THE WHITE NATION HAS A LOT TO ANSWER FOR: Towards an analysis of racism in the state structures responsible for New Zealand's health

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INTRODUCTION

This paper attempts to examine the relationship between Maori health and State health policies in New Zealand. It takes as its point of departure the basic assumption that the most brutal weapons of oppression against both indigenous and immigrant groups have been wielded by state policy and state agencies (Te Awakotuku, 1984, 245). Sivanandan's theory of racism is used as a framework and its shortcomings are identified.

I pursue this investigation keeping in mind the danger that racism can become yet another academic interest that colonises: the assertion of one group's skills, needs, desires and intentions wilfully over another group (Te Awakotuku, 1984, 147).

The task for nurses is to understand the part they play in perpetuating the oppressive practices of the state that result in conflict, stress and unrest expressed as ill health in the Maori people.

THEORETICAL FRAMEWORK

Sivanandan writes about Britain in the sixties and seventies. He sees racism and capitalism as inextricably linked and even suggests that if capitalism no longer required racism, then racism would diminish and possibly even disappear. Sivanandan addresses the problem of a black under-class, an under-class of black workers imported to fulfil the needs of British capital. He sees the contemporary crisis firmly rooted in labour relations and characterised by the various mechanisms of capital that have shifted, re-aligned, and adapted to maintain control and ensure the maintenance of capital. This is particularly true of the activities of the state. When a new under-class was imported from the colonies after World War Two, a consciousness of race was fostered, with the result that class consciousness was less well developed. The sixties and seventies brought the institutionalization of racism by the state. The 1958 'race riots' provided the rationale for the management of racism. It was becoming disruptive or counter-productive so legislation was passed to restrict citizenship, and consequently, capital was maintained by the continuing exploitation of the labour force. The more

recent state strategy has been to foster integration, (while restricting entry into Britain) in other words, to quell the rising black militancy.

Sivanandan places the more recent developments in Britain in the realm of domestic neo-colonialism, that is the creation of black collaborators; the black bourgeoisie. The aim of this policy was to justify the ways of the state to local and sectional interests through the agency of the black bourgeoisie — for example the creation of the Race Relations Board and the Community Relations Commission. The Commission taught the white power structure to accept blacks, and the blacks to accept the white structure of power, by defining, controlling, ordaining black concerns. It also created and isolated a black middle class. All in all, the power structures of the state have worked to maintain capitalism.

IN THE NEW ZEALAND CONTEXT

Before attempting to apply Sivanandan's theory to the New Zealand setting it is necessary to provide some background to the issues involved. New Zealand is a part of world

society with its origins as a capitalist white-settler colony. The development of New Zealand as a dependent economy occurred in conjunction with the destruction of Maori society. This involved a total frontal assault at all levels of society — economic, political, and ideological — in order to remake Maori society in its own image (Bedggood, 1980, 24-27). A consequence of this destruction was demonstrated by the level of the population at the end of the nineteenth century, that is 40,000, marking the low-point in a long decline of possibly 60% since the beginning of the century. Since then the Maori population is said to have gone through a 'demographic transition', associated with the recent long-term increases of life expectancy, and the reduction of the impact of infectious diseases. Urbanisation is argued to have had a major impact on these features, yet there are still significant differences between Maori and non-Maori health indicators (Davis, 1984, 143-146). According to statistics collated by the very state structures under scrutiny, the younger age groups in the Maori population often show a higher mortality rate than in the equivalent group of non-Maori (Bureau of Public Health Priorities 1984/85). A radical Maori perspective describes Maori health like this:

Maori people are, every day, forced to live by the rules of another culture. All the Maori people I know suffer ill-health — a malaise of conflict and stress and spiritual unrest — even the ones who seem to be spiritually happy with the white nation. They are the ones resolved to follow the rules of the dominant culture. In this pragmatic solution, the individual seeks their own wellbeing, at the expense of their commitment to their taha Maori. This is not what I call good health. (Awatere, 1984).

Another important concept for the understanding of the New Zealand context is the welfare state. Sivanandan's analysis of the British context includes direct links between the oppressed and the economy through labour relations. The aim of state policy, then, is to

quell black militancy so that the labour needs of capital are served. The way that the state does the same thing through health policy in New Zealand is necessarily more subtle.

The Health Department, could be seen by radical theorists like Sivanandan and Awatere as a further state instrument of colonisation. To elaborate, the aim of health policy would be to direct resources to areas which promoted the cause of capitalism, and conversely to restrict the use of resources in areas that were costly and tended not to maintain and reproduce capitalist structures. This would include reproducing the labour force with the minimum of outlay of resources, through a health care system that provided minimum standards of care.

