Oral health inequalities/inequities: Looking back and looking forward

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The past 50 years

The burden of oral diseases, such as dental caries, periodontal diseases, tooth loss and oral cancer, is disproportionally carried by individuals of minoritized and disadvantaged groups in a society across countries regardless of their level of economic development. These inequities are important problems of social injustice worldwide and are observed across the lifecourse starting in the first years of life. In this Special Issue, as we commemorate the 50th Anniversary of *Community Dentistry and Oral Epidemiology*, we invited papers to understand the state of oral health inequalities/inequities in the world and enrich the discussions on the ethics and social justice aspects of such inequalities. We use the terms inequalities and inequities interchangeably according to their uses in the papers. However, we would like to emphasize that both terms refer to avoidable and unjust differences across groups or the population.[1,2] This Special Issue comprises a collection of 14 papers including commentaries (n=4), analytical essays and reviews (n=3), and empirical research (n=7) calling attention to or underscoring oral health inequities. These papers are aggregated into three categories: equity and justice; systems and forms of oppression; and oral health inequities across the lifecourse.

Equity and Social Justice

The commentaries bring attention to a common theme, oral health inequities as an issue of social justice, and communication as a tool for knowledge transfer of inequities from academic and non-academic institutions within and between countries. The first commentary took us back 50 years focusing on the lessons learned around health equity and justice using a domestic and global lens, and how these lessons have had spills over on oral health (Venkatapuram &

Marmot). Venkatapuram & Marmot (p.xx) called for global health justice to be the epicenter for policy approaches to oral health and health in general to eliminate inequities. The second paper provided an overview of the developments in research, policy and practice related to oral health inequalities in the past 50 years and the impact of our understanding of the social, economic and political causes of these inequities across the lifecourse (Watts). Watt (p.xx) ended with a call for transformative policy and system reforms to tackle the underlying determinants of oral health inequalities (Aida et al). In the third paper, Aida and colleagues (p.xx) pointed to economic factors as upstream social determinants of oral health inequalities and proposed two approaches to address these factors, an indirect approach such as financial support to obtain dental care and policies to target unhealthy commodities, and a direct one via cash transfers or universal basic income. The last commentary made a compelling argument for the importance and need of accurate communication and transfer of knowledge on oral health inequities among academic and non-academic institutions (Abbas et al). Abbas and colleagues (p.xx) argued that academic institutions should go beyond producing knowledge and be an active player on transferring and applying knowledge towards the public benefit, and specifically, oral health inequalities and their social and commercial determinants.

Systems and forms of oppression

The three analytical essays focus on systems of oppression such as racism and its consequences at the society and individual levels. The first essay proposed a provocative argument for dentistry to re-invent itself by embracing an anti-oppressive framing of equity that elevates justice in addition to fairness (Fleming et al). Fleming and colleagues (p.xx) called on dentistry as

a profession to advocate for an intersectional framework to center the profession in social justice and liberation. As a follow up, the second essay pointed at access to dental insurance as a major political and structural determinant of oral health inequities influenced by historical and contemporary policies rooted in racism. Such policies have perpetuated racial/ethnic inequity in access to care in the United States. However, Borrell and colleagues (p.xx) stated that although dental insurance may not be enough to reduce inequities in access to care and oral health, access to it may benefit the population as a whole. Lastly, ableism, a form of discrimination against disabled persons, puts individuals in risk position for oral health inequities given that health status and the social determinants of health interact. When it comes to oral health inequalities, Faulks and colleagues (p.xx) called for a common ground approach between all groups using the World Health Organization International Classification of Functioning to improve outcomes while considering disability as a primary variable like we do with age or gender. This will require much improved efforts by the dental community to identify and include disabled persons in inequalities research.

Oral health inequities across the lifecourse

The last seven papers examine inequities in oral health and access to care across the lifecourse in several countries. Specifically, Lopez and colleagues (p.xx), using longitudinal data from Victoria, Australia, found inequalities in early childhood caries between 2008 and 2019 according to cultural and diversity in language, cardholder status, area-deprivation, and indigenous status. In Libya, Arheiam and colleagues (p.xx) showed the impact of war on children's oral health. They found that children aged 8 to 12 years in the post-war group had

significantly more decayed primary and permanent teeth than children living during the war in Benghazi. Moreover, Madera and colleagues (p.xx), using data from the United States, found substantial inequalities in self-rated health, tooth loss, untreated caries and periodontitis among adults across interlocking strata of systems of oppression such as gender, race/ethnicity, socioeconomic position, and nativity status using a multilevel analysis of individual heterogeneity and discriminatory accuracy. Borgeat and colleagues (p.xx) identified educational attainment and employment status as the social determinants that explained gender inequality in the number of remaining teeth among Chilean adults. Using data from adults in Thailand, Chaianant and colleagues (p.xx) showed that despite the implementation of the Universal Coverage Health Scheme in 2002, inequalities in dental care utilization remained with those with less formal education and lower income being less likely to use dental services. Comparing findings from two different countries, Japan and Singapore, Kiuchi and colleagues (p.xx) showed that inequalities by education for being dentate and for not having a minimal functional dentition were less steep in Japan, relative to Singapore. Lastly, pulling data from multiple sources, Perera and colleagues (p.xx) reviewed the evidence on oral cancer inequalities in Sri Lanka and showed striking gender/sex differences with greater incidence among men than among women. Notably, they showed that this gender inequity has been increasing over the past 14 years (2005-2019). Regardless of sex/gender, the highest incidence was observed among adults aged 70 to 74 years. The authors called for restructuring and reorienting oral cancer services using equity and social justice as the next step to address these inequities.

Moving the agenda forward

Together, this collection of papers calls attention to oral health inequities across the lifecourse and to the need to have a serious discourse about these avoidable and preventable but yet persistent and systemic inequities around the world. Over the past 50 years, we have made some progress in understanding the importance of oral health as indicated by improvements in oral health outcomes as well as inclusion of oral health in the global health agenda, oral health outcomes initiatives and commissions.[3,4,5,6] However, these papers underscored that regardless of outcomes, and the age and country of the population, we need to look beyond individual-level factors when examining oral health. In fact, most of the determinants of poor oral health are structural, and require attention beyond the social determinants to include political and commercial determinants of health. In addition, the papers' findings called for more work and a variety of strategies at different levels to address and eventually eliminate inequities in oral health outcomes. Finally, while we have come a long way, to continue progress in the future calls for practices, policies and research centered in health justice to improve oral health for all in the world.

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