Essay One
POPST501-22A
Social determinates of Health – Education
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Reports to the Minister of Health in New Zealand since the late 1990's have prioritised attention to the socio-economic determinants of health in order to advance population health gain and achieve health equity.

Why has education been identified as one of the most important social determinants of health?

Introduction

Nelson Mandela said that 'education is the most powerful weapon we can use to change the world.' That power is greatest when all children and young people, no matter their ethnicity, where they live or how much money their parents make, have access to a high-quality education that meets their unique needs (Bolton, 2017).

In 21st century New Zealand the gap that exists between those that enjoy economically privileged lifestyles and those that live in disadvantage, continues to widen, the impact of this on society is costly and disruptive to every New Zealander being able to enjoy a higher standard of living. This conversation has now become highly political and as each successive Government takes office they pledge to 'do better' to ensure that all New Zealander's have affordable access to the basics of life, health care, education and housing. The intergenerational trauma, racism and disadvantage that has been imposed on Māori through the imperialistic colonisers, arriving in New Zealand in 1840, to conquer, trade and confiscate (Walker, 2016, p. 19), has created massive and intentional social disadvantage for Māori, presenting in a myriad of ways, across a diversity of social sectors.

Māori have been disenfranchised, disadvantaged, and marginalised and therefore naturally present poorly in the New Zealand's Government reports on health, education, justice, and housing. Nearly one third of working age Māori in New Zealand are now on social welfare benefits, this attaches to poor mental and physical health and risky behaviours (OECD, 2013). Twice as many Māori as opposed to their European counterparts, lack school qualifications, and this long tail of underachievement is linked to low socio-origins and unaddressed historical trauma. Minorities now account for one third of the school population in New Zealand. In 2040 Māori and Pacific students will make up the majority of school students, this will have huge impact on New Zealand's economic growth (OECD, 2013).

The mono-culturalism of our education system is no doubt a key reason Māori kids drop out, or are stood down, at a rate more than double their Pākehā peers (Hura, 2017*).*

Therefore it is essential to fully develop this human capital for New Zealand's future economic growth potential and social cohesion (OECD, 2013). Should the systemic inequities in education not be addressed, New Zealand will be unable to fill job opportunities with its own people (Bolton, 2017).

Human Capital Theory posits that education improves an individual's knowledge, skills, reasoning effectiveness and personal control, all required to produce good health (Zajacova & Lawrence, 2018). Coloniality, (historical and ongoing), drives the systemic disadvantage that continues to be bestowed on Māori, this in itself creates a moral imperative to better support Māori communities, through a meaningful and relevant education system that allows Māori students to succeed as Māori. It is unfair to NOT support people that have been historically disadvantaged by the social system (Bolton, 2017).

Full participation in society and the labour market are linked to a country's wellbeing, and an individual's ability to accumulate knowledge and skills, are acquired through a country's education system. Education, on the financial side of the ledger equals employment, acquisition of housing and making a tax contribution, on the non-financial side it equals wellbeing (OECD, 2013), and an equitable education system enhances a country's overall social unity and trust. For education to be equitable in, gender, economic status, ethnicity, and multiculturalism, discrimination cannot be a barrier. Therefore, key government policy needs to address how educational systems are designed and how resources are allocated, so that educational equity is the result. Higher living standards for all New Zealanders, can only be achieved through a Government that prioritises education and health (OECD, 2013). A country's resources need to fairly be allocated against sustainable sources of prosperity through equitable policy construction to be able achieve sustainable economic growth. Systemic educational inequity impacts on communities and national economies, where citizens are left unable and unprepared to participate in the workforce or civic life (Bolton, 2017). New Zealand needs to build world class equitable education system, where every student can succeed regardless of ethnicity, that upholds the articles of Te Tiriti o Waitangi (Treaty of Waitangi) (Bolton, 2017).

Education is the best life-long protection against unemployment, low wages, health and poverty (OECD, 2013).

This essay is an attempt to understand how educational inequity and its subsequent outcomes are a key determinant of the poor social and health consequences that continue to widen the gap of economic privilege and social wellbeing in New Zealand.

Why education as a socio-economic determinant of health, is important within the New Zealand context.

To understand the relationship between education as a social determinant of health and the impact that it has today on the poor health outcomes for Māori, one has to initially look at the trajectory and agenda of the Colonisers of New Zealand.

The act of colonisation is the invasion and control, over indigenous people, whereby the Colonisers secure and sustain the means to profit from the resources of the land and as part of this process they supplant indigenous social, cultural, political and economic ways of being with their own (Waziyatawin & Yellow Bird, 2012).