HEALTH POLICY

The Health Department has been in existence since 1900. This government department has recently been part of a more high profile state response to Maori issues for example the Department of Maori Affairs (Fleras, 1984, 33) and the Department of Social Welfare (Rankine, 1985, 20). In the annual report of 1985, the Department of Health's stated Priorities for Maori Health were to assist Maori people to initiate activities which they felt would improve their health. The programme focussed on:

1. Providing administrative, technical and advisory support to Te Waiora O Aotearoa Trust, begun and planned to implement a major national Maori health programme.
2. Improving cross-cultural communication between Maori people and health care providers.
3. Encouraging Maori people to participate in health conferences.
4. Arranging marae experience courses for departmental and hospital board staff.
5. Providing administrative, technical and advisory support to assist the development of Maori health activities, for example health hui and the appointment of Maori health education officers.
6. Assisting groups to incorporate a Maori

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health perspective in the training and education of their personnel.

7. Development of resource groups within head and regional offices.
8. Liaison with the organisations, for example Maori Women's Welfare League, National Council of Maori Nurses (Department of Health 1986a, pp. 18-19).

Keeping in mind Sivanandan's points about state objectives in teaching the white power structure to accept Maori people and Maori people to accept the white structures, it may be useful at this stage to look at the above policy statement in relation to its implementation. One way of doing this is to refer to an account of a hui, written by a member of staff at the Health Department. Although this document predates the actual policy statement, I believe it represents its underlying assumptions accurately.

A wide range of Maori expertise was co-opted for the hui, which was supported by the Department for a number of stated reasons. These included a recognition of the concern Maori communities had for their health, and a commitment to supporting Maori health initiatives. In this way, the Department's interests in setting boundaries and defining legitimate concerns are revealed. The report acknowledges the contradictions of complying with Departmental procedures while recognising the Maori way of doing things (Dyall, 1984). What it does not acknowledge but nevertheless implies through omission is the obvious power differential between the Department and Maori groups.

Since 1984 a great deal of activity has occurred in the Health Department in relation to Maori Health. The most recently published annual report states that fourteen seminars, workshops and hui have been held with the stated aim being to enhance cross-cultural awareness and understanding (Department of Health, 1987, 74). Likewise, here, there is no stated commitment to sharing decision-making with people of other cultures.

Another Health Department priority stipu-

lates support of groups incorporating a Maori health perspective in the training and education of their personnel. Encouraging non-pakeha people into nursing was one of the anticipated outcomes of a residential course held at Lopdell House, Auckland in June 1985. The theme of the course was 'Teaching Strategies for Multi-cultural Awareness in Nursing'. A report reflects concern at the current monocultural character of nursing practice and a desire to increase sensitivity to people of other cultures (Butterfield, 1985). That the course represents yet another version of state agencies' maintenance of control is evident in the absence of an understanding of crucial issues in the report. The content of the course focussed on multi-culturalism and by so doing trivialised the particular place of the Maori culture. By focussing on nursing as an individualised expression of caring, attention was deflected from the structural barriers to effective health practices. By focussing on finding out more about other cultures, attention was directed away from the oppressive practices of the state and its agencies.

A consideration of health policy must necessarily include mention of the role of medical ideology. The medical profession, both historically and currently, wields an enormous amount of influence in decision-making at national and regional levels. The links between medicine and capitalism are evident in the workings of the medical-industrial complex. These help sustain and reproduce the social relations of production and patterns of domination. For example, equating biological homeostasis with the workings of a machine allows the acceptance of a general ideology that attaches unjustified positive evaluation to industrial technology. This helps justify medical approaches that depend on advanced technology (Waitzkin, 1983, 57), and is in total contradiction to the Maori understanding of health, and also deflects attention away from multi-factorial causes of illness, for example working conditions, stress, unemployment. This ideology expresses itself in the racism of health professionals. Victim-blaming is com-

pounded by a failure to offer appropriate services. A Waikato survey showed that even though the incidence of cervical cancer is higher in Maori women they were less likely to be offered a smear test to screen for the condition, than were non-Maori women (Department of Health, 1986b).

That state structures are involved in strategies to involve the Maori people at community level is no accident, particularly in the health area. While the state remains publicly loyal to the concept of welfare and a health system that does not discriminate against the disadvantaged, the public health service is contracting and the private health care system expanding (Fougere 1982, 23). Moving health services into the community can be interpreted as providing care on the cheap, through the enlistment of an already over-worked voluntary corps — a phenomenon that has been recognised in other spheres (Fleras, 1984, 35). The co-option process used by the state applies extra pressures to a group already oppressed by state policies. As is apparent from the Department of Health priorities, Maori people are expected to participate in activities on a voluntary basis, organised by the very structures that maintain their oppression. Self-determination and autonomy are promoted on the one hand, on the other, effective means to ensure adequate support are lacking. The vast majority of health funding continues to be poured into curative services, and only 2.1% of the health budget is allocated to health promotion and prevention of disease. With the majority of Maori people being in the lower socio-economic groups their capacity to contribute at both a personal and financial level must be less than other socio-economic groups in New Zealand.

