Examining Health Equity and Antiracism in Dental Public Health Professionals

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Introduction

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Conflicts of Interest

The presenters declare that they do not have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing dental education program, nor do they have a financial interest in any commercial product(s) or service(s) they will discuss in the presentation.

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Background: Health Equity

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. (Braveman, 2017)

- Health equity is a core public health principle
- Racism is the cause of many health inequities (Gee & Ford, 2011)

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Background: Antiracism

Antiracism can be defined as "forms of thought and/or practice that seek to confront, eradicate and/or ameliorate racism. Anti-racism implies the ability to identify a phenomenon—racism—and to do something about it"
(Bonnet, 2000 p.4)

- The health workforce is still overwhelmingly White (Ford & Airhihenbuwa, 2010; McKenzie, 2003)
- Equity cannot be achieved without antiracism (Gee & Ford, 2011)

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Background: Oral Health

- Oral disease is among the most prevalent diseases globally (Peres et al., 2019)
- The burden of oral disease lies predominantly within socially disadvantaged populations (Watt, Venturelli, & Daly, 2019).
- Many negative health outcomes for BIPOC people (e.g. more chronic disease, higher rates of morbidity and mortality, and lack of access to health care systems and providers) are the direct effects of racism, yet little research exists on the relationship between public health and antiracist work (Bailey et al., 2017).

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Purpose

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Advancing health equity necessitates the dismantling of inequitable systems, predominantly racist systems, that perpetuate disparate health outcomes

The purpose of the study was to:

1) Understand how dental public health professionals self-report their orientation to health equity
2) Explore the relationship between demographic characteristics, level of engagement in antiracist work, and health equity among dental public health professionals

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Methods

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Survey Design

Quantitative, cross-sectional design

34 items with three sections: demographics, health equity, and antiracism

Demographics:

race, ethnicity, and gender, age, educational attainment, oral health career field organizational affiliation, and self-identified leadership position

Health Equity:

I believe that health equity is a core principle of public health practice and policy; I value health equity as a public health professional; and I actively work toward advancing health equity in my daily work

ARBI:

21-item questionnaire:

1. Institutional Advocacy
2. Individual Advocacy
3. Awareness of Racism
4. Total

Results

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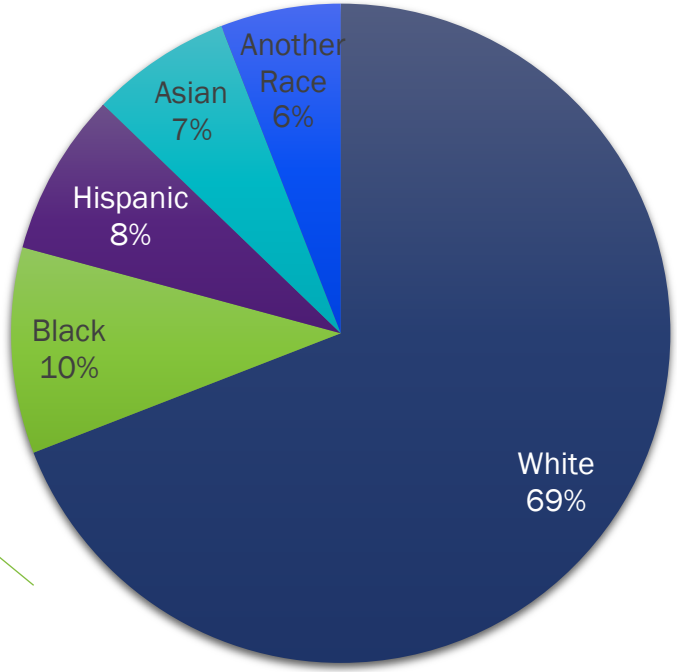
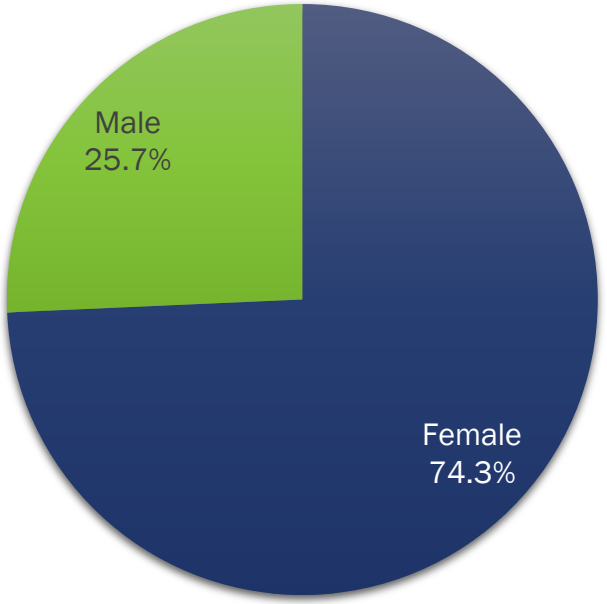
Sample Characteristics

