



# The mouth as a site of structural inequalities; the experience of Aboriginal Australians

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**Objective:** To address the mouth as a site of structural inequalities looking through the lens of Aboriginal Australian experience. **Research design:** This is a critical review of published literature relevant to our objective. Criteria for selection included articles on: the social context of oral and general health inequalities for Aboriginal Australians; Aboriginal perceptions and meanings of the mouth and experiences of oral health care and the role of the current political-economic climate in promoting or compromising oral health for Aboriginal Australians. **Results:** Evidence suggests oral health is important for Aboriginal Australians yet constrained by challenges beyond their control as individuals, including accessing dental services. Competing demands on limited budgets often led to oral health dropping off the radar unless there was an emergency. **Conclusions:** Structural (social, political and economic) factors often inhibited Aboriginal people making optimum health choices to prevent oral disease and access services for treatment. Factors included cost of services, limited education about oral health, intense advertising of sugary drinks and discrimination from service providers. Yet the literature indicates individuals, rather than structural factors, are held responsible and blamed for the poor state of their oral health. The current neoliberal climate focuses on individual responsibility for health and wellbeing often ignoring the social context. To avoid the mouth becoming an ongoing site for structural inequality, critically reviewing oral health policies and practices for whether they promote or compromise Aboriginal Australians' oral health is a step towards accountability-related oral health outcomes.

**Key words:** inequalities, structural factors, oral health, health services, Indigenous

## Introduction

*“Oral health is a mirror of systemic health, is related to health and disease throughout the body, and is critical to social and economic functioning at all stages of life.”* (Kahn, 2013; p55)

We draw on this perspective of oral health to explore the mouth as a site of structural inequalities. Kahn (2013: p55) goes on to describe oral disease as the “silent epidemic”. Poor oral health and inadequate access to services persist across the life-span for Australia’s Aboriginal and Torres Strait Islander (hereafter Aboriginal) population (Jamieson *et al.*, 2010; Roberts-Thomson *et al.*, 2008), raising questions of where the problem lies. Despite government commitments to improve oral health, inequalities and significant morbidity persist for Aboriginal Australians suggesting a ‘wicked’ or intractable problem that is complex and requires innovative solutions (Department of the Prime Minister and Cabinet, 2016; Rittel and Webber, 1973).

If we assume that a measure of good oral health is absence of tooth decay and that dental caries is preventable, at least in theory, and if we follow evidence-based public health messages to maintain oral health including eating a healthy diet with a low sugar intake, tooth-brushing and stopping smoking, then we need to explain why there is a higher rate of dental disease, higher levels of untreated caries, more missing teeth and worse periodontal health or gum disease in Aboriginal compared to non-Aboriginal Australians (Jamieson

*et al.*, 2010; Roberts-Thomson *et al.*, 2014). Understanding why inequalities in oral health persist between Aboriginal and non-Aboriginal Australians is important, so that such inequities might be suitably addressed in culturally-safe ways.

In Australia, colonisation has left a legacy of discrimination or racism where Aboriginal people continue to be marginalised across a range of social indicators including health, education and employment with ongoing negative effects on health and wellbeing (Saggers and Gray, 2007). White, English-speaking Australians have been privileged as a group since the colonisation and dispossession of Aboriginal Australians by the British in 1788. Aboriginal rights and occupancy were ignored (“terra nullius”) and British authority determined policies and practices (Moreton-Robinson, 2009). Being White provided structural advantage, usually invisible to those who were White, and reproduced inequities that continue to shape the lives of the privileged and the marginalised. Such advantage is often taken for granted, unnoticed and unexamined by those who benefit (Moreton-Robinson, 2009; Pease, 2010). However, the legacy of colonisation and discrimination impacting on Aboriginal people’s lives across generations is generally ignored, so policies and practices that can compromise oral health are often not called to account for socio-economic and political factors that can adversely affect health yet are beyond individual control (White, 2002).

Given that oral health mirrors systemic health, this paper explores whether Aboriginal perspectives and meanings associated with oral health reflect the mouth as a site of structural inequalities.

### *The mouth and structural inequalities – contextual literature*

Repeated Australian governments have committed to Closing the Gap in health inequalities between Aboriginal and non-Aboriginal Australians through building partnerships between governments, service providers and local Aboriginal stakeholders (Council of Australian Governments, 2008). Yet the Prime Minister of Australia's 2016 report on "Closing the Gap" in Aboriginal disadvantage found little improvement in life expectancy with Aboriginal Australians dying at least ten years earlier than non-Aboriginal Australians (Department of Prime the Minister and Cabinet, 2016). Equity in health service use is an international priority (Starfield, 2011) yet evidence suggests that Aboriginal people may be reluctant to attend services for treatment because of discrimination from service providers (Durey *et al.*, 2016; Shahid *et al.*, 2009). Inequalities in health care raise questions about the appropriateness of current oral health practice for Aboriginal Australians who are offered fewer procedures for diagnosis and treatment for disorders such as cancer and are less likely to attend dental services than other Australians (AIHW, 2015; Boffa, 2008). Yet, the problem of poor oral health is often blamed on Aboriginal people's 'non-compliance' with evidence based public health messages – if only Aboriginal people would stop smoking, brush their teeth, and eat a healthy diet to reduce sugar intake then they wouldn't have a problem (Durey *et al.*, 2016). However, the reality is more complex.

