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The Prevalence and Impact of Racism Toward Indigenous Māori in New Zealand

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Intolerance toward indigenous people is a common feature of colonial societies, and New Zealand is no exception. Despite aspirations of equality, evidence suggests that discrimination toward Māori remains pervasive and may relate to continued inequalities in social, economic, and psychological domains. This article analyzes self-report questionnaire data from 1,790 Māori sampled as part of the New Zealand Attitudes and Values Study. We describe a Bayesian regression model assessing the links between perceived discrimination and 15 social, economic, and psychological indicators of well-being (including health care access, evaluation of own health, job security, self-esteem, life satisfaction, and psychological distress). The model adjusts for relevant covariates (including age, ethnicity, gender, and income). Forty-three percent of the sample reported experiencing either some discrimination or high levels of discrimination. Higher levels of perceived discrimination among Māori were associated with poorer outcomes in every measure, across multiple domains. This study demonstrates that New Zealand's "bi-cultural" aspirations are far from realized, and should raise concerns for all countries with a history of colonisation. We call for more research on the incidences and impact of various forms of discrimination throughout New Zealand society, specifically in relation to the perpetuation of Māori disadvantage.

Keywords: discrimination, latent-racism, Māori, biculturalism, indigenous

Māori (indigenous New Zealanders) face significant disadvantages in health and socioeconomic status as an ethnic minority group in New Zealand (Harris et al., 2006a; New Zealand Human Rights Commission [NZHRC], 2012), due in part to New Zealand's history of colonialism. Although overt racism is less common than in the past and comprehensive legislation is in place to address inequities (NZHRC, 2012, 2013), discrimination and racism continue to exist. Both international research and New Zealand research demonstrate the impact that experiences of discrimination and racism have on physical and mental health (Harris et al., 2006a; Paradies et al., 2015); however, racism may impact beyond these domains. In this article, we examine the extent to which Māori continue to experience discrimination in New Zealand, and the extent to which these experiences are associated with numerous social, economic, and psychological indicators of well-being (including health care access, evaluation of own health, job security, self-esteem, life satisfaction, and psychological distress).

The New Zealand Context

New Zealand's colonial history plays a fundamental role in shaping contemporary race relations. Māori were colonized by British settlers ("New Zealand Europeans" or "Pākehā," the latter being the Māori term for descendants of early white settlers; Sibley, Houkamau, & Hoverd, 2011) in the late 18th century. The Treaty of Waitangi ("the Treaty") was signed by Māori

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chiefs and the British Crown in 1840, and effectively established New Zealand as a British colony. The Treaty guaranteed that not only would Māori retain their lands and natural resources, they would also live together with Pākehā as equals (New Zealand Ministry for Culture & Heritage, 2016). However, the Treaty was largely disregarded by the New Zealand Government for >100 years. Colonization saw Māori lose most of their lands and natural resources (New Zealand Ministry for Culture & Heritage, 2015), and these socioeconomic disparities persist to this day (NZHRC, 2012). In 2016, Pākehā are the dominant ethnic group (74% of the population), whereas Māori are an ethnic minority (14.9% of the population; Statistics New Zealand, 2015).

However, persistent Māori political activism has seen the Treaty gain legal and political influence (Walker, 1990). The Waitangi Tribunal was formed in 1975, providing a forum where Māori could make claims for compensation for breaches of their Treaty rights, and a policy of "bi-culturalism" (equality and partnership between Māori and Pākehā) was adopted by the Government in the 1980s. This provided Māori with the legally recognized right to equality alongside Pākehā (New Zealand Ministry of Justice, 2014). Approximately 30 Acts of Parliament now require Government officials to take into account the Treaty or its principles when exercising State powers (New Zealand Constitutional Advisory Panel, 2013). Within this sociopolitical context, if significant inequalities between Māori and Pākehā exist, the Treaty compels the New Zealand Government to address these inequalities through research, policy, and practical intervention.

