increasing trend among states to explore ways to increase access to care through maximum utilization of the experience, education, and expertise of the dental hygienist.

CONCLUSION

In closing, the American Dental Hygienists' Association appreciates this opportunity to provide written testimony on "The Crisis in Children's Dental Health: A Silent Epidemic." ADHA looks forward to a future in which the education, experience and expertise of dental hygienists are appropriately recognized and utilized; this will increase access to oral health services and work to ameliorate oral health disparities. ADHA is committed to working with lawmakers, educators, researchers, policymakers, the public and dental and non-dental groups to improve the nation's oral health which, as Oral Health in America: A Report of the Surgeon General so rightly recognizes, is a vital part of overall health and well-being.

Thank you for this opportunity to submit the views of the American Dental Hygienists' Association. Please do not hesitate to contact me or our Washington Counsel, Karen Sealander of McDermott, Will & Emery (202/756-8024), with questions or for further information.

PREPARED STATEMENT OF SARAH M. GREENE

On behalf of the National Head Start Association, I am pleased to testify in support of increasing access to dental care for all children in America. I know that without the leadership of this committee this important issue may not have been brought to the forefront.

The National Head Start Association is a private nonprofit membership organization representing more than 900,000 children and their families, 168,000 staff, in nearly 2,400 Head Start programs across the country, including over 550 Early Head Start programs and the more than 40,000 children and families they currently serve.

Children's health is an essential component to assuring children's overall wellness and performance. If children are to develop strong literacy and language skills, good health is essential. Burton Edelstein, of the Children's Dental Health Project, stated that "it is simply impossible for a child to focus and accomplish well in school when they are distracted by a relentless toothache." At Head Start we believe that the comprehensive services we provide, such as the dental services, are critical for successful child development.

Head Start children in particular tend to have significant dental health issues. Several studies have found that more than 60 percent of Head Start children have cavities and that the average number of teeth affected is five. Self reported data from the 1998 Head Start Program Information Reports (PIR) found that 76 percent of enrolled children needed dental care. Finally, low-income children in Minneapolis who qualified for Medicaid were 1.4 times more likely to be in need of emergency services than children of higher incomes.

Unfortunately, medical services for low-income families are often unaffordable, and crucial medical and dental procedures are often a low priority for low-income families. Without essential preventive measures, severe conditions can develop in a child that will affect their health even as they become adults. Therefore, subsidized programs are necessary to ensure low-income children and families receive medical services.

Sadly, most state Medicaid dental plans have been little more than a hollow entitlement for Head Start children. The children are provided dental coverage, but they are unable to benefit from it in a meaningful way. Low reimbursement rates only aggravate the situation. Medical professionals, especially dental providers, can be hesitant to provide services when payment barely covers their cost for the services they provide. In a July 2000 study by the American Public Human Services Association, researchers concluded from a survey of 44 state Medicaid agencies that low—reimbursement rates to dental providers was the leading barrier to dental care for low-income children. Presently, adequate medical resources are inaccessible when a Head Start program or other community-based program attempts to provide the services through federal, state, tribal, and/or local medical and dental treatment programs due to reimbursement rates lower than the market value of the services.

Low reimbursement rates have forced many Head Start programs to use their regular grant funds to supplement medical expenses for their program's children. Covering those medical expenses in turn frequently becomes an unanticipated expense forcing the program to reduce funding for other services it provides. (Head Start and Early Head Start funds may be used for professional medical and dental services when no other source of funding is available.) Once a program experiences this situation, they do anticipate and budget for the expenses into their subsequent annual grant application. Adequate reimbursement rates that reflect true market value would cure budget shortfalls and ensure all children in Head Start programs adequately receive necessary medical and dental screenings.

