Theorising the structural dynamics of ethnic privilege in Aotearoa: Unpacking "this breeze at my back" (Kimmell and Ferber 2003)

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Abstract

Colonial praxis has been imposed on the culture, epistemologies and praxis of indigenous Maori in Aotearoa, entrenching the settler cultural project that ensures the continuation of the colonial state, producing damaging disparities. This article theorises ways in which settler privilege works at multiple levels supporting settler interests, aspirations and sensibilities. In institutions, myriad mundane processes operate through commerce, law, media, education, health services, environment, religion and international relations constituting settler culture, values and norms. Among individuals, settler discursive/ideological frameworks are hegemonic, powerfully influencing interactions with Maori to produce outcomes that routinely suit settlers. In the internalised domain, there is a symbiotic sense of belonging, rightness, entitlement and confidence that the established social hierarchies will serve settler interests. This structure of privilege works together with overt and implicit acts of racism to reproduce a collective sense of superiority. It requires progressive de-mobilising together with anti-racism efforts to enable our society to move toward social justice.

Keywords

Theory, structural analysis, racism, privilege, social order.

Introduction

> The Maori people … want to have things both ways. They expect all the privileges of racial equality … but when some claim can be made for preferential treatment, they vigorously demand to be treated not as New Zealanders but as Maoris …" (*Observer*, 29 April, 1953 cited in Ballara, 1986, p117.)

In the context of the entrenched colonial society of New Zealand, this quote, from a newspaper editorial 60 years ago, is among myriad mundane expressions of the contempt with which the established social order has long judged Maori society and culture. Maori, the indigenous people of Aotearoa, are explicitly double-positioned as privileged through enjoying the same benefits as other citizens of colonial society, but also as having 'preferential treatment'. These notions of privilege reconstruct our history of injustice and colonisation, and fly in the face of most measurable indicators of Maori social standing and wellbeing (Robson and Harris 2007; Smith 2012; Walker 2004)

Such manoeuvres reflect the discursive component of what Billig (1995) has referred to as "banal nationalism", the practices and processes by which an illicit and unjust colonialism (Walker 2004; Smith 2012) has been imposed and maintained through all the instruments of

state upon the indigenous cultures of this land. Anti-Maori sentiment abounds throughout the written and oral public records from early contact to the most recent times (Ballara 1986; Colvin 2010) as a virulent contributor to a wider hegemonic discourse about relations between settlers and Maori (Reid and Cram 2005; Nairn et al 2006; Wetherell and Potter 1992; Moewaka Barnes et al 2012; Smith 2012; Walker 2004).

In this article, we offer a theoretical exploration of the concepts and discourses of privilege that have emerged iteratively from a study of the ways in which such conferred advantage is manifested in the field of population health in Aotearoa/New Zealand. The study has gathered data in multiple forms including policy documents, media reporting and individual interviews in the broad domain of health and wellbeing. While we do not draw directly upon these materials in our theorising of privilege, engagement with them has informed what we offer here.

Our position, somewhat contrary to entrenched 'common sense' in Aotearoa, is that it is accurate to describe the settler population (hereafter referred to by the Maori term, Pakeha) as privileged in this context. We suggest that a theoretical framework, similar to that applied to the structural analysis of racism, can be elaborated for what it is; a less obvious conceptualisation of privilege—at least for those who benefit. We are guided by the theorising of racism through structural analysis and its articulation as a social determinant of the health of marginalised population groups (CSDH 2007; Paradies et al 2008),although we extend the notion of privilege to patterns of systematic benefits, differentially distributed across social groupings. We argue that Pakeha privilege is more than the inverse of Maori marginalisation, but that it functions with racism against indigenous people, as a fundamental social determinant of health here and, with variations, in other developed colonial states. We see a multifaceted, multi-level phenomenon that operates to include, centre and rationalise settler ideologies, practices, agendas and the settler cultural norms at the expense of indigenous cultures, communities and peoples.

We begin by reviewing critical writings about racism and privilege, turn to offer a structural framing of Pakeha privilege and, finally, discuss implications for understandings of social determinants of health, health policy and practice in Aotearoa.