Race/Ethnicity



Gender Identity



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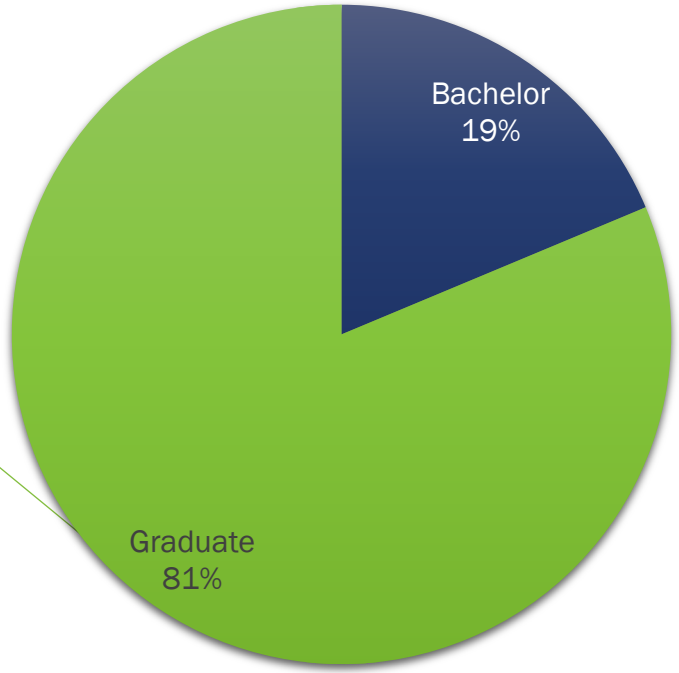
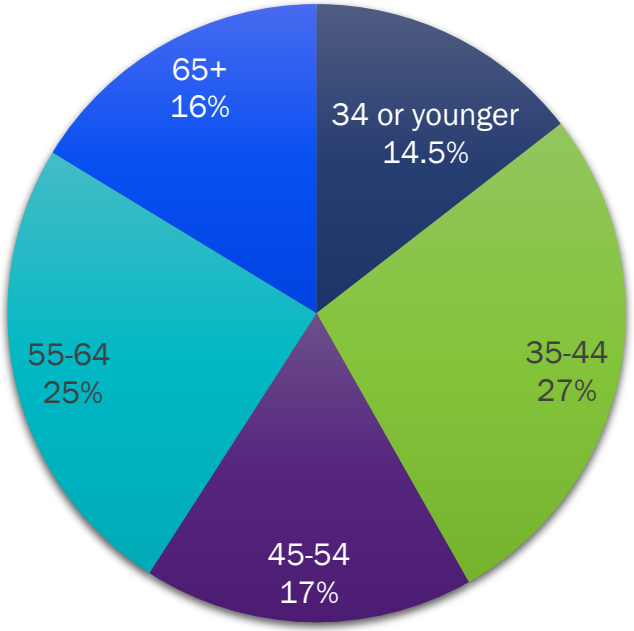
Sample Characteristics

