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Racism and oral health inequities among Indigenous Australians

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Racial discrimination, which can be structural, interpersonal and intrapersonal, has causal links with oral health morbidity (dental caries, periodontal disease) and mortality (tooth loss). Racism impacts on oral health in three main ways: (1) institutional racism creates differential access to oral health services; (2) cultural racism, which is structurally pervasive, results in poorer psychological and physiological wellbeing of those discriminated against and; (3) interpersonal racism undermines important dental health service provider-patient relationships. Indigenous Australians have experienced sustained racial discrimination since European colonisation in the 1780s. This includes Government policies of land and custom theft, assimilation, child removal and restrictions on Indigenous people's civil rights, residence, mobility and employment. Australia failed to enumerate Indigenous people in the Census until 1967, with the 'White Australia' policy only ending in 1973. In our paper we posit that all minority groups experience racial discrimination that impacts oral health, but that this is amplified among Indigenous groups in Australia because of ongoing legacies of colonialism, institutional racism and intergenerational trauma.

Keywords: *Indigenous Australian, oral health inequities, racial discrimination*

Introduction

Racial discrimination is the unjust treatment of social groups on the basis of racial or ethnic background (Reskin, 2012). Whilst manifestations of racial discrimination vary, it generally arises from a societal system that produces an unequal distribution of power and social resources along racial lines within and between societies (Paradies, 2006). Racial discrimination thus occurs across various social settings, including institutional and interpersonal contexts through unfair policies, racial stereotypes, racial prejudice and unconscious bias (Brown *et al.,* 2015; Doyle *et al.,* 2018; McCluney *et al.,* 2018). Groups that are racially discriminated against typically have less power, less control over their environment, and are less able to avoid instances in which racial and other forms of discrimination co-occur. These individuals are also more likely to have fewer social, economic and psychological resources to deal with prejudice-based mistreatment. Although the consequences of discrimination accumulates over the life course for all social groups, they take an especially large toll on those who are socially disadvantaged (Krieger, 2014). Aboriginal and/or Torres Strait Islander Australians (hereafter respectfully termed 'Indigenous Australians') are one such group.

It is important to draw upon theories that underpin racial discrimination, namely, group-based dominance (Verkuyten, 2009; Morrison *et al.,* 2008; Dunn *et al.,* 2011). Social Dominance Orientation, for example, posits that certain societal members believe that hierarchy-based dominance between social groups is natural (Pratto *et al.,* 2006). Discrimination against minorities, therefore, can be explained by endorsement of certain groups that societal-based hierarchies are natural and inevitable (Pratto *et al.,* 2006). Those who strongly identify with the dominant group represent a mechanism by which the in-group status quo (i.e. power) can be maintained. Endorsement of group-based dominance and out-group prejudice, either conscious or unconscious, typically increases among this group in situations of perceived threat (Morrison *et al.,* 2008).

Dominant group status quo can also be perpetuated by not acknowledging ethnic or racial inequalities in the first place. There may be people not of colour who see racial vilification, but are too afraid to speak up. Not speaking up is a silent, passive form of facilitating racial abuse. This so-called 'colour-blind' racial ideology denies the existence of racism and justifies racial inequalities as a result of personal decisions, meritocratic achievements and market forces (Doane, 2017; Bonilla-Silva, 2003). This ideology, through the denial of racist practices and racial inequalities, provides the underlying foundation upon which policy proposals aimed at promoting racial justice can be downplayed. This perpetuates the power imbalance between ethnic-racial groups (Doane, 2017). Most Australians fail to recognise the existence of Anglo-privilege, a necessary step in reducing the imbalance in resource distribution and political representation among all ethnic and racial minority groups

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(Dunn *et al.,* 2011). Indeed, public denial of racism, and increasing claims of white victimhood (Sharples and Blair, in press) across all levels of society, politics and industry has been described as one of the biggest challenges to a deeper commitment to Indigenous reconciliation in Australia (Ferdinand *et al.,* 2017).