Education has long been used as a way of normalising one set of ideals and values over another, it is colonisation by stealth. Nadine Millar (Bolton, 2017).

In 1840 when the Colonisers of New Zealand annexed to New Zealand's Te Tiriti o Waitangi they had considerable experience in domination, subjugation and domestication of indigenous people, as they now ruled over 25% of the global population (Walker, 2016, p. 19). The Colonisers saw themselves as superior, and the new worlds they were opening up as savage and inferior, their techniques included trade, exploiting resources, cultural invasion through missionary activity, confiscation of land, military invasion and political domination. The effect of this for Māori, was population decline, loss of chiefly mana, political marginalisation, poverty, language, identity and culture loss. The structure of this historical process resulted in Pākehā domination and Māori subordination, where subsequent institutional arrangements functioned to maintain this structural disadvantage for Māori, with ongoing systematic attacks via education on their culture, language and identity (Walker, 2016, p. 20).

Pre-colonisation, New Zealand's Māori, with their fishing, hunting and gardening economy had established a sustainable lifestyle. The original education of Māori, through pūrākau (a pedological tool for teaching and learning) using well-crafted thoughtful narrative to effect engagement and to teach knowledge and genealogy through a highly intricate knowledge base (Walker, 2016, p. 5), was destroyed by a Colonisers agenda, predicated on notions of racial and cultural superiority, intent on converting Māori's perceived barbarism to Christianity and civilisation (Walker, 2016, p.19). The missionaries believed Māori could be raised from their primitive state through schooling (Walker, 2016, p.20), and they taught Māori to read and write in their native Māori language through Native Schools. In 1816 the first missionary school was opened in the Bay of Islands and even though Māori had schools that taught their genealogy of knowledge, they preferred the missionary schools, believing they would advance their own material wealth (ships, guns and goods), however the material trappings remained elusive for Māori (Walker, 2016, p. 21). Later, assimilation was seen as the best way forward to negate tangata whenua (people of the land) and in 1847 the Government offered subsidises to church boarding schools, established to isolate Māori from

the demoralising influences of their villages, where Māori language and tikanga was purposely excluded from the curriculum (Walker, 2016, p. 23). With the expansion of Native Schools in 1867, English became the main teaching language, the schools were used to civilise Māori, and in doing so discouraged the reo and tikanga Māori. These schools were an intent to pacify, civilize and enhance the moral influence of Government and provide industrial and labour training, that would ultimately assign to assign Māori to a societal underclass (Walker, 2016, p. 23).

I do not advocate for the natives under present circumstances a refined education or high mental culture,… they are better calculated to get their living by manual rather than mental. A declaration made by Henry Taylor, a school inspector. (Walker, 2016, p. 23)

In 1877 the national system of secular and compulsory primary school education board was established, they had an objective to phase out Native Schools, these however continued well into the 20th Century. The board schools took preference in education provision, especially as Māori migrated to urban centres in search of work, these schools that required Māori's cultural surrender, steered Māori students towards manual and domestic labour, and very few went on to high school (Bolton, 2017). Ongoing structural disadvantage supported two tiers of education that was established to assert Pākehā dominance, tracking Māori way from the professions and into manual labour with the underlaying intention of continuing to subordinate Māori (Bolton, 2017).

At the end of World War II many Māori had urbanised and as a result of an earlier inferior education and removal of their traditional ways of home life, the social inequities where further solidified for them (Bolton, 2017). Māori now forced to urbanise, and heavily discriminated against both personally, educationally, and systemically, were left to their own devices in the cities, the systemic disadvantages increased, and more and Māori where living and bringing up tamariki in urban poverty, the lower educational outcomes became normalised and intergenerational (Bolton, 2017). Māori moving around to increase their work opportunities or address their living environments, also interrupted the schooling for their tamariki, this in turn reflected in high rates of absenteeism. Māori's removal from the traditional ways of living and learning, and from their support systems, further marginalised their outcomes. The industrialization of the economy relied heavily on Māori in the work force, paying wages that only just enabled them to live and providing roles that were to later result in health deficits for them (Bolton, 2017). So while many in the European economy made huge personal income gains from the economies massive period of growth this was at the expense of those with inferior educations, who had never experienced the social wellbeing that educational success should deliver, and worked daily to ensure the success of the privileged and educated. These privileged and educated, were in turn the people that formed and supported the Governments and influenced the policies that further enhanced the inequality (Bolton, 2017).