Background

Exploitation and oppression of social groups have become structured into human relations, and reactions of resistance, revolt and upheaval against established injustice have provided some of the defining moments in human history. Ethnicity, gender and class are, perhaps, the most obvious domains in which the effects of privilege on disparities in health and wellbeing are empirically established (CSDH 2007; Wilkinson and Pickett 2010). Social movements have taken up these concerns in an effort to rebut and change the established explanations and associated actions that reproduce inequality in society.

Academics have explicitly joined these debates about forms of injustice. Dorling (2010) summarises the understandings developed within social geography to argue that unequal outcomes, such as poverty, racism and oppression, are the result of deliberate, structured strategies. These are underwritten by discursive arguments in five key domains—elitism, exclusion, prejudice, greed and despair—that work to naturalise and legitimate inequalities.

Within social psychology, Reicher, Spears and Haslam's (2010) critique of Allport's 'perceptual paradigm' of prejudice and the related 'contact hypothesis' approach to improving race relations is congruent with Dorling's position. Rather than being located in the characteristics and behaviours of individuals, Reicher et al argue that prejudice should be understood as a rich representational practice that is mobilised by leaders and institutions such as media. Racism does not arise through personal ignorance or error, but through the motivated social action of those whose interests it serves. Reicher et al conclude that its elimination will not come from education or contact alone, but from struggle; struggle to undercut racist discourses and practices, and to mobilise anti-racist alternatives.

From empirical studies in the economic domain of mechanisms of intergenerational transmission of wealth in the United States of America (US), Bowles and Gintis (2002) argue that cognitive and personality traits are insignificant in accounting for the established patterns that see the offspring of wealthy families enjoy economic success. Rather, they conclude that "wealth, race and schooling are important to the inheritance of economic status, but IQ is not a major contributor" (p. 22)

These generalised approaches to racism as a determinant of life outcomes is elaborated by Krieger (2003), who describes an ecosocial model of five pathways of embodiment through which racism produces health disparity: Economic and deprivation, harmful exposures hazardous conditions and toxic substances, socially inflicted trauma, targeted marketing of harmful products and inadequate or degrading access to healthcare. To these, she has critically added an historical factor: The impacts of colonisation on the health of Indigenous peoples (Krieger 2011), particularly via the loss and degradation of traditional lands.

The clear inclusion of racism among the social determinants of health by the World Health Organization, Commission on the Social Determinants of Health (CSDH 2008), together with the theorising considered above, represents a sea-change in thinking about issues of justice and oppression. Such thinking challenges the entrenched notion that the fairness of society is guaranteed by its democratic, meritocratic ideology, and asserts that alternative philosophical and theoretical underpinnings are necessary and desirable (Battiste 2000; Robinson 2004; Smith 2012).

The study of racism has noted interlocking and reciprocal relationships among societal, institutional and personal domains (Jones 2000). Paradies et al (2008) outline four dimensions:

- Societal—values, culture and sensibilities of one culture are imposed on another.
- Institutional—practices, policies and processes maintain avoidable inequalities across ethnic groups.
- Interpersonal—interactions between people reproduce inequalities.
- Internalised—attitudes, beliefs or ideologies are held by marginalised groups about their own inferiority.

This composite structures the life experiences of target group members (Ziersch et al 2011) in ways that accumulated over lifetimes and aggregated within marginalised populations, the sum of entrenched disparities.

Societal racism enacts marginalisation and produces stressful events that lead to direct harms of exclusion, psychological distress and physiological stresses affecting mental health. Institutional racism contributes to lower socio-economic status and poorer living conditions in which poverty, crime and violence are persistent stressors. Interpersonal racism stresses individuals and undermines their sense

of self-worth and value to society. Internalised racism evokes negative imagery, denigrates individual self-worth and damages social and psychological efficacy.

Colonisation and privilege

Bolstered by social and scientific theories of racial superiority (Goldberg 1993; Lorimer 1978), European colonisation of the lands of Indigenous peoples has routinely presumed its right to acquire the intellectual, human and resource capital (Said 1978; Smith 2012; Denzin et al 2008; Collins 2010) of such nations. One outcome has been that Indigenous populations within colonial states have been marginalised in power structures and economic development, with consequent sustained population-level disadvantage and disparities in key life domains (Battiste 2000; Denzin et al 2008; Robinson 2004). Notions of natural justice and other supposedly humanitarian ideologies of colonial societies mean that explanation is called for, accountability is required and transformation is indicated as being fundamental to achieving social equity and the elimination of disparities in health and wellbeing.