Australia's Indigenous population

Indigenous Australians comprise 3.3 percent of the total Australian population (AIHW, 2019). Indigenous groups resided in Australia for 65,000 years before European colonisation in the 1780s. Since then, Indigenous Australians have been subject to wholesale and sustained Government policies including land, custom and language theft; forced relocation to Church-run missions; removal of children; unequal opportunities in labour, education, trade and governance and; systemic racism (Anderson *et al.,* 2016). Compared with other Australians, Indigenous Australians have poorer general health and health-related behaviours, elevated levels of psychological distress, five times the youth suicide rate and a life expectancy 11.5 years lower for males and 9.7 years lower for females (Thompson *et al.,* 2017). This has resulted in the historical underpinnings of Indigenous Australian culture being severely damaged; with contemporary Indigenous Australians being over-represented in incarceration, addiction, unemployment, low educational attainment and poor health outcome statistics (Walker *et al.,* 2017).

Racist attitudes towards Indigenous Australians have been confirmed empirically (Carlson *et al.,* 2018; Kamp *et al.,* 2017; Paradies 2018). Ziersch and colleagues (2011) reported that up to 93% of Indigenous Australians had experienced racism in the last 12 months. Among those, 41% reported experiencing racism in public settings, 40% in the legal setting and 30% in the work setting. The prevalence of racial discrimination was highest among those aged 35 to 44 years. Experiencing racial discrimination was associated with removal from family, low trust, unemployment, having a university degree, and indicators of cultural identity and participation. Lower reporting of racial discrimination was associated with home ownership, geographically remote residence and having relatively few Indigenous friends (Cunningham *et al.,* 2013).

Levels through which racism impacts health

There are three main constructs through which racism impacts health (all are interchangeable); structural, interpersonal and intrapersonal. Structural racism has been broadly defined as the totality of ways in which societies foster racial discrimination through mutually reinforcing systems which include, but are not limited to, housing, education, employment, earnings, benefits, credit, media, health care and criminal justice. It includes the requirements, conditions, practises, policies and processes that both maintain and reproduce inequalities across racial and ethnic groups (Paradies 2018). An example includes Indigenous Australians being 12-13 times more likely to be arrested and charged with an offense than their non-Indigenous counterparts (McDonald *et al.,* 2016). Interpersonal racism is defined as the interactions between societal members that maintain and reproduce health inequalities across racial and ethnic groups (Paradies 2018). An example is being racially abused whilst walking along the street. The impacts of interpersonal racism is what most empirical research has focussed on to date. Intrapersonal racism is the acceptance of attitudes, beliefs or ideologies about the inferiority of one's own ethnic or racial group (Paradies 2018). An example might be an African American person believing that they are more prone to poor health than White people.

There are three main pathways by which racism results in poor health. The first is through reduced access to societal resources required for health, for example, employment, education, housing, safe communities, reliable drinking water and culturally acceptable, affordable and appropriate medical care. The second is through inequitable exposure to risk factors associated with poor health, for example, increased levels of stress leading to increased tobacco smoking, alcohol consumption, illicit drug use, consumption of unhealthy foods and beverages, risk-taking behaviours (reckless car driving, for example) and domestic violence. The third is through stress-mediated changes in immune, cardiovascular, endocrine and other physiological systems which, over time, contribute to substantial morbidity and mortality outcomes (Krieger *et al.,* 2014).

Impact of racism on Indigenous Australian health

Experience of interpersonal racism has been significantly associated with poor mental health among Indigenous Australians of various ages across diverse locations (Paradies, 2018). In a longitudinal study involving 1,200 Indigenous Australian children aged 5-10 years, 40% of primary carers, 45% of families and 14% of children reported experiencing racism, with between 28 and 40% experiencing racism at multiple time points. Carer and child experiences of racism were significantly associated with poor child mental health, sleep difficulties, obesity and asthma. The poor health outcomes were higher among those persistently exposed to racism (Shepherd *et al.,* 2017).

In terms of structural racism, that is, Indigenous Australians receiving differential access to care, and treatment itself, compared with non-Indigenous Australians, empirical research demonstrates inequities in hospital procedures across almost all conditions (Cunningham, 2002), lung cancer (Hall *et al.,* 2004), cancer survival (Condon *et al.,* 2014), cervical cancer diagnosis and treatment (Diaz *et al.,* 2015), head and neck cancer diagnosis (Gibberd *et al.,* 2015), coronary procedures (Lopez *et al.,* 2014) and kidney transplants (Khanal *et al.,* 2018). These inequities persist even after adjustment for age, sex, marital status, socio-economic status, residential location, hospital type and co-morbidities.

