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Commentary

Racism and oral health inequities; An overview

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Oral health is uniquely positioned to reflect both contemporary and cumulative race-based health inequities. For example, the most common clinical measure of dental caries experience, the Decayed, Missing or Filled Teeth (DMFT) index, may be used to simultaneously present current inequities in experience of dental disease (D), as well as past exposure to inequitable treatment of that disease that is either radical (M) or conservative (F) across the life course. In so doing, this index captures the cumulative effect of racism operating at various societal levels, including race-based discrimination in dental care. Current evidence at a global level shows that: (i) racially marginalized groups often bear the greatest burden of oral diseases and; (ii) racial inequities in oral health persist over time and across space [1].

Racism has a structural basis and is embedded in long-standing social policy in almost every nation, regardless of its income level. Structural racism is more than private prejudices held by individuals. It is produced and sustained by laws, economic and political systems, and cultural and societal norms. Addressing racism therefore requires not only changing individual values, beliefs and attitudes, but dismantling the policies, institutions, governance structures and social and cultural dynamics that undergird racial hierarchies. The international Black Lives Matter movement, which gained momentum in 2020, has resulted in many calls to arms for greater exposure of the insidious impacts of racism on all facets of health and wellbeing, and the regulatory regimes in which they operate. This includes in the field of oral health [2].

Racism impacts oral health in three main ways: (1) through the creation of inequitable access to oral health services and/or receipt of lower-quality care; (2) through psychological and physiological outcomes of those discriminated against that directly impacts oral health, for example, experiences of racism causing psychosocial stress, which impacts on oral health behaviors and ultimately clinical oral health outcomes and; (3) through the undermining of dental health service provider-patient relationships. Structural racism persists, and is able to be facilitated through: (1) the recruitment and selection of dental students, with demonstrably low proportions of racially marginalized groups in dental schools around the globe. The dental professional is, in itself, an expression of power and privilege, as accrued by class, race, gender, and other factors; (2) the training of oral health personnel with little to no cultural competency assessment [3]; (3) few incentives for oral health personnel to work in communities in which racially underpowered groups reside [4]; (4) dental services structured to provide non-culturally sensitive care. This includes receptionist staff who are unwelcoming, and clinics that do not accommodate large numbers of support personnel joining the patient [5]; (5) policies that do not recognize the historical, cumulative impact of racism on education, occupation, and income, factors which in turn determine access to dental care insurance, for example; (6) clinician bias resulting in inequitable dental health service provider-patient relationships, with consequences including more extraction versus restorative services [6]; (7) marketing of oral health-damaging foods, beverages and products through specific strategies targeting socially vulnerable groups, a large proportion of whom, in many countries, are people of color [7] and; (8) low participation of racially marginalized groups within oral health care systems, academic institutions and in the health policy arena [5]. Examples of intrapersonal racism that impact on oral health include: (1) community acceptance of poor oral health; (2) personal feelings of shame/guilt/lack of confidence because of poor oral health [8] and; (3) low self-efficacy and sense of fatalism, with poor oral health being the considered norm for some [9]. Recent reviews of the literature on racism and general health have consistently shown that, while studies on perceived discrimination and health abound, research on the health effects of either institutional or structural racism is still scarce.

In their critical analysis of under-representation of racialized minorities in the UK dental workforce, Lala and colleagues argue that, while they appear to be adequately represented in entrance to dental schools and completion of dental education, racialized groups are under-represented in career development and progression [10]. White people in the dental workforce are more likely to be recruited and promoted to senior levels, while racial minorities are more likely to be bullied and exposed to inequitable disciplinary processes [10]. Intersectional forms of discrimination rooted in race, gender, sexual

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orientation, religious beliefs and social class further compound these inequities. Paradoxically, racial inequities also persist in dental academia, with dental research literature (even on racial inequities) being dominated by White researchers.

Unless forceful steps are taken to expose and eliminate structural racism in all countries, oral health inequities will persist. This is especially true for countries with limited resources/public health infrastructure, who will likely face increasing race-based oral health inequities in the future. Implementation of comprehensive, international strategies to dismantle structural racism, including within the dental workforce and dental teaching institutions, together with strong, country-level political regulation, are needed to eradicate race-based oral health inequities as they persist in contemporary society.

Declaration of Competing Interest

The authors have nothing to declare.

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