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Neoliberalism and Indigenous oral health inequalities: a global perspective

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Abstract: Neoliberalism is the dominant ideology underpinning the operation of many governments. Its tenets include policies of economic liberalization such as privatization, deregulation, free trade and reduced public expenditures on infrastructure and social services. Champions of neoliberalism claim that expansion of global trade has rescued millions from abject poverty and that direct foreign investment successfully transfers technology to developing economies. However, critics have urged governments to pay greater attention to how neoliberalism shapes population health. Indigenous populations experience inequalities in ways that are unique and distinct from the experiences of other marginalised groups. This is largely due to colonial influences that have resulted in sustained loss of lands, identity, languages and the control to live life in a traditional, cultural way that is meaningful. Oral health is simultaneously a reflection of material circumstances, structural inequities and access to health services. Indigenous populations carry a disproportionate burden of oral health inequalities at a global level. In this commentary, we contend that neoliberalism has overwhelmingly contributed to these inequities in three ways: (1) increased dominance of transnational corporations; (2) privatization of health and; (3) the neoliberal emphasis on personal responsibility.

Keywords: *Indigenous, Corporate determinants of health, Oral health inequalities*

Introduction

Neoliberalism, a political orientation influenced by economists Friedman and Hayek, is the dominant economic and philosophical model underpinning the operation of many OECD governments (Freeman, 2018). It is characterised by private and competitive markets, social services and infrastructure, with reduced public expenditure, and economic activity and freedom of choice facilitated by deregulation (Huber *et al.,* 2018). Individual autonomy is strongly endorsed, particularly individual responsibility for health and wellbeing (Peacock *et al.*, 2014). Acknowledging the large contemporary debate on the definition of 'neoliberalism'(Venugopal, 2015) and its multiple and contradictory interpretations, we apply a framework for the purposes of this commentary that encapsulates neoliberalism in the context of global health, specifically through a social justice/human rights lens (Birn *et al.,* 2018).

Champions of neoliberalism in the context of global health cite how the expansion of global trade has rescued millions from abject poverty and improved economic efficiency, and emphasise that foreign direct investment has been an effective means of transferring technology and know-how to developing economies (Davies, 2014). Privatisation of state-owned enterprises has, in many cases, led to more efficient provision of services and lowered the fiscal burden on governments (Braedley *et al.,* 2010). However, critics (who view health from a social justice/human rights perspective) have described how neoliberal policies increase both economic and health inequality (Sparke, 2017), with more today living in poverty than before neoliberalism (Ostrey *et al.,* 2016).

How does neoliberalism increase health inequalities?

The health of a given population is strongly influenced by the social and economic determinants which shape day-to-day lives and livelihoods. These determinants include income, housing, food security, employment, stress and educational opportunities. Poor social conditions are not accidental but result from the collateral damage from neoliberal policies that impact on mortality, obesity, mental health and health behaviours (Peacock *et al.,* 2014). The burden of poor health resulting from neoliberalism is disproportionately carried by vulnerable populations, including Indigenous populations, and exacerbated for them by the ongoing impacts of colonisation, cultural loss and experiences of racism (Reid *et al.,* 2019). Although neoliberal ideology does not deliberately set out to increase inequalities in health, there are four main ways in which it does so.

The first is through greater availability, affordability and societal acceptance of unhealthy foods and beverages that are ruthlessly marketed by some transnational corporations and which disproportionately impact vulnerable populations over socially advantaged groups. For example, Anaf and colleagues (2017) reported that there was a higher likelihood of McDonald's outlets to be located in deprived areas in Australia.

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The second is through the 'social risk effect', where those already socially vulnerable bear the consequences of the deterioration in the upstream social and corporate determinants of health (Hacker, 2006). The deregulation of the labour market has led to workers in precarious, casual or 'zero hours' work having poorer health, in both developing and developed countries (Standing, 2011); they have been labelled the 'precariat'. Increasing in number worldwide (Muntaner, 2016), the lives of the precariat are dominated by poor pay and lack of security, with stress and its subsequent health sequelae likely outcomes. Similarly, neoliberal deregulation of work and safety practices in turn creates health risks. Taking an example from New Zealand, a review of the Pike River Mine tragedy, in which 29 coal miners died in 2010, indicated serious regulatory failure attributed to neoliberal influences (Gunningham, 2015).

The third is through the direct impact on health services; the underinvestment by governments and the marketisation of health care which creates, in part, the conditions for transnational corporations to dominate (Armada *et al.,* 2001). Sustained government underinvestment in health services leads to poorly remunerated health teams and subsequently a demoralised workforce. The literature suggests that such workers experience stress, burn-out and unrelenting workloads (West *et al.,* 2018). The "marketisation" of health care services may drive unrealistic financial goals, which can create aggressive management that subverts health care provider/management relationships, which causes mistrust and impacts on service quality and culture. Across many countries with neoliberal ideologies, there has been persistent marginalisation of health professionals through the dominance of a neoliberal-influenced business culture that has become embedded in the health system (even public health systems), pervading the language and the planning and delivery of services (Bagshaw and Barnett, 2017). There has been persistent marginalisation of health care professionals through the dominance of rules and guidelines over clinical judgement. In a neoliberal climate, those with means can access private health care (for example, for surgery) while those without are mostly unable to access the care they need through private hospitals. The impacts extend to primary health care too, with a multi-country study of primary care in 2016 highlighting problems for low-income people in access to timely and high-quality care (Osborn *et al.,* 2016).