Data from Aotearoa show that health disparities between Maori and non-Maori/non Pacific persist when class and gender are controlled (Robson and Harris 2007; Robson 2008). Wilkinson and Pickett (2010) have pointed out that New Zealand is one of the most unequal societies in the Organization for Economic Cooperation and Development (OECD) and that health inequalities flow directly from this characteristic. As international comparisons demonstrate, high inequality correlates strongly with poorer outcomes across the social strata (Wilkinson and Pickett 2010) and, in the case of Aotearoa, the inequalities were laid down and are maintained by the colonial processes of marginalisation and exclusion of Maori (Smith 2012; Walker 2004).

Privilege and public health

Racism, as a key determinant of social outcomes, has helped to focus research and policy attention on sources of preventable damage wrought upon Indigenous and minority populations. However, the theorising and investigation of privilege is neglected and under-researched. As Paradies et al (2008) note, "the phenomenon of oppression is also intrinsically linked to that of privilege. In addition to disadvantaging minority racial groups in society, racism also results in groups (such as Whites) being privileged and accruing social power."

The dominant culture remains largely invisible and whiteness is "relatively uncharted territory" (Moreton-Robinson (2005, 79). Not only does this impact on the way people experience privilege and disadvantage, but the benefits accrue over generations. As Collins (2010) queries:

Were your fathers, uncles and grandfathers really more capable than mine or can their accomplishments be explained in part by the racism [that] members of my family experienced?
Did your mothers stand silently by and watch all this happen? More importantly, how have they passed on the benefits of their whiteness to you? (p. 390)

Kimmell and Ferber (2003) characterise ethnic, gender and class privilege as powering a warm tailwind that propels the advantaged through life. Describing a number of dimensions of these invisible forces they assert that, "our task is to begin to make visible the privilege that accompanies and conceals that invisibility" (p. 6).

Turning our gaze from the marginalisation and exclusion that produces ill-health, privilege may be conceptualised as contributing to good health and wellbeing. For example, it is likely to contribute to the social gradient (Marmot and Wilkinson 2001) of a society and to the broad inequalities that are now widely recognised as being crucial social determinants of health (Wilkinson and Pickett 2010).

In Aotearoa, disparities between Indigenous Maori and settler Pakeha populations, which have been monitored for several decades (Robson et al 2007), can be used to demonstrate the effects of intergenerational privilege for the Pakeha population. Disparity discourses can be inverted to describe how Pakeha, as a group, continue to show higher rates of positive outcomes in education, employment, income and health. Pakeha are under-represented in negative data across most domains, including poverty and hardship, housing, contact with the justice system, and self-reported discrimination (Robson and Harris 2007). Pakeha levels of unemployment are a third of those for Maori, and the youth unemployment rate was half that of Maori (Ministry of Social Development 2007). Pakeha are less likely to be in the lowest quintile of household incomes and twice as likely to be in the highest quintile. Pakeha children are far less likely to live in poverty or in households on 'benefits'. Significantly fewer Pakeha families are living in severe hardship than those of Maori and Pacific Island people. Pakeha are more likely to own their home and less likely to be living in crowded housing or deprived areas (Robson and Harris 2007).

Non-Maori, age-standardised rates are significantly lower than those of Maori for most health indicators, including cardiovascular disease, cancer, respiratory disease, infant mortality, diabetes and suicide. Significant differences exist between non-Maori and Maori in mortality, morbidity and independent living. Life expectancy disparities range from 7.9 years for non-Maori/non-Pacific females and 8.6 years for non-Maori/non-Pacific males compared to their Maori counterparts (Statistics New Zealand 2008). Non-Maori report that they are less likely to experience racism in many areas, including work or job applications, renting or buying property, and health services (Harris et al 2006).

