Nationwide Survey of Dentist Recruitment and Salaries in Community Health Centers

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Abstract: Recruitment of dentists continues to be a problem in community health center (CHC) dental practices. This study was carried out to quantify the scope of the problem and to determine CHC dentist salaries and benefits. Community health center executive directors nationwide were surveyed regarding dentist vacancies, recruiting issues, and salary and benefit information. Of 345 surveys mailed, 159 responses were received (46.1%). Slightly fewer than half of the responding executive directors (47.8%) reported one vacant dentist position. An additional 11.9% of executive directors reported a second vacancy. The overall vacancy rate was 17.6%. Median salaries ranged from $78,000 for entry-level dentists to $90,000 for dentists with 10 or more years of experience, not including benefits. There are difficulties in recruiting dentists to CHC dental practices. Mean salaries in CHCs are slightly higher than in academic positions, but less than in private practice employment or ownership. Caution should be used when comparing salaried positions with substantial benefits to self-employment or sole proprietorships.

Key words: Community health centers, job satisfaction, community dentistry, salaries, fringe benefits.

To improve access to oral health care, an adequate number and distribution of culturally competent providers must be ensured, particularly in areas where there is a health care shortage.[1] Four major federal programs other than Medicaid and the State Children's Health Insurance Program target services or providers to underserved or special populations with poor dental health: (1) the Health Center program (Public Health Service 329, 330 grant funding), (2) the National Health Service Corps (NHSC), (3) the Indian Health Service (IHS) dental program, and 4) the IHS loan repayment program. The Health Center program supports community and migrant health centers in medically underserved areas. In 1998, more than 85% of health center users had incomes at or below 200% of the federal poverty level.[2]

The fiscal year 2002 budget submitted to Congress by President Bush requested almost $1.3 billion for health centers, a $124 million increase from the fiscal year 2001 allocation and about $280 million above the funding level of 2000. The increase

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for fiscal year 2002 alone will provide services to 1 million additional patients in community and migrant health centers around the country.[3] The administration's 5-year plan (2001 to 2006) will add or expand health centers in 1,200 communities by 2006 and increase the number of patients served annually to more than 16 million, up from 10 million in 2001. In fiscal 2002, the first full year of this initiative, the Department of Health and Human Services (DHHS) funded 171 new health center sites and awarded 131 grants to existing centers to help them to build capacity and expand services. As part of the expansion plan, all new federally funded community health centers (CHCs) are required to provide comprehensive dental services.[4] Prior to this new requirement, only a fraction of CHCs provided comprehensive dental services. In 1998, health centers reported providing dental services to only 1.2 million of 8.6 million CHC users.[2]

Government incentives to recruit and retain dentists, such as the scholarship program and loan repayment program operated by the NHSC, have not been completely successful. Government studies as well as independent research have documented that too few health care professionals participate, retention rates are low, and, consistently, programs have been underfunded.[2,5] In fiscal 1999, the NHSC loan repayment program filled only 83 of the more than 260 vacant positions available for eligible dentists.[2] However, the fiscal 2003 Congressional Appropriations added an additional $64.3 million to the Bureau of Health Professions, which included a $44 million increase in the budget for the NHSC.[6] This increase, in conjunction with the CHC expansion grants, is expected to result in increased demand for dentists in CHCs and expanded loan repayment programs, which will include dentists.

In spite of increases in funding, reports of vacancies for dentists in community, migrant, and homeless health care centers persist. Reasons for difficulty in recruiting dentists continue to be topics of speculation. This study attempts to quantify the extent of vacancies in these dental safety net programs and compare current salaries and benefits with those of other career options for dentists.

Methods

Survey Instrument and Implementation. We designed the survey instrument in informal consultation with the Health Resources and Services Administration (HRSA) regional dental consultants, and dental directors from selected community and migrant health centers. These key dental directors, selected by the 10 HRSA regional dental consultants, as well as the dental consultants themselves, served as contributors and editors of the survey instrument.