The fourth is through more insidious psychosocial processes and constructs of shame (Ivison *et al.,* 2020). Particularly damaging is the way in which the prevalent notions of personal responsibility and 'choice' have led to stigmatisation of the most vulnerable, blaming individuals for their poverty, precarious employment and poor health.

Indigenous populations and health inequalities

Indigenous populations (some 370 million people in over 70 countries) experience inequalities in ways that are unique and distinct from the experiences of other marginalised groups. This is largely due to colonial influences that have resulted in sustained loss of lands, identity, languages and the control to live life in a traditional, cultural way that is meaningful (Anderson *et al.,* 2016). Inequalities in indigenous morbidity and mortality are present from birth and increase throughout the lifecourse.

Oral health is simultaneously a reflection of material circumstances, structural inequities and access to health services. Indigenous populations carry a disproportionate burden of oral health inequalities at a global level. We contend that the pervasiveness of neoliberalism both economically and socially has overwhelmingly contributed to these inequities in at least three ways: (1) increased dominance of transnational corporations; (2) privatisation of health care and; (3) the neoliberal emphasis on personal responsibility.

1. Increased dominance of transnational corporations without adequate regulation or oversight

Transnational corporations' products and marketing manifestly impact the oral health of Indigenous populations. Examples include the tobacco and sugar industries. Tobacco smoking rates are 70% in some Indigenous Australian communities, including among children as young as 8 years (Johnston *et al.,* 2012). Consumption of sugar-sweetened beverages (SSBs) in Indigenous communities in Australia, Brazil, Canada, New Zealand and the United States is both high and normalised, with evidence suggesting that SSB consumption in these populations is likely to increase without legislation to limit it (Lee *et al.,* 2016). Many Indigenous people do not trust governments with respect to safety of drinking water, which is frequently perceived to be undrinkable. Freely available and affordable SSBs thus become the beverages of choice.

2. Privatisation of healthcare

Under the guise of free markets, powerful groups can influence access to dental care through promotion of specific dental service models. However, Batliner and colleagues (2014) described how 70% of Navajo children in the United States have untreated dental decay, with 36,000 people being serviced by only 9 dentists in the Pine Ridge reservation alone. Different models of dental service provision for Indigenous groups have caused conflict between various stakeholder groups, for example Alaskan Native dental therapists (who are able to provide basic dental and community preventive services for cheaper than traditional services) and the American Dental Association (ADA), which publicly claims to advocate for the oral health of all. Due to perceived threats against private dentistry, the ADA filed lawsuits against the Alaskan Native Tribal Health Consortium and each of the training Alaskan Native dental therapists, and threatened both academic institutions and American Indian organisations with a loss of donations if they became involved with the Consortium. Thus, we see the negative effects of neoliberalism through increased emphasis on privatisation and shifts away from State welfare provision.

3. Domination of concepts of personal autonomy and responsibility

Neoliberal ideology promotes personal autonomy and responsibility, resulting in classist social derision of the lifestyles, purchasing decisions and subsequent health outcomes of the poor (Peacock *et al.,* 2014). One example

is the shame some New Zealand Maori feel about their inability to pay dental bills (Ministry of Health, 2011). Labelling of difference and the exploitation of these labels can be used to express systemic disapproval, rejection, exclusion and discrimination, resulting in shame and stigma. Stigma is an under-recognized determinant of health, social inequality and life chances, with manifest impacts on Indigenous oral health inequalities such as not applying for jobs because of embarrassment about missing teeth or not seeking dental care because of fear of dentists' moral judgement (Jamieson *et al.,* 2008).

Conclusions

Neoliberalism not only impacts indigenous oral health globally through policies structuring social resources, but also through more insidious psychosocial processes and constructs of shame (Ivison *et al.,* 2020). These judgments clearly reflect the neoliberal values of individual autonomy, unconstrained personal freedom and personal responsibility. However, it is important to consider some evidence that disconfirms this position. For example, privatization of indigenous state-owned enterprises has, in some cases, led to more efficient provision of services and lowered the overall fiscal burden on indigenous groups at both local and state levels (Craig and Porter, 2006; Howard-Wagner *et al.,* 2018). Factors that appear to have mitigated the more negative impacts of neoliberalism in these circumstances include indigenous control and autonomy, with state and federal governments allowing indigenous groups to administer, operate and govern their own health services through independent, community-owned boards (Howard-Wagner *et al.,* 2018). The development of not-for-profit organisations providing health care, including dental health care, free-of-charge to indigenous groups at an international level are also important innovations to benefit indigenous populations.

Reducing inequalities in indigenous oral health at a global level requires robust policy recommendations and social change within our current socio-political context: a deeper understanding of the role of neoliberalism and its problematic implications is central to this.

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