My positionality

For the last eight years I have worked in the New Zealand women's prisons with high and complex wahine (women) offenders. This work is effected through RAW 2014 (Reclaim Another Woman), an organisation that I have foundered with my sister (a mental health practitioner). RAW's work has identified this particular group of wahine, predominately Māori, as having extreme social disadvantage and strong intergenerational influence, that unless willingly interrupted through models they trust, they are likely to continue on this socially destructive intergenerational criminal pathway, not only for themselves but also by way of setting higher and higher benchmarks for their tamariki and mokopuna. Through this work I have observed their absolute lack of exposure to education, their ongoing battle with health, and absolute distrust all things Pakeha, these have been severe life enablers for them. Firstly, there is little knowledge as to what out-comes can be achieved through an educational journey and subsequently very little appetite to advance life differently. The wahine have normalised the disadvantage, the chaos and the disruption that their lives have become. RAW has an absolute focus on education and this operates against all levels of life, wellness, and academia.

We have identified this as the only way the disadvantage can be understood and interrupted, assuming there is willingness from wahine to embark on the RAW journey. The wahine on the RAW program have largely been in the justice system all of their lives and with RAW's older wahine they are also now incarcerated alongside their tamariki.

RAW's educational focus starts inside with the building of trusted relationships that advances possibility over a period of time, this is done through literature, conversation and hui with relevant and inspirational (nominated by the wahine) guests. Wahine electing to come to RAW and advance on a pathway of educational amplification generally do incredibly well. In fact RAW itself has had some impressive outcomes, but this essay is to establish my credibility to have commentary on the education-health relationship, which is well observed in RAW's work.

Wahine that choose to educate in the higher educational space have managed to experience sustainable change that continues to grow, they have secured jobs they love, bought their own homes through social schemes (Habitat for Humanity), and completed degrees and diplomas. Once living with stability and support they have selected schools that will assist tamariki with their educational and learning challenges. These tamariki then become the circuit breakers of whanau social disadvantage, as they educate and advance the family's coping strategies.

The social welfare system we have in New Zealand today is well structured to continue to provide handouts to those that are most at need, but with no real strategy to assist the transition from 'hand out to hand up', the entitlement and despair grow and the poverty simply increases, as no one values what they get for nothing. Benefit payments to recipients

increased from 286,225 in June 2017 to 363,497 in June 2021 (Palmer, 2022), and Maori as 15% of the population are over represented, receiving 36% of the benefits (WEAG, 2022). Therefore 'teaching wahine to fish' rather than simply continuing to provide them with fish has been the RAW philosophy, giving them back their tino rangatiratanga (self-determination) and creating a life place to stand in the RAW whare (home) with their sisters.

RAW, unusually, is a model for life, and as with most change it is an ongoing process that can take a lifetime to achieve, and RAW's model acknowledges this. Wahine arriving at RAW also come with a myriad of health challenges, these are systemically linked to a birth-right that has been bestowed upon them, of violence, crime, sexual molestation and drug and alcohol abuse. The wahine have simply learnt to normalise these social disruptors and manage their health through avoidance or masking with drugs and alcohol. Their health challenges are many, from the dental rot and cognitive decay that the many years of drug and alcohol use has caused, to the health challenges that align with obesity, once the drugs have gone, (methamphetamine especially) weight management becomes a challenge and often diabetes is a result. Regular hospital visits to manage health care are the norm, enabling them to deal with a new normality, these are always via the emergency care in public hospitals. With no regular doctor of their own to assist and manage their wellness, and even more so, no likelihood of this opportunity, as all medical books are largely closed, this privilege remains with the functionally privileged. The wahine struggle to understand their health challenges and often resort to strong medication reminiscent of the drugs they used to take. This time they are treating themselves with legal pharmaceuticals, that ironically also have street value in criminal spaces, hence the wahine are never far from their past lives and negative influences. Those that choose not to add to their educational portfolio, if they can find a company that won't apply criminal checks against employment outcomes, remain on minimum wages, unskilled and voiceless to even negotiate their worth with their employers. They are often shifting from job to job as their dissatisfaction continues and the lure of criminal activity strengthens. The disconnect from society is so systemic that only a few courageous wahine totally leave a criminal lifestyle, when they do the intergenerational outcomes are expediential, but they often exist within a capsule of mental and physical health challenges that continue to raise their heads, reminding them constantly that their normality is never far away and it may just be the easier way to exist.

The relationship between education and health, and the subsequent outcomes.