The differences arise primarily from life-course exposure to affirming conditions in the form of higher incomes, educational achievement, good housing, healthy diets, active lifestyles and better access to quality healthcare (Crengle et al 2005). These material conditions are, in turn, produced through a complex set of social determinants that produce inclusion by centring Pakeha culture and practices (Nairn et al 2006). Among social determinants, privilege is becoming increasingly acknowledged in how we understand population differentials and wider societal inequity (Paradies and Williams 2008).

Privilege discourse

Established discursive patterns apply commonplace notions of privilege to individuals and groups who are already marginalised. Studies (Borell et al 2009; Wetherell and Potter 1992) have deconstructed this phenomenon in which arrangements made to mitigate inequalities are described as privileged, unfair and racist. For example, designated seats in representative bodies, specific resource allocations (such as fishing quota), grievance settlements and budgetary support for growing Maori institutions are all targets for attack (Moewaka Barnes et al 2012). Other more superficial arrangements, such as Maori sports teams, educational affirmative action and Maori protocols in public life, are similarly criticised. An illustration of mobilisation (Reicher et al 2010) of this pattern is drawn from mass media items in Aotearoa:

A lot of benefits are specifically focused on Maori, such as education grants, loans and the Maori All Blacks. If you had a Pakeha All Black team people would be hitting the roof. (New Zealand Herald 2004)

In both public and private discourse, including politicians' speeches, newspaper items, magazine articles, historical texts, research interviews, talkback radio, informal interactions and internet sites, a 'privilege' trope is used to question the legitimacy of such arrangements and to argue for their removal. Rarely heard is the contextual information that the criticised arrangements have arisen either to confer advantage to the settler majority or to mitigate harms caused by the imposition of white ideologies and practices upon Maori via the supposedly culturally neutral, colour-blind workings of society (Moewaka Barnes et al 2012). The key effect of this discursive strategy is to create a classic 'elephant on the sofa' scenario in which, despite the obviousness of the phenomenon to the critical observer, the everyday realities of Pakeha advantage are effectively obscured to the unwilling or non-reflexive.

Theorising privilege

Despite the obvious linkage of racism and privilege, there is a growing interest in treating them, for research purposes, as phenomena in their own right. The rise of studies of whiteness (Moreton-Robinson 2005; Jensen 2005) and settler culture in Aotearoa (Bell 2004; Huygens 2008; Tuffin 2008; Wetherell and Potter 1992; Spoonley et al 2004) is evidence of the value of this distinction. A sense of the form and impact of such cultural capital can be derived from the structural analysis of whiteness produced by Peggy McIntosh (1990), who developed some 50 brief statements about everyday experiences to describe her own social position. Discursive studies have focussed on patterning in the talk of Pakeha people as a means of understanding cultural inclusion (Bell 2004; Huygens 2008), belonging and identity (Campbell 2005) alongside the ways in which such discourses serve to exclude and marginalise. Borell et al (2009) reported that key informant understandings of privilege revolved around the notion that privilege is multi-layered, invisible (to those that benefit) and closely related to class and culture.

We argue that privilege—the systematic accrual of advantage by a social or ethnic group—is amenable to the types of structural analysis that are applied to racism as discussed above. Such an analysis includes the characteristics of the dimensions of power in play at each level (societal, institutional, interpersonal and internalised) as being important influences on population level disparities in health and wellbeing. We will discuss each level and suggest how the structural dimensions of privilege may impact on health.

Societal privilege

The broad social mores of nations flow recursively through common sense to constitute what Bourdieu (1986) might have called the habitus—the myriad naturalised actions, practices, roles and norms that people enact in mundane social life—of the Pakeha cultural project (Huygens 2008). This latter enterprise is constituted in the patterned social transactions, especially in the dominant discourses, that facilitate and enact Pakeha understandings of the relationships, power dynamics, meanings and material outcomes in everyday experiences, collective identities and the cultural life of the nation.

Societal privilege entails the imposition of the values, epistemologies and sensibilities of settler culture upon that of Maori in ways that assume superiority and rights of domination in all spheres. Social life, with its prescriptive norms and practices, is produced and consumed through the lens of the Pakeha

cultural project, seamlessly remaking history, current social orders and futures in an unwaveringly colonial gaze (Spurr 1993).

