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Racism and oral health inequities; an introduction

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L. M. Jamieson

Australian Research Centre for Population Oral Health, School of Dentistry, University of Adelaide, South Australia 5005, AUSTRALIA

Contemporary evidence shows that: (i) racial minorities often bear the greatest burden of oral diseases; (ii) there are notable differences between socially advantaged and disadvantaged racial groups and; (iii) racial inequities in oral health persist over time and across space. In the four papers that follow, we seek to contribute to the discourse around oral health and racial inequities through recognition that racism has a structural basis and is embedded in long-standing social policy in almost every developed (and developing) nation. The papers formed the basis of a symposium entitled *'Racism and oral health inequities'* at the 99th General Session of the International Association of Dental Research held July 2021 in Boston, United States. The authors responded to the international Black Lives Matter movement that gained momentum in 2019, responding in many calls to arms for greater exposure to the insidious impacts on racism on all facets of health and wellbeing, and the regulatory regimes in which they operate. The papers provide an overview of the history of racism in oral health inequities at an international level, with a specific focus on the implications of addressing (or not addressing) racism in population oral health at an international level. This includes the role of advocacy and engaging with health policymakers to both minimize racism and to increase comprehension of its residual effects that may lead to misinformed policy.

Throughout the papers, we argue that structural racism is more than private prejudices held by individuals, but is produced and reproduced by laws, rules and practices, sanctioned and often implemented across various levels of government. Irrespective of country (for the most part), structural racism is embedded in the economic system as well as in cultural and societal norms. Addressing racism requires not only changing individual attitudes, but dismantling the policies and institutions that undergird racial hierarchies in almost all OECD countries. Bastos and colleagues describe how structural racism is a system of oppression that cuts across institutional, cultural and behavioural dimensions of life. The direction and magnitude of racial inequities in oral health are described, with an analysis of the persistence of inequitable distribution of adverse outcomes over time provided. Sociological frameworks are used to describe how initiatives may be formed to effectively reduce racial inequities in oral health. Caswell and Smith provide a commentary on the effects of racism on oral health in the United States, including an historical overview of how race was conceptually defined originally, what it means in the contemporary setting and how racial categories been enumerated. The potential vagaries of race-based data are described, together with its interpretation and application, regarding oral health. In their critical analysis of under-representation of racialised minorities in the UK dental workforce, Lala and colleagues argue that, while there appears to be adequate representation of racialised minorities in entry to dental schools and completion of dental education, racialized groups were under-represented in career development and progression. White people in the dental workforce are more likely to be recruited and promoted at senior levels, and racialised minorities are more likely to be bullied and exposed to inequitable disciplinary processes. The authors noted that intersectional forms of discrimination rooted in race, gender and class likely impacted on these inequities. Providing some Australian context, Hedges and colleagues described how racism impacts oral health in three main ways in that country: (1) through the creation of differential access to oral health services; (2) through poorer psychological and physiological wellbeing of those discriminated against and; (3) through the undermining of important dental health service provider-patient relationships. The authors describe how, while all minority groups experience racial discrimination that impacts oral health, in Australia, this is amplified among Indigenous groups because of ongoing legacies of colonialism, institutional racism and intergenerational trauma.

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

Correspondence to: L. M. Jamieson, Australian Research Centre for Population Oral Health, School of Dentistry, University of Adelaide, South Australia 5005, AUSTRALIA. Email: lisa.jamieson@adelaide.edu.au