Changes in Iowa Dentist Workforce Composition, 1997-2013: First in a Series of Issue Briefs

Julie Christine Reynolds  
*University of Iowa*

Susan Christine McKernan  
*University of Iowa*

Raymond A. Kuthy  
*University of Iowa*
Changes in Iowa Dentist Workforce Composition, 1997-2013

First Brief in a Series

Julie C. Reynolds, DDS, MS
Visiting Assistant Professor

Susan C. McKernan, DMD, MS, PhD
Visiting Assistant Professor

Raymond A. Kuthy, DDS, MPH
Professor
**Background**

The U.S. health care system has undergone numerous changes in recent years, and as a result, access to care is a key priority. Access to care is influenced by many factors which relate to both the availability (supply) and public need (demand) for care. This issue brief series focuses on supply-related factors and how they may impact access to dental care in the state of Iowa, including the size and capacity of the dental professions workforce. Numerous influences to the dentist workforce supply have been identified, including the age and sex of dental practitioners, practice location, size of the community where the dentist was born, race/ethnicity, and family factors.1-4

Trends in age and sex of the dentist workforce have raised concerns about a potential dentist shortage in the near future. Concerns stem from a large number of dentists nearing retirement age and a growing trend of younger dentists and female dentists choosing to work part-time. Recent studies from the American Dental Association (ADA) and from the Health Resources and Services Administration (HRSA) predict an increase in the number of dentists entering the field in the next decade.5,6 However, HRSA further predicts that this increase will not keep up with anticipated demand and that all 50 states will experience dentist shortages to varying degrees.

The aim of this issue brief series is to examine dentist workforce supply trends in the state of Iowa in order to anticipate potential shortages that could impact access to dental care. This brief describes shifts in Iowa’s dentist workforce and characteristics since 1997, including age, sex, dental school attended, and birth state.

**Approach**

The Iowa Dentist Tracking System (IDTS) is the primary source of data for this issue brief series. The IDTS is part of the University of Iowa’s Office of Statewide Clinical Education Programs, which tracks state workforce information for five health professions: physicians, pharmacists, dentists, physician assistants, and advanced practice nurses. The dentist tracking system was established in 1997. Since then, all dentists actively practicing in Iowa have been contacted every six months to update information regarding individual and practice characteristics.7 In this series, the term “active dentist” refers to those who are currently practicing in the state.

**Results**

**Growth in Dentist Workforce Supply**

Increases in the number of dentists are occurring at a lower rate in Iowa than they are nationally. From 1997-2013, the total number of active dentists in Iowa increased by 8% (1,446 to 1,557), while the number of active dentists in private practice increased 4% (1,343 to 1,400). At the national level, however, the number of private practice dentists increased by 21% in roughly the same timeframe (147,778 in 1997 to 178,136 in 2011).8

The national HRSA projections suggest a potential nationwide increase of 11,800 full-time equivalent (FTE) dentists by 2025, or 6%. However, projections for Iowa suggest a 15% decrease in the dental workforce in the same timeframe.5 The exact reason for this is unclear, but it is likely due, in part, to a combination of more dentists working part-time and an aging dentist workforce.

From 1997-2013, the number of Iowa dental specialists (e.g., endodontists, periodontists, etc.) has increased at a higher rate than for general practice (GP) dentists in the state, but for both groups the increase is considerably smaller.
compared to nationwide increases. The total number of private practitioners in
the six most common specialties (listed in Exhibit 1) has increased by 20% (208
to 249), whereas the number of GP’s in private practice increased by 4% (1135 to
1185). At a national level, the total supply of practitioners in these six specialties
(including those not in private practice) has increased by 24% from 1997-2011,
and the supply of GP’s has increased by 19%.8

The number of dental specialists in private practice in Iowa has increased for
all specialties except periodontics and prosthodontics, while pediatric dentistry
has seen the largest increase (Exhibit 1). National workforce data show a similar
trend, with the pediatric dentistry workforce growing the most (71% increase
from 1997-2011) and prosthodontics growing at the lowest rate (6% increase).

Exhibit 1. Dental Specialists in Private Practice in Iowa, 1997-2013

![Graph showing the number of specialists in private practice in Iowa from 1997 to 2013.]

Since 1997, the proportion of Iowa dentists aged 55 and older has almost doubled.

Source: Iowa Health Professions Tracking Center, Office of Statewide Clinical Education Programs,
UI Carver College of Medicine.

