

Maori-Pakeha Health Disparities

Can Treaty Settlements Reverse the Impacts of Racism?

Prepared by

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Public sector

Department of Internal Affairs, Department of Police, Department of Prime Minister and Cabinet, Department of Social Welfare, Environmental Risk Management Authority, Ministry for the Environment, Ministry of Education, Ministry of Foreign Affairs and Trade, Ministry of Health, Ministry of Justice, Ministry of Research, Science and Technology, State Services Commission and The Treasury.

Prologue

The somewhat provocative topic of this work represents the confluence of four factors:

1. The observation of strong parallels between black-white disparities in the United States and Maori-Pakeha disparities in New Zealand in terms of health status, educational attainment, income, employment status and representation in correctional facilities (treatment by the justice system).
2. My work in the United States on the impacts of racism on health.
3. My analysis that intervention at the level of institutionalised racism is necessary in order to reverse the detrimental impacts of racism on a society.
4. My guess from half a world away that treaty settlements (under the Treaty of Waitangi) represented intervention at the level of institutionalised racism.

Chapter One of this report summarises the work I set out to do. Chapter Two presents my perspectives after eight months on the question: “Maori-Pakeha health disparities: can treaty settlements reverse the impacts of racism?” Chapter Three presents a new perspective on looking at health status by socio-economic status that I developed while working at the Ministry of Health. Chapter Four presents my views on the similarities and differences between the African-American and New Zealand Maori experiences.

Appendices at the end of the document include the text of the Treaty of Waitangi in both Maori and English, a draft proposal for reparations to African-Americans, a list of presentations that I made as an Ian Axford Fellow and a list of the media coverage of my work in New Zealand.

It was a tremendous privilege for me to be able to live and learn in New Zealand for eight months (14 January 1999 through 16 September 1999). I never could have learned what I did or grown the way I did without being here.

Chapter 1: Description of programme

This chapter contains my “description of programme” that was submitted to my mentor, Ria Earp, Deputy Director-General of the Ministry of Health’s Maori Health Branch (Te Kete Hauora) in April 1999. It outlines my proposed plan of work that was developed after having been at the Ministry for two months.

I was able to accomplish most of the work outlined here through readings, meetings, participation in the work and planning within Te Kete Hauora, secondments with the Waitangi Tribunal and Te Puni Kokiri, attendance at portions of three Waitangi Tribunal hearings (the Wellington Tenth hearing, the Radio Spectrum Management hearing and the Napier Hospital Claim hearing) and original research and interactions with policymakers and scientists at my presentations around the country.

Title of project

Maori-Pakeha health disparities: can treaty settlements reverse the impacts of racism?

Focus of programme

I will examine Maori-Pakeha health disparities and attempts to eliminate these disparities at the policy level. This work will occur in three phases.

The first phase will examine how New Zealand policymakers conceptualise the causes of these disparities and whether racism plays any part in their analyses. The second phase will focus on the history and current status of settlements under the Treaty of Waitangi and their possible role in improving Maori health. The third phase will involve collaborative empirical studies with New Zealand investigators to directly evaluate the impacts of racism and of treaty settlements on Maori health.

Maori health

How does Maori health compare to the health of other groups in New Zealand? What is the role of racism in causing ethnic disparities? What is the impact of current social policy on reducing ethnic disparities?

1. What is the current status of Maori health in both absolute terms and relative to other groups in New Zealand?
2. What are the appropriate indicators for evaluating Maori physical, psychological and social health?
3. What routinely collected data can be used to monitor trends in Maori health? What additional data need to be routinely collected?
4. How does the way in which ethnicity is measured impact on the ability to study trends in Maori health?
5. What social policies are currently aimed at improving Maori health? How is their impact being evaluated?

Racism

Does racism exist in New Zealand? If so, how does it compare to racism in the United States?

1. Does my conceptualisation of racism on three levels – institutionalised, personally-mediated and internalised – apply in the New Zealand context? For example, what is the role of racism in causing differences in socio-economic position between ethnic groups in New Zealand?
2. How do policymakers and politicians conceptualise the basis of Maori-Pakeha health differentials? Does racism have a role in their analyses?
3. Which New Zealand scholars are talking about racism? What measures of racism are being developed for the New Zealand context?
4. What is the general social climate in New Zealand with respect to issues of race and racism? How do New Zealanders who have spent time in the United States compare levels of racism between the two countries?

Treaty settlements

What social and political forces have culminated in the current negotiation of Maori claims under the Treaty of Waitangi?

1. How is the Treaty of Waitangi conceptualised by different constituencies?
2. What levels and forms of political organisation among Maori groups were necessary to bring about treaty negotiations? How was political will mobilised among government officials and the general New Zealand public? How is this political will being sustained or challenged?
3. What are the mechanics of making and settling claims to Maori groups under the Treaty of Waitangi? What structures are in place to make the process orderly? How is the process being challenged?
4. To what extent do the various types of treaty settlements address issues of institutionalised racism? What efforts are underway to ensure full participation of Maori in determining their own futures? What efforts are underway to ensure equity in the distribution of government resources between Maori and other groups?
5. How can the history and mechanics of treaty settlements to Maori groups in New Zealand inform efforts to achieve reparations for African-Americans in the United States?

Collaborative empirical studies

What cross-national studies can be established to elucidate the role of racism in causing ill-health and the roles of structural interventions in ameliorating ill-health?

1. What are the levels of race-consciousness among different ethnic groups in New Zealand? Do responses to my question: “How often do you think about your race?” differ between groups? How do distributions of responses across ethnic groups compare between New Zealand and the United States?
2. What are the impacts of treaty settlements on Maori health? Do these impacts differ by type of settlement, level of redress of institutionalised racism, baseline iwi (tribe) organisation and resources, and region? Do the settlements impact the health of Maori who are not directly benefited?

3. Does my “accelerated ageing hypothesis” have any currency in the New Zealand context to explain Maori-Pakeha health status differentials? What can be learned from parallel analyses of the New Zealand National Nutrition Survey (1996-97) and the United States National Health and Nutrition Examination Survey III (1988-94)?

Mechanics

I am seeking input from placements and people in the following categories:

- Te Puni Kokiri
- Office of Treaty Settlements
- Eru Pomare Centre
- Te Pumanawa Hauora
- Other academic groups (Department of Public Health at the Wellington School of Medicine, Department of Maori Studies at Waikato University, Department of Maori Studies at Victoria University)
- The Prime Minister
- Cabinet Ministers (especially those in the disparities group)
- Directors-General of the various ministries (especially Health, Education, Treasury, Te Puni Kokiri, Social Welfare and the Waitangi Tribunal)
- General management team at the Ministry of Health
- Maori Health Branch at the Ministry of Health
- Maori providers (including those in the Maori Providers Reference Committee)
- Community workers and community activists
- Former Harkness fellows
- General population-based surveys
- Conferences (public health, indigenous peoples, racism, Maori affairs)

During my tenure in New Zealand, I would also like to visit the following geographic areas:

- South Island (Dunedin, Christchurch, Queenstown, Fiordland)
- The east coast of the North Island
- The far north of the North Island
- Auckland
- Rotorua
- Others (Hutt Valley, Lake Taupo area)
- Australia
- Fiji
- Samoa

I welcome the opportunity to present my analyses of race and racism, my accelerated ageing hypothesis and the findings emerging from my Ian Axford Fellowship at academic and public fora.

Chapter 2: Racism, Maori health and the Treaty of Waitangi: my perspective after eight months

This chapter contains the annotated slides from my talk entitled: “Maori-Pakeha health disparities: can treaty settlements reverse the impacts of racism?”

This material was initially presented at the Ian Axford Fellows’ report evening held at the National Library in Wellington on 4 August 1999. The talk was received with great interest and I was subsequently invited to present it to the following organisations:

- Te Wananga o Raukawa
- Ministry of Women’s Affairs
- Social Policy Agency of the Department of Social Welfare
- Mokai Marae in Wellington
- School of Maori Studies at Massey University
- Victoria University Centre for Continuing Education

It contains my provisional answer (after eight months) to the original question I posed on the experience of racism in New Zealand, Maori health and health disparities and settlements under the Treaty of Waitangi.

Maori-Pakeha health disparities:

**can treaty settlements reverse
the impacts of racism?**

the impacts of racism on health.

Placements and contacts

- ◆ Maori Health Branch, Ministry of Health
- ◆ Waitangi Tribunal
- ◆ Te Puni Kokiri

- ◆ Wellington School of Medicine
- ◆ Massey University
- ◆ University of Auckland
- ◆ Te Wananga o Raukawa

Wellington. My mentor is Kia Earp, the Deputy Director-General of the Ministry's Maori Health Branch.

I have also been seconded to the Waitangi Tribunal for three weeks and have sat in on three Waitangi Tribunal claims hearings: the closing Crown arguments of the Wellington Tenth hearing, most of the Radio Spectrum Management Rights hearing and the claimant arguments in the Napier Hospital Closure hearing. I have also been seconded to Te Puni Kokiri. Here I spent time both in the head office and the Wellington regional office and so was able to get out and meet "real people" in addition to bureaucrats.

I have also had significant contact with colleagues at academic institutions including the Wellington School of Medicine (both the Eru Pomare Centre and the Department of Public Health), Massey University (the School of Maori Studies), the University of Auckland (both the Department of Maori and Pacific Health at the Medical School and the Department of Maori Development) and Te Wananga o Raukawa.

So what have I been doing at all of these places? Well, a lot of talking and a lot of listening. I have been organising my questions and learning along three themes.

Three areas of focus

- ◆ Impacts of racism
- ◆ Maori health
- ◆ Treaty of Waitangi

My three areas of focus have been the impacts of racism, Maori health and the Treaty of Waitangi. I will discuss each of these areas in turn and then weave them together to answer the provocative question that I posed at the beginning.

Levels of racism

- ◆ Institutionalised
- ◆ Personally-mediated
- ◆ Internalised

I will start by discussing the impacts of racism on health. I describe racism on three levels: institutionalised, personally-mediated and internalised.

These levels are useful for me as an academic as I try to hypothesise how racism could for example, result in higher blood pressures for blacks than for whites. These levels are also useful for policymakers as they try to think about how to usefully target their interventions. I will describe each of these levels in turn.

I would also like to comment that I realise in New Zealand you no longer talk about “race” but about ethnicity instead. I would just like to say that even though you don’t mention the word “race” any more, doesn’t mean that racism no longer exists in New Zealand.

Institutionalised racism

- ◆ Differential access to the goods, services, and opportunities of society by race
- ◆ Examples
 - Housing, education, employment, income
 - Medical facilities
 - Clean environment
 - Information, resources, voice
- ◆ Explains the association between socio-economic status and race

I define institutionalised racism as differential access to the goods, services and opportunities of society by race. This kind of racism usually has no identifiable perpetrator. It is often manifest as inherited disadvantage.

This is the kind of racism that would be evident to a Martian landing in the United States or indeed here in New Zealand, who would look around at the distribution of housing, education and other goods and services and say: “There is something systematic going on here by ethnicity.”

Institutionalised racism is manifest in material conditions, access to power and societal norms. Examples of institutionalised racism include differential access to sound housing, quality education, employment opportunities and income. These factors are all recognised as being related to health status. Institutionalised racism also manifests in access to medical facilities and a clean environment.

In addition to these material conditions, institutionalised racism manifests in terms of access to power and information (including information about one’s own history), access to resources (both capital resources and organisational resources) and access to voice (that includes representation at decision-making levels and representation in the media).

I am often asked whether what I describe as institutionalised racism isn’t really just socio-economic status. I would like to address that question for a minute. It doesn’t just so happen that black people in the United States are over-represented in poverty while white people are over-represented in wealth. There was the initial historical insult of the enslavement of Africans but you expect that after generations things would even themselves out (similarly with the alienation of land from Maori).

That hasn't happened because of contemporary structural factors that perpetuate the historical injustice. In other words, the contemporary structural factors of institutionalised racism explain the fact that there is an association between socio-economic status and race. It is not a question of whether I am talking about socio-economic status or racism. It is because of institutionalised racism that we observe an association between socio-economic status and race.

Another important aspect of institutionalised racism is that it can be expressed through acts of commission as well as through acts of omission. In fact, institutionalised racism is often manifest as inaction in the face of need.

Personally-mediated racism

- ◆ Differential assumptions about the abilities, motives and intents of others by race
- ◆ Examples
 - Police brutality
 - Physician disrespect
 - Shopkeeper vigilance
 - Waiter indifference
 - Teacher devaluation
- ◆ Prejudice and discrimination

I define personally-mediated racism as differential assumptions about the abilities, motives and intents of others by race, and the differential actions that follow from these assumptions.

This is what most people think of when they hear the word “racism.” It includes prejudice, the different idea, discrimination and the different action. Like institutionalised racism, it can be expressed through acts of commission as well as acts of omission. It can also be intentional as well as unintentional.

Examples of personally-mediated racism that can impact your health include police brutality. In the United States, in addition to an offence called “driving while intoxicated,” there seems to be another offence called “driving while black.” Black male drivers are especially vulnerable to being pulled over by police officers and if it appears that they are resisting arrest, they are likely to be hit over the head with a billy club or worse. This certainly affects their health.

Other examples include physician disrespect, which can be as subtle as a physician not giving a patient of colour the full range of treatment options because she feels that they can’t understand, won’t accept, can’t afford, et cetera. Or it can be as blatant as sterilisation abuse.

I had a patient, an African-American woman in her sixties, who had grown up in the southern United States and had had a hysterectomy at age 16 for no indication except that her white physician felt that she didn’t need her uterus.

Other examples include shopkeeper vigilance. This is when you walk in a store and the clerk is right on you trying to make sure that you don’t steal. Indeed, after only a week in New Zealand I came home and exclaimed to my husband how nice it was to be able

to just go in a store and shop instead of being followed around. And my husband said that he had noticed the same thing! It wasn't that we had planned to compare notes on that one aspect of life, but the difference for us was so great that we both commented on it. I may still be followed around in shops here but it is to such a lesser degree than in the States that I don't even notice it. Things like shopkeeper vigilance and waiter indifference, when you don't get prompt or courteous service, affect your health because they are small daily stresses whose toll accumulates over time.

Teacher devaluation is a particularly subtle but potent form of personally-mediated racism. When a teacher thinks that a brown child can't learn or interprets a child's question at a low level of sophistication as opposed to a high level of sophistication, that teacher puts the child on a track of lowered self-expectations that translate into lowered performance and a life trajectory that doesn't fulfil the child's full potential.

Internalised racism

- ◆ Acceptance by the stigmatised races of negative messages about our own abilities and intrinsic worth
- ◆ Examples
 - Self-devaluation
 - White man's ice is colder
 - Resignation, helplessness, hopelessness
- ◆ Not believing in others who look like us
- ◆ Accepting limitations to our full humanity

I have described institutionalised and personally-mediated racism. The third level of racism that I describe is internalised racism.

I define internalised racism as acceptance by members of the stigmatised races of negative messages about our own abilities and intrinsic worth. We accept the lower value that is put on us by society and end up with self-devaluation. We feel that we can't be a doctor, can't be a judge and shouldn't even try to succeed in areas that have been defined by society as white domains (such as the violin or ballet).

This next item, the “white man’s ice is colder syndrome,” is an expression that comes from my parents’ generation. At the time (and for many still today), if you were black and you wanted a doctor, you would choose a white doctor over a black doctor. If you wanted a lawyer, you would choose a white lawyer over a black lawyer. Indeed, if you wanted ice, you would pick the white man’s ice over the black man’s ice because the white man’s ice is colder. It is about deeply believing that all things white are superior.

Internalised racism also manifests as resignation, helplessness and hopelessness. This often translates as fratricide, that is so-called “black on black crime,” as well as destructive health behaviours including smoking and the abuse of alcohol and other drugs.

Internalised racism is not believing in others who look like us because we don’t believe in ourselves. Fundamentally, it is about accepting the limitations to our own full humanity and accepting the confines of the box into which we have been put.

Levels of racism

A gardener's tale

When my husband and I bought a house in Baltimore, we had two large flower boxes on the front porch. When the spring came we decided to grow flowers in these boxes.

One of the flower boxes was empty so we bought potting soil to fill it. We did nothing to the soil in the other flower box, assuming that it was fine. Then we planted seeds from a single seed packet into the two boxes. The seeds that were sown into the new potting soil quickly sprang up and flourished! All of the seeds sprouted, the most vital among them towering strong and tall while even the weak seeds among them made it to a middling height.

However, the flowers planted into the old soil did not fare so well. Fewer seeds sprouted with the strong among them only making it to a middling height, while the weak among them died. It turns out that the old soil was poor and rocky in contrast to the new potting soil that was rich and fertile. The difference in yield and appearance in the two flower boxes was a vivid, real-life illustration of the importance of environment.

So now I will use this image of the two flower boxes to illustrate the three levels of racism (institutionalised, personally-mediated and internalised).

Let's imagine a gardener with two flower boxes, one filled with rich and fertile soil and the other filled with poor and rocky soil. This gardener has two packets of flower seed for the same kind of flower except that one packet produces pink flowers and the other packet produces red flowers.