The current neoliberal political and economic climate has increasingly focused on individual responsibility to make optimum health and lifestyle choices (Schrecker and Bamba, 2015). This would include individuals making optimum oral health choices by regular attendance at the dentist for check-ups, eating healthy, sugar free food and brushing and flossing regularly. According to Beck and Beck-Gernsheim (2002; p24), penalties for 'non-compliance' with such public health messages to stay healthy are 'blame' and 'personal failure'. This neoliberal focus on individual responsibility for health reproduces the discourse that Aboriginal people are seen as the problem for not making good oral health choices or, if they see a dentist, not complying with expert advice to improve their oral health (Durey *et al.*, 2016; Playle and Keeley, 1998). What is avoided in this discourse are the socioeconomic and historic inequities impacting on Aboriginal people's lives and collective experiences of discrimination including in healthcare (Durey *et al.*, 2016).

### *The mouth and structural inequalities – Western Australian research*

Qualitative research on Aboriginal people's experience of the mouth as a site of structural inequalities is limited and what exists highlights the need for Aboriginal people's voice to be heard in the current discourse to avoid misrepresentation. Findings in a recent paper indicated that oral health was important for Aboriginal participants with many people looking after their oral health by regular tooth brushing, avoiding sugary drinks and not smoking. However, they also faced challenges maintaining oral health and accessing services that included discrimination from health providers, competing demands on limited budgets such as food for the family and paying rent often resulting in oral health dropping off the radar (Durey *et al.*, 2016).

Recent qualitative research on Aboriginal Australians' perceptions identified barriers to maintaining oral health (Durey *et al.*, 2016). Accessing oral health care was a key theme and the model by Harris (2013) was used to explain access through the lens of opportunity, use of services, equity and outcomes. Findings indicated opportunities for accessing care were constrained by limited availability of public dental services for Aboriginal adults, often with long waiting lists or waiting times where the focus of care was on treating rather than preventing disease. Participants were aware of no public oral health services for 0-4 year olds apart from emergency hospital care. Use of services was constrained by cost with private services generally out of reach financially and public services often incurring a co-payment. Aboriginal participants' perceptions that they were discriminated against by health providers also reduced access. Findings also indicated that despite evidence of poor oral health for Aboriginal Australians, demand for services was not met by supply; the system of oral health care in Western Australia is mainly a private model of treatment with limited public oral health services including those related to education on prevention. Many participants who accessed oral health care privately or publicly perceived health providers discriminated against them for various reasons – they felt judged for the state of their oral health, for being Aboriginal or for bringing children to the service. Despite the importance of oral health, preventing oral disease was also constrained by high cost of healthy diets on limited budgets and intense marketing of sugary products. This often led to participants accessing dental services for treatment not prevention, oral health being compromised by little or no education on preventing disease and promoting health. Discrimination from health providers often led to a sense of 'shame' and humiliation and a reluctance to attend the service for follow up appointments (Durey *et al.*, 2016).

## **Discussion**

Structural inequalities informing Aboriginal Australians' decisions about oral health lead us to question how future discourse will be framed. While structural factors such as discrimination, cost of services and limited education to promote oral health can act as barriers to making optimum oral health choices, Aboriginal people felt they were held responsible for the state of their oral health, often feeling blamed and judged by health providers (Durey *et al.*, 2016).

Ongoing health inequalities between Aboriginal and non-Aboriginal Australians call into question the effectiveness of a neoliberal model placing responsibility on individuals to make optimum health choices. Implicit assumptions of a level playing field for all Australians are reinforced when the social, historic and economic contexts of Aboriginal Australians' lives that inform choices are ignored. The WHO Commission on Social Determinants of Health (CSDH, 2008) clearly states that structural conditions inform lived experience and are responsible for significant health inequalities.

According to Schrecker and Bamba (2015), neoliberalism can actually make people sick by not addressing structural inequalities that underpin choices. Responding appropriately to poor oral health for Aboriginal Australians as a 'wicked' problem takes into account the social context of their lives that is informed by broader structural issues. Evidence suggests ongoing racial discrimination including in health services, is harmful to health and wellbeing (Johnstone and Kanitsaki,

2009) and can result in Aboriginal people choosing not to attend services (Durey *et al.*, 2016; Shahid *et al.*, 2009). For a new discourse to emerge, discriminatory policies and practices towards Aboriginal people that are unrecognised and unreported by policy makers and service providers, despite the harm they can cause, need critical review if oral health inequalities between Aboriginal and non-Aboriginal Australians are to improve.

Given that discrimination and cost, for example of providing a healthy diet for families, influence choices about oral health, research suggests more is needed than just delivering evidence-based interventions that may ignore the significant role structural issues play in informing such choices. A step forward is for non-Aboriginal policy makers and health providers to engage with Aboriginal stakeholders around oral health policies and practice and reflect on any unconscious bias that undermines rather than promotes the health and wellbeing of Aboriginal Australians (Durey *et al.*, 2016). Unconscious bias towards the dominant neoliberal view that focuses on individual responsibility to make good health choices doesn't take into account the social context of people's lives that can compromise those choices and further disadvantage those who are already marginalised. Given that Aboriginal people are often held responsible for not making the 'right' choices and thereby tacitly blamed, reflects the invisibility of privilege that ignores power relations inherent in the broader structural factors that disadvantage some groups while benefiting others (Pease, 2010). The objective of such reflection is to avoid projecting any negative beliefs onto Aboriginal people that could damage their health and wellbeing (Pitner and Sakamoto, 2005).

Oral health policies and practices must be critically reviewed for inequalities in care. This requires shifting the focus away from Aboriginal people being held responsible for their health choices to refocusing the lens onto the broader structural context that can inform how the problem of poor oral health in Aboriginal people can be more effectively addressed. Policy makers and health providers committed to providing care that is non-discriminatory, non-judgemental and respectful of Aboriginal people and their lived experience is important if attendance at dental services is to increase and health outcomes improve. Without this commitment, inequalities are set to continue.

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