In many states, shoddy Medicaid programs with low reimbursement rates have required Head Start children to wait unreasonably long to get appointments, travel long distances to receive services, and in some cases to go without treatment until it was too late. The Children's Dental Health Project estimates that only 25 to 35 percent of dentists nationwide participate in Medicaid even in a limited way. One reason is that there are very few dentists who accept Medicaid. In Missouri, only 38 percent of the state's 115 counties had a dentist willing to accept M+Medicaid. With so few dentists willing to accept Medicaid, a child in a Missouri Head Start program has to wait an average of 6½ weeks just to get an appointment. While in a recent study of 54 centers in North and South Carolina, only 7 percent of 3,375 dentists reported that they accept Head Start children as patients. The average wait for an initial visit was 3.7 weeks.

In Tennessee the situation is not any better. Glenda Jewell, Assistant Director for Child Health Services, at the Southwest HRA Head Start in Henderson, Tennessee asserts that "getting dental care for our children is a real problem." She reports that often Head Start families must travel close to 100 miles and sometimes up to two hours just to find a dentist willing to accept TennCARE, the state's Medicaid program. Ms. Jewell says that dentists are simply unwilling to accept reimbursements so low that they won't even cover the cost of a procedure. Area dentists have told her that the confusing red tape, inconsistent plans, and the inefficiency of state offices makes accepting TennCARE an unattractive choice for most.

Due to such an inadequate system of dental coverage, Head Start children are truly suffering. Because of the long drive, Head Start children frequently miss school for the day and must stay over night at the place of treatment. Many children also go so long without necessary dental treatment that minor oral health problems develop into much more serious conditions. Jewell claims that many Head Start children end up being hospitalized because of problems that go untreated. A little boy in her program had to have his front teeth removed last year because his dental problems went untreated for so long. Furthermore, because TennCARE would not pick the cost of a necessary bridge for the child, the Head Start program was forced to divert its own funds so that the child would not be tormented with speech problems.

Since the enactment of SCHIP, every state has expanded health care coverage to children in low-income families. Fifteen states developed separate programs, 19 expanded Medicaid, and 17 used a combination of these two approaches. Before SCHIP, income eligibility for children averaged 121 percent of the federal poverty level across all states and ages. After SCHIP, the average increased to 206 percent of the federal poverty level. Still, steps can be taken to facilitate the provision of medical insurance to the uninsured millions falling within the eligibility guidelines. This includes allowing additional facilities such as child-care referral centers to determine presumptive eligibility (Head Start agencies currently are able to do so) and strongly encouraging all states to streamline and simplify their SCHIP and Medicaid application processes.

Despite the incredible inadequacy of dental health coverage, there are many dentists that have gone beyond the call of duty. We consider them to be real Head Start heroes. In particular, I would like to highlight the work of Justin Moody. Dr. Moody, DDS recently received the Alliance for Youth award at our national conference in Phoenix, Arizona held in late April. For four years Dr. Moody has driven 2½ hours to make sure that children enrolled at the Northwest Community Action Head Start in Chadon, Nebraska receive professional dental screenings. The mass screening takes up the entire day and is always done within the mandated 45-day deadline. Dr. Moody's volunteerism is equivalent to a yearly donation of almost \$2,000. It is the work of heroes like Dr. Moody and many other dentists across the country that make it possible for many Head Start children to receive the important dental care they desperately need. However, it is clear that more must be done so that all Head Start children do not need to depend on the heroic acts of a few dentists, but can rather rely on having regular access to quality dental care.

To remedy the problems that plague children as a result of inadequate dental care, the National Head Start Association recommends that:

- 1) The federal government take over a larger share of Medicaid funding.
- 2) Incentive grants be provided to states to increase their Medicaid reimbursement rates.
- 3) An extensive study be commissioned by the Head Start Bureau to examine the problem of inadequate dental coverage and its findings brought before this committee in a timely manner.
- 4) The Head Start Bureau be required to work more closely with states to form partnerships and collaborations to improve dental services.

Thank you for allowing NHSA to present issues of importance to the Head Start community before the committee.

[Whereupon, at 4:32 p.m., the subcommittee was adjourned.]