The gardener prefers red over pink so she plants the red seed in the rich and fertile soil and the pink seed in the poor and rocky soil. And sure enough, what we described above happened. All of the red flowers grow up and flourish with the fittest growing tall and strong and even the weakest making it to a middling height. But in the box with

the poor and rocky soil things look different, scrawnier. The weak among the pink seeds don't even make it and the strongest among them only make it to a middling height. The flowers in these two boxes go to seed, dropping their seed into the same soil in which they are growing. And year after year, the same thing happens.

Ten years later the gardener comes to survey her garden. She compares the two boxes and thinks: "I was right to prefer red over pink! Look how beautiful the red flower box looks and how poor and pitiful the pink box looks."

We will interrupt our story here to say that this first part illustrates some important aspects of institutionalised racism. There is the initial historical insult of separating the seed into the two different types of soil, followed by the act of omission in not recognising the difference in the soil or in not addressing that difference if it is recognised. Indeed, the normative aspects of institutionalised racism are illustrated by the initial preference of the gardener for red over pink and her assumption that red was better than pink may have contributed to her blindness about the difference between the soils.

So where is personally-mediated racism in this gardener's tale? That is when the gardener, disdaining the pink flowers because they look poor and scraggly, plucks the pink blossoms off before they can even go to seed. Or when she plucks out a pink seed that has been blown over into the rich soil before it can establish itself.

And where is the internalised racism in this tale? That is when a bee comes along and the pink flowers say: "Stop! Don't bring me any of that pink pollen – I prefer the red!" The pink flowers have internalised that red is better than pink because they look across at the other flower box and see the red flowers strong and flourishing.

So what are we to do if we want to put things right in this garden? Well, we could start with the internalised racism and tell the pink flowers that "pink is beautiful!" That might make them feel a bit better but it will do little to change the conditions in which they live.

Or we could address personally-mediated racism by conducting workshops with the gardener to convince her not to pluck the pink blossoms before they have had a chance to go to seed. Yet even if she is convinced to stop plucking the pink flowers we have still done little to address the poor and rocky condition of the soil in which they live.

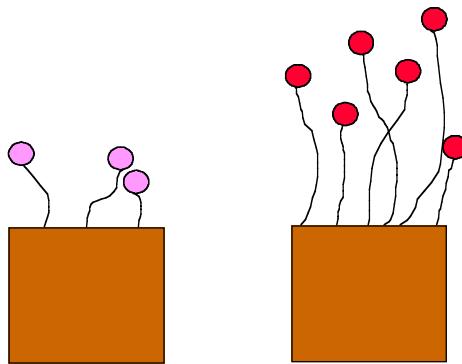
What we really have to do to set things right in this garden is to address the institutionalised racism. We have to break down the boxes and mix up the soil or even leave the two boxes separate but fertilise the poor and rocky soil until it is as rich as the other soil.

When we do that the pink flowers will grow up at least as strong as the red (and perhaps stronger as they have been selected for survival). And when they do, the pink flowers will no longer think that red pollen is better than pink because they will look over at red and see that they are equally strong and beautiful.

And although the original gardener may have to go to her grave preferring red over pink, the gardener's children who grow up seeing that pink and red are equally beautiful will be unlikely to develop the same prejudicial attitudes as the previous generation.

This story illustrates the relationship between the three levels of racism and the fact that institutionalised racism is the most fundamental of the three levels. It also illustrates that once institutionalised racism is addressed the other levels of racism will cure themselves. Many questions arise from this simple story and I invite you to raise them now as we open our discussion.

Institutionalised racism



- ◆ Initial historical insult
- ◆ Structural barriers
- ◆ Inaction in face of need
- ◆ Societal norms
- ◆ Biological determinism
- ◆ Unearned privilege

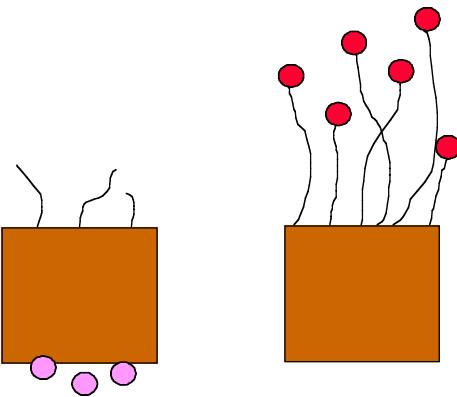
I have culled a few of the lessons from the story on these next few slides. Here you see the effects of institutionalised racism with half as many flowers in the poor soil as in the rich, and the flowers in the poor soil only half as high as the flowers in the rich soil.

The story illustrated the role of the initial historical insult (separation of the flowers into different types of soil) that is perpetuated by contemporary structural factors (the boxes).

In this case there is inaction in the face of need that is supported by societal norms (the preference for red). Indeed, ideas of biological determinism (that pink were inherently inferior to red) may have been operating to prevent the gardener from even questioning why the pink flowers were doing more poorly than the red.

Finally, another aspect of institutionalised racism is the taking for granted of unearned privilege. That is, the red flowers are feeling pretty fine and deserving in their splendour without realising that they are benefiting from richer soil.

Personally-mediated racism

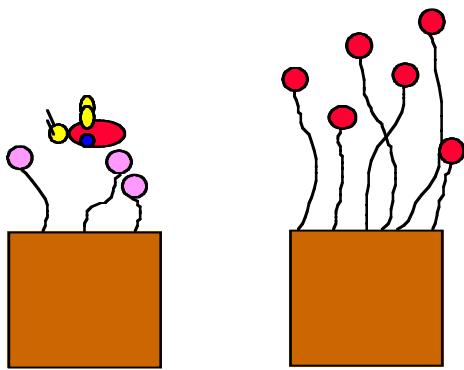


- ◆ Intentional
- ◆ Unintentional
- ◆ Acts of commission
- ◆ Acts of omission
- ◆ Maintains structural barriers
- ◆ Condoned by societal norms

With regard to personally-mediated racism you will notice that the pink blossoms have been plucked and discarded. Personally-mediated racism can be intentional (as in the plucking of the blossoms) or unintentional (as in picking up pink seed that has fallen to the concrete and putting it back in the poor soil). It includes acts of commission as well as acts of omission.

Indeed sometimes the interface between personally-mediated and institutionalised racism is blurred. People maintain the structural barriers or fail to act, thereby supporting institutionalised racism. Their personally-mediated acts of racism are allowed to continue because they are supported by institutions and condoned by societal norms.

Internalised racism

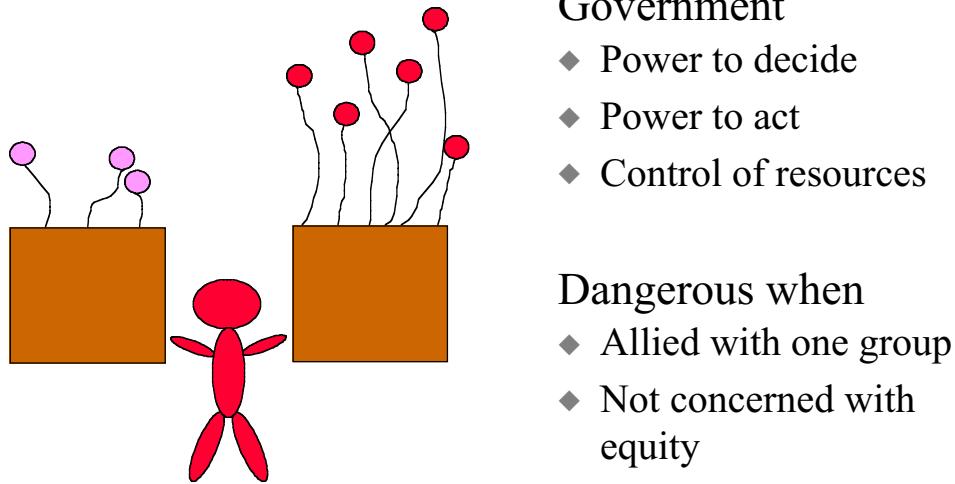


- ◆ Reflects systems of privilege
- ◆ Reflects societal values
- ◆ Erodes individual sense of value
- ◆ Undermines collective action

I am particularly proud of this picture. Do you recognise the bee? (Buzzy Bee.) Look at the pink flower shrinking back. Internalised racism is not something intrinsic but reflects systems of privilege (the difference in soils) and reflects societal values (the preference for red).

Internalised racism erodes individual sense of value and undermines collective action because the pink flowers are so busy wanting to be red that they don't come together to create pink solutions.

Who is the gardener?



But there is a very important question that I have not raised so far. Who is the gardener? It is the one with agency and the control of resources and in this country that is the government.

It is particularly dangerous when the gardener is allied with one group over others (you see I have coloured the gardener red, explaining the preference for red flowers). It is also dangerous when the gardener is not concerned with equity. If she had been, she would have asked the question why the pink flowers were not faring so well. Just asking the question would have led her to seek solutions.

So that is the end of my story on levels of racism. The story was meant to illustrate the different levels of racism and how they are related and to highlight that institutionalised racism is the most fundamental level. If you want to make real change in the garden you have to at least deal with the institutionalised racism, even as you might also want to address the other two levels. When you do address the institutionalised racism, the other levels will fix themselves over time.

How often do you think about your race?

- Never
- Once a year
- Once a month
- Once a week
- Once a day
- Once an hour
- Constantly

I distributed a brief questionnaire at the beginning of this talk. I would like you to take a few seconds to answer the question: “How often do you think about your race?” I know that here in New Zealand you do not speak about “race” any more, so you can interpret the question as how often do you think about your ethnicity. (I have kept the wording as “race” to allow comparability with data from the United States, since in the US “race” and ethnicity have quite different meanings.)

Now I would like you to raise your hands when I call out the response you checked. How often do you think about your race? Who said never? Once a year? Once a month? Once a week? Once a day? Once an hour? Constantly?

The first thing that surprises many people when I do this exercise is that not everyone said the same thing that you did. It is especially astonishing to those that said “never” that some people think about their race constantly and vice versa, because never and constantly are an eternity away from one another. It is also striking in the United States that you tend to get a colour gradient in responses to this question.

Results from the United States

My “race-consciousness” question was included on the 1997 Black Women’s Health Study (Lynn Rosenberg and Lucille Adams-Campbell, principal investigators) and on the 1995 Nurses’ Health Study II (Walter Willett, principal investigator). The Black Women’s Health Study includes a national sample of Essence magazine. The Nurses’ Health Study II includes a sample of registered nurses from 11 American states.

The responses are displayed from “never” to “constantly.” Let’s look at the results as shown on the following slide.

The first thing I notice is that the distribution of responses for the black women from the BWHS and black women from the NHSII are almost identical, although the two surveys were done two years apart and included different women. The second thing I notice is that the distribution for the black women is very different from the distribution for the white women. Let’s take a closer look at those distributions.

More than 50% of the white women say that they never think about their race, down to 0.3% of white women who say that they constantly think about their race. It is interesting that although this question is only one question on a long questionnaire about oral contraceptive use, cancer incidence and diet, many of the 0.3% of white women who constantly think about their race enclosed letters with their survey forms explaining why: “I am married to a black man” or “I have black children,” et cetera.

On the other hand more than 20% of black women say that they constantly think about their race and none of them wrote letters explaining why that was. It was a given. If you add up those who think about their race once a day, once an hour or constantly, more than 50% of black women think about their race at least once a day. That is in marked contrast to the white women, 50% of whom never think about their race.

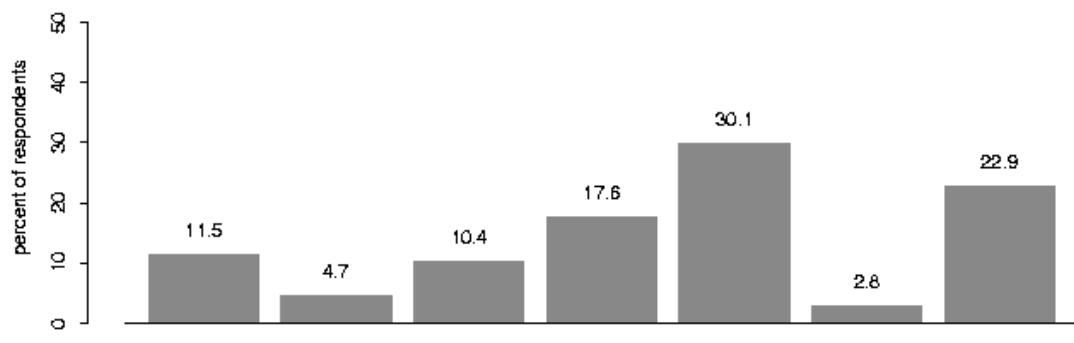
I was quite surprised to see on these surveys that 11% of black women say they never

have ever had a black person raise their hand that they never think about their race. I hypothesise that these 11% of black women are living in highly segregated settings, which in the United States also tend to be poor. Although they are not thinking about their race they may be constantly dealing with the effects of institutionalised racism.

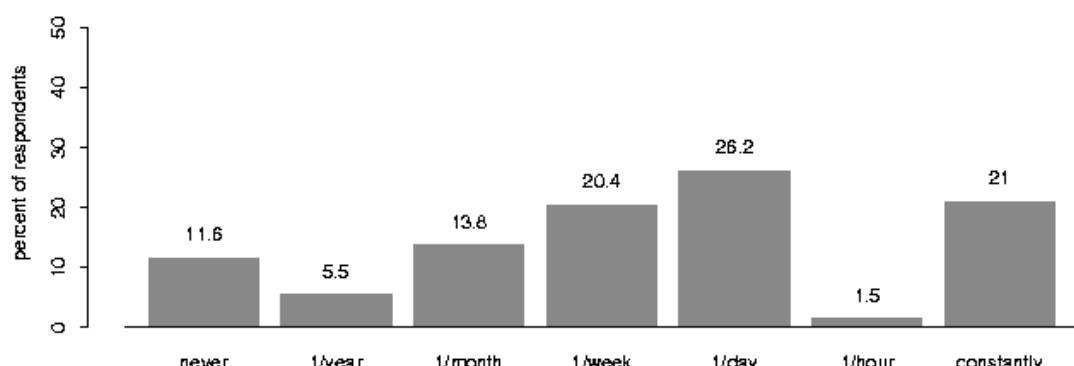
In fact, I initially developed this question as a measure of the psychological impact of chronic racial stigmatisation on the individual level. However, it seems to me now that the distribution of responses also conveys extremely useful information. They measure the racial climate for a given group at a given time and place, and differences over time can be quite informative.

It seems for example that between 1995 and 1997 in the United States there was little change in the racial climate for black women. It is also interesting to compare the distributions of responses between different groups. This reflects the differential impact of race-consciousness in the society and may say something about racial polarisation.

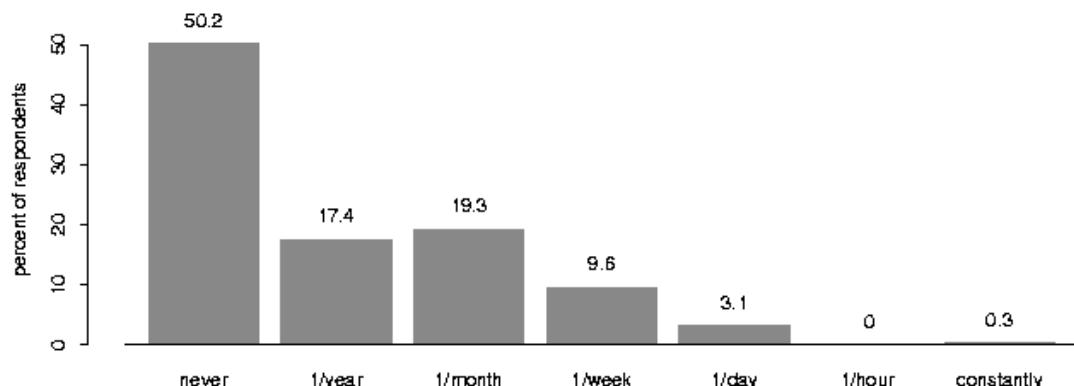
How often do you think about your race?