Although Māori and Pākehā remain socially and culturally distinct as social groups (King, 1988, 1999; Macpherson, 1991), as a reflection of 140 years of intercultural contact there is a high level of integration between individuals and communities. The latest census data show that in 2013, nearly half (48.9%) of those who identified with the ethnic Group Māori also identified as European/Pākehā (i.e., nearly half of the Māori population have at least one parent who is either European/Pākehā or part-European/Pākehā; Statistics New Zealand, 2013). Given the high level of connection between Māori and Pākehā, day-to-day interactions between the two groups are civil and harmonious (NZHRC, 2012). At the same time, because of New Zealand's colonial history, an underlying uneasiness remains (King, 1988, 1999). Although the Treaty was intended to create unity, different understandings of the Treaty and subsequent breaches continue to cause tension and disagreement (Orange, 1992; Walker, 1990). Although some Pākehā may support biculturalism as a social ideal, the majority are reluctant to see Government money spent on compensating Māori for any lands or resources lost as a result of colonization (Cumming, 2004; Kightley, 2016; Meihana, 2016; Sibley, Robertson, & Kirkwood, 2005).

It is also important to note that, despite a variety of Government initiatives designed to support equity between Māori and European/Pākehā, significant and enduring social and economic inequalities remain. In fact, one in five older Māori (ages 80–90) report that colonization is still impacting on their life today (Dyall et al., 2014). On the whole Māori have lower incomes and poorer quality housing than European/Pākehā (NZHRC, 2012) and tend to be concentrated in lower-paid primary and semi-skilled occupations (Statistics New Zealand, 2014a, 2014b). Māori are also less likely to succeed in New Zealand's mainstream educational system compared with Pākehā (Te Puni Kôkiri, 2012). There are major health disparities between Māori and Pākehā, with Māori experiencing higher rates of illness, infection, and disease (Harris et al., 2006a; Harris, Cormack, & Stanley, 2013; New Zealand Ministry of Health, 2015). According to a 2012 report from the NZHRC, the life expectancy for Māori men is 70.4 years, and for non-Māori men it is 79.0 years. Likewise, life expectancy for Māori women is 75.1 years and for non-Māori women it is 83.0 years (NZHRC, 2012). In sum, although Māori have achieved legal recognition of their right to equality alongside Pākehā, significant inequities remain.

The lower socioeconomic status or position of Māori associated with New Zealand's history of colonization is typically cited as the key determinant of ongoing Māori disadvantage (Carroll et al., 2011; Marriot & Sim, 2014). However, a recent review from the NZHRC has suggested that racism and discrimination are key factors underlying the persistent disadvantage experienced by Māori people (NZHRC, 2012, 2013). Data from the Christchurch Health

and Development Study (New Zealand's largest study on the life trajectories of New Zealanders) has found Māori have greater rates of adverse economic, psychological, and social outcomes in adulthood than Pākehā even when controlling for their childhood circumstances and familial socioeconomic position (Marie, Fergusson, & Boden, 2014). Similarly, data from the New Zealand Health Survey (a national survey of ~13,000 adults and 4,500 children; New Zealand Health Survey, 2016) find that although controlling for deprivation does not completely eliminate health inequities between Māori and Pākehā, controlling for both deprivation and discrimination does (Harris et al., 2006a). Although lower socioeconomic status certainly compromises Māori well-being, ongoing racism is an equally important factor that does not always receive the same recognition.

Experiences of Racism Among Māori

Racism has been defined as an ideology of racial superiority followed by discriminatory and prejudicial behavior toward those targeted (Jones, 2000). New Zealand has comprehensive laws, policies, and practices in place to prevent racism and discrimination, and owing to shifting social attitudes and legal sanctions, there has been a decline in overt racism toward Māori over the past several decades (NZHRC, 2012, 2013). However, a distinction may be made between blatant racism (obvious race-based bigotry, discrimination, and social exclusion) and latent racism (when racism is present but not explicitly articulated or clearly expressed, both at the personal and institutional level; Hamilton & Ture, 1967; Yamato, 2004). Latent racism may occur as institutionalized racism, where there is differential access to resources such as housing, health services, and employment, and limited access to power such as representation in the government, information about one's own history, and lower socioeconomic status (Hamilton & Ture, 1967; Jones, 2000). Latent racism may also manifest in the form of language and nonverbal behavior which subtly denigrates individuals and the groups they affiliate with (e.g., racist jokes and slurs, Nelson & Walton, 2014) or attitudes and behaviors that exclude or intimidate particular individuals on the basis of race or ethnicity (e.g., disapproving glances, heightened scrutiny from shop assistants and police, being avoided and ignored by dominant group members; Sue, 2010; Trepagnier, 2006). A key aspect of latent racism is that it is difficult to challenge, because it is never completely clear if the target is being discriminated against or if the perpetrator actually intends to be racist (Sue, 2010).