As a scion of Western thought and practice, Pakeha worldviews, ideologies, norms and practices cohere to the notion of the meritocratic, self-determining sovereign and individual. The colonial ideology of majoritarian democracy—what Henry and Tator (2002) have called "democratic racism"—underpins resistance to social change at all levels, maintaining social inequality. In health, this is reflected in the persistence of the disparities outlined above and the seemingly unattainable character of health equity (CSDH 2007), across almost every domain (Robson and Harris 2007).

Discourse, as articulated in politics, media, everyday debate and conversation, is fundamental to Pakeha culture, which is constantly articulating its achievements, anxieties, challenges and successes. Resurfacing privilege can be achieved through exploring statements of the kind that McIntosh (1990) developed:

- How fair and ethical is the society you live in?
- How well does your democratic system work to produce equitable outcomes for all citizens?
- How is your culture treated in stories of national life?

While most Pakeha are likely to argue positively on such points, many may acknowledge that there are many unresolved issues around Maori. Such self-critique is widely discounted by claims that Maori enjoy multiple initiatives, ensuring inclusion and access to resources, that they are on a positive trajectory in relation to equity and the country has done comparatively well. These features work synergistically to produce social, cultural, economic and religious environments that reproduce a sense of rights, expectations and diverse functional practices for those enculturated to, and comfortable with, such flows of power and resources.

There is a broad understanding within the Pakeha polity, reflected in dominant discourse, common sense and public opinion, that, while the detail may change through social movements, political evolution and bureaucratic reform, this fundamental structuring is a public good that produces just, healthy and sustainable social orders. Such arrangements are mundanely policed by popular adherence and institutional praxis, and are maintained by their own momentum: Ultimately, they are backed by force to maintain a unitary national sovereignty.

Institutional privilege

Societal, interpersonal and personal discourses, ideologies and practices of the Pakeha cultural project have become sedimented into institutions that were, themselves, imported wholesale from nineteenth century England (King 2003) and developed locally to meet the evolving needs of colony and state. The myriad mundane actions that are utilised in the conduct of relationships between citizens and state, in domains such as commerce, law, media, education, health services, environment, religion, international issues and so on, are profoundly and inescapably shaped by, and constitutive of, Pakeha culture. Maori values, practices and aspirations are, at best, minor chords in this symphony and most commonly patronised, ignored or obliterated. We suggest some questions that could be expected to promote debates around Pakeha experience:

- How does ethnicity impact on the way your judicial system deals with citizens?
- How impartial are your financial service systems in respect of ethnicity?

- How well does your education system meet the needs of all ethnic groups?

While there are some concessions to Maori praxis within Pakeha institutions, these are begrudging and often tokenistic, failing to reflect a broad Maori cultural project or produce changes to Pakeha society that shift ethnic relations in the direction of social equity. To paraphrase Paradies et al (2008), institutional privilege is constituted in requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair advantages to particular ethnic/cultural groups.

There is a comfortable congruence among Pakeha institutions that ensures their maintenance even when their orientations, objectives and goals may, at operational levels, be seriously conflicted. This coherence helps to maintain the sense of unity, commonwealth and national identity that is integral to the reproduction of social orders. Maori institutions are likely to be perceived by Pakeha as special and different. Negative perceptions may frame them as improper, illegitimate and irrelevant. Both sets of characteristics cast Maori institutions as marginal to everyday 'public' systems. In both routine and extraordinary interactions with the institutions of society, Pakeha experience the reassurance (and absence of anxiety) of familiar praxis and alignment with the objectives, processes and outcomes of institutional operations. Whatever their effectiveness, there is an overwhelming sense that these institutions are the natural way to serve the needs of society.