A list of Public Health Service 329 and 330 grantees as well as names of dentists located in the 10 HRSA regions nationwide was provided by HRSA contacts. Because no master list of community and migrant health centers that offer dental services exists, we had to construct the list deductively. By cross-referencing the dentists' names from all 10 HRSA regions by address with the CHC grantee list, we obtained a total of 345 health centers that had dental components in their scope of services. We sent the survey to all 345 of these executive directors. We asked questions about

budgeted and filled positions, number and duration of vacancies, methods of recruitment, and salary and benefits offered. The questionnaire was approved by the Baylor College of Dentistry Institutional Review Board. The surveys were mailed to the executive directors in February and March of 2002. A self-addressed, postage-paid envelope was enclosed with each mailing, but, owing to limited funding, no follow-up mailings or phone calls were made to nonrespondents.

We entered the data from the responses on Microsoft® Excel® spreadsheets and transferred them to SPSS® PC version 11. We then performed a frequency analysis for each question answered on the survey to obtain reportable results.

Results

Of the 345 surveys mailed to executive directors, we received responses from 159, for a response rate of 46.1%. No differentiation was made between types or sizes of CHCs, but responses were received from all 10 regions. Out of the 159 respondents, 47.8% reported one dentist vacancy and an additional 11.9% reported a second vacancy. Out of 480.2 budgeted full-time equivalent dentist positions, 395.8 positions were filled, resulting in an overall vacancy rate of 17.6%. The mean number of budgeted full-time dentist positions was 3.04 (standard deviation [SD] 2.79) and the mean number of employed full-time dentists was 2.55 (SD 2.52). Of those executive directors reporting one vacancy, the duration of the vacancy was less than 1 year in a majority of the cases (81.6%) and less than 6 months 60.5% of the time. In 18.4% of cases, the vacancy had existed for more than 12 months.

Methods used to recruit for the existing vacancy varied. A list of nine choices was provided in the survey instrument, and the executive directors were asked to indicate all methods used for recruitment of new dentists to fill vacant positions. Choices available included newspaper advertisement, dental journal (state or national) advertisement, posting at dental schools, speaking to students/residents about community-based dentistry, displays at job fairs/dental conventions, dental temporary/recruiting agencies, working with the National Health Service Corps, networking through primary care associations, and CHC web sites. The top four methods used were newspaper advertisements (61.3%), postings at dental schools (58.8%), working with the National Health Service Corps (58.8%), and dental journal advertisements (47.5%). The least used method was dental temporary/recruiting agencies (8.8%). Totals are more than 100% due to multiple responses.

The recruiting efforts used by executive directors of CHCs gathered applicant responses in a wide range from 0 to 30, with a median number of four applicants. The number of offers made ranged from 0 to 7, with a median of one offer. Executive directors were offered five reasons that firm job offers were rejected and asked to select all that applied. These included salary/benefits inadequate, location of CHC, level of staffing of the dental clinic, condition of equipment of the dental clinic, and no loan repayment available. Major reported reasons for job offers being rejected were inadequate salary/benefits (71.0%) and location of the CHC (51.6%). The fact that no loan repayment was available was reported as a reason for 22.6% of the rejected offers.

Salaries reported by executive directors were grouped by experience of the dentist, from entry-level to 10 years or more of experience. The median salary offered to entry-level dentists was $78,000 with an increase of up to $90,000 for dentists with more than 10 years of experience. Although 159 executive directors returned the survey, not all respondents provided salary data at the entry level, 1- to 5-year, 5- to 10-year, or more than 10-year levels (Table 1). Data also were requested for the highest and lowest salaries currently being paid to employed dentists. Centers with more than one dentist reported the lowest and highest salaries, whereas centers with only one dentist reported in only one category. The lowest mean salary reported was $79,075 (SD $15,845), and the mean highest paid dental salary was $90,913 (SD $18,085) (Table 2). Centers that did not have dentists as employees or centers that augment salaried dental workforce with contract (self-employed) dentists reported a median low contract annualized amount of $93,600 and a median high of $104,000 (Table 3).

Benefits and other perquisites for the highest- and lowest-paid dentists reported by the executive directors including number of paid holidays, number of vacation days, continuing education reimbursement dollar amounts, as well as other commonly expected benefits for employed dentists are summarized in Tables 4 and 5.