Black women (Black Women's Health Study, n = 31,338)



Black women (Nurses' Health Study II, n = 1,292)

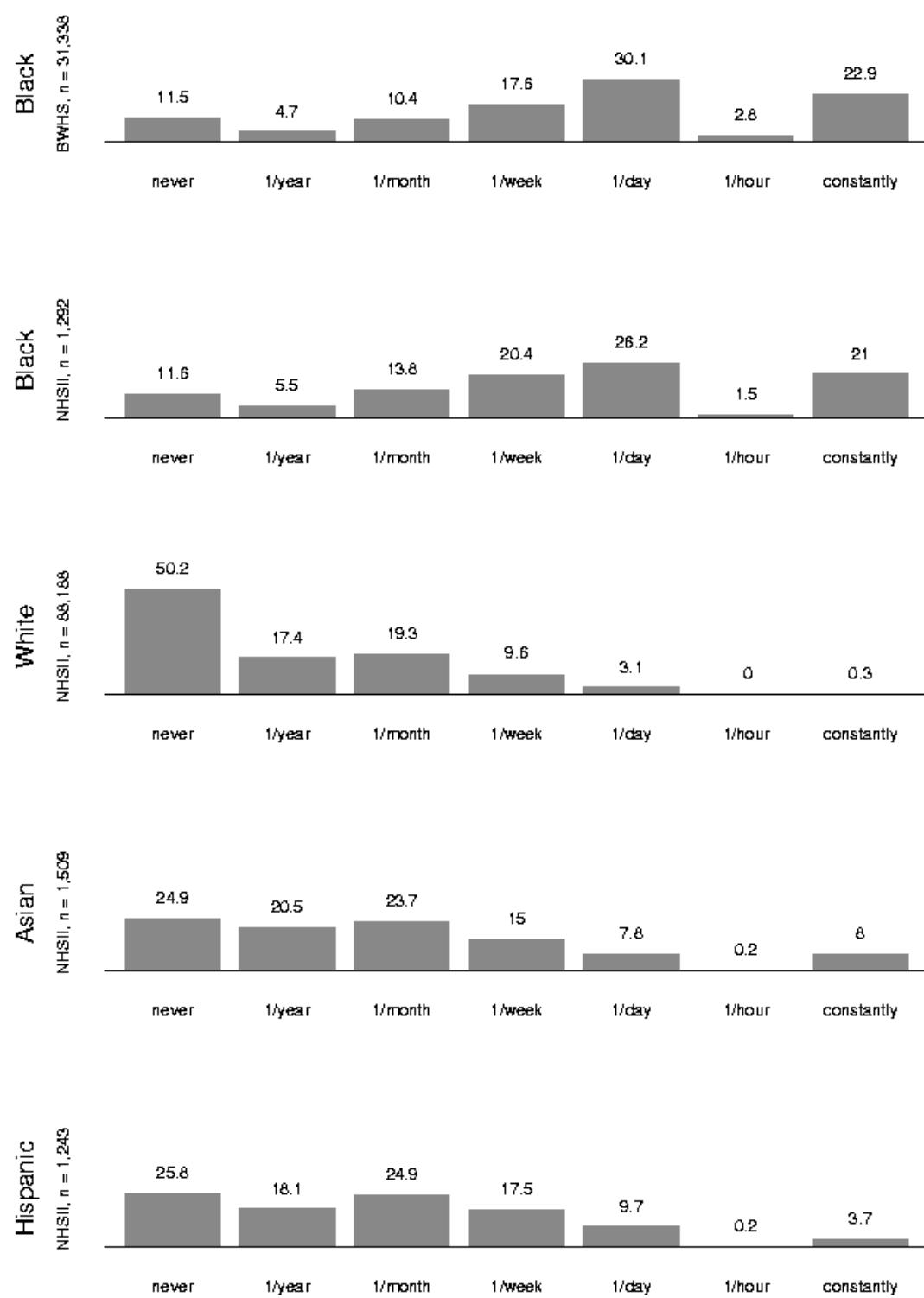


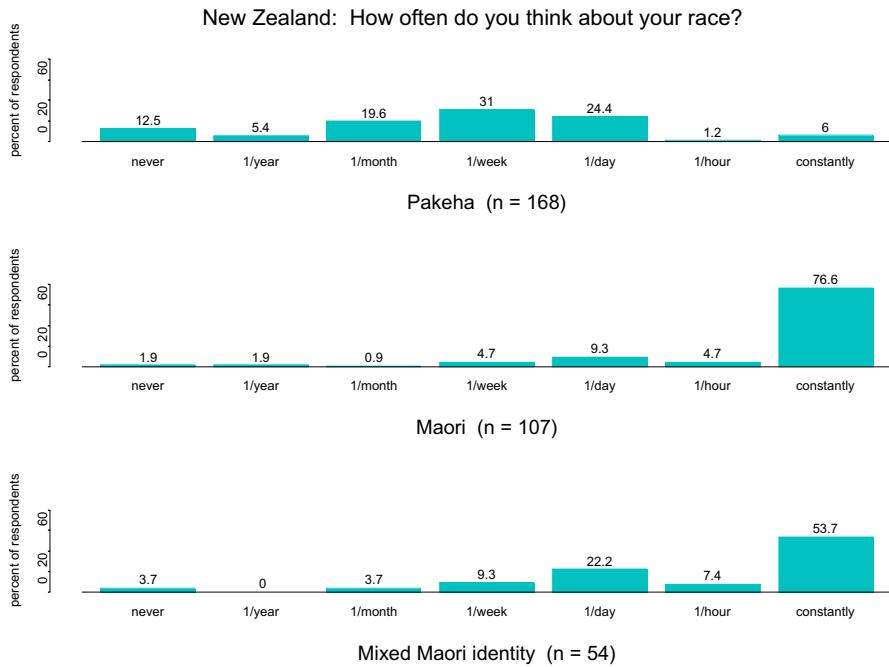
White women (Nurses' Health Study II, n = 88,188)

Results from the United States

On the next slide I show you the same black women from the BWHS, the black women from the NHSII and the white women from the NHSII. But I also included the Asian and Hispanic women from the NHSII. Notice how their distribution of responses is between that of black women and that of white women.

How often do you think about your race?





So now I will show you data from New Zealand. These responses come from people who have come to hear me speak. The first group includes people who are usually classified as Pakeha and also classify themselves as Pakeha. The second group includes people who are usually classified as Maori and classify themselves as Maori. The third group may be sometimes classified as Pakeha but classify themselves as Maori, or otherwise have some sort of mixed Maori identity. So let's look at the results.

More than 75% of the Maori-Maori group reports thinking about their race constantly. That is much more frequently than was reported by the black women in the United States. The mixed Maori identity group has a distribution quite similar to the Maori-Maori group. The Pakeha group has quite a different distribution from the Maori group but it is also markedly different from the white women in the United States. Note that only roughly 10% report that they never think about their race and the modal response is once a week.

I think the difference between those of European descent in New Zealand and those of European descent in the United States is that Pakeha in New Zealand have a label applied to them that they did not chose themselves. That is, they have been named by others.

Many white people in the United States do not even consider that they have a race. They consider themselves "normal," "human" or "universal." In fact, one white respondent to the Nurses' Health Study II sent in a note saying: "I don't run," in response to the question: "How often do you think about your race?" She didn't even understand the question because she did not think of herself as having a race.

Maori health

- ◆ Causes of disparities
- ◆ Levels of health intervention
- ◆ Accelerated ageing hypothesis

I have now completed my discussion of the impacts of racism on health and will shift to my second focus, Maori health and Maori health policy.

I will briefly touch on three topics in this area: how the causes of Maori-Pakeha health disparities are conceptualised; a model for understanding different levels of health intervention and the accelerated ageing hypothesis. This is a hypothesis about the basis of black-white health disparities that I have brought with me from the United States and tested for its relevance to the situation in New Zealand.

Causes of disparities

- ◆ Socio-economic status
 - Not an explanation
 - Symptom of contemporary structural factors which perpetuate historical injustices
- ◆ Loss of self-determination
 - Treaty partnership not being honoured
- ◆ Devaluation by the larger society
 - Marginalisation

When I first arrived in New Zealand, I asked people what they thought were the causes of Maori-Pakeha health disparities.

The most frequent answer I got was “socio-economic status.” As I alluded to earlier during my discussion of institutionalised racism, I don’t think we can accept socio-economic status as an explanation of ethnic differences in health status unless we are prepared to accept as a given the unequal distribution of wealth and poverty by ethnicity.

Instead, we should view socio-economic status as a symptom of contemporary structural factors that perpetuate historical injustices. And if we are to do anything about the disparities we need to address the underlying structures that cause Maori to be over-represented in poverty while Pakeha are over-represented in wealth.

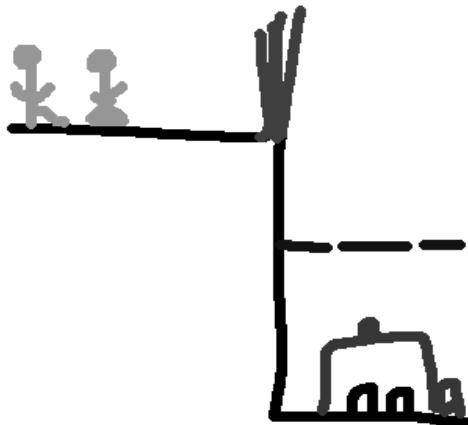
(Fortunately, the other explanations that are rampant in the United States for race-associated differences in health outcomes are not being brought up much here. Those are genetics and culture. The genetic argument is a particularly pernicious one because if you think a group is at higher risk of poor health because of their genes, there is little you can do for them. However, there was a lead article in a recent issue of the New Zealand Medical Journal calling for more research into the genetic basis of health differences between Europeans and Polynesians.)

Another cause of Maori-Pakeha health disparities that has been suggested by Maori is the loss of self-determination. In particular, it is viewed that the partnership called for by the Treaty of Waitangi is not being honoured. That is, Maori are not centrally involved in decision-making, acting and controlling resources on their own behalf.

Finally, another cause that occurs to me out of my experience as an African-American woman is the devaluation of Maori by the larger society. That is, Maori have been marginalised and are not viewed as being central to the progress of New Zealand as a nation. Their contributions are not valued or incorporated into the national plan for progress.

These latter two causes, as well as the structural factors that perpetuate socio-economic status disparities by ethnicity are important areas for future research and action.

Levels of health intervention



The second topic I would like to address relating to Maori health is how to conceptualise possible levels of health intervention. When I first showed this picture to my husband he couldn't make out what I was trying to draw. He asked: "Is it a tree with a building underneath?" Who can guess what I am trying to represent here? Right, this is the ambulance at the bottom of the cliff! That is a metaphor we are familiar with but I want to extend that metaphor to consider other possible levels of health intervention.

Here we have a trampoline or a net halfway down the cliff. This is intended to catch people after they have fallen but before they impact the bottom to protect them from being hurt too badly. If this is a trampoline you have the problem of people just bouncing up and down on it without being able to get back up to the top of the cliff. I suppose you also need to build a ladder back up. If this is a net you have the problem of some people falling through the holes.

Here we have a strong fence built at the edge of the cliff. This is intended to prevent people from falling. Depending on the pressure against it, it might need to be very strong.

Here I have drawn some people to represent the community living at the cliff face. I would like to suggest that a fourth level of health intervention would be to move the centre of the community away from the cliff face. This would reduce the pressure on a fence and reduce the numbers coming close enough to the edge of the cliff to fall off.

This little figure is useful to at least two audiences. It is certainly useful for communities who want to have a say in how health resources are spent. A community could consider the options and decide, for example, that it wanted to have an ambulance on call and build a strong fence at the edge of the cliff, but that it wanted to spend most of its resources moving the community away from the cliff face.

The second audience who may find this figure useful are policymakers who are considering at what level their policy recommendations intervene.

Levels of health intervention

- ◆ Ambulance at the bottom of the cliff
 - Curative health services
- ◆ Trampoline (or net) halfway down
 - Strengthening Families
- ◆ Fence at the edge of the cliff
 - Family Start
- ◆ Movement of population from the cliff face
 - Maori development

This next slide shows my start at classifying some health strategies according to levels of health intervention. For example, I consider the ambulance at the bottom of the cliff to include curative health services. The trampoline (or net) halfway down includes Strengthening Families, which identifies families who are already in trouble and tries to minimise the hurt. The fence at the edge of the cliff includes Family Start, which identifies families of at-risk children before there have been any bad outcomes. And movement of the population from the cliff face includes Maori development and community development in general.

Although some may argue with the classification of particular programmes at particular levels, policymakers should find that doing this exercise points out whether there is a broad spread of interventions being attempted or whether all interventions cluster at a particular level. And communities and policymakers can decide together on an optimal mix of interventions.

Accelerated ageing hypothesis

- ◆ Black-white differences in health outcomes in the United States are due to accelerated ageing of the black population compared to the white population.

- ◆ Accelerated ageing of the black population in the United States is due to racism.

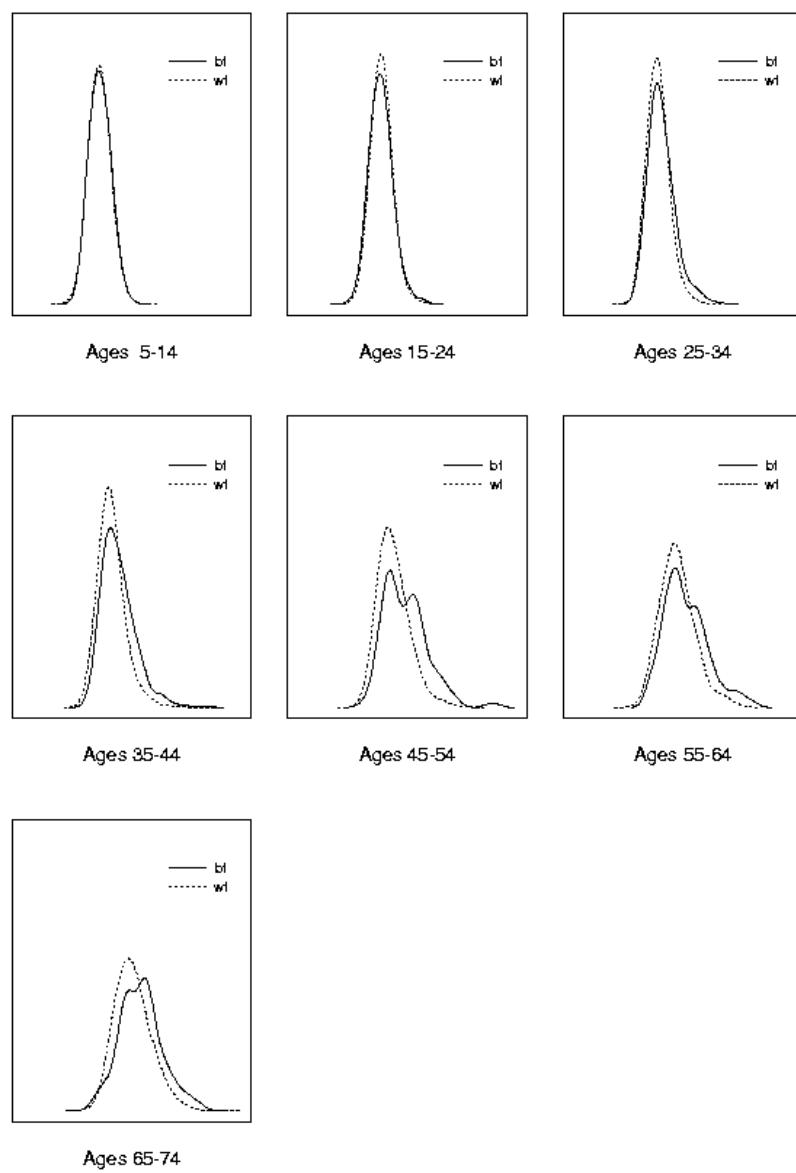
Now I would like to turn to the third topic in my discussion of Maori health, which is the testing of my accelerated ageing hypothesis in the New Zealand context. I have brought the accelerated ageing hypothesis with me from the United States. It has evolved out of my work comparing black and white distributions of systolic blood pressure.

The accelerated ageing hypothesis has two parts. The first is that black-white differences in health outcomes in the United States are due to accelerated ageing of the black population compared to the white population. I have very strong evidence of this first part with regard to systolic blood pressure that I will share with you today.

The second part of the hypothesis is that accelerated ageing of the black population in the United States is due to racism. I am currently developing measures of racism at three levels (institutionalised, personally-mediated, and internalised) in order to test this part of the hypothesis.

I will now show you some of my comparisons of black and white systolic blood pressure distributions.

Figure 1. Kernel density estimates, crude



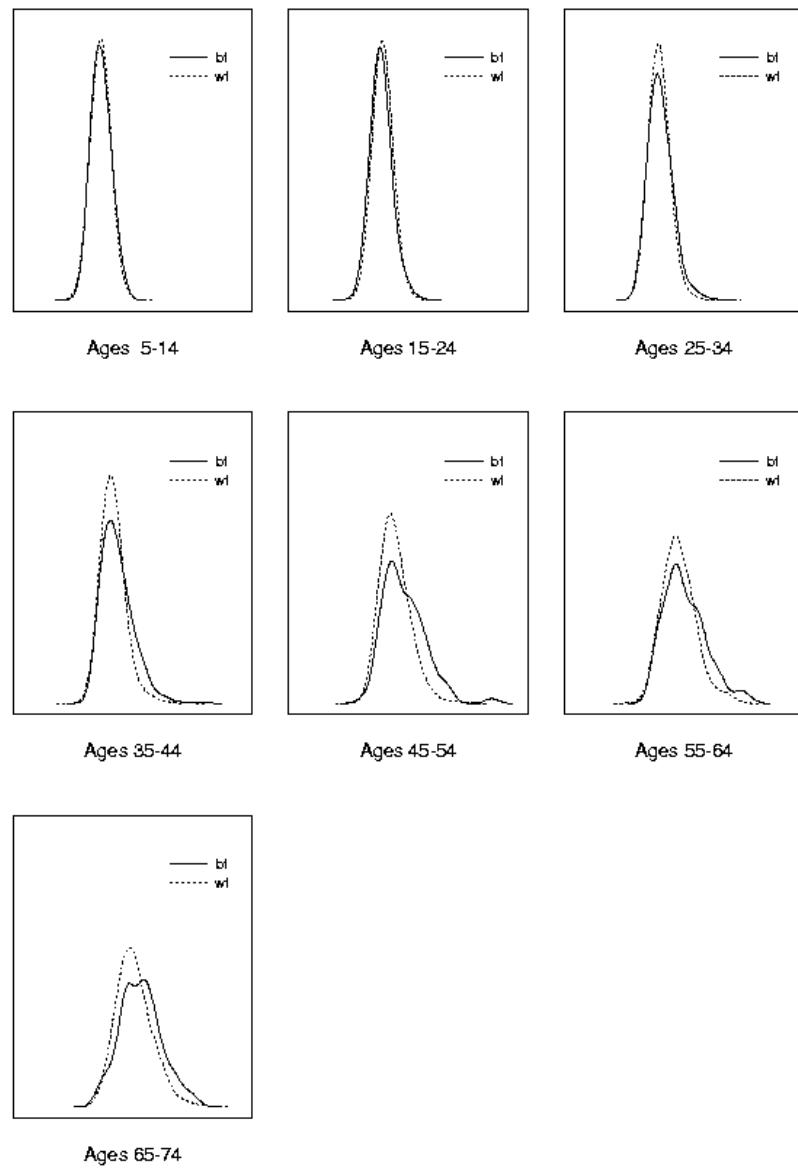
The slide above shows kernel density estimates of crude systolic blood pressure. On each plot we have systolic blood pressure from 0 to 300mm of mercury on the x-axis and probability on the y-axis. You can think of these kernel density estimates as smoothed histograms.