Incidences of both latent and blatant racism toward Māori have been described in literature and research in New Zealand (Ballara, 1986; Kearns, Moewaka-Barnes, & McCreanor, 2009; Revell, Papoutsaki, & Kolesova, 2014). For example, research among both university and high school students found that many Māori students reported Pākehā students or teachers would express surprise and disbelief at their academic successes, and suggest that their success was due to "special treatment" such as equity programs (Holmes, Murachver, & Bayard, 2001; Mayeda et al., 2014; Turner, 2013). In relation to health, a number of data sources demonstrate a bias in the way medical services are prescribed for Māori compared with other ethnic groups, such as less medical intervention (Westbrooke, Baxter, & Hogan, 2001), lower quality medical treatment (Rumball-Smith, 2009), and poorer survival rates (Hill et al., 2010). Jansen and Jansen (2013) reported that Pākehā doctors spent 17% less time (2 min out of a 12-min consultation) interviewing Māori than patients from other ethnic groups. Differential treatment of Māori has also been demonstrated in the area of justice and policing, with reports concluding that higher conviction and sentencing rates for Māori compared with non-Māori illustrate evidence of discrimination within the justice system and sentencing process (Workman, 2011).

Furthermore, data from the 2011/2012 New Zealand Health Survey (New Zealand Ministry of Health, 2012) indicated Māori are almost three times as likely as non-Māori to have experienced unfair treatment on the basis of ethnicity (12.4% of Māori reported unfair treatment in the areas of health care, housing, or work between 2011 and 2012, compared with 4.2% of non-Māori). Data comparing earlier waves of the survey found no significant decrease over time in the prevalence of discrimination among Māori (Harris et al., 2012). The New Zealand General Social Survey found similar results, with around 1 in 10 Māori reporting they had experienced discrimination in the last year (Statistics New Zealand, 2012), although

other estimates put the prevalence as high as 1 in 4 (Ministry of Social Development, 2016).

Notably, the extent and nature of discrimination experienced by Māori appears to vary according to whether Māori are mixed-Māori (i.e., are of Māori and European/Pākehā descent) or sole-Māori (have two Māori parents; Gould, 1990, 1996; Harris et al., 2013). Kukutai (2004) has observed that those of Māori descent who also report non-Māori ethnic affiliations are at a social and economic advantage relative to those of Māori descent who identify only as Māori (Callister, 2008; Chapple & Rea, 1998). Results from a national probability sample show that both sole and mixed-Māori/European reported poorer outcomes than European/Pākehā on various indicators of social and economic status (including educational outcomes, economic outcomes, and life satisfaction); however, those who identified as sole-Māori experienced worse outcomes on all measures (Houkamau & Sibley, 2014). Māori who identify as Māori only are also less likely to own a home (Houkamau & Sibley, 2015). Moreover, data from the 2006/2007 New Zealand Health Survey found that Māori who reported that they were perceived as being European experienced less discrimination and had better physical and mental health outcomes than Māori who were perceived to be non-European (Harris et al., 2013).

The Impact of Racism on Māori

International research has consistently demonstrated that racism has a range of harmful effects on those targeted. According to Bhugra, Cochrane, and Royal (2001), an individual's subjective perception of society as racist and the experience of everyday acts of discrimination constitute chronic stressors, which have an insidious negative impact on those targeted. This view has been empirically supported by a significant number of studies which have established the deleterious impact of racism for ethnic/racial minorities in a wide variety of domains including education (Museus, Ledesma, & Parker, 2015; Steele, 1997), self-reported levels of self-esteem (Chao et al., 2014; Tawa, Suyemoto, & Roemer, 2012), self-efficacy (Rollins, 2006), physical health and well-being (Feagin & Bennefield, 2014; Giscombé & Lobel, 2005; Paradies et al., 2013; Paradies et al., 2015; Priest et al., 2013; Williams & Mohammed, 2008), socioeconomic status (Kwate & Goodman, 2015), physiological distress (Kaholokula et al., 2012), psychological distress (Pieterse & Carter, 2007), mental well-being (Anderson, 2013), employment and career-related outcomes (Rollins, 2006), satisfaction with body weight and appearance (Cozier et al., 2014; Vines et al., 2007), and depression, anxiety, and substance abuse (Clark, Salas-Wright, Vaughn, & Whitfield, 2015).