Interpersonal privilege

At the social level, privilege takes material form in the ways relationships between empowered and marginalised individuals and groups play out. Norms and practices are heavily entrenched and the interlocking nature of coloniser and colonised in a dialectic whole (Said 1978; Smith 2012) means interactions between Maori and Pakeha take on a certain stable, scripted formats. In the context of Pakeha power and dominance, this overwhelmingly favours outcomes that suit Pakeha. Underpinning such interactions is a certainty that Pakeha knowledge, processes and practices are valid, normal and naturally superior to those of Maori; in the event of conflict, Pakeha institutions will support and ultimately enforce this status quo. For example, Pakeha epistemological traditions, particularly the realm of Western science, are held to be pre-eminent and universal. Thus, recourse to particular types of scientific accounting is regarded as a 'winning argument' that will brook no debate, except in its own terms. Similar arguments apply in most domains, so interactions in law, political representation, employment, media, arts, sports and so on are all inflected with Pakeha meaning and practice. Such subjectivities may be surfaced by these questions:

- How conscious are you of your ethnicity or culture in social interactions?
- How fairly does your employer treat people of your ethnicity?
- How welcome and 'normal' do you feel in everyday public settings?

As with any social interaction in any sphere, there are complexities, contradictions and counter-examples that leave such analyses fragile and awkward when applied to everyday situations. In aggregate and in the presence of the entrenched patterns of Maori/Pakeha relations, there is, however, a naturalisation of Pakeha practice in this domain. Again building on Paradies et al (2008), we characterise interpersonal privilege as being constituted in interactions between people that maintain and reproduce avoidable and unfair advantages across ethnic/cultural groups.

Societal and institutional privilege underpins the Pakeha cultural capital available to social interaction through protective family, social and community networks of power, and access to resources. Each

person's connections are a conduit for the exchange and accrual of this cultural capital in the mundane practices of social life.

Interpersonal and 'within-group' hierarchies of power and influence exist, but advantages to Pakeha persist as measureable outcomes in domains such as wealth, health, education and justice. Individuals may fail, or rebel (and still 'pass'), but, at the population level, these effects aggregate to ensure that social and economic statuses are progressively enhanced for the privileged groups.

Internalised privilege

Pakeha take on board and incorporate into their identities political analysis and cultural perspectives that justify, enable and embody differential resource distribution and use. This is reflected in a symbiotic sense of belonging, rights, comfort and entitlement and in the confidence that established social hierarchies will serve their interests. Their active understanding of this, however, is likely to be at the level of a 'cultural unconsciousness', a sedimented set of norms, beliefs, discourses and practices that, together with overt, implicit and unconscious racism, mundanely reproduce a sense of superiority over Maori.

- How often do you question your sense of identity and self-worth?
- How much do your achievements depend on ethnicity and culture?
- How freely can you choose your life goals?

Internalised effects generated via the social processes suggested above converge with an inherited sense of self-worth that promotes and builds social and psychological agency and efficacy. An upshot of this is that there is little energy for concern over the life experiences of out-group members, since, if they are competent, they ought to be able to provide for themselves in an idealised egalitarian society.

The Pakeha individual is 'empowered' within a framework that produces both standards of achievement and justifiable outcomes in a self-fulfilling prophecy; the belief that personal, meritocratic advancement is a paramount goal of inherent social value. Internalised privilege entails the acceptance and adoption of discourses, beliefs or ideologies by members of privileged ethnic/racial groups about the value of one's own ethnic/racial group (Paradies et al 2008).

Discussion

We argue that there are potential gains from the naming and defining of privilege as a social determinant of population health and wellbeing, and that it is the turn to focus on privilege, as well as racism, in structural analysis. Challenging the hegemonic gaze, we see relevance in a number of domains of social life in Aotearoa, including policy, equity monitoring, beliefs/values, and identities.

Determinants of social and health inequity

Privilege structures, interwoven with those of racism, maintain inequalities and disparities between Maori and Pakeha. In health domains, colonial mechanisms, through the enactment of Pakeha cultural values, the norms and expectations of providers and clinicians, and the health beliefs and practices of those using such services, inequitably serve the needs and preferences of Pakeha and, thereby, contribute to health inequity (CSDH 2007; Krieger 2011).

As Dorling (2010) argued, the links between power and outcomes are relatively easy to understand; the challenges are around adjustments to the expression of power through inequitable structures, policies and the discourses that support them. Reicher's (2010) insight that prejudice is always mobilised might be reworked to say that privilege is not mobilised or 'forgotten', as suggested by Billig (1995). The task for those working for equity could be extended to include actions and discourses that articulate and critique the hidden hegemonies of privilege.