There is evidence of a dose-response relationship between the frequency of racial discrimination and health outcomes (Cunningham *et al.,* 2012; Macedo *et al.,* 2019). These findings indicate that early and prolonged exposure to racial discrimination can impact on multiple domains of health in later life, and is consistent with an understanding of racism as a causal determinant of health inequities between Indigenous and non-Indigenous Australians.

The costs of racism to the health care budget are substantial. Using economic modelling approaches, Elias and Paradies (2016) showed that the mental health costs directly attributable to racism resulted in 235,452 disability-adjusted life years lost. This is equivalent to an average $37.9 billion in productivity loss per annum, or 3 percent of Australia's annual Gross Domestic Product from 2001–2011.

How does racism impact oral health?

Oral health offers a unique perspective through which racial inequities can be viewed, being simultaneously a reflection of current dental disease (for example, untreated decayed teeth) and experience of treatment (for example, teeth that have been filled or removed). Although racism impacts the oral health of Indigenous Australians through the same structural, interpersonal and intrapersonal pathways as general health, there are some unique features.

Structural racism persists, and is able to be facilitated through:

1. the training of oral health personnel including little to no cultural competency assessment (Forsyth *et al.,* 2019);
2. few incentives for oral health personnel to work in regional or remote locations in which the majority of Indigenous Australians reside, meaning dentist availability in these locations is often low to non-existent (Stuart *et al.,* 2017);
3. waiting lists for dental public health services in some regional and remote locations being up to two years (Williams *et al.,* 2011);
4. dental services structured to provide non-culturally sensitive care, in both the private and public sector. This includes receptionist staff who are unwelcoming, service structures that do not allow for flexible appointments, policies that mean if two consequent appointments are missed no more are able to be made and clinics that do not accommodate large numbers of support personnel joining the patient (Williams *et al.,* 2011);
5. differential access to safe drinking water that is fluoridated (Bourke *et al.,* 2020);
6. households without infrastructure, for example, functioning bathrooms, to support safekeeping of toothbrushes;
7. clinician bias resulting in inequitable dental health service provider-patient relationships, with consequences including more extraction versus restorative services (one example is the high rates of Indigenous children receiving dental care under a general anaesthetic relative to non-Indigenous children and a higher rate of Indigenous adults receiving dental extractions than their non-Indigenous counterparts) (AMA, 2019);
8. marketing of cariogenic foods and beverages through specific strategies targeting socially vulnerable groups such as Indigenous Australians, for example, promotional activities of certain carbonated beverage companies (Brimblecombe *et al.,* 2018);
9. increased cost of toothbrushes and fluoridated toothpastes in remote stores relative to the purchasing price in more metropolitan locations (Jamieson *et al.,* 2006);
10. dental health personnel, including reception staff, assistants and technicians, usually being non-Indigenous (AMA, 2019);
11. advertising for toothbrushes and toothpastes, and good dental health generally, usually showing non-Indigenous actors and;
12. considerable out-of-pocket costs for those not eligible for public dental care, with dental insurance among Indigenous Australians in the 2017-18 National Survey of Adult Oral Health being 18% compared to 51% of the general adult population (ARCPOH, 2019).

Examples of interpersonal racism resulting in oral health inequalities include: (1) Indigenous children and adults being teased because of poor oral health (Williams *et al.,* 2012); (2) dental health providers providing differential dental care based on patient Indigeneity (Nair *et al.,* 2020); (3) dental service staff providing culturally insensitive treatment that results in many Indigenous clients not wanting to return to complete their course of care (Jones *et al.,* 2016); (4) Indigenous people not being employed because of poor oral health (Butten *et al.,* 2019) and; (5) dental fear of Indigenous clients not being fully appreciated or addressed, leading to delayed future care and extension of fears to children and other family members (Jamieson *et al.,* 2008). Examples of intrapersonal racism that impact on Indigenous oral health include: (1) community acceptance of poor oral health (Parker *et al.,* 2012); (2) personal feelings of shame/guilt/lack of confidence because of poor oral health (Krichauff *et al.,* 2020) and; (3) low self-efficacy and sense of fatalism; with poor oral health among Indigenous Australians being the considered norm for some (Jamieson *et al.,* 2006).