Education Level



Age



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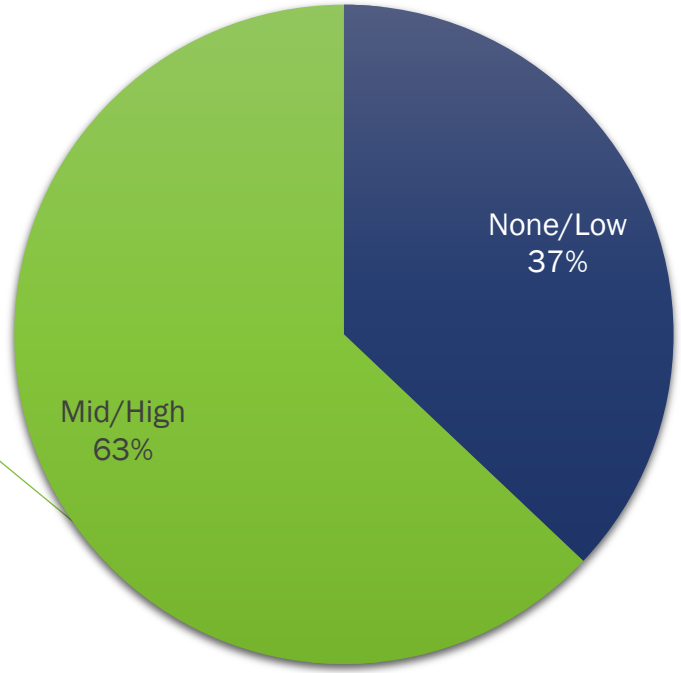
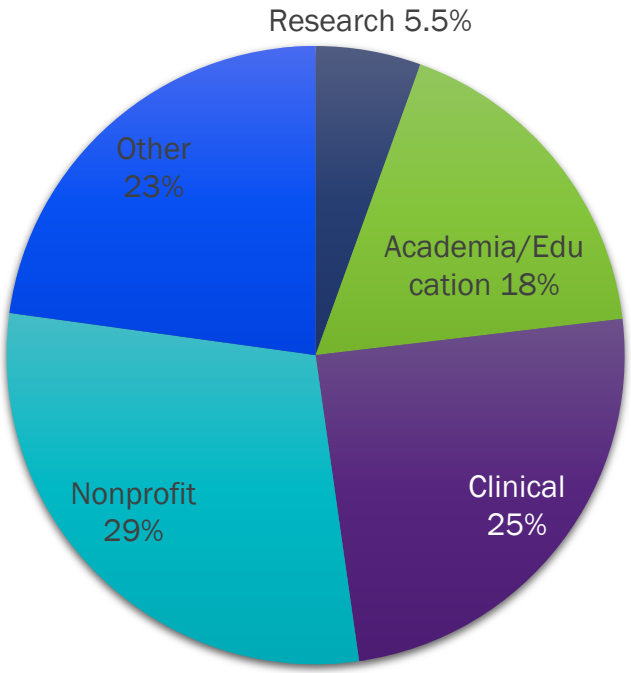
Sample Characteristics

Level of Leadership



Career Field



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Inferential Analysis

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Demographics and ARBI Score Correlations with Health Equity Questions

	I believe that health equity is a core principle of public health practice and policy	I value health equity as a public health professional	I actively work toward advancing health equity in my daily work
Leadership position	NS	NS	.168**
Education	NS	NS	NS
Age			
ARBI- Institutional Advocacy	.254**	.240**	.304**
ARBI- Individual Advocacy	.345**	.355**	.272**
ARBI- Awareness of Racism	.432**	.407**	.277**
ARBI- Total	.432**	.421**	.309**

Note. * = $p < .05$, ** = $p < .01$, NS = not statistically significant. $N = 279$.

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Demographics and ARBI Score Correlations

	Age	Education	Leadership Position
ARBI- Institutional Advocacy	NS	NS	NS
ARBI- Individual Advocacy	NS	NS	NS
ARBI- Awareness of Racism	-.128*	.171**	NS
ARBI- Total	NS	.131*	NS

Note. * = $p < .05$, ** = $p < .01$, NS = not statistically significant. $N = 280$.

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t-Test Analysis with Education with ARBI Scores

	Education						
	Bachelor's Degree		Graduate Degree		t(278)	p	d
	M	SD	M	SD			
Institutional Advocacy	2.75	.73	3.04	.76	-2.33	.020*	.75
Individual Advocacy	3.66	.62	3.77	.61	-1.06	.287	.61
Awareness of Racism	3.34	1.0	3.78	.87	-3.03	.003*	.89
ARBI- Total	3.37	.66	3.61	.62	-2.39	.017*	.62

Note. * = statistically significant. $N = 280$.

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ANOVA with Age and ARBI Scores

Age

		Sum of Squares	df	Mean Square	F
Awareness of Racism	Between Groups	11.97	4	2.99	3.75*
	Within Groups	219.35	275	.798	
	Total	231.33	279		

		Sum of Squares	df	Mean Square	F
Total ARBI Score	Between Groups	3.79	4	.950	2.40*
	Within Groups	108.411	275	.394	
	Total	112.21	279		

Note. * = $p < .05$, ** = $p < .01$.