Giving up power and privilege for altruistic reasons is an unlikely aspiration for empowered groups (Ramsden and Spoonley 1993). However, as Wilkinson and Pickett (2010) pointed out, large social gradients are bad for everyone in a society, including the most privileged. For many Pakeha, collective identity is tightly fused with notions of equity; a 'fair go' for all is a strong value. Addressing Pakeha privilege highlights how precarious notions of fairness are for Maori and challenges the assumption that their benefits are universally accessible. Questioning such values can go some way to preparing Pakeha for a more open dialogue with Maori aspirations for self-determination. We hope that our theoretical framing of privilege in this way will contribute to better understandings of why collective work on reducing social gradients is critical to aspirations for social and health equity.

Structural analysis of Pakeha cultural beliefs/values

Structural analysis of racism has long been an important tool for Treaty of Waitangi education enterprises (Huygens 2008), but the additional focus on privilege may sharpen Pakeha learning experiences in this domain. Such analyses can help to shift focus from personal guilt reactions and defensiveness to a realisation that the privileged are also part of a racialised environment that discounts their humanity. Articulating the social positioning of Pakeha allows a more inclusive and nuanced sense of their ethnic identity and collective responsibilities for achieving social equity. We argue that collaborative and negotiated movements towards eliminating injustices brought about by colonial oppression require negotiated commitment by both the coloniser and the colonised (Freire 1970; Smith 2012). This perspective is strengthened in the work of Wilkinson and Pickett (2010), which demonstrates that countries such as the US, the United Kingdom and New Zealand, where social inequalities are extreme, have much worse health outcomes for all social classes than do countries including Japan, Sweden and Demark where inequalities are not as extreme.

Pakeha identity work

Through re-centring the analysis of health inequity as being a collective challenge for society, there is an impetus to promote and legitimise a more robust cultural identity for Pakeha people, as distinct from the current 'default to the West'. There is emerging evidence (Huygens 2008) that Pakeha feel a certain 'hollowness', most obvious in the appropriation of Maori icons to express distinctive identity (Fleras and Spoonley 1999). Addressing Pakeha privilege can highlight the Pakeha cultural project in ways that will enable it to contribute more effectively to the constructive development of Pakeha identities.

Having accurate and specific information that monitors society's performance for all groups is a basic right that has long been argued as being necessary to inform judgements, norms and practices about justice and equity. The invisibility of the dominant culture means that information about the cultural specificities of that group is consistently obscured from view. For example, questions that we developed to illustrate personal proximity to indicators of privilege in this country have been informally shown to demarcate major differences between Maori and Pakeha. They could become a

complementary tool to broaden and strengthen research that links racism and health (Crengle et al 2005; Harris et al 2006).

Policy frameworks

Finally, and critically, there are significant implications for policy settings that underpin social order. Te Tiriti o Waitangi, as the foundational document of the nation, encodes equity as being fundamental to the enactment of Maori rights and to good governance. Too often, in Pakeha common sense, Te Tiriti is framed solely as a Maori concern of negligible relevance to Pakeha (Moewaka Barnes et al 2012). The theorising of privilege that is suggested here challenges this view by putting the coloniser firmly in the frame of social equity. The articulation of Pakeha privilege with racism helps to foreground this. In the policy arena, such work helps to dispel hegemonic notions, such as the 'level playing-field', and offers constructive pathways toward policy changes through which health and social equity might be achieved.

Conclusion

We have described a series of conceptual elements of privilege that work synergistically with personal and collective identity. Pakeha norms, values, behavioural practices and naturalised expectations about rights, roles and rewards for group members are fundamentally promoting belonging, health and wellbeing. We do not mean to suggest that these should be seen as meaningfully separable in practical everyday terms, but feel that teasing them apart, as we have, can contribute at a conceptual level to a poorly understood, but critically important aspect of the structure of inequality. Nor do we contend that personal Pakeha dissent is futile; it exists (Huygens 2008; Walker 2004) and contributes valuable critique and resistance. However, more generally, the impetus for radical change of the kind that may produce just relations between Indigenous and settler people remains weak and compromised by the continual pay-offs of normalised population-level ascribed privilege.

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