Although oral health is an integral component of overall health and well-being, few studies have examined associations between racial discrimination and oral health empirically in the Indigenous Australian context. In a birth cohort of young Indigenous adults in the Northern Territory, experience of racial discrimination was the only significant association with having never visited a dentist before (Jamieson *et al.,* 2013). In a study involving women pregnant with an Indigenous child, experience of racism was associated with non-optimal tooth brushing behaviours, with this relationship mediated by levels of perceived stress (Ben *et al.,* 2014a). Experience of racism was also associated with toothache, with sense of personal control acting as a mediator (Ben *et al.,* 2014b).

Provision of dental care models in Australia

Although Australia offers universal general health care coverage, it does not extend to dental health. Dental service provision is thus predominately via the private sector, with substantial out-of-pocket costs for extensive treatment (Chrisopoulos *et al.,* 2013). The public dental sector is means-tested, with large eligibility (and waiting time) variations across states and territories. A substantial proportion of Indigenous Australians are eligible for public dental services, either through each state and territory's dental public health sector, or through dental services that might be provided through Aboriginal Community Controlled Health Organisations (ACCHOs). Both services face similar challenges in recruiting and

retaining culturally sensitive personnel, and in providing timely, culturally acceptable care (Steffens *et al.,* 2016). Given Australia's vast geography and sparsely distributed population in regional and remote locations (areas with a high proportion of Indigenous Australians), poor access to dental services in these hard-to-reach locations has long been acknowledged (Brennan *et al.,* 2020). Improving the dental health of Indigenous Australians is one of five priorities in the 2015-2024 National Oral Health Plan (Australian Government, 2015).

Conclusion

Although all minority groups who experience racial discrimination will have impacts on oral health (Bastos *et al.,* 2018), we argue that this is amplified among Indigenous groups in Australia because of ongoing legacies of colonialism, institutional racism and intergenerational trauma (Paradies, 2016). The evidence of racial inequities in Indigenous Australian oral health shows outcomes in the burdens of dental disease (Jamieson *et al.,* 2016; Ben *et al.,* 2014), self-rated oral health (Jamieson *et al.,* 2016), oral health-related quality of life (Williams *et al.,* 2010), avoidance of dental care (Jamieson *et al.,* 2013) and dental health behaviours (Ben *et al.,* 2014).

If the gap in Indigenous Australian oral health inequities due to racism is to be reduced, a number of broad societal constructs need to be addressed. These include society-wide initiatives to reduce prejudice, to foster community harmony and social cohesion, and to acknowledge Indigenous Australian history by demonstrating gratitude; organisational change to address institutional racism, conflict resolution and intercultural relations; and collective action to advocate for social change. At a personal level, Paradies and colleagues (2009) emphasised eight key ways in which anti-racism principles can be adopted: (1) increasing empathy; (2) raising awareness; (3) providing accurate information; (4) recognising incompatible beliefs; (5) increasing personal accountability; (6) breaking down barriers between groups; (7) increasing organisational accountability and; (8) promoting positive social norms, with a more recent review demonstrating promising approaches to implementing these principles in practice (Ben *et al*., 2020).

With respect to oral health and structural racism, regulation agencies such as the Australian Health Practitioner Regulation Authority and the Dental Board of Australia need to include cultural competency as a core requirement. Institutions that provide training for dental personnel need to embrace cultural competency programs and make them a mandatory requirement of course completion. All dental schools need to have intake quotas of Indigenous students each year, and provide the resources and support structures to enable timely and successful completion. Private and public dental services across Australia should actively employ, and engage with, local Indigenous stakeholder groups to provide flexible and culturally acceptable business models. Access to fluoridated drinking water should be a fundamental right for all Indigenous Australians, as should provision of affordable toothbrushes and fluoridated toothpastes. All such initiatives should be conducted in collaboration and partnership with key Indigenous groups.

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