Aging of Dentist Workforce

The average age of dentists in Iowa is slowly and steadily rising. From 1997-
2013, the mean age of Iowa dentists increased from 47 to 50. The proportion of
Iowa dentists aged 55 and older has almost doubled – from 23% to 42% – and
the proportion aged 35-54 has decreased by 26% – from 62% to 36% (Exhibit 2).
This trend is occurring nationally as well; from 1997-2011, the proportion of U.S.
active dentists aged 55 or older increased from 24% to 42%, and those in the age
category of 35-54 decreased from 61% to 45%.6 The effect of this aging dentist
workforce may be impacted by the fact that some studies show that currently,
older dentists are delaying retirement and working longer than in past years.6,9

The proportion of dentists under age 35 in Iowa has increased as well, albeit
less so than the older age groups (Exhibit 2). Nationwide, the proportion in
the under-35 age group has stayed relatively constant from 1997-2011.6 ADA
projections for the national dental workforce suggest that this proportion will
increase in the coming decades as a result of several new dental schools opening
across the country.6 However, this increase is likely to vary by region, and it
is unclear how this projected supply of new dental graduates will impact the
dental workforce in Iowa.
An increasing proportion of younger dentists could impact practice patterns of Iowa’s future dentist workforce. Studies of younger dentists have found that they are far less likely to own their own practice compared to older dentists, as well as compared to younger dentists in previous years. This could lead to an increasing proportion of dentists who practice in group-based or corporate settings.

**Exhibit 2. Iowa Dentists by Age, 1997-2013**

Since 1997, the proportion of women in the Iowa dentist workforce has more than doubled. In 2013, women comprised 25% of active Iowa dentists (Exhibit 3). Recent increases in the percentage of women graduating from the University of Iowa’s College of Dentistry (41% in 2012-2013), combined with a projected large number of retiring Iowa dentists suggests a continued increasing proportion of women entering Iowa’s dentist workforce. This trend is similar nationwide; in 2005-2007, 46% of new dentists were women, and in 2013, 23% of the total U.S. dentist workforce were women.

Numerous studies have documented differences between male and female dentists in terms of their practice patterns, hours worked, income, practice location, and patient rapport. Women tend to work fewer hours than men and are less likely to practice in rural areas, which could impact the state’s workforce capacity.
The University of Iowa’s Role in State Dentist Workforce Supply

Approximately 75% of Iowa’s dentists are graduates of the University of Iowa’s College of Dentistry (UI COD), and that proportion has remained unchanged since 1997 (Exhibit 3). However, the proportion of UI COD graduates from the classes of 1997-2013 who were practicing in Iowa in 2013 ranged from 25% to 57%, indicating that more dental graduates leave the state than stay in Iowa (Exhibit 4). This is likely related to many factors, including birthplace, location of post-dental school education, and other lifestyle considerations.

The UI COD established an Office of Iowa Practice Opportunities (OIPO) in 2006 to link graduates with employment opportunities across the state. Improved retention rates from 2006-2010 may be related to the OIPO. The low retention rate from 2010-2013 can be expected; many recent graduates (e.g., those who graduated within several years prior to the year the data were collected, 2013) leave the state temporarily to complete either post dental school educational opportunities (general practice or dental specialty residencies), fulfill military obligations, or accompany spouses who have obligations elsewhere.
Conclusions & Policy Implications

This brief represents 17 years of historical workforce data on active Iowa dentists to document trends in Iowa’s dentist workforce by specialty, age, sex, dental school attended, and birth state. The capacity of Iowa’s dentist workforce is affected by the increasing number of dentists practicing in Iowa, as well as the increasing proportions of older dentists and female dentists in the state. These changing demographics are likely to impact overall practice patterns, as well as the geographic distribution of Iowa’s dentists.

The University of Iowa’s College of Dentistry continues to be the major source of Iowa’s dentist workforce, and the proportion of dentists choosing to stay or return to Iowa to practice within several years of graduating appears to be increasing. Dentist retention efforts should continue in order to maintain the current capacity of the dentist workforce in Iowa.

Author Information

Julie Reynolds and Susan McKernan are visiting assistant professors at the University of Iowa, College of Dentistry and the University of Iowa Public Policy Center. Raymond Kuthy is a professor at the University of Iowa, College of Dentistry and the University of Iowa Public Policy Center.

Acknowledgements

This policy brief series was funded, in part, by the Health Resources and Services Administration, DHHS (T12HP14992). We also thank the Office of Statewide Clinical Education Programs and Minh Nguyen, Graduate Research Assistant, for assistance with this series.
Endnotes