Research using the large-scale New Zealand Health Survey also supports the link between discrimination and poorer physical and mental health within New Zealand. Results show a dose–response relationship, where more experiences of discrimination relate to poorer mental health, self-rated physical health and physical functioning, as well as greater likelihood of smoking, risky drinking, and cardiovascular disease (Harris et al., 2006a, 2006b, 2012). Among high school students in New Zealand, ethnic discrimination is again linked to poorer self-rated physical health and binge drinking (Crengle, Robinson, Ameratunga, Clark, & Raphael, 2012).

Similar themes have been found within a handful of qualitative studies exploring Māori perspectives (Hippolite & Bruce, 2010; Huria et al., 2014; Mayeda et al., 2014). Drawing from focus groups with Māori (n = 19), Moewaka-Barnes et al. (2013) found participants were exposed to latent and institutional racism on a day-to-day basis, such as media portrayals of Māori in a negative light and unwarranted surveillance from police and social service agencies. Participants reported that racism made them feel distressed, anxious, and angry, and some reported a sense of shame and embarrassment attached to being Māori.

Although these studies indicate Māori experience racism, and are negatively impacted by racism, what is currently missing from literature in this area is an insight into how racism affects Māori across a broad range of life experiences—including relationships, work satisfaction, general life satisfaction, sense of security about the future, self-esteem, and sense of self-control over one's own life. Currently, large-scale quantitative research in New Zealand solely examines physical health and psychological distress (Harris et al., 2012). However, the impact of racism stretches across multiple domains and

many areas of Māori life, impacting on subjective well-being and self-evaluation.

To address this gap in knowledge, we present an analysis of self-report questionnaire data from Māori participants in the New Zealand Attitudes and Values Study (NZAVS). We aim to ascertain the extent to which discrimination is experienced by Māori and what the impact may be. We propose and test a model that assesses the prevalence of ethnic discrimination among Māori, and investigate the link between 15 social, economic, and psychological indicators of well-being and perceptions of discrimination. Furthermore, we aim to assess whether the relationships between perceived discrimination and each indicator are mediated by individual differences in relation to age, ethnicity as mixed or sole Māori, gender, income, relationship status, regional deprivation, history of unemployment, whether individuals smoke and also their history of recent unemployment.

Method

Participants

Participants were 1,790 (65.25% women) New Zealanders who completed Wave V of the New Zealand Attitudes and Values Study (NZAVS, 2016), who identified as Māori and completed all exogenous measures included in the model. The sole exception was (log) household income, for which there were 190 missing values that were replaced with the log of the sample mean. Participants had a mean age of 44.60 ($SD = 12.85$, age range 18–86). Demographic details about the sample, including religious status, parental status, sexual orientation, household income (log), smoking and BMI, are reported in Table 1. Table 1 provides the mean and proportion, questionnaire items, and units of measurement, for every exogenous variable included in our Bayesian regression model.

Sampling Procedure

This research used data from Wave V (2013) of the NZAVS, which contained responses from 18,264 participants. The full Wave V sample retained 3,934 from Wave I (a retention rate of 60.4% over four years). Wave I (2009) of the NZAVS sampled randomly from the 2009 New Zealand electoral roll. This represented all citizens over 18 years of age who were eligible to vote regardless of whether they chose to vote, barring people who had their contact details removed due to specific case-by-case concerns about privacy. The response rate to the initial random NZAVS sample was 16.6%. A further 6,568 participants were retained from waves II, III, or IV. Booster sampling was also conducted from the New Zealand electoral roll during Wave V, yielding 7,581 new participants from two sample frames. Finally, Wave V included 181 unmatched participants or unsolicited opt-ins.

A total of 2,328 participants identified as Māori in Wave V (12.5% of the sample), but many had missing data on multiple demographic items, and were thus excluded from the analysis. This yielded the final sample size of 1,790 Māori, which represented 9.8% of the sample. At the time of the 2013 census, Māori comprised 14.9% of the population (Statistics New Zealand, 2013). Detailed information about the full NZAVS sampling procedure, including booster sampling of minority groups and unrepresented regions, and the response and sample attrition rates for each wave are reported in Sibley (2014). Analysis of panel attrition and the demographic and psychological factors predicting nonrandom attrition are reported in Satherley et al. (2015).