Discussion

Almost half of all executive directors responding to this survey reported one vacancy for a dentist in their health centers (47.8%), and an additional 11.9% reported a second vacancy. However, when comparing the total number of budgeted positions versus filled positions, the vacancy rate is less than 1 in 5 (17.6%). Anecdotal reports that inadequate salaries are the cause of difficulty in recruiting dentists for CHC employment were instrumental in initiating this study. The data obtained from this survey support this conjecture, in that applicants rejecting job offers cited inadequate salary/benefits 71% of the time. However, when comparing salary figures from other sources, the median salaries for CHC dentists do not differ greatly from other, nonowner types of dental practice or employment (Table 6). Over one third of dentists currently employed in CHC dental practices were prior employees or associates in private practice (33.5%), and 25.7% were dental students prior to CHC employment (i.e., new graduates).[7] Perhaps newly graduated dentists as well as previously privately employed dentists have unrealistically high expectations of income in CHC practices, but it is entirely understandable that a new graduate with an average of $80,000 to $100,000 in educational debt cannot accept a below-market salary without the aid of loan repayment. Conversely, with most health centers offering benefits including paid leave, sick leave, continuing education reimbursement, malpractice coverage, and matching federal employment and Medicare taxes, the compensation differential with private practice begins to diminish.

In close second place, the location of the CHC was cited by executive directors for rejected employment offers (51.6%). Dentists, like their physician counterparts, possibly expect higher pay to compensate for remote geographic locations of some CHCs, degree of opportunity for close contact with other professionals, degree of

Table 1.

BUDGETED SALARY RANGE REPORTED BY EXECUTIVE DIRECTORS

	Entry level	1–5 years	5–10 years	>10 years
n	**71**	**58**	**46**	**40**
Mean	$77,732	$86,456	$91,421	$95,564
Median	78,000	85,000	90,000	90,000
SD	15,181	19,078	21,489	22,813

Abbreviation: SD, standard deviation.

Table 2.

LOWEST AND HIGHEST DENTIST SALARIES REPORTED BY EXECUTIVE DIRECTORS

	Lowest Paid FTE Dentist	Highest Paid FTE Dentist
n	**138**	**118**
Mean	$79,075	$90,913
Median	78,000	90,000
SD	15,845	18,085

Abbreviations: SD, standard deviation; FTE, full-time employee.

Table 3.

LOWEST AND HIGHEST DENTIST CONTRACT WAGES (NON-EMPLOYEE)

	Annualized lowest contract	Annualized highest contract
	19	**21**
Mean	$98,393	$122,978
Median	93,600	104,000
SD	27,273	59,445

Abbreviation: SD, standard deviation.

Table 4.

NUMBER OF VACATION DAYS, HOLIDAYS, AND CE BENEFITS REPORTED BY EXECUTIVE DIRECTORS

	Lowest paid			Highest paid		
	Mean	SD	*n*	Mean	SD	*n*
Number of paid holidays	9.7	2.1	131	9.8	2.2	112
Number of vacation days	17.7	5.6	131	19.6	5.6	111
CE dollar amount	1,542	806	109	1,720	770	88

Abbreviations: CE, continuing education; SD, standard deviation.

Table 5.

EXECUTIVE DIRECTOR REPORT OF OTHER SELECTED DENTIST BENEFITS (percentages answering yes)

	Lowest paid dentist	Highest paid dentist
Drug license fee reimbursed/paid	66.1 (74/112)	83.7 (72/86)
Dental license fee reimbursed/paid	66.7 (78/117)	81.8 (72/88)
Malpractice insurance reimbursed/paid	89.8 (106/118)	95.7 (88/92)
403b or other retirement plan offered	92.3 (120/130)	92.8 (103/111)
Medical/dental insurance provided	97.7 (127/130)	99.1 (106/107)
Other insurance—disability/life	94.9 (111/117)	96.9 (95/98)
CE allowance, no amount specified	94.6 (123/130)	94.6 (106/112)

Abbreviation: CE, continuing education.

opportunity for spousal employment, quality of schools, and other community amenities.[8]

Although the response rate was good (46.1%), there is nonetheless a probability of nonresponse bias. The reported vacancy rate could be artificially high if a disproportionate share of executive directors who felt that dentist recruitment was a crisis issue within their organization responded to the survey. Also, we do not know if there is a geographic bias in the respondents or their answers. By design, the survey was completely anonymous to encourage candor in revealing salary information. Therefore, no geographic tracking or regional analysis was possible in this pilot study. Future studies should include methods to track and regionally analyze data, as well as provide for minimizing nonresponse bias.