It has to be suggested, then, that state structures have an interest in maintaining themselves, and their agencies, along with continuation of the status of their workers, including the health professions. Underlying this concern is the protection of the interests of the owners of the means of production. This means that health policy reflects the ultimate interests of this group. Racism in health care is, therefore, used to promote the interests of capitalism.

CRITIQUE OF SIVANANDAN

One difficulty to be identified is the transposition of theory to the New Zealand context. The history of racism in Britain traces a different course from that in New Zealand notwithstanding the lessons that can be learned from both settings. Migrant labour and neo-colonialism are concepts that could just as readily be applied to an explanation of Pacific Islanders' experience in New Zealand. Perhaps the most obvious problem in considering the relevance of Sivanandan's theory is the respective importance of the concepts of race, class, and ethnicity. Peter Davis discusses Maori health as a combination of social class, ethnic and cultural factors.

It seems that there has not yet been developed a conceptual framework that adequately deals with the complexities of the issues. While Sivanandan's approach presupposes the primacy of racism as a tool to support the structures of the capitalist state, other writers regard his and other Marxist interpretations as unnecessarily economic and instrumentalist. The Marxist strand of thought that considers issues in their ideological form also comes under criticism. A more comprehensive view is apparent in those who argue that racism signifies an almost indiscriminate range of practices that cannot be conceived together as effects either of dominant economic class relations and/or the political will of the ruling class (Gabriel & Ben Tovim, 1978, 157). It is rather a phenomenon that is being constantly transformed, a phenomenon that is organic in nature, occurring as a result of economic, political, ideological and cultural processes. This does not mean to say that the conditions of late capitalism are irrelevant. Indeed, the same authors go on to point out what underlies the superficial appearance of the British state: when the normal processes of political authority cannot proceed by co-operation they will proceed by confrontation through the state's orchestration and legitimisation of repression. While New Zealand's history of racism differs from Britain, the

above scenario is not an unrealistic consideration for New Zealand (Solomos, et al, 1982, 11).

Feminist criticism of Sivanandan's theory of racism echoes feminist criticism of all orthodox Marxist theories; that it fails to account for the experiences of Black women. The same criticism is directed at mainstream feminism, and is expressed as follows:

The fact that Black women are subject to the simultaneous oppression of patriarchy, class, and 'race' is the prime reason for not employing parallels that render their position and experience not only marginal but also invisible. (Carby, 1982, p.93)

Translated into the New Zealand setting, a Marxist explanation of racism in the health care system does not adequately interpret the place of patriarchy in the oppression of Maori women. Other writers in the Black women's movement reject feminism as irrelevant to their lives, while maintaining a focus on women's issues (Bryan, et al, 1985, 173). Sivanandan's writings virtually ignore the experiences of women in racism. Such blatant sexism severely limits the use of his theory of racism to explain the oppression of Black women.

CONCLUSION

This paper reflects some of the many difficulties in tackling the problem of racism. There is a real need to develop a theoretical framework that can account for the reality of

the experiences of racism. The theoretical stance must be applicable to the New Zealand context. One of the hindrances of growth of knowledge must be the complexity of the issues involved, and thence the enormity of the task. This paper has been an attempt to look at one perspective on racism, and its application to one area of the activities of the state. The major limitation of the usefulness of the theory chosen, is the difficulty in making the links between ideological practice and the control of the means of production. Whether, on the basis of that, this theory should be discarded, or whether it should be developed further to overcome that inadequacy is a point that must lie outside the confines of this paper. The question remains too, of the legitimacy of racism as an academic field of study. It seems what white people need to do is analyse their own racism, and analyse the structures that support and foster that racism. I hope this paper demonstrates my attempt to do that. Finally, the remaining issue is what will happen in the future. Solomos, et al described Britain in the early nineteen eighties as being a very dangerous time. That sentiment applies equally to New Zealand in the late nineteen eighties, partially because some of the political trends here are echoing events in Britain in the last few years, for example the dismantling of the public health service. What perhaps is more dangerous in New Zealand is that it is being carried out by an allegedly democratic and liberal government. There is a long struggle ahead for those who would seek to transform society by ridding social structures of racist practices and policies.

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