There is an iterative relationship between education and health. While poor education is associated with poor health due to income, resources, healthy behaviours, healthy neighbourhood, and other socioeconomic factors, poor health, in turn, is associated with educational setbacks and interference with schooling through difficulties with learning disabilities, absenteeism, or cognitive disorders. ***Education is therefore considered an important social determinant of health****.* (Raghupathi & Raghupathi, 2020)

Understanding the health benefits of education is integral to improving health disparities and improving the wellbeing of 21st century citizens. Education however, must not only be seen as a driver of opportunity, but also as a re-producer of inequality (Raghupathi & Raghupathi, 2020). Education as the principle pathway to opportunity, becomes a vehicle for social success, access to valuable resources and resultant good health. It is, however, also the producer of intergenerational inequity, with an individual's success being dependent on the schools they attended, the neighbourhoods they have lived in, their skin colour, race, and gender, Government's resource allocation, and the socio economic status of their family (Zajacova & Lawrence, 2018).

Fundamental Cause Theory, posits social factors (such as education) as causes of health and disease, in that academic achievement determines a person's access to material and non-material resources, income, safe neighbourhoods and healthy lifestyles, these all protect and enhance an individual's health (Zajacova & Lawrence, 2018).

Education that is largely assessed in terms of academic attainment rather than understanding the socio economic factors that shape the schooling process, will fail to inform government policy and resource allocation decisions fairly. Therefore, it is important to recognise the dual function of education, in as well as being an opportunity enhancer, it is also a driver of inequity through systemic differences in schooling, school resource allocation, quality of instruction, academic opportunities, peer influences and teacher expectations (Zajacova & Lawrence, 2018).

Understanding a life course for a person, yields a greater insight to provide relevant interventions that avoid the consequence of disparities. Educational attainment matters for health and longevity of life, therefore policy that addresses income tax structures, social inclusion (income inequality and unemployment rates) and education expenditures per capita, also matters (Zajacova & Lawrence, 2018). Pro-market neo liberal policies of successive New Zealand Governments have increased social inequity through decreasing economic wellbeing, economic segregation, mass incarceration, downward social mobility and despair for working class communities, the health-education relationship, is therefore inextricably linked in a social context. Furthermore, the subsequent decline of the manufacturing economy and the rise of globalisation, has now eroded the middle classes and increased returns to the highly educated, amplifying the economic gaps and the subsequent inequality that arises (Zajacova & Lawrence, 2018).

Therefore linking education to health in a broader social sense brings to the fore the health and economic disparities and highlights the need for Government to take action through social policy.

How does a higher education lead to increased health outcomes?

Education, lowers crime rates, improves community involvement, and improves personal health. It also lowers mortality rates, as deaths that are linked to social and behaviour risk factors, are also linked to educational attainments, as are preventable causes of death, respiratory, heart disease, lung cancer, homicide and accidents (Massachusetts University,

Global, 2019). Higher education means less exposure to economic stress and the resultant adoption of unhealthy and risky coping strategies, behaviours which increase mortality and disease, especially among lower socio demographics. Meaning that educated individuals are less likely to smoke, less likely to be unemployed, less likely to commit crime, and less likely to get a preventable illness (diabetes 2, hyper-tension, emphysema) (Massachusetts University Global, 2019). They also demonstrate fewer mental health struggles, as the economic variables that have the strongest association with poor mental health, are income decreases and substandard housing (Massachusetts University Global, 2019). Educated people are more likely to make and eat healthier food and maintain regular exercise habits, as their higher income, a result of a higher education, gives them an understanding and an access to resources that are related to healthy lifestyles enabling preventative health to be a priority, this will often be supported by health insurance that gives further choice around health care options when needed. Where-as uneducated people often with transient lifestyles will rely on emergency care in public hospitals when needed (Massachusetts University Global, 2019). Understanding these macro level concepts is important to improve health and social policy, in that the health effects of education are at the grass roots of creating better overall self- awareness and personal health and making health care more assessable (Rajhupatui & Rajhupatui, 2020). It is the economic variables (income and occupation) that mediate the relationship between health and education, and determine an individual's level of access to preventative and medical care. It is important to note that education for the highly educated also may also have a negative delivery, those that become focused on preventative health will incur increasing cost, and occupational and mental health stresses, through self-imposed achievement standards, that may lead to excess drug and alcohol use and abuse. Therefore educated people will also be at the mercy of their own set of social factors that influence health outcomes (Rajhupatui & Rajhupatui, 2020). Increasing an awareness and understanding of the social contexting of the health-education relationship, will assist solving some of the challenges. Education develops a broad range of skills, traits, cognitive and problem solving abilities, learned effectiveness and personal control for an individual, and this paves the way economically for a countries financial security, stable employment and social success (Rajhupatui & Rajhupatui, 2020). Countries that adopt policies to improve education also reap the benefits of health behaviours, i.e. controlling youth drop out at school, increasing health and economic outcomes and reducing negative social outcomes, therefore the social context of the health- education relationship always need to be considered, to enable effective social policy to be introduced that reduces disparities. Only a focus on educations social contexting and resultant inequities will disrupt social inequity within communities (Rajhupatui & Rajhupatui, 2020).