We have seven little boxes because the data are split up into ten-year age groups, from 5-14 years up through 65-74 years. In each box there are two graphs. The solid line shows systolic blood pressures for black females and the broken line shows systolic blood pressures for white females. So let's take a look at the data.

In the youngest age group, 5-14 year olds, you can hardly tell that there are two plots. The two distributions are virtually identical. But by ages 25-34 years the black distribution is skew to higher values than the white distribution. This continues into middle and older age with the suggestion of a bimodal distribution among black females from ages 45-54 on.

I developed statistical methods, the projection methods, to test whether the differences suggested by pictures like these are statistically significant. For the 5-14 and 15-24 year age groups, the results are not significantly different. However, the black and white distributions are significantly different from ages 25-34 on, with the 25-34 through 55-64 year distributions differing in shape and the 65-74 year distribution differing in spread.

Figure 2. Kernel density estimates, adjusted for body mass index



I initially embarked on the comparison of black and white systolic blood pressure distributions because hypertension is the holy cow of race-associated diseases.

Black-white differences in mean blood pressure and percent hypertensive have been noted in the United States since 1930, yet the basis of these differences remains unexplained. Even after adjustment for body mass index, salt intake, education, income and other factors, there typically remains a black excess in percent hypertension.

This has resulted in scientists in the United States presuming a genetic basis to the difference and investigators have started studying the cation handling of red blood cells and the like.

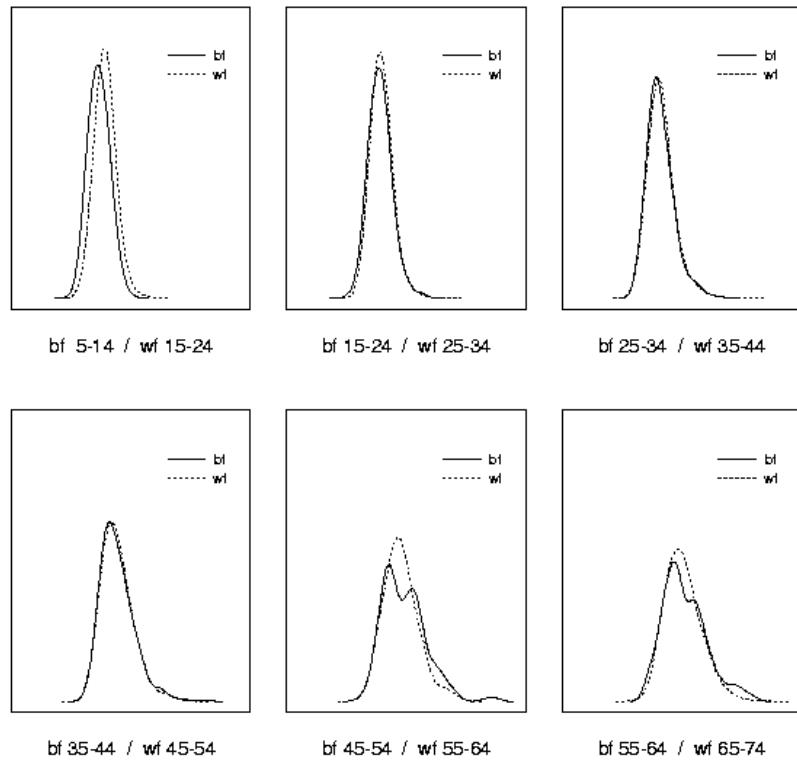
But because of my analysis of race as a social construct, not a biological reality, I wanted to take another look at these differences. I wanted to identify modifiable risk factors that would explain the differences. I chose to look at distributions of blood pressure as opposed to percent beyond a threshold (percent hypertensive) or mean blood pressure. This is because distributions contain information about shape, spread and location, not just location.

The plot above shows systolic blood pressure distributions that have been adjusted for body mass index (using the centrejust methods that I developed). Body mass index is a measure of obesity. I did this adjustment because black women in the United States are heavier compared to white women in the United States and obesity is correlated with hypertension.

The adjustment for body mass index did not take away the differences between the distributions in middle and older ages. In fact, it unmasked a significant difference in the 15-24 year age group. The adjustment does seem to have muted the apparent bimodality of the black distribution in the 45-54 and 55-64 year age groups.

In fact, simultaneous adjustment for body mass index, poverty index and heart rate results in plots similar in appearance to this one.

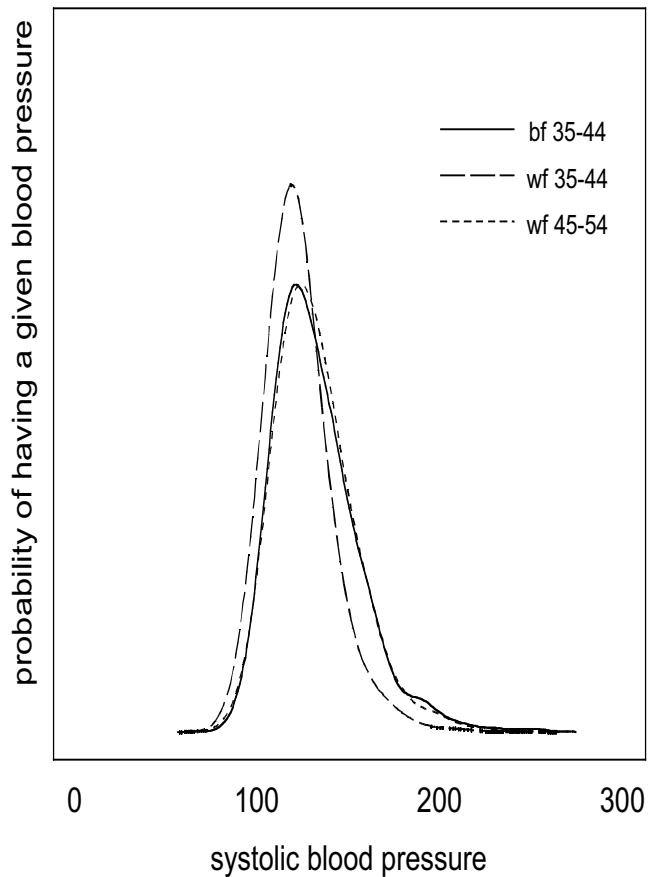
Figure 3. Kernel density estimates, age-shifted analysis



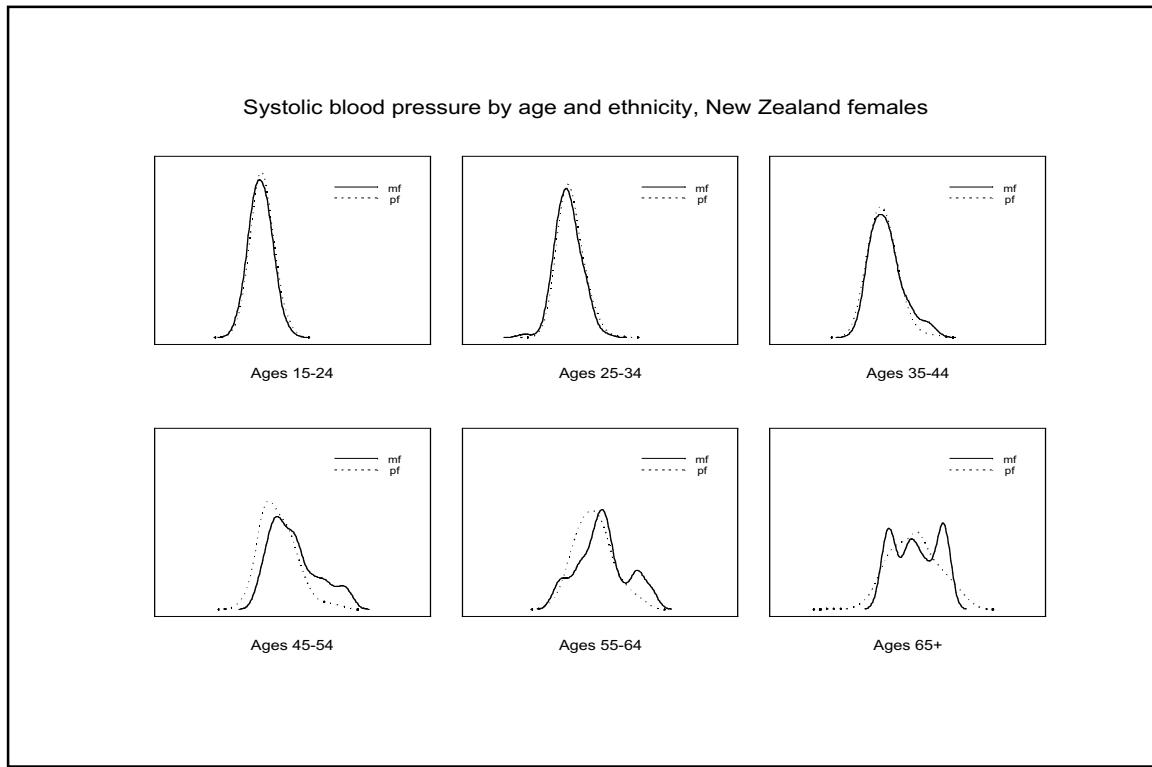
The plot above shows what I describe as my age-shifted analysis. Here I compare the distribution of black women with the distribution of white women who are ten years older. What we see is that for the youngest age group where the same-age comparison showed the distributions to be identical, the age-shifted comparison shows the white distribution at higher levels of blood pressure than the black distribution. This is because in the United States blood pressure tends to increase with age for both black folks and white folks.

But by the time the black women are 25-34 years old their distribution looks identical to that of white women ten years older. The same is true for the next ten-year age group. The blood pressure distribution for black women 45-54 outstrips that of white women ten years older. But by the time we look at the 55-64 year age group the distributions test as the same again. Perhaps the black women with the highest blood pressures die before reaching the ages of 55-64.

Same-age and age-shifted comparisons



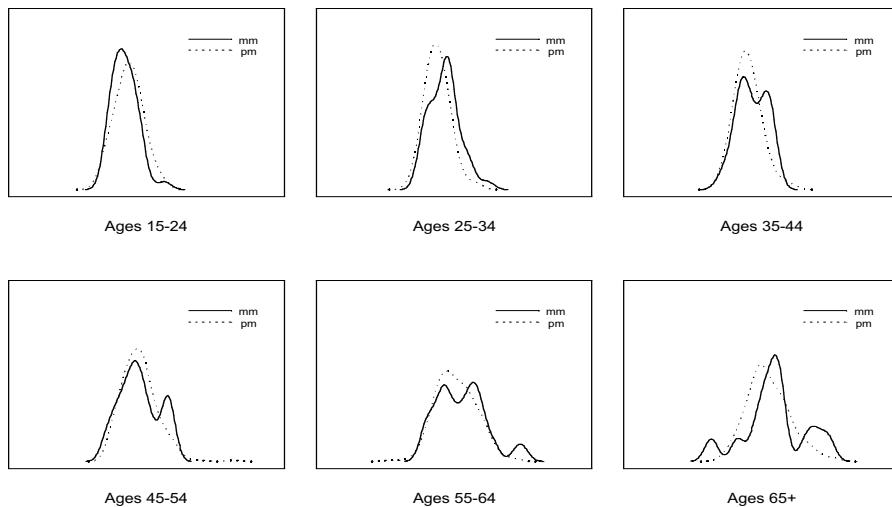
This slide summarises in one picture the main message of my analysis. Here we see in the solid line the systolic blood pressure distribution of black women 35-44 years old, compared to same-age white women in the shaded area, and with white women who are ten years older in the broken line.



I wanted to see if the same phenomenon was happening in New Zealand. I had the opportunity to analyse data from the 1996/97 National Nutrition Survey, an examination survey done on a sub sample of respondents to the New Zealand Health Survey.

Here are pictures comparing systolic blood pressure distributions for Maori females and Pakeha females by ten-year age group. It is interesting that we get some of the same appearance as with the black-white comparison.

Systolic blood pressure by age and ethnicity, New Zealand males



These plots show data for comparing Maori and Pakeha males.

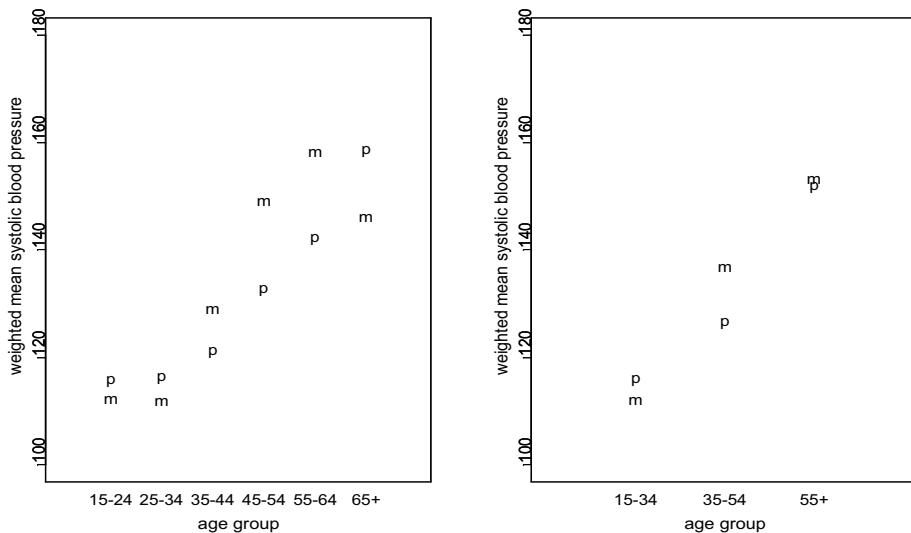
Sample sizes

	mf	pf	mm	pm
15-24	61	204	37	173
25-34	96	379	36	235
35-44	70	370	42	309
45-54	30	277	22	231
55-64	16	227	31	205
65+	10	380	13	263
Total	283	1837	181	1416

However, when I went to test whether the apparent differences were statistically significant I found that I did not have the statistical power to detect differences because the sample sizes of Maori participants were small.

Note that in the oldest age groups for Maori females, we have only 16 and 10 examinees. In the oldest age groups for Maori males, we have only 31 and 13 examinees.

Mean systolic blood pressure by age and ethnicity, New Zealand females

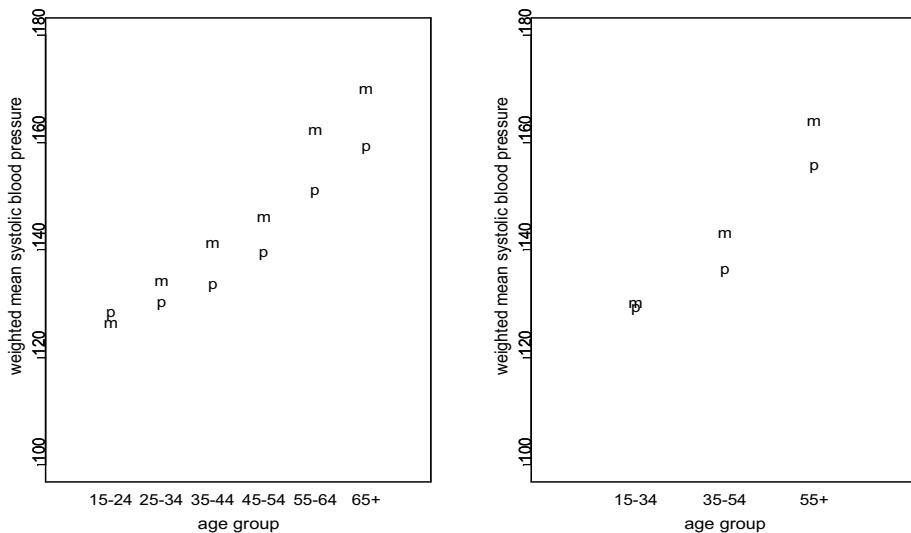


I felt that perhaps I would have greater ability to test differences in mean systolic blood pressure. These plots for New Zealand females show that the average systolic blood pressure is lower for Maori than for Pakeha through age 34, but higher thereafter until the oldest age group. We need to remember that this last data point is based on only ten examinees (although the data have been weighted using the National Nutrition Survey examination weights). If this pattern is true, perhaps the women with the highest blood pressures die before reaching age 65 and the rest are healthy survivors.

