Guest Editorial

U.S. Dental Workforce: Is Anyone Driving This Ship?

At the 2014 AAPD Annual Session, a record number of poster sessions were presented covering a variety of topics relevant to pediatric dentistry. One particular poster caught my eye, a study from Washington State about the effect on Medicaid preventive visits after placing a pediatric dentist in a geographic region.[1] My naïve expectation of a rise in visits was doused with the finding that the pediatric dentist's presence had no real effect. After some reflection on this finding, I realized just one or a couple of providers, particularly new graduates drowning in debt, would not rush to cushion their financial health with Medicaid clients. I also realized that the mere presence of a pediatric dentist had no real effect on the oral health literacy of that region's population. No messianic effect here. What this study really showed was that dental workforce is but one factor in a complex mix impacting oral health care delivery.

The debate on dental workforce continues and perhaps debate would be better stated as conjecture. In a recent commentary, American Dental Education Association CEO Dr. Richard Valachovic questioned whether we should use shortage or maldistribution to describe the state of dental workforce.[2] He cites comments by several dental deans as well as Dr. Marko Vujicic of the American Dental Association's (**ADA**) Health Policy Resources Center. It is clear that workforce adequacy can be viewed using a variety of lenses, some local and some national. What is less clear is the state of the dental workforce, our national needs, and the impact on training and on the existing workforce as we tinker with adding dentists or modifying roles of traditional dental team members.

What is clear is that no one is steering this ship.

Our colleagues in medicine seem to have a better grasp of workforce needs for physicians. In 2025, they estimate the need for 124,400 more physicians.[3] This estimate dives deep into the weeds and even looks at specialty and sub-specialty care. What is most impressive to me about medicine's impressively precise estimate is the fact that it appears to be a unified and accepted projection and one that should guide that profession to develop strategies to address the problem of physician shortage. Medicine has a few legs up on dentistry. They aren't as hamstrung by geographic constraints as medical licensure is national in character. Also, medicine mitigated shortages long ago with a pathway to licensure for foreign-trained physicians, which we have not done in dentistry. They also have the advantage of assuming everyone requires and needs a physician. Not so true for dentistry, as national data suggests a cooling off of our population's use of dental service for many adults.[4]

Most impressive, however, is that there appears to be someone at the helm.

Perhaps our biggest obstacle in determining workforce needs is a trait seemingly inherent in dentistry of making something "work in my hands." I call this the "square peg in the round hole" phenomenon. With workforce, it is the tendency to isolate provider numbers and locations from well-established factors like economics and health literacy. The workforce equation in dentistry is often simply, workforce equals access. Increase workforce, increase access. Another limitation of our approach to workforce is no real temporal perspective. For example, the ADA has shown a retrospective pattern of flat or even declining use of dental services.[4] The ADA also reports that dentists are not retiring according to the previous "natural order," and replacement is exceeding retirement, at least for now. The logical question most would ask is why are there twenty new dental schools in planning or operation.

Today, our answer to access to care problems seems to be primarily train more providers. We continue to employ a cold war mentality in our approaches to dental workforce adequacy – the more providers we produce, the better off we are. The more dental schools we create, the better access to care. And to continue the antiquated calculus, we hang on to the health profession shortage area (**HPSA**) as the hammer driving the square peg, in spite of its origins in the 1960s. Little attention is given to overproduction or shutting down the pipeline if oversupply threatens. We saw the result of the last century's overproduction of dentists in closing of a number of dental schools as applicant numbers dropped. Will we see in a decade or so a "dental education Detroit" with shuttered dental schools as applicants see the dim future in the dental profession? The legal education system is already dealing with public recognition of the poor return on investment of a legal degree with declining applicants and in some cases, the reduction of faculty. Veterinary medicine is not far behind.

How do we fix the problem? We have many obstacles, not the least of which is the creation of dental schools by universities that see the current demand for a dental

education as a cash cow, damn the consequences. We also potentially risk the ire of the federal government that constantly looks at restriction of trade (but seems to be ambivalent about producing thousands of professionals who have no hope of retiring their debt). This latter point probably discourages the American Dental Association from exerting its leadership. I heartily commend the ADA for its recent efforts to present factual, if not sobering, information about oral health, workforce, and strategic changes in dentistry. My hope is that the work of its Health Policy Resources Center is seen as an honest effort to prevent dental Armageddon in the next decade or two. I would like nothing more than to have the ADA enlist the country's best experts to generate a national strategy to balance our workforce needs with access to care in both the short- and long-term.

Pending someone stepping up, plan for a rocky road with continued growth of dental schools, excess capacity in our current workforce, delayed retirements, more calls for alternative providers, increasing dental disease amidst an abundance of struggling providers, failing institutions, and other unforeseen consequences of poor planning.

I hope we can find a captain for this ship!

References

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