Questionnaire Measures

The NZAVS is an eight-page questionnaire containing a broad range of items across a variety of domains. The breadth of the questionnaire allowed us to assess the unique association of perceived discrimination with numerous different outcomes relating to health and psychological well-being. Owing to the size of the NZAVS questionnaire, short-form measures of two to three items are used throughout (from preexisting scales, the highest loading items are selected). Although using the full measures would clearly be ideal, trade-offs must be made to measure a broad array of variables with a large, nationally representative sample. As mentioned above, Table 1 lists the various demographic predictors that we included in the regression model, while Table 2 lists the various health and well-being outcomes, along with the number of people providing data for each out-

Table 1
Measurement Details and Descriptive Statistics for Predictors/Covariates

Predictor variables	*N*	%	*M*	*SD*	Item content	Units
Perceived discrimination	1,790		2.72	1.77	Feel that I am often discriminated against because of my ethnicity.	1 (*very inaccurate*) to 7 (*very accurate*)
Male	1,790	34.75%			Are you male or female?	1 = male, 0 = female
Age	1,790		44.60	12.85	What is your date of birth?	Age in years, difference from date of survey completion
Household income (log)	1,790		11.05	1.29	Please estimate your total household income (before tax) for the year 2013	Logarithm of reported $
Regional deprivation	1,790		6.10	2.88	Deprivation of immediate neighborhood region (meshblock), based on census data.	1 (*least deprived*) to 10 (*most deprived*)
Also identified as European	1,790	68.83%			Which ethnic groups do you belong to?	1 = also selected European, 0 = did not
Religious	1,790	42.46%			Do you identify with a religion and/or spiritual group?	1 = yes, 0 = no
Parent	1,790	76.20%			How many children have you given birth to, fathered, or adopted?	1 = at least one child, 0 = no children
Partner	1,790	66.15%			What is your relationship status?	Open-ended response, coded so that 1 = relationship, 0 = single
Employed	1,790	74.80%			Are you currently employed	1 = yes, 0 = no
Urban location	1,790	59.72%			Urban versus rural residential location coded from meshblock data.	1 = urban, 0 = rural (nonurban)
BMI	1,790		29.89	7.89	What is your height? (metres)—What is your weight (kg)?	kg/m^2
Disability	1,790	25.20%			Do you have a health condition or disability that limits you, and that has lasted for 6 + months?	1 = yes, 0 = no
Nonheterosexual	1,790	5.87%			How would you describe your sexual orientation?	Open-ended response, coded so that 1 = nonheterosexual, 0 = heterosexual or not responded
Job loss previous year	1,790	22.29%			In the last year have you personally . . . or the principal earner in your household been out-of-work?	1 = yes, 0 = no
Smoker	1,790	22.63%			Do you smoke?	1 = yes, 0 = no

come (missing data on endogenous measures were allowed for in our Bayesian model). Tables 1 and 2 also provide the item content for each outcome measure, along with the mean and standard deviation for each score, the units and scale anchor points, and references for the scales. Finally, Table 2 provides Cronbachs alphas for the short-form measures where applicable, and reliability is reasonable throughout.

Results

Model Overview

Using *MPlus 7.4* (Muthén & Muthén, 1998–2015), we constructed a Bayesian regression model in which the full set of outcomes (as outlined in Table 2) were simultaneously regressed on our set of predictors or covariates (as

Table 2
Measurement Details and Descriptive Statistics for Outcome Variables

Outcome variables	*N*	*M*	*SD*	Item content	Units	Reference
Subjective rating of fatigue	1,784	1.66	1.09	During the last 30 days, how often did . . . you feel exhausted?	0 (*none of the time*) to 4 (*all of the time*)	McNair, Lorr, and Droppleman (1981)
Average hours of sleep per night	1,764	6.83	1.39	During the past month, on average, how many hours of actual sleep did you get per night?	Stated hours per night.	Buysse et al. (1989)
Subjective healthcare access	1,710	7.43	2.51	Please rate your level of satisfaction with the following aspects of your life and New Zealand. . . . Your access to health care when you need it (e.g., doctor, GP).	0 (*completely dissatisfied*) to 10 (*completely satisfied*)	Developed for the NZAVS
Subjective evaluation of own health (mean of three