Strategies being used in New Zealand to target education to improve health and health equity.

*Equity in education has two dimensions. The first is **fairness**, which basically means making sure that personal and social circumstances – for example gender, socio-economic status or ethnic origin – should not be an obstacle to achieving educational potential. The second is **inclusion**, in other words ensuring a basic minimum standard of education for all* (OECD, 2008).

The Hunn report on Māori affairs of 1960 became the first official document to identify the educational gaps between Maori and Pākehā in New Zealand, its findings claimed that Māori lived 15 years less than Pākehā, that there was a statistical blackout in higher education for Māori, and that Māori unemployment was three times higher than non-Māori. Whilst this report did little to question the moral integrity of an educational system that tracked Māori way from academia into domestic and labouring work, neither did it address structural inequality and the distribution of power as being the root cause of the disparities (Walker, 2016, p.30). The Government responded to the Hunn report with further inclusion of taha Māori in the school curriculum of mainstream schools, this inclusion was managed mainly by Pākehā teachers, where a lack of systematic inclusion of the culture, language and identity did nothing to support an understanding or expectation of Māori succeeding as Māori (Bolton, 2017). In 1981 Māori leaders responded to the Benton Report of 1979 (this report identified a Māori language death)(Benton, 1979), by creating preschool Māori language nests, Kōhanga reo's, where Māori kuia (nannies and aunties) were the teachers. In 1990 the New Zealand Government took back control of the nests from Te Puni Kōkiri, requiring them to be staffed by qualified teachers in early childhood education. By 1993, 50% of Māori infants were in the 800 Kōhanga reo's that had been established in rural and urban Māori communities (Walker, 2016, p.33). In 1985 Kura Kaupapa an alternative to primary schools, were set up off the concept of the Kōhanga reo model, they had an objective of maintaining Māori culture language and identity, by 2008 there were 15 schools in this category (Bolton, 2017). Marae ā-kura (school marae's) have also been introduced into the secondary school landscape today to educate for colonisation-free rangatiratanga-embracing education, not just academic success (Walker, 2016, p.9).

Zoning of schools, an evolutionary process from the 1940's, was established to create greater equity within educational frameworks by equalising the social class mix of different schools (McCullough, 2006), this once again, through its often free market and liberal application in an attempt to attract the more privileged students, parents and capable teachers, has resulted in further inequity for Māori, as more engaged and advantaged parents purchased homes in reality areas, where schools are seen to attract stronger resources and offer higher academic opportunity, given their proactive community approaches and stronger leadership (McCullough, 2006).

Tomorrows schools, a 1989 Labour Government blue print for education, designed to give higher parental involvement in schools, and increase revenue streams from parent

involvement and activity, further clarified and established zoning, introduced a decile system to assist with government funding, and increased disadvantage for Māori. As Maori working class parents, located in the poorer areas, who generally deferred to the teachers as experts, had limited involvement, and limited time and financial resources to support the school in the way the parents of the middle class demographics where able to.

In 2008, Ka Hikitia (Henare et al, 1991), the government's culturally responsive strategy for the education of Māori students was adopted as policy, this was further amended in 2013 to increase the response, and was based on research that had identified that Māori students have more academic success when culture, identity and language are included in their learning (Bolton, 2017). However, regardless of the successive attempts of Governments to address the educational gap, unconscious teacher bias, attaching to priority learners (Bolton, 2017) and Maori students, from lower socio economic backgrounds, broken homes and criminal environments, remained another huge hurdle to overcome within the education system.

Teachers that set low expectations for students, often based on early streaming arrangements, steered students towards vocational rather than academic opportunity, in an attempt to manage ever increasing workloads and public expectations. These low expectations become self-fulfilling prophecies for the students, leading to poor educational outcomes and ultimately social disruption (Bolton, 2017). These outcomes then drive the resulting social determinants that systematically continue to disadvantage Māori, who with limited education find, housing, employment and income opportunities are reduced and often non-existent, lifestyle choices are poor, driven out of survival needs that have intergenerationally normalised illegal activities and the resultant health challenges begin to arise.

Decolonising education becomes key to enable Māori to stand equally with Pākehā in New Zealand this will involve good quality teachers, a broadening of the teaching of the reo across all schools, adequate funding for the establishment and continuance of kura and enabling whanau inclusion in all non-kura schools. Preparing Māori students in Māori ways that are educationally and politically astute and enable self- determination, pride, safety, a. and confidence to tackle 21st century life ((Jackson, 2016).

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