Because of the small numbers, I also show the means for twenty-year age groups (two age groups combined). Note that the results for the 55+ age group reflect the crossover phenomenon we just noted.

Unfortunately, the numbers were too small to detect as statistically significant these apparently large differences.

Mean systolic blood pressure by age and ethnicity, New Zealand males



Here are the mean systolic blood pressures for Maori and Pakeha men. Here are the data by ten-year age group and by twenty-year age group. Again, the data show that the Maori mean is lower than the Pakeha mean in the youngest age group but outstrips it at older ages.

Again, the small numbers mean that I don't have enough statistical power to say that these apparent differences are statistically different, that is, that they don't arise by chance. Still, the pattern by age and across gender does suggest that this is not a chance phenomenon.

I will just let you know that when I attempted an age-shifted analysis, it seemed that ten years was too great a shift and that five years was more appropriate. This may correspond well with the 5-6 year difference in life expectancy between Maori and Pakeha.

Treaty of Waitangi

- ◆ Each agency has its own interpretation
- ◆ The public is poorly educated
- ◆ The claims process illuminates history
- ◆ Settlements partially redress historical grievances
- ◆ Settlements do not absolve government of contemporary responsibilities
- ◆ Partnership between Maori and the Crown has not yet been achieved

I have dealt with the first two strands of my inquiry, the impacts of racism and issues around Maori health. Now I would like to briefly pick up the third strand, the Treaty of Waitangi.

After eight months I do not pretend to be a Treaty expert. But the interesting thing is that nobody else seems to be either! Each agency I visited had its own interpretation of the Treaty, its own Treaty framework and its own commitment to understanding and addressing Treaty obligations.

I have also been struck by the impression that the New Zealand public is generally poorly educated about New Zealand's colonial history, the Treaty of Waitangi and the current Treaty claims process.

I have been struck by the importance of the claims process, not only to in some small way make reparations for past historical grievances, but also as a way of illuminating history and validating Maori perspectives of history.

I have learned since being here that the settlements are intended to provide some redress of historical grievances. The settlements do not in any way absolve government of contemporary responsibilities to invest in infrastructure or social services.

Finally, it is my observation that full partnership between Maori and the Crown as called for by the Treaty of Waitangi has not yet been achieved. Consultation seems to be the current understanding of partnership. Full decision-making, agency (the ability to act) and control of resources by Maori (for Maori and for all) have not yet been achieved.

Weaving the strands

- ◆ Impacts of racism
 - Levels of racism
 - A Gardener’s Tale
 - Data on race-consciousness
- ◆ Maori health
 - Causes of disparities
 - Levels of health intervention
 - Data on accelerated ageing
- ◆ Treaty of Waitangi

So now I will attempt to weave the strands of my work in order to fashion an answer to my initial question.

In discussing the impacts of racism I have defined three levels of racism (institutionalised, personally-mediated, and internalised) that can each impact on health. I shared my allegory, “A Gardener’s Tale,” which described the relationship between the three levels of racism and illustrated that institutionalised racism is the most fundamental level that must be addressed in order to improve things. This allegory also showed that when institutionalised racism is addressed all the other levels take care of themselves. I also shared with you data of race-consciousness in response to the question: “How often do you think about your race?” from both the United States and New Zealand.

In discussing Maori health and Maori health policy I described various conceptions of the causes of Maori-Pakeha health disparities and indicated that we should not accept socio-economic status as an explanation unless we are prepared to accept ethnic differences in the distribution of wealth and poverty as a given. Instead, we should view socio-economic status as a symptom of fundamental structural factors that perpetuate inequality. We will be successful in achieving health and social equity only when we address these fundamental causes of institutionalised racism.

I also presented a model for conceptualising four levels of health intervention and suggested that this simple picture might be useful for both communities and policymakers. Finally, I presented my accelerated ageing hypothesis and presented comparisons of systolic blood pressure distributions from both the United States and New Zealand.

With regard to the Treaty of Waitangi I presented some of my impressions including the observation that Treaty partnership between Maori and the Crown has not yet been achieved.

My question

Maori-Pakeha health disparities:

can treaty settlements
reverse
the impacts of racism?

So now let's turn again to the question I posed at the beginning of this talk. Maori-Pakeha health disparities: can treaty settlements reverse the impacts of racism? I'm curious, how do you think I will answer this question?

My answer

Perhaps . . .

- ◆ Treaty settlements
 - Enrich the soil for some, for a time
 - May move a community from the cliff face
 - Do not address structural barriers to equity
- ◆ Data needed
 - Extent to which a settlement addresses aspects of institutionalised racism
 - Health outcomes over time

My answer is “perhaps.” Treaty settlements may enrich the soil for some, for a time. They may move a community from the cliff face. But they do not address structural barriers to equity. If we are really interested in answering my question, we will need more than eight months and we will need data.

I suggest that data be collected settlement by settlement on the extent to which a given settlement addresses aspects of institutionalised racism. Then health outcomes of direct beneficiaries and a comparison group need be collected over time.

However, if we really want to address Maori-Pakeha health disparities, there is a more certain strategy.

A more certain strategy

- ◆ Treaty partnership
 - Engages a gardener for the pink flowers
 - Lets the community at the cliff face decide where it will move
 - Addresses structural barriers to equity
 - Enriches the whole nation by valuing and incorporating the contributions of Maori

That more certain strategy is a treaty partnership. A treaty partnership engages a gardener for the pink flowers. It could be the same old gardener that was catering to the red flowers now convinced to attend to the whole of the garden. Or perhaps the pink flowers will hire their own gardener. That really is up to the pink flowers to decide.

A treaty partnership also lets the community at the cliff face decide where, when and how it will move.

A treaty partnership addresses structural barriers to equity and enriches the whole nation by valuing and incorporating the contributions of Maori. That is, a treaty partnership is not just good for Maori, it is good for the entire nation.

Dual Reality

A Restaurant Saga

So that could be the end of my presentation. But I would like to share two more stories that explain why I could be so cheeky as to come over to a foreign country and start talking about the uncomfortable subject of racism. These two stories illustrate different aspects of the importance of naming racism. As with all of my teaching stories, these come out of my own experience. The first story is called “Dual Reality: A Restaurant Saga.”

This story is from the days when I was a medical student at Stanford University in California. My friends and I had been studying late and were now hungry and ready to get a meal. At about 8:30pm we walked down one of the streets in Palo Alto and found a restaurant that looked good, walked in, sat down, ordered our food and were served.

About a half-hour later as we were eating I glanced up and noticed a sign on the door that read “Open.” If I had thought no more about it, I would have assumed that anyone walking down the street could have come in and sat beside us, ordered their food and eaten. After all, wasn’t I eating and didn’t the sign proclaim “Open?” But I knew something about the two-sided nature of those signs. And even though it proclaimed “Open” to me, in fact the restaurant was now closed (it was 9pm) and someone just feet away from me but on the other side of the sign would not have been able to come in and eat.

Racism makes race a two-sided sign. Many white Americans are sitting down at the table of opportunity, partaking and looking up and seeing a sign that proclaims “Open.” They assume that others standing feet away from them can easily sit down and partake as well. But they need to realise the two-sided (or multi-sided) nature of the race sign. Others standing just feet away but on the other side of the race sign have a very different reality.

This story is about understanding and naming racism, which causes people in the same space and time to have such different realities.

Understanding

this bus we are on

The next story I would like to share is actually a New Zealand story. It is called “Understanding this bus we are on.”

My family and I took a holiday in the South Island and went to Queenstown. From there we took a bus trip to Milford Sound. My husband, nine year-old daughter Calah, three year-old son Malcolm and I were sitting in the back of the bus when my daughter said: “Look Mommy! See how when the bus turns all of the people lean the same way. It looks like they are trying to move together, like they are doing some kind of dance.”

I thought that was a very interesting observation. Indeed, someone could look at all of those people and describe them as “leaners,” choosing to lean together. But a different way of seeing them would describe them as people being made to lean by the movements of the bus. This distinction is an especially important one if the leaning causes a problem. If people bang into the windows of the bus and hurt themselves every time the bus swerves, then how we see their actions makes a lot of difference to how we think we can help them.

Someone who sees the people as “leaners” would ask: “Why do those people keep banging themselves into the side of the bus?” It is analogous to the question: “Why do those poor people keep smoking so much?” The strategy is to teach the “leaners” to stop leaning. But someone who understands that there is a bigger systemic influence causing the people to lean will ask a different question, such as: “How can we slow this bus down on the curves?” or “Which is a straighter route to our destination?” The difference is one of blaming the individual versus acknowledging structural influences for what looks like personal behaviour.

Which is not to say that people do not have responsibility for their personal behaviours. Certainly people throwing popcorn at the front of the bus or propping their feet up on the seats at the back are exercising personal behaviours. But it is important to acknowledge

This is important for the policymaker who wants to know how to intervene. But it is also important for the bus rider, the “leaner,” to know that she is on a bus that is causing her to lean. She needs to know that she is on a bus so she can anticipate the swerves, if only to hold herself upright so that she doesn’t bang against the side. But if she understands that a bus is causing her to lean dangerously, she may also choose to talk to the driver and advise her to slow down, or hijack the bus and take it on a different road or get off the bus and choose some other means of conveyance.

So I tell this story to illustrate the importance of acknowledging the influence of structural factors. We need to name them and understand them and then deal with them. If we don’t, we will continue to blame those hurt by the structures for being “leaners” instead of dealing with the structural factors causing the people to lean.

New Zealand gifts

- ◆ Strategy for proposing reparations to African-Americans
- ◆ Strengthened sense of personal value
- ◆ Commitment to maintain a high quality of life for my family
- ◆ New eyes with which to see the United States on my return

I would like to end by commenting on some of the wonderful gifts I received while here in New Zealand. When I came here one of my personal goals was to gain an increased understanding of how to successfully broach the issue of reparations to African-Americans when I return home.

I will not be the first to raise the issue but hopefully I can join with others and we can be the last because we are successful. The issue is a complex one because African-Americans are not the indigenous people in the Americas and therefore do not have an indigenous claim on the land. But neither are we the colonisers. We are in some no-man's land shared by few other groups. We have no legal instrument to shore up our claims for justice and reparations (although there was the promise of forty acres and a mule at the time of emancipation).

But through my reflections while here in New Zealand, I have developed a strategy that is based on full development of our human potential since that is what was exploited during our enslavement. I won't go into more detail here but I will be actively pursuing reparations for African-Americans on my return home.

I have also benefited from a strengthened sense of personal value and my own power. It is interesting but one of the effects of racism in the United States has been to erode my sense of value. I will be returning feeling strong and powerful.

In addition, I will return with a commitment to maintain the high quality of life that my family and I have experienced while here. No more running around madly without time to spend with one another. And no more mad acquisition just to have.

Finally, one of the most valuable gifts that I have received from this time here will be new, fresh eyes with which to see my own country on my return. Thank you and kia ora.

Chapter 3: Why socio-economic status is not the full explanation for health disparities

This chapter contains annotated slides from a talk entitled: “Socio-economic status and health: isolating the impacts of racism.”

This material evolved from many stimulating discussions I had with colleagues at the Ministry of Health and at the Eru Pomare Centre for Maori Health Research at the Wellington School of Medicine. It is my response to the fact that the usual explanation given to me for Maori-Pakeha health disparities was that they were due to socio-economic status differentials. While it is certainly true that socio-economic differentials are in the causal pathway of the disparities, the underlying question that we need to address is what causes and perpetuates the socio-economic status differentials.

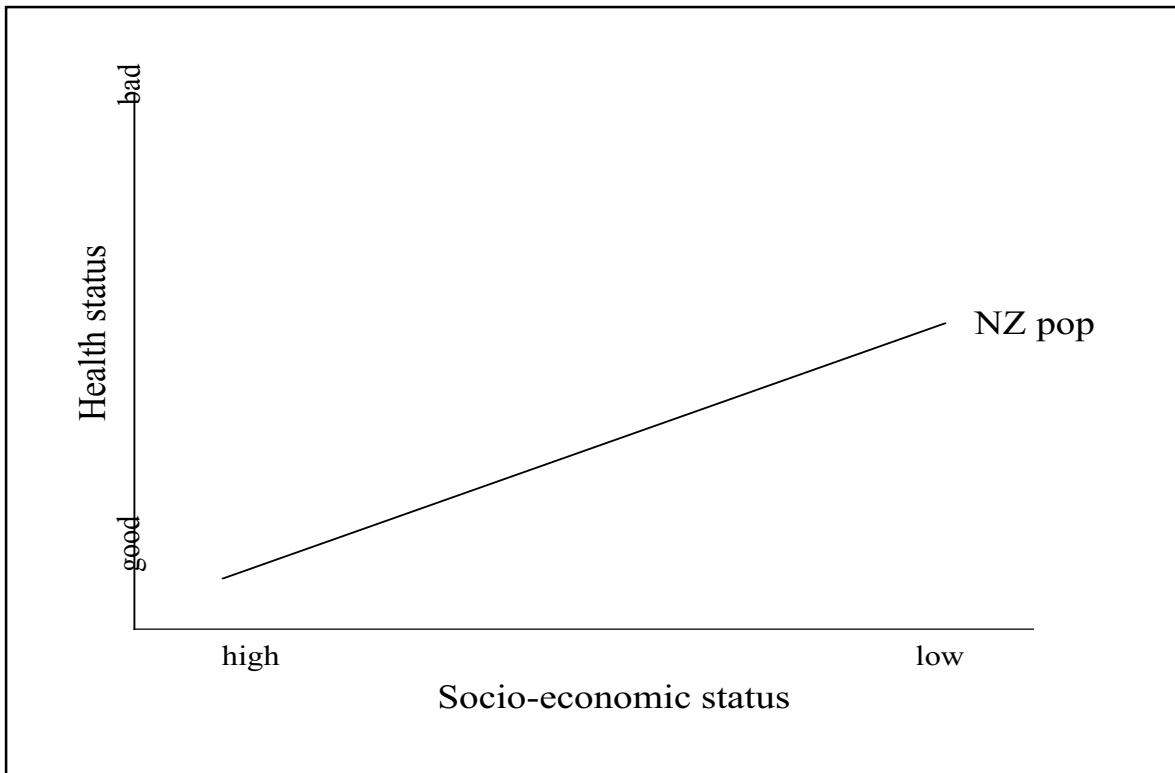
When we look at data on health status by socio-economic status, the unevenness in the underlying distribution of wealth by ethnicity is hidden. We need to highlight that uneven distribution and make the causes of that uneven distribution the primary focus of our efforts to eliminate ethnic health disparities.

This presentation was made to a working group meeting at the Ministry of Health during the week of 9 August 1999 and was part of a presentation made at a conference sponsored by the Eru Pomare Centre on 13 August 1999. Many of my ideas on this subject are referenced in a Ministry of Health document on socio-economic status and health published in late 1999.

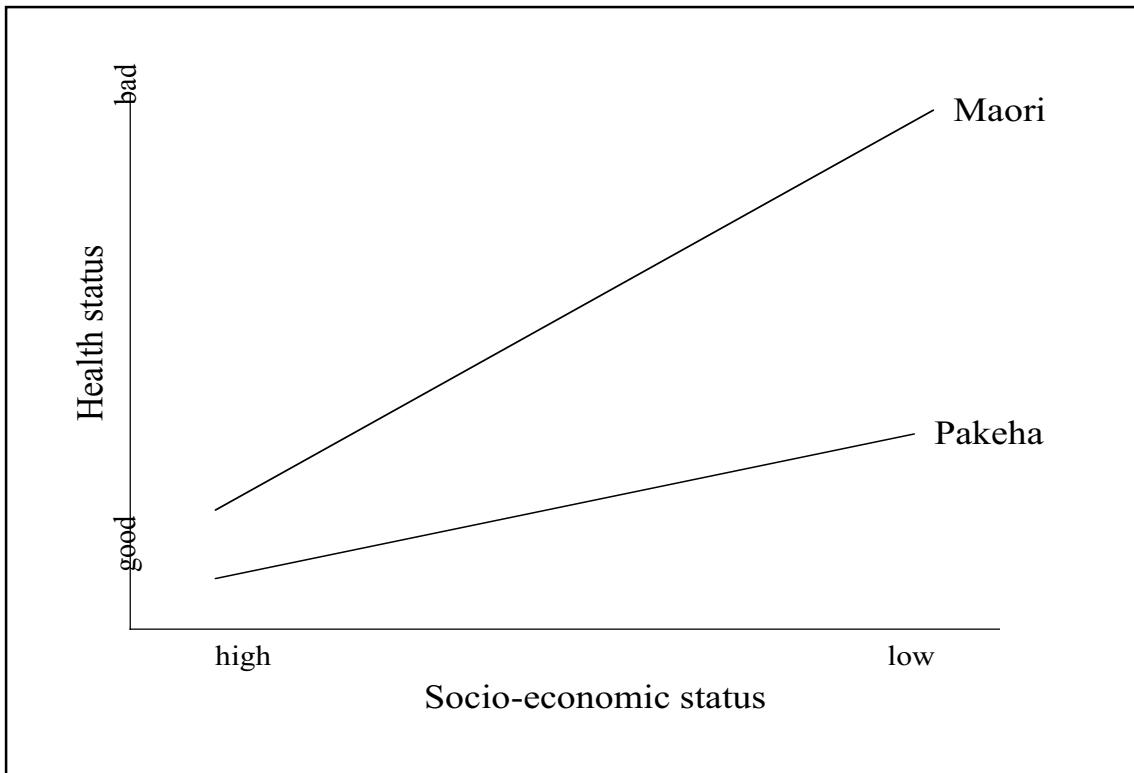
Socio-economic status and health

Isolating the impacts of racism

This talk looks at data on socio-economic status and health with regard to ethnic differences in health status. A number of different equity goals are considered. The impacts of racism on health can be isolated from plots of socio-economic status and health.

