"If you, as my constituent, do not ask me to support your programs, you can be certain that some other constituent, with different interests, will."

The Art of Advocacy

I am writing this month about the art of advocacy. Notice I didn't say the "science" of advocacy. In many ways advocacy is an acquired taste, one that is performed better when it is practiced often. It is an ongoing process to educate, motivate, and activate individuals and institutions for the purpose of influencing the formulation of public policy. And, in my opinion, it is an integral part of the democratic system in which we Americans live. Consequently, it is a necessary skill for dental educators and researchers, as well as a professional responsibility.

Like it or not, government plays a major role in our lives. Indeed, government in large measure finances and regulates higher education and the delivery of health care. Therefore, decisions made by elected and appointed officials in Washington or in state capitals nationwide affect academic dentistry and the oral health of U.S. citizens. Enhancing what is beneficial or mitigating what is harmful through the ongoing education of these elected and appointed officials is the ultimate objective of advocacy.

Win or Lose, Advocacy is Essential -- ADEA takes very seriously the responsibility to advocate on behalf of its members' interests. Those interests include increasing federal funding for our programs and emphasizing to Congress and the federal government the importance and value of oral health. Let me offer two contrasting examples of government actions that have affected our dental schools, advanced education programs and allied education programs, which we commonly refer to as "academic dental institutions," one positively and other in a severely negative manner.

On both issues ADEA members mounted impressive advocacy campaigns. The first is a bill that was signed into law in 1990, the Ryan White CARE Act. It provides federal monies for the care of persons living with HIV/AIDS. The law presently includes two programs critical to academic dental institutions: 1) the Dental Reimbursement Program and 2) the Community-Based Dental Partnership Program. These programs reimburse academic dental institutions for the oral health care services they render to individuals living with HIV, either in academic dental institutions or in off-site community settings. Since 1991, for instance, the Dental Reimbursement Program has provided more than $115,000,000 for oral health care provided to HIV/AIDS patients, with nearly $50 million going to dental schools and over $65 million going to hospital-based dental residency programs. These programs would not have happened without the strong advocacy role provided by ADEA.

Advocacy doesn't always result in positive outcomes. For instance, a harmful government action in 2003 by the Centers for Medicare and Medicaid Services, an agency within the U.S. Department of Health and Human Services, effectively ended Graduate Medical Education (GME) reimbursement to dental schools for the purpose of educating and training residents in their schools and clinics. Twenty-six of the 32 dental schools that had GME-funded residency programs have lost or will lose by October 2006 this key federal revenue source for education and training.

Win or lose, advocacy by ADEA and its members is essential to our
profession. Responsibility for this vital activity can either be embraced by
dental educators and researchers or can be abdicated by them. ADEA
chooses to embrace advocacy and be as artful at it as possible.

Advocacy Infrastructure -- ADEA has a professional staff of advocates and
policy analysts to advance legislative and public policy priorities. This
professional team makes up the ADEA Center for Public Policy and Advocacy
(CPPA). The priorities that the team pursues are defined by the ADEA Board
of Directors based on recommendations from the National Oral Health
Advocacy Committee (NOHAC), a joint committee of members from ADEA
and the American Association for Dental Research (AADR). NOHAC
objectively prioritizes issues to advance the needs of academic dentistry and
dental research. The committee advises the ADEA and AADR Boards of
Directors on advocacy issues and assists CPPA staff in promoting, building,
and mobilizing an effective grassroots advocacy network. The grassroots
network of ADEA and AADR members in academic dental institutions
nationwide is called the AADR/ADEA National Advocacy Network. The ADEA
Board of Directors usually establishes the priorities for the Association.
Occasionally, though, policy decisions require broader involvement, and at
that point, the ADEA House of Delegates reviews and debates policy matters
during its business meetings at the ADEA Annual Session.

ADEA’s CPPA staff routinely visit with Members of Congress, their legislative
staffs, and the Executive Branch of government to discuss important
legislation and policies affecting academic dentistry. But, individual ADEA
members do also. To educate members in the art of advocacy and to prepare
them for their conversations with their two U.S. Senators and member of the
House of Representatives, ADEA sponsors seminars both in Washington and
around the country at dental schools. Over 500 dental educators and
researchers have participated in these trainings over the last ten years. Also,
more than 1,000 dental students have received advocacy training as part of
the ADEA/ASDA National Dental Student Lobby Day, a joint venture of ADEA
and the American Student Dental Association. These seminars help
educators, researchers, and students hone their advocacy skills and deliver
effective messages to Congress.

Much of ADEA’s advocacy centers on securing federal dollars that support
education, training, and research programs that benefit academic dental
institutions, residency training programs, dental researchers, and students.
Examples of these programs include grants supporting residency training for
dental public health and general and pediatric dentistry and grants to
conduct dental and biomedical research and programs that assist students to
attend and pay for their education. These programs fall under what is
referred to in the federal budget as “domestic discretionary spending.” About
$960 billion of the total federal budget ($2.47 trillion in fiscal year 2006) is
devoted to discretionary (domestic and security) spending. The remainder of
the federal budget is called “mandatory spending.” ADEA and others in its
coalition monitor all of these programs.

Given the magnitude of what’s going on it’s easy to see that above all else,
advocacy requires persistence and constancy. Nothing happens quickly in
Washington. It literally can take years to convince Congress to do something
about a legislative priority. An example is the funding for the Dental Health
Improvement Act, which assists states in addressing their dental workforce
issues. Enacted in 2001 after years of advocacy by ADEA and a coalition of
dental groups, including the American Dental Association, the Dental Health
Improvement Act did not receive funding from Congress until fiscal year
2006! Funding would not have happened even then had not ADEA members
and coalition partners practiced dogged advocacy. The networks ADEA has
put in place do, indeed, work, but require an extraordinary level of diligence.

Advocacy Tools -- Any ADEA or AADR member may join our Volunteer
Advocacy Coordinators.

Those of you who have a case of “Potomac fever” may apply for a fellowship
at ADEA generously sponsored by Sunstar Butler Inc., the ADEA State Issues
Update. Its purpose is to keep ADEA members and others abreast of what is
happening in states and state capitals on issues and events of interest to the
academic dental community. Any ADEA member may request to be placed on
the distribution lists for these publications or access them on ADEA Advocacy
Alerts by communicating with their officials as constituents is the most
influential advocacy possible. More often than not, the ADEA Advocacy
Alerts require members to take action immediately to let their elected
officials know the public policy position of dental educators and researchers
on a given issue.
The Value of Advocacy -- Only about 8 percent of the U. S. discretionary
domestic budget is spent on education, training, and social services
programs. This includes research funded by the National Institutes of Health
(NIH), the premiere biomedical research organization in the world.
Approximately $28 billion is spent on NIH research. Of this amount, $389
million is devoted to the National Institute of Dental and Craniofacial
Research (NIDCR), which is the scientific underpinning of the dental
profession. NIDCR is the only NIH institute that focuses entirely on research
and research training programs directly relevant to the clinical practice of
dentistry. In the 10 years that I have had the privilege to serve the
American Dental Education Association, 52 dental schools have been
awarded NIDCR grants valued at about $1.08 billion. Funding in this amount
would not have been available had dental educators, dental researchers, and
others not advocated so effectively. Learn more about NIDCR.
Richard W. Valachovic, D.M.D., M.P.H.
Executive Director
valachovicr@adea.org

American Dental Education Association
1400 K Street, NW, Suite 1100, Washington, DC 20005
Phone: 202-289-7201 Fax: 202-289-7204
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