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LSD Post-Hoc Test with Age and ARBI Scores

Age					
				95% CI	
	Comparisons	Mean Difference	Std. Error	Lower Bound	**Upper Bound**
Awareness of Racism	>34 vs 45-54	.62	.18	.25	**.99**
	>34 vs 55-64	.52	.17	.18	**.87**
Total ARBI	>34 vs 45-54	.30	.13	.04	**.56**
	>34 vs 55-64	.31	.12	.07	**.56**
Institutional Advocacy	65+ vs 35-44	.30	.14	.01	**.58**
	65+ vs 45-54	.37	.15	.06	**.68**
	65+ vs 55-64	**.33**	**.14**	**.04**	**.62**

Correlations Between Education, Age, and Leadership Position with Individual ARBI Questions

	Education	Age	Leadership Position
I give money to organizations working against racism and discrimination	.145**	NS	NS
I often speak to my friends about the problem of racism in the US and what we can do about it.	.122*	NS	NS
It bothers me that my country has yet to acknowledge the impact of slavery.	.141**		NS
The US should offer some type of payment to the descendants of slaves.	.162**	-.138*	NS
Because of racism in the US, Blacks do not have the same educational opportunities compared to Whites.	.172**	-.174**	NS
The police unfairly target Black men and Latinos.	.160**	NS	NS
I interrupt racist conversations and jokes when I hear my friends talking that way.	NS	NS	-.137*
Within the US, racism is largely perpetuated by the White racial majority.	NS	-.122*	NS

Note. * = $p < .05$, ** = $p < .01$, NS = not statistically significant. $N = 280$.

Discussion and Conclusions

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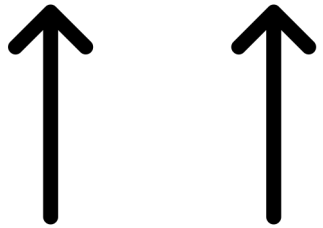
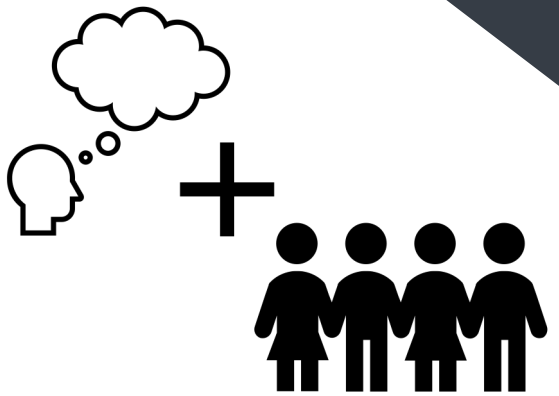
Education and Antiracism



As education increased, ARBI scores increased

Can communicate a less prejudiced response



Results suggest connection with thoughts and actions

We don’t know WHY and HOW education is a predictor.

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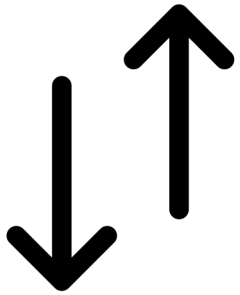
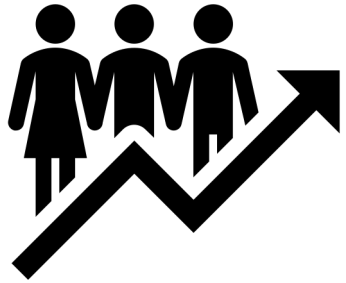
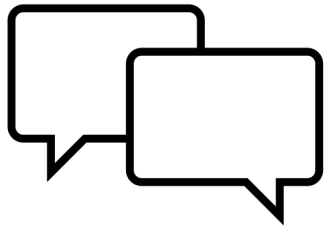
Age and Leadership



As age decreased, ARBI scores increased



Willing to claim and and understand white privilege



Leaders less willing to interrupt racism but highest response advancing health equity

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Strengths and Limitations

Strengths:

- Only study examining antiracism and public health/oral health in a quantitative manner
- Exploratory research can be used as foundation for future research
- Points to specific attitudes and behaviors that can be used for antiracist intervention or curricula

Limitations:

- Socially desirable responding
- ARBI was not specific to health professions
- Highly homogenous sample may limit some generalizability of results

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Recommendations

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WE NEED MORE DIVERSE RESEARCH INSTRUMENTS

WE NEED TO MEASURE ANTIRACISM IN HEALTH

WE NEED MORE RESEARCH

WE NEED ANTIRACIST PRAXIS

QUESTIONS

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