Table 6.

COMPARISON OF SALARIES OF SELECTED DENTIST POSITIONS[a]

Employment status	Mean	1st Q	Median	3rd Q	SD	*N*
General practitioners: nonowner dentist (employees/associates)	97,740	65,000	90,000	120,000	49,840	46
General practitioners: sole proprietors (unincorporated)	142,720	85,000	128,000	186,920	82,930	391
Full-time faculty:guaranteed annual salary assistant professor (all dental schools)	70,545	60,000	70,000	79,363	NA	764
Full-time faculty: guaranteed annual salary associate professor (all dental schools)	82,968	70,955	81,559	93,424	NA	641
Staff dentist, community health center (all regions)	81,604	70,000	80,000	91,250	23,775	178
Dental director, community health center (all regions)	91,653	78,000	90,000	102,000	23,038	179

[a]Salary reports from the American Dental Association, Survey Center. The 2000 survey of dental practice: Income from the private practice of dentistry. Chicago: ADA, 2002. American Dental Education Association, Center for Educational Policy and Research. Faculty salary survey, summary report: Guaranteed annual salary: 2000–2001, total compensation: 1999–2000. Washington, D.C.: Bolin K, Shulman J. Nationwide dentist survey of salaries & work environment perceptions in community health centers. JADA (in press).

Conclusions

Regular monitoring of factors associated with recruitment of dentists in community and migrant health center clinics by using biannual surveys would be very useful. If current plans to expand dental services in CHCs are to be successful, effective recruitment strategies and competitive salaries must be considered in health center budgets. Considering the amount of money spent on dental services in CHCs, the cost of thorough, periodic evaluations would be minimal. Future studies of dentist recruitment in these safety net health center programs should have follow-up costs built in to the budget to pursue higher response rates with second mailings and follow-up phone calls to nonresponders. Ideally, these studies should be funded by HRSA's Bureau of Primary Health Care, the agency that has mandated that dental services be provided in all new Public Health Service–funded health centers. If enough reliable and contemporary salary data can be obtained, CHC executive directors and boards of directors could be equipped to modify their respective budgets to pay appropriate compensation to dentists, who have many choices in today's marketplace.

Additional information in the form of a standardized anonymous exit survey delivered to Regional HRSA consultants for review could be obtained from dentists

who leave CHC practice. This tactic might be especially useful for particular geographic areas or specific CHCs within regions with recruiting difficulties or high turnover rates of dental providers. Although salary and other forms of material compensation are generally considered to be paramount in career decisions, other factors may play an important role in the recruitment of dentists to underserved areas or groups. These factors should be explored in future CHC surveys of dentists. If accurate information could be obtained from both dentists who are remaining in community dental practices and dentists who are leaving for other career options, executive directors could use this information to focus recruiting efforts on the most promising candidates.

By periodic, regular surveys offered to executive directors, CHC administrators could be kept informed of the current conditions in the dental practice marketplace, know what other CHCs are budgeting for dentist positions, and offer competitive salaries and benefits to new recruits as well as experienced practitioners. Executive directors, who are aware of other career paths available to dentists, should be able to convey to potential recruits a comparison of the salary and often generous benefits offered in CHCs as compared to self-employment or ownership positions, which provide only self-supplied benefits. This important distinction can result in a bottom-line difference in the tens of thousands of dollars depending on each individual dentist's personal situation or the differences among particular nonprofit employers. Without competitive salaries and benefits, dental workforce needs in CHC practices cannot be met, despite increased federal funding for expansion of programs and loan repayment schemes.

Notes

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