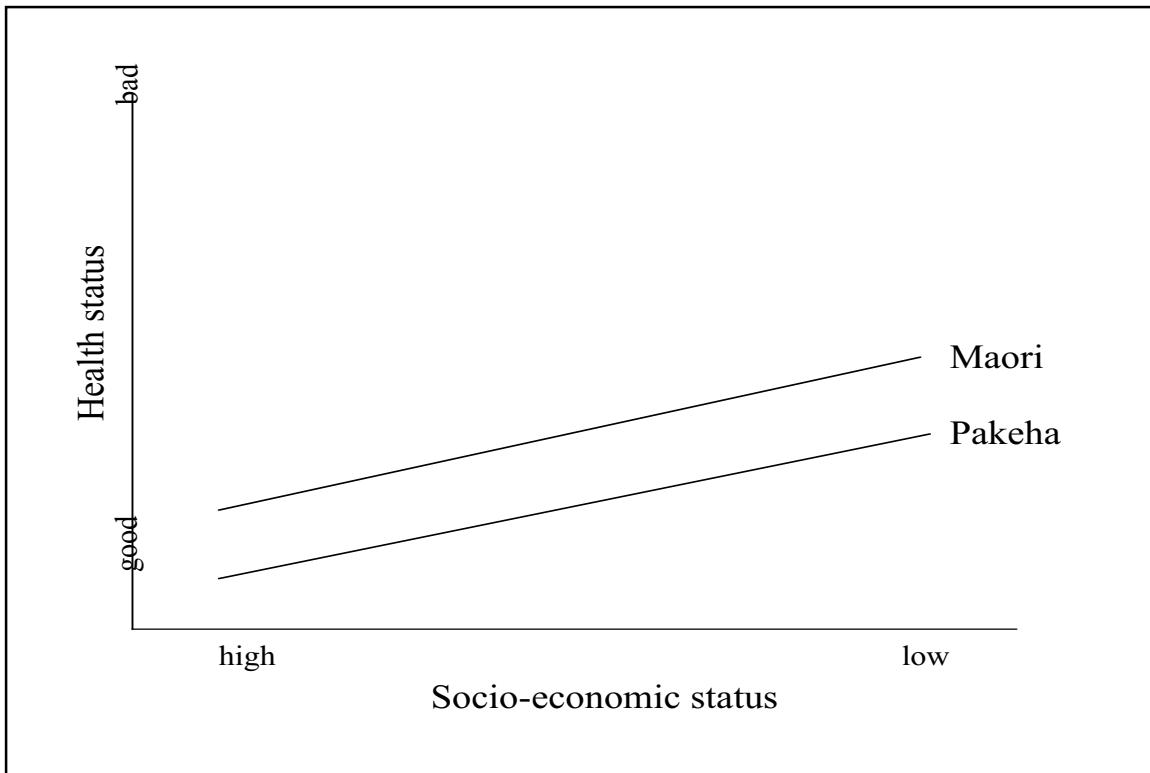


In New Zealand (as in all other countries where the data have been examined), there is a relationship between socio-economic status and health, such that those with higher socio-economic status enjoy better health.

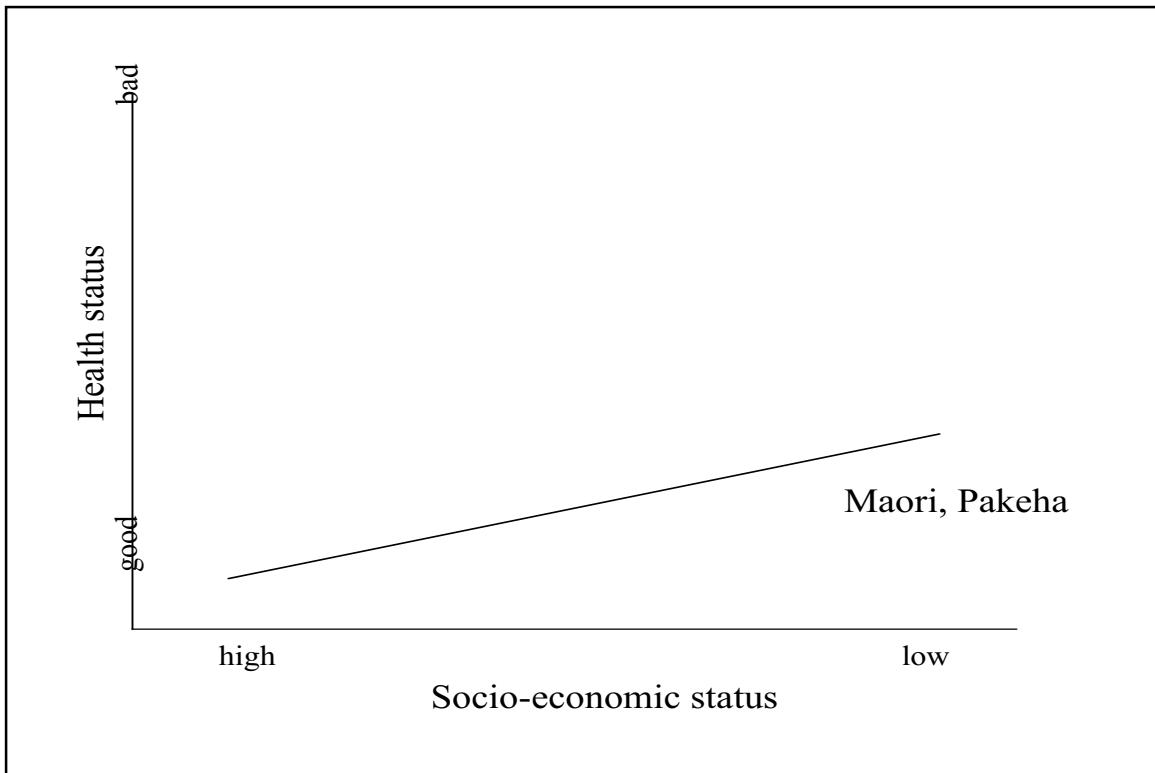


When data are stratified by ethnicity, this is a typical picture. Maori have poorer health status than Pakeha at any given level of socio-economic status and the slope describing the dependence of Maori health on socio-economic status is steeper than the corresponding slope for Pakeha.

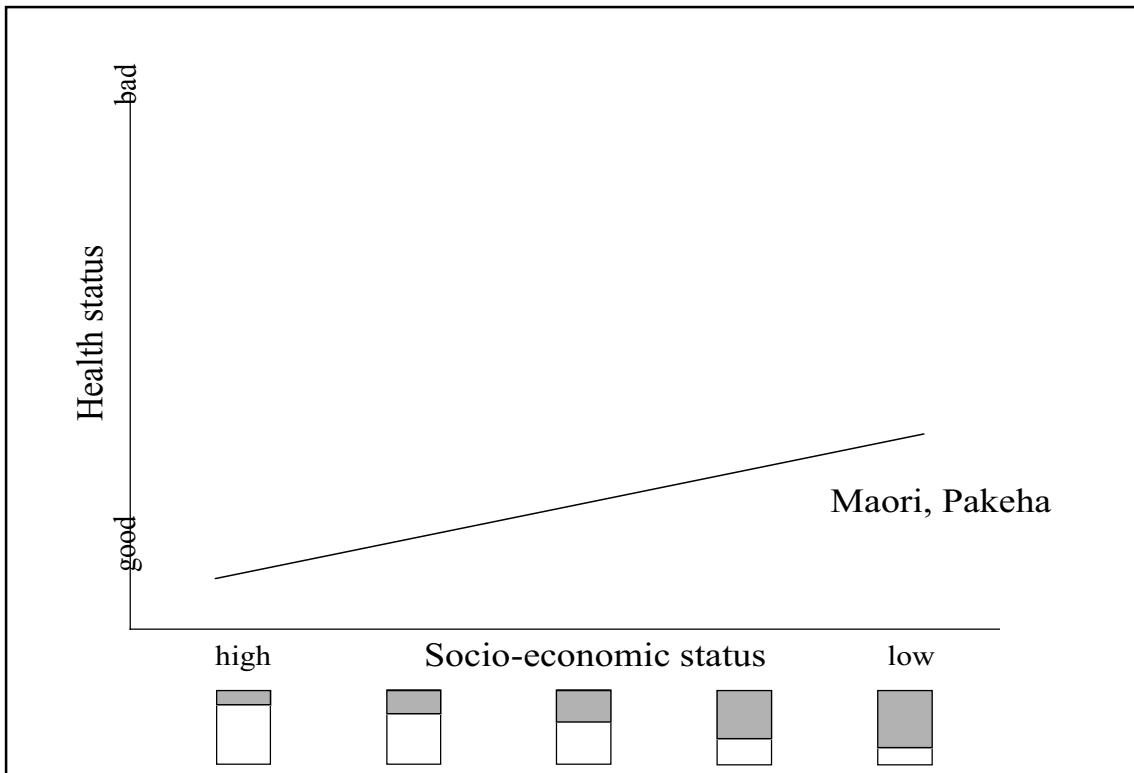
This picture suggests a number of foci for intervention.



The first might be to equalise the slopes so that Maori and Pakeha have the same amount of decrement in health for an equal decrement in socio-economic status. That is, there would be no interaction (effect modification) between ethnicity and socio-economic status.



A second goal might be to make the absolute levels of health the same for Maori and Pakeha who are at the same socio-economic level.



However, even if this were accomplished the health disparities between Maori and Pakeha would still exist.

What is hidden in our plots of health status by socio-economic status is the underlying distribution of wealth by ethnicity. Maori are over-represented in poverty in New Zealand while Pakeha are over-represented in wealth. And this state of affairs didn't "just so happen." There was the initial alienation of Maori land, the effects of which are perpetuated today through contemporary structural factors including the lack of true partnership between Maori and the Crown. (This partnership would be evident if there were equal sharing of the power to decide, the power to act and the control over resources.)

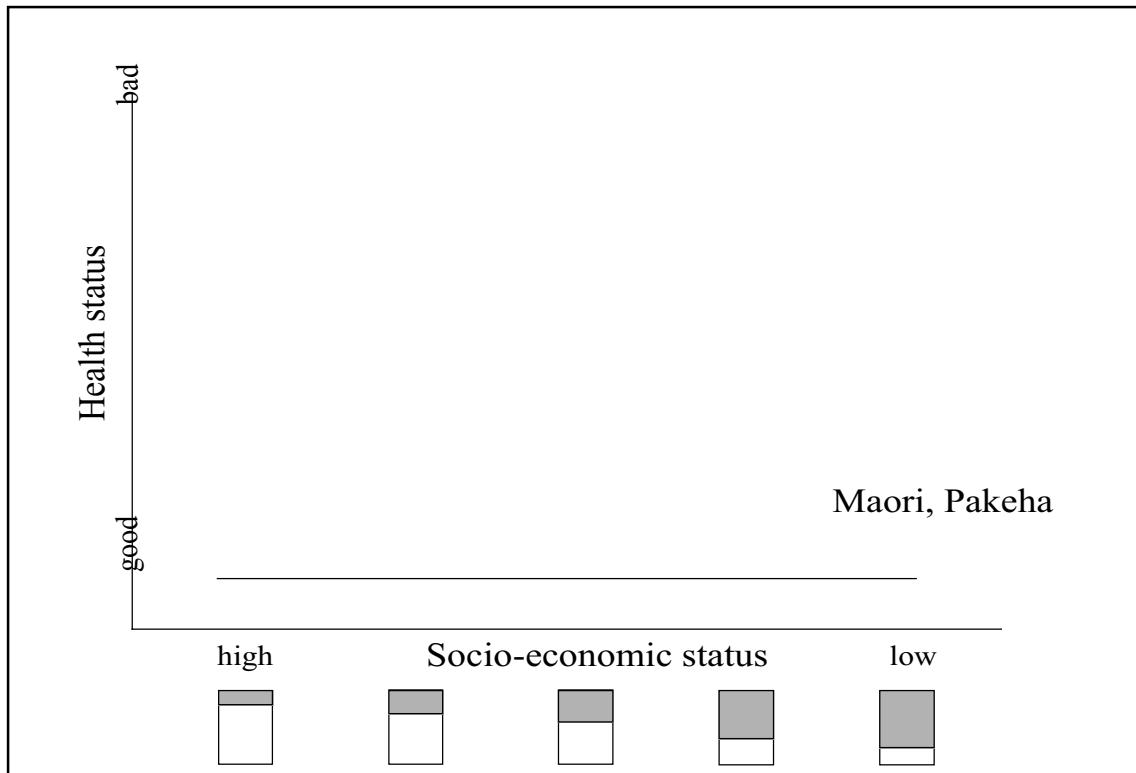
As long as wealth is unevenly distributed by ethnicity we will continue to see ethnic disparities in health. Understanding the impacts of socio-economic status on health and how this contributes to ethnic disparities in health does not go far enough. If we are really going to eliminate health disparities, we need to understand the contemporary structural factors that perpetuate the uneven distribution of wealth by ethnicity and address these. That is, we need to address institutionalised racism if we are really going to make change. Statistically adjusting for socio-economic status is not a useful intervention.

Three strategies . . .

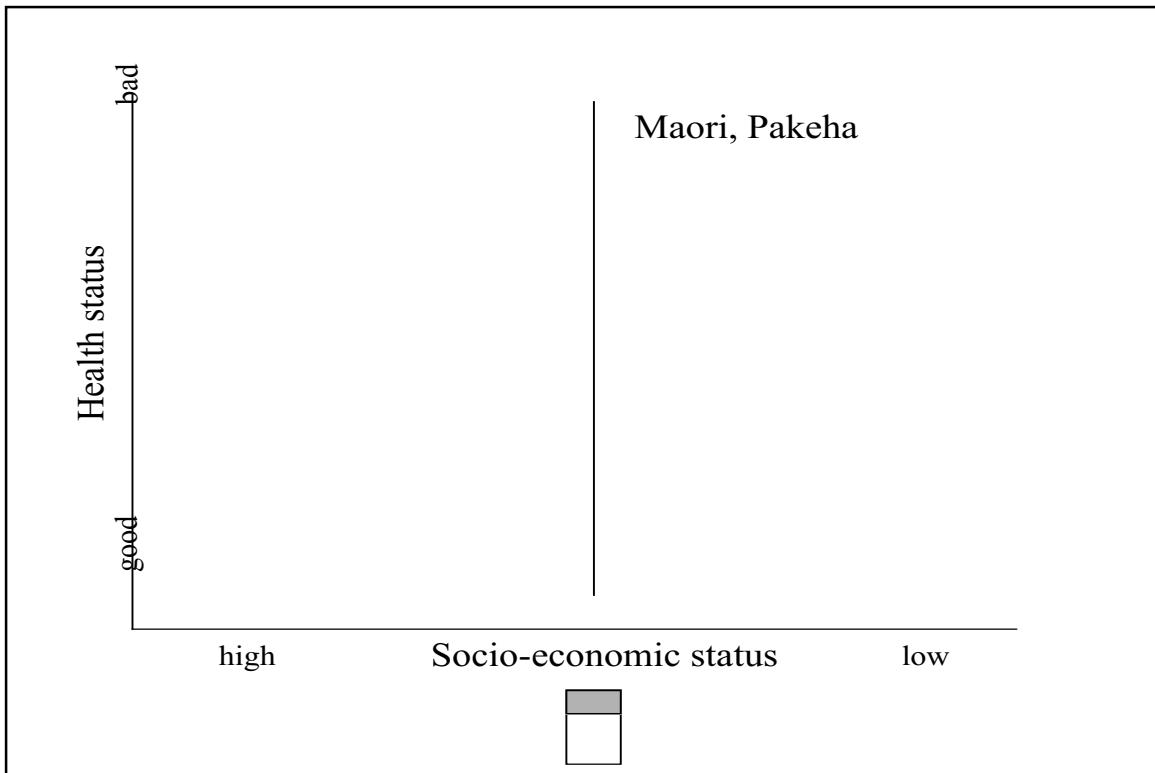
. . . to address ethnic health disparities due to socio-economic status (SES)

- ◆ Eliminate the dependence of health on SES
- ◆ Eliminate SES stratification in society
- ◆ Eliminate ethnic differences in the distribution of SES

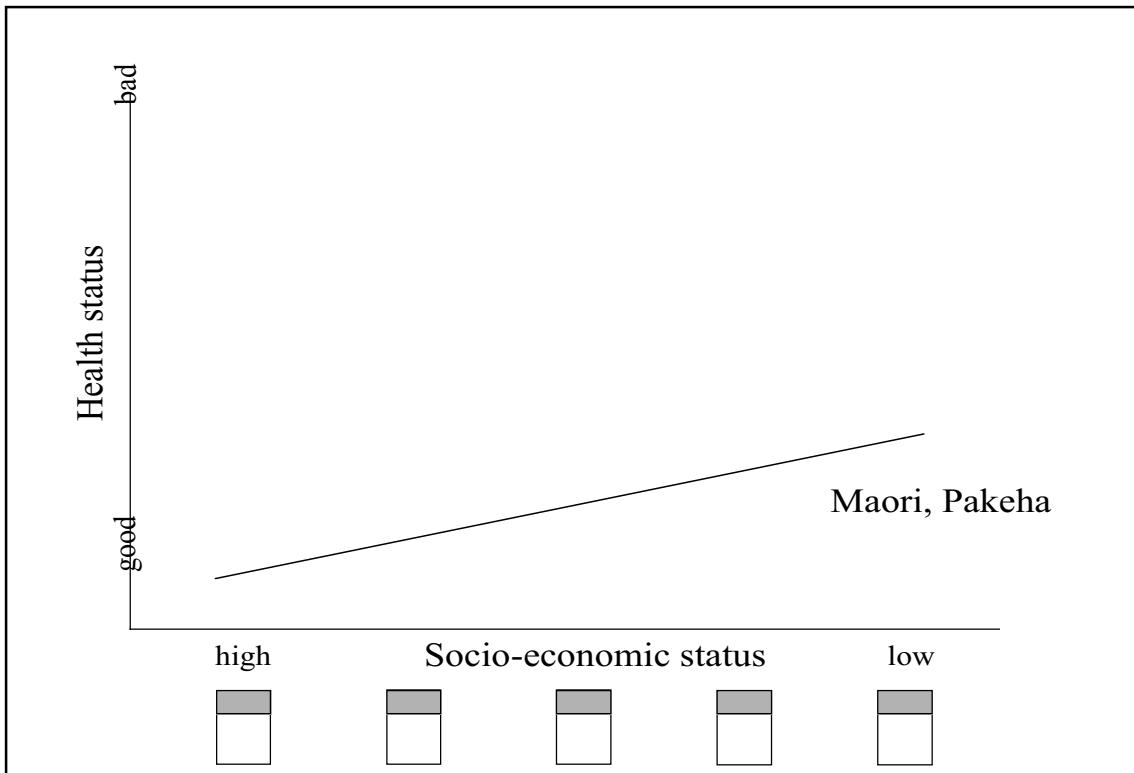
On a theoretical level there are three strategies to address ethnic health disparities due to socio-economic status. They are to eliminate the dependence of health on socio-economic status, to eliminate socio-economic status stratification in society and to eliminate ethnic differences in the distribution of socio-economic status.



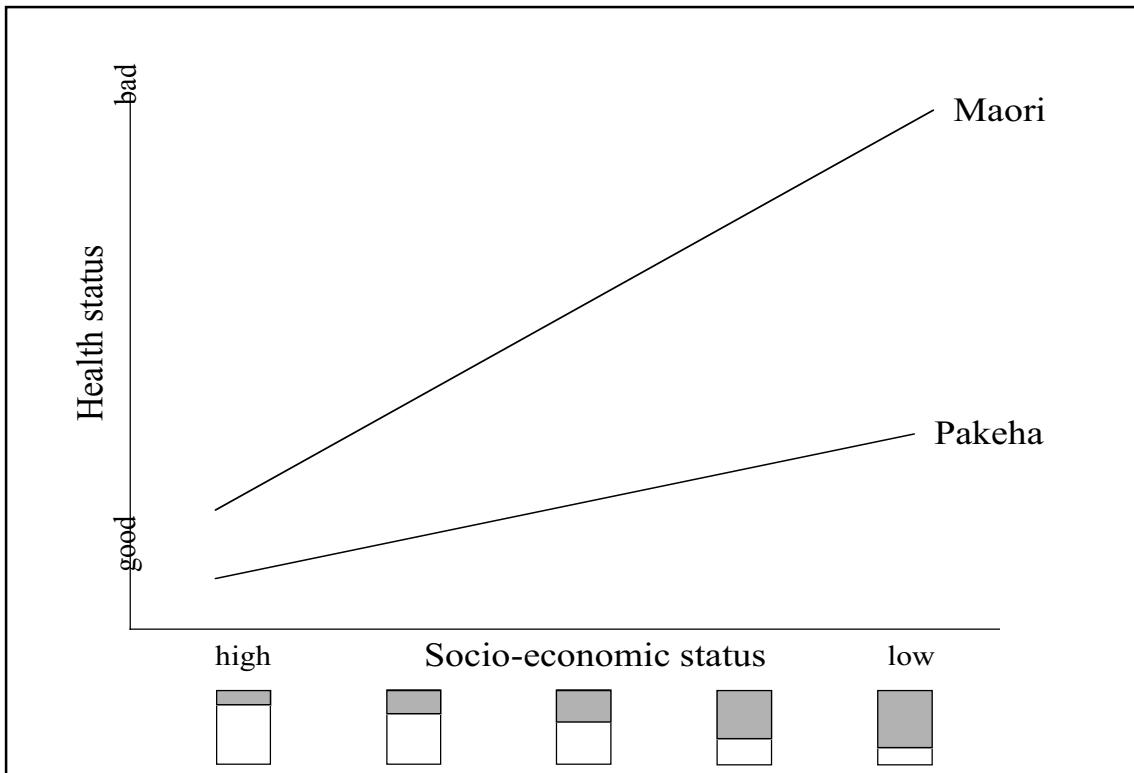
Here is an illustration of the first strategy, eliminating the dependence of health on socio-economic status. In this graph health status has no relationship to socio-economic status. Therefore it does not matter from a health point of view whether you are rich or poor. It is interesting to ponder what kinds of strategies would be necessary to bring this about.



Here is an illustration of the second strategy, eliminating socio-economic status stratification in society. In this graph there is only one socio-economic status group. Again, health status has no relationship with socio-economic status because there is no variability in socio-economic status.



Here is an illustration of the third strategy, eliminating the ethnic differences in the distribution of socio-economic status. In this graph the proportion of Maori and Pakeha is constant across all socio-economic status categories. Even though there is a dependence of health on socio-economic status, it will not result in ethnic differences in health status.



But here we are back at the reality of the current situation. We have differences in slope, differences in levels (intercept) and differences in the underlying distribution of socio-economic status by ethnicity. I propose that we use graphs such as this to isolate different aspects and impacts of racism on health.

Isolating the impacts of racism

- ◆ Distribution of SES by ethnicity
- ◆ Dependence of health on SES (slope)
- ◆ Level of health at highest SES (intercept)

Institutionalised racism is manifest in part through differences in the distribution of socio-economic status by ethnicity. Factors such as access to care, cumulative stress, accelerated ageing and personally-mediated racism may contribute to differences in the dependence of health on socio-economic status (slope). And differences in the level of health at the highest socio-economic status (intercept) may be due to similar factors.

That is, certain aspects of institutionalised racism manifest themselves through the differences in underlying distribution of socio-economic status. Institutionalised racism as well as personally-mediated and internalised racism can manifest in the slope and intercept differences. I will refine my thinking on this matter.

Chapter 4: Parallels and differences between the African-American and Maori experiences

This chapter contains annotated slides from my talk entitled: “Beyond rap and baggy pants: African-American connections to te ao Maori.”

This talk was prompted by my observation that much of the music and clothing of young African-Americans has been adopted by some young Maori. Indeed, one young man on learning that I was African-American changed his whole way of talking to me and fell into a hip-hop speech pattern. This talk goes beyond the superficial sharing of rap and baggy pants between two groups of young people. It examines the profound differences in histories of Maori and African-American peoples, but the strong commonalities of our current conditions. I am impressed that Maori people are currently in a potentially strong position to re-achieve self-determination. We have much to learn from one another.

This talk was presented to both the Department of Maori and Pacific Health at the University of Auckland School of Medicine and the Department of Maori Development at the University of Auckland. The same topic was the subject of an interview with me that was published in the June 1999 issue of “Tu Mai” magazine and a second interview with me that was aired on “Te Atiawa” radio on 17 June 1999. There was obviously great interest in this topic.

Beyond rap and baggy pants

African-American connections to te ao Maori

Some may wonder why I would even suggest that there are connections between African-Americans and te ao Maori. You may have come more out of curiosity to hear what I might say than out of a belief that there really are connections.

I will share with you today my observations about the profound differences in our histories, yet the striking similarities in our contemporary situations. I believe that we have much that we can learn from one another.

My title comes from an experience I had while visiting a work-training programme in Lower Hutt. I was introduced to some young men and women who were studying hairdressing. One young man admired how I twisted my hair. When he learned that I was African-American he suddenly adopted a very “cool” stance and started to talk to me in a sort of hip-hop way. I just smiled.

I had seen other young people that day painting posters of Malcolm X. I thought about the rap styles being used by some young Maori groups. I thought about clothing styles including baggy pants that I had seen on both sides of the Pacific. And I decided to explore African-American connections to te ao Maori that might go beyond rap and baggy pants.

Historical comparison

Maori:

- ◆ Indigenous to NZ
- ◆ Colonised
 - Dispossessed of land
 - Retained language, history, culture
 - Retained humanity
- ◆ Treaty of Waitangi

African-Americans:

- ◆ Not indigenous to US
- ◆ Enslaved
 - Dislocated from land
 - Denied language, history, culture
 - Stripped of humanity
- ◆ No legal instrument

An historical comparison between the Maori people and African-Americans shows important differences. The Maori are the indigenous people of New Zealand. African-Americans are not the indigenous people of the United States. Yet, they are not the colonisers either. They are in a peculiar in-between position, having been kidnapped and brought against their will to the Americas to have their coerced, unpaid labour exploited for centuries to build the economy in the United States.

The only other peoples that I am aware of in a similar historical position are the Indians in Fiji. But even their situation is different, for now they are a majority of the Fijian population and control the economic and political processes on the island. That is not the case for Africans in America.

The Maori were colonised and dispossessed of their own lands. However, they were able to retain their language, history and culture. African-Americans were enslaved and dislocated from their lands. They were deliberately denied their languages, history and cultures. Persons who spoke the same language were deliberately separated when being sold into slavery in order that the languages and cultures would not survive.

Importantly, although the Maori people suffered many wrongs at the hands of the British colonisers they retained their sense of humanity. On the other hand, African-Americans were stripped of their sense of humanity. They were treated as sub-human animals and viewed as property, even under the law.

Most importantly however, is the fact that Maori people had a legal instrument that guaranteed them certain rights. Although it was viewed as “a simple nullity” a few decades after its signing, the Treaty of Waitangi is recognised today as the founding document of New Zealand. African-Americans made no agreements when they were kidnapped and enslaved and therefore have no legal instrument specifically

Contemporary parallels

- ◆ 12-15% of population
- ◆ Largely urban
- ◆ Public visibility
- ◆ Poor health
- ◆ Disproportionate poverty
- ◆ Experience of racism

Despite the historical differences it is striking how similar the contemporary experiences of the Maori people and African-Americans are.

Each group represents somewhere between 12 and 15% of its national population. Both groups are largely urban and have high public visibility. Both groups experience poorer health than the majority population. The similarity in degree and kind of black-white health disparities in the United States and Maori-Pakeha health disparities in New Zealand are striking.

Both African-Americans and Maori are disproportionately represented among the poor. And both share the experience of racism.

I have been speaking to a number of New Zealanders as well as reading the newspapers and making my own observations. It appears that the way that I conceptualise racism on three levels within the United States context has a lot of currency in the New Zealand context. As previously outlined, these levels are institutionalised, personally-mediated and internalised.

Experiences of racism: Maori and African-American

- ◆ Ethnicity
- ◆ Self-identification for some
- ◆ Persistent effects of colonisation denied
- ◆ Contemporary redress in treaty settlements
- ◆ Disregard for partnership
- ◆ “Race” not ethnicity
- ◆ External classification for all
- ◆ Persistent effects of racism denied
- ◆ Affirmative action under attack
- ◆ Disregard for human potential

During the several months that I have spent in this country, I have noted some commonalities and some differences between the experiences of racism of Maori people and those of African-Americans.

In New Zealand you have dispensed with the word “race” and now describe different groups by “ethnicity.” In the United States we are still stuck with the concept of “race,” a concept that has very strong biological overtones. It is common for lay people and even physicians and scientists to presume that observed race-associated differences in health outcomes are biologically determined. Even the newly approved federal categories for collecting demographic data distinguish between “race” (African-American or Black, White, Asian, Native Hawaiian or Pacific Islander, and American Indian or Alaska Native) and ethnicity (Hispanic or non-Hispanic). The two concepts are still very distinct in the American mind.

For some Maori in New Zealand identification as Maori is a matter of personal decision and is not a classification imposed by others. Within the United States “race” is still very much an externally imposed classification. Anyone with identifiable African ancestry in the United States is classified as Black, whether they want to be or not. Indeed, Aboriginal people from Australia would also be classified as Black in the United States, although their ancestry is quite distinct from that of African-Americans. Interestingly, some Maori would be classified as White, some Maori would be classified as Black, and some Maori would be classified as Pacific Islander in the United States context. It wouldn’t matter much how you classified yourself. The response you would get from the society would depend on that externally-imposed racial classification.

In both New Zealand and the United States the persistent effects of the initial historical oppression are denied by the dominant society. In New Zealand many people deny the persistent effects of colonisation on today’s population. In the United States many people

deny the persistent effects of racism on today's population. It is as if that happened a lot time ago and we should forgive and forget. There is a general lack of understanding of the present-day impacts of these continuing oppressions on the affected peoples and on the society as a whole.

At least in New Zealand, there are now attempts at redress through the hearing of Treaty of Waitangi claims and the negotiation of treaty settlements. In the United States, African-Americans have no treaty. Even affirmative action, a very limited effort to open the doors of opportunity to African-Americans (and other minority peoples), is now very much under attack. It is also only helpful to those who are already well-prepared and well-positioned.

Finally, racism in New Zealand manifests as a disregard for the partnership between Maori and the Crown that was established by the Treaty of Waitangi. In the United States racism manifests as a disregard for the human potential of African-Americans and other stigmatised persons of colour.

Strengths of Maori society: retaining culture

- ◆ Knowledge of whakapapa
- ◆ Marae as land-based centre
- ◆ Freedom of cultural expression through kapa haka
- ◆ Whanau focus
- ◆ Te reo Maori

I have been struck by many strengths of Maori society. These can be summarised as “retaining culture.”

They include the knowledge of whakapapa, that strong sense of history and place in the world that provides also for connections with others. When you stand and introduce yourself by first describing your ancestral canoe, your mountain, your river, your ancestors and then end with “and I am . . .” you clearly feel connected with what came before, and therefore with what will come after. You understand that you stand on the shoulders of those who came before and that you also need to stand tall so that those who come after can stand on your shoulders.

I fear that when the histories and cultures of the Africans brought to America were stolen from them, we lost that sense of connection to long lines in the past. We have a sense of being here only for ourselves, as if our lives are for us to use as we please with no impact on the future. We also lost knowledge of our ancestral lands and cannot look upon the mountains or the rivers or even know their names. There are attempts now to retrieve our stolen legacies but I think we will never realise the depth of our loss.

In addition, the marae as a land-based centre of community is another strength because of its permanence. People can go away and come back many years later and still know that they have a place to stand and speak. In many African-American communities the church serves some of the same functions for births, weddings and funerals, and even for important community meetings. But the location of a church can change over the decades and the church is more a centre for communities of common interests, not communities united by ancestry.

I was extremely struck by what I perceived as the freedom of cultural expression through kapa haka. I attended some of the Waitangi Day festivities in Frank Kitts Park in

Wellington. Even though it was just shortly after my arrival in New Zealand and I didn't understand any Maori, I did understand much of the strong emotion in the haka and was amazed that Maori people could express this strong emotion publicly and not be strongly censured for it.

Even the brandishing of weapons was "allowed!" Although many of our rap artists express anger and dissatisfaction in their work, they would never be able to do so while brandishing weapons. Of course, the strengths of kapa haka extend beyond the passion of the haka, because through this cultural art form the histories of the different hapu and iwi are sustained.

The whanau focus of Maori culture is another tremendous strength. Definitions of whanau range from the nuclear family to a wide extended family that can be relied upon in times of need. In all of these formulations, the children are treasured as the most precious resource for building the future.

Finally, the resurgence of te reo Maori is a strength that cannot be underestimated. From the kohanga reo and the kura kaupapa all the way to the wananga, the embracing again of Maori language, culture and knowledge sets the stage for Maori self-determination.

I am pleasantly surprised by the number of parents who are unconcerned that their children may not become fluent in English until they are teenagers. There is a self-confidence that comes from running your own affairs in your own language and in your own way. It is on considering this strength that I become aware again of the tremendous loss suffered by African-Americans when our languages, histories and cultures were denied us.

Strengths of African-American society: Regaining culture

◆ Kwanzaa

- Umoja (unity)
- Kujichagulia (self-determination)
- Ujima (collective work and responsibility)
- Ujamaa (cooperative economics)
- Nia (purpose)
- Kuumba (creativity)
- Imani (faith)

◆ Creating ourselves anew

On the other hand, there are tremendous strengths of African-American culture. These can be summarised as “regaining culture.”

There is a uniquely African-American holiday created in 1966 by Dr. Ron Maulana Karenga, Chair and Professor of Black Studies at California State University at Long Beach. Although it was based on the tradition of an African harvest festival, it is not an African holiday but an African-American holiday. Its name, “Kwanzaa,” is derived from the word “kwanza” that means “first” (from the expression “first fruits”). The word was lengthened with a second “a” so that the name would have seven letters. Even the words used to describe the principles and symbols of Kwanzaa are not from West Africa (where most African-Americans’ ancestors were kidnapped) but are from the East African trade language, Kiswahili.

Kwanzaa is not a religious holiday, but a holiday of community-building based on seven principles (the “nguzo saba”). The seven principles are umoja (unity), kujichagulia (self-determination), ujima (collective work and responsibility), ujamaa (cooperative economics), nia (purpose), kuumba (creativity) and imani (faith).

Kwanzaa is celebrated the seven days from December 26 (the day after Christmas) until January 1 (New Year’s Day). On each day people of African descent gather as families, groups of families or communities to discuss the principle of that day and what it means to them. There are cultural performances and food. On the final day of Kwanzaa, there may be a feast (or karamu) and the children may receive handmade or cultural gifts for promises kept.

Although a relatively new holiday, only 33 years old, Kwanzaa is celebrated by increasing numbers of African-Americans and is now considered mainstream. Even mainstream schools and mainstream media acknowledge the holiday and wish people a

The holiday is reminding African-Americans of our connectedness, the need to focus on the seven principles of community-building and the importance of learning about our heritage.

Another major strength of African-American society is our creativity. It comes I think from not knowing our place in the chain of our ancestry, but the results are tremendous creativity in the arts. This creativity even manifests in how we name our children! As the outlets made available to our people expand it will also manifest as tremendous creativity in the sciences and in governance. The realisation of our potential as African-Americans will be a boon to the United States, indeed the world, as a whole.

Reparations for African-Americans

- ◆ Apology for slavery
- ◆ Investment in human potential
- ◆ African-American control over investment
- ◆ Legal entitlements to equity

As I said earlier, I came to New Zealand not only to learn about Maori health, treaty settlements and the experience of racism here, but also to take back some insights on how to successfully broach the issue of reparations for African-Americans to policymakers in the United States.

The issue of reparations for African-Americans cannot be made on the grounds of an indigenous right to the land because African-Americans are not indigenous to North America, but were kidnapped and forcibly taken there. In addition, there was no treaty or any other legal agreement to our enslavement.

What we have is a reference to forty acres and a mule at the time of emancipation and the thirteenth amendment to the Constitution abolishing slavery, the fourteenth amendment giving us citizenship and guaranteeing due process and the fifteenth amendment establishing our right to vote.

However, our human resource was exploited to build the nation of the United States and our human potential is what is now being neglected as there seems to be deliberate under-investment in our education and development. It is on this basis that I make my case for reparations for African-Americans.

I propose four elements to these reparations. The first of these is an apology for slavery. There has never been a formal acknowledgement by the United States government of the tremendous wrong done in the enslavement of Africans, the ways in which the government participated in this and the great benefits that the government derived from it.

The second of these is involves investment in our human potential. I see this taking the form of funding for educational institutions at all levels that is under the control of

te reo Maori-based education in New Zealand, but I don't think that the majority of African-Americans are ready to subscribe to African-centred education. We don't even know what languages the education should be in, for our languages have been stripped from us. Still, it would be beneficial to us to have education from pre-school through university under our control. And for those who are already past the age of formal education, we should have community-based educational programmes in history, culture and skills to let people know and develop their own potential.

In addition, I propose that the tertiary education of all students of African descent be fully funded by the government, no matter where they choose to undertake that education. This would mean that at the same time that we are building institutions, we can also participate in the finest institutions already operating in the country. And this provision should be in force for at least the next four generations.

Finally, the fourth element is that there be some legal document developed that establishes the legal right of African-Americans to equity. In the same way that the Treaty of Waitangi establishes the basis for a partnership between Maori and the Crown, there needs to be a legal commitment to achieve equity in outcomes between African-Americans and other Americans.

When I return to the United States, I will take these ideas that have been stimulated and enriched by what I have learned here in New Zealand. I will join with others who have been and continue to wage a struggle for reparations for African-Americans. I hope to be successful in my lifetime.

Appendix A: Te Tiriti o Waitangi/The Treaty of Waitangi

The text in Maori

Ko Wikitoria, te Kuini o Ingarani, i tana mahara atawai ki nga Rangatira me nga Hapu of Nu Tirani i tana hiahia hoki kia tohungia ki a ratou o ratou rangatiratanga, me to ratou wenua, a kia mau tonu hoki te Rongo ki a ratou me te Atanoho hoki kua wakaaro ia he mea tika kia tukua mai tetahi Rangatira hei kai wakarite ki nga Tangata maori o Nu tirani - kia wakaetia e nga Rangatira maori te Kawanatanga o te Kuini ki nga wahikatoa o te Wenua nei me nga Motu - na te mea hoki he tokomaha ke nga tangata o tona Iwi Kua noho ki tenei wenua, a e haere mai nei.

Na ko te Kuini e hiahia ana kia wakaritea te Kawanatanga kia kaua ai nga kino e puta mai ki te tangata Maori ke te Pakeha e noho ture kore ana.

Na, kua pai te Kuini kia tukua a hau a Wiremu Hopihona he Kapitana i te Roiara Nawi hei Kawana mo nga wahi katoa o Nu Tirani e tukua aianei, amua atu ki te Kuini e mea atu ana ia ki nga Rangatira o te Wakaminenga o nga hapu o Nu Tirani me era Rangatira atu enei ture ka korerotia nei.

Ko te tuatahi

Ko nga Rangatira o te Wakaminenga me nga Rangatira katoa hoki ki hai i uru ki taua wakaminenga ka tuku rawa atu ki te Kuini o Ingarani ake tonu atu - te Kawanatanga katoa o o ratou wenua.

Ko te tuarua

Ko te Kuini o Ingarani ka wakarite ka wakaae ki nga Rangatira ki nga hapu - ki nga tangata katoa o Nu Tirani te tino rangatiratanga o o ratou wenua o ratou kainga me o ratou taonga katoa. Otiia ko nga Rangatira o te Wakaminenga me nga Rangatira katoa atu ka tuku ki te Kuini te hokonga o era wahi wenua e pai ai te tangata nona te Wenua – ki te ritenga o te utu e wakaritea ai e ratou ko te kai hoko e meatia nei e te Kuini hei kai hoko mona.

Ko te tuatoru

Hei wakaritenga mai hoki tenei mo te wakaetanga ki te Kawanatanga o te Kuini - Ka tiakina e te Kuini o Ingarani nga tangata maori katoa o Nu Tirani ka tukua ki a ratou nga tikanga katoa rite tahi ki ana mea ki nga tangata o Ingarani.

(Signed) William Hobson
Consul and Lieutenant-Governor

Na ko matou ko nga Rangatira o te Wakaminenga o nga hapu o Nu Tirani ka huihui nei ki Waitangi ko matou hoki ko nga Rangatira o Nu Tirani ka kite nei i te ritenga o enei kupu, ka tangohia ka wakaetaia katoatia e matou, koia ka tohungia ai o matou ingoa o matou tohu.

Ka meatia tenei ki Waitangi i te ono o nga ra o Pepueri I te tau kotahi mano, e waru rau e wa te kau o to tatou Ariki.

Ko nga Rangatira o te wakaminenga.

(From the Treaty of Waitangi Amendment Act 1985)

The text in English

Her Majesty Victoria Queen of the United Kingdom of Great Britain and Ireland regarding with Her Royal Favour the Native Chiefs and Tribes of New Zealand and anxious to protect their just Rights and Property and to secure to them the enjoyment of Peace and Good Order has deemed it necessary in consequence of the great number of Her Majesty's Subjects who have already settled in New Zealand and the rapid extension of Emigration both from Europe and Australia which is still in progress to constitute and appoint a functionary properly authorised to treat with the Aborigines of New Zealand for the recognition of Her Majesty's Sovereign authority over the whole or any part of those islands - Her Majesty therefore being desirous to establish a settled form of Civil Government with a view to avert the evil consequences which must result from the absence of the necessary Laws and Institutions alike to the native population and to Her subjects has been graciously pleased to empower and to authorise me William Hobson a Captain in Her Majesty's Royal Navy Consul and Lieutenant Governor of such parts of New Zealand as may be or hereafter shall be ceded to Her Majesty to invite the confederated and independent Chiefs of New Zealand to concur in the following Articles and Conditions.

Article the first

The Chiefs of the Confederation of the United Tribes of New Zealand and the separate and independent Chiefs who have not become members of the Confederation cede to Her Majesty the Queen of England absolutely and without reservation all the rights and powers of Sovereignty which the said Confederation or Individual Chiefs respectively exercise or possess, or may be supposed to exercise or to possess over their respective Territories as the sole Sovereigns thereof.

Article the second

Her Majesty the Queen of England confirms and guarantees to the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof the full exclusive and undisturbed possession of their Lands and Estates Forests Fisheries and other properties which they may collectively or individually possess so long as it is their wish and desire to retain the same in their possession: but the Chiefs of the United Tribes and the

individual Chiefs yield to Her Majesty the exclusive right of Preemption over such lands as the proprietors thereof may be disposed to alienate at such prices as may be agreed upon between the respective Proprietors and persons appointed by Her Majesty to treat with them in that behalf.

Article the third

In consideration thereof Her Majesty the Queen of England extends to the Natives of New Zealand Her royal protection and imparts to them all the Rights and Privileges of British Subjects.

(Signed) William Hobson
Consul and Lieutenant-Governor

Now therefore We the Chiefs of the Confederation of the United Tribes of New Zealand being assembled in Congress at Victoria in Waitangi and We the Separate and Independent Chiefs of New Zealand claiming authority over the Tribes and Territories which are specified after our respective names, having been made fully to understand the Provisions of the foregoing Treaty, accept and enter into the same in the full spirit and meaning thereof: in witness of which we have attached our signatures or marks at the places and the dates respectively specified.

Done at Waitangi this Sixth day of February in the year of Our Lord One thousand eight hundred and forty.

[Here follow signatures, dates, etc.]

(From the Treaty of Waitangi Act 1975)

Appendix B: Draft proposal for reparations to African-Americans

The United States continues to benefit from the fact that Africans were brought to these shores in shackles and their coerced, unpaid labour was exploited for three centuries.

We do not have claims to the land because we are not the indigenous people here. But neither are we the coloniser. We were brought against our will by the colonisers and our labour was coerced and unpaid. Although we cannot claim land as a reparation, we can reclaim control of our own labour and the ability to fully realise the joys and fruits of our own abilities.

Reparations for the centuries-long atrocities of slavery should include:

1. A national apology for slavery.
2. A public acknowledgement that the country suffers because of under-investment in the potentials of African-Americans.
3. Investment in our human potential in return for centuries of our free labour.

Historically, African-Americans had full employment as slaves with zero percent unemployment. But when we could no longer be exploited as slaves and it was no longer profitable to have us fully employed, we were thrown into the disuse category. Today, our potential is under-utilised, indeed under-recognised, as the productive potential, creativity and genius of millions of African-Americans lies fallow and squandered in poor city centres and rural areas. And mainstream America feels as if it can go wherever it wants to go without the contributions of those who are written off as having nothing to contribute.

We need to highlight to the country that this is a loss not only to those whose potential is under-developed and under-utilised, but also to the nation as a whole and to the world.

As fair recompense for this under-utilisation when it no longer became profitable, we propose the full investment in all of us through education and training in whatever forms and to whatever extent we desire. That is, the reparations will not be as lump sums to individual people or as deeds of land, but as investment in the development of our potentials and in the development of institutions which can appropriately participate and sustain that investment.

So, analogous to the kohanga reo and the kura kaupapa of Maori in New Zealand, we should have national investment in African-centred schools as well as in any other schools controlled by African-Americans that we would like to see.

There should also be major investment in recovery of adults who have fallen by the wayside in terms of literacy programmes, community training programmes and higher education, similar to the model of Waipareira in Auckland.

Finally, there should be support for the flourishing of black university centres including the establishment of new ones, as well as the financial support for students of African descent to attend any university to which they aspire and for which they qualify. This should include not only college training but postgraduate and professional training as well.

[My original notes on the issue:

Reparations – apology for slavery, unlimited resources to develop our human potential.

African-centred schools like the kohanga reo, kura kaupapa, wananga raukawa.
Funding for students to go to any university.

In return for centuries of our free labour, investment in our human potential.

How much is the Ministry of Education paying for kohanga, et cetera?

How are community health worker education programmes being funded?

Look at experience where millionaire guaranteed college to those who graduated high school.

We want a guarantee of quality, appropriate education to all of our families without limitation. (Let this become in fact a meritocracy.)

Investment in human potential:

1. E-mail HSB 207 female student who did review on reparations.
2. Do web search on reparations.
3. Get Bittker (book on African-American reparations).
4. Ask Bronwyn, the librarian at the Waitangi Tribunal, for information on South Africa's Truth and Reconciliation Committee.
5. See the Waitangi Tribunal website for Justice Eddie Durie's speech in South Africa.]

[Other early notes:

Need e-mail Vanessa Northington Gamble to get her as a colleague in this effort.

Unpaid labour exploited for three centuries.

Reparations:

Apologise for slavery.

Acknowledge cost of wasting human potential.

Develop schools / fund higher education.]

The fallout from such reparations may be improved educational quality for all with funding for public schools no longer coming out of local property taxes and free tertiary education for all. But even if it does not happen this way for all, we will insure that it happens this way for those of African descent.

Added 2 September 1999:

The initial injustice was the seizing us from our lands against our will, enslaving us and exploiting our unpaid, coerced labour to build the country for centuries. We were valued as assets (not people) under this system of exploitation. At the time of emancipation, we

became surplus. We lost our value, or even became competitors. There was no investment in our reaching our full potentials. The current injustice is keeping us from developing to our full potential. That is why I suggest the form of reparations that I do.

Other forms of reparations that could or have been considered:

Land: We are not the indigenous peoples of the Americas (nor are we the colonisers – we are in a no-man's land situation). We do not have indigenous claims on the land, although many of us do have Native American ancestry. We were promised forty acres and a mule at the time of emancipation, but claims for reparations on that basis have not yet been successful.

Money: Claims on that basis have not yet been successful. Just a few weeks ago, several West African nation states have called for \$25 million (?) in reparations from Europe and the United States for the loss due to their stolen peoples.

Investment in our potential: My call for reparations is on this basis. The investment will be in two general areas, building of educational institutions under African-American control and full support for the tertiary education of students of African descent for the next four generations (at whatever institution they choose).

Appendix C: Talks delivered as an Ian Axford Fellow

“Does racism impact on Maori health?”

- Maori Providers Reference Committee, Ministry of Health, Wellington, March 19, 1999.

“Race, racism and the accelerated ageing hypothesis.”

- Waitangi Tribunal, Wellington, May 3, 1999.
- Department of Public Health, Wellington School of Medicine, May 7, 1999.
- University of Auckland, School of Medicine, Department of Maori and Pacific Health, July 1, 1999.
- Ministry of Health, Wellington, July 23, 1999.

“Beyond rap and baggy pants: African-American connections to te ao Maori.”

- University of Auckland, School of Medicine, Department of Maori and Pacific Health, July 1, 1999.
- University of Auckland, Department of Maori Development, July 2, 1999.

“Naming racism: power or peril?”

- Eru Pomare Maori Health Research Centre, Wellington School of Medicine, August 13, 1999.

“Maori-Pakeha health disparities: can treaty settlements reverse the impacts of racism?”

- Ian Axford Fellowship seminar, National Library, Wellington, August 4, 1999.
- Te Wananga o Raukawa, Otaki, August 16, 1999.
- Ministry of Women's Affairs, Wellington, August 20, 1999.
- Social Policy Agency, Department of Social Welfare, Wellington, August 20, 1999.
- Mokai Marae, Wellington, August 22, 1999.
- Massey University, School of Maori Studies, Palmerston North, August 25, 1999.
- Fulbright Lecture Series, Victoria University Centre for Continuing Education, September 2, 1999.

Appendix D: Coverage of my work in the New Zealand media

- Simmons-Donaldson, Lana. Striking Similarities for African-Americans and New Zealand Maori. Interview published in “Tu Mai” magazine, June 1999, pages 19-21.
- Eruera, Ken. Radio interview aired on “Te Atiawa” radio (96.9 FM), June 17, 1999.
- Stockwell, Kerryn. Race barriers ‘need tackling.’ Coverage of my August 25 lecture at the Massey University School of Maori Studies, published in the “Evening Standard,” August 27, 1999, page 2.
- An outside look at race relations. Editorial published in the “Evening Standard,” August 30, 1999, page 8.
- Collins, Heeni. Maori ‘age 5 years faster than Pakeha.’ Interview published in the “City Voice,” September 9, 1999, front page.

In addition, my work as an Ian Axford Fellow was covered in the Ministry of Health newsletter “In Health” (February, 1999 and August, 1999), in the Waitangi Tribunal newsletter and in “Fulbright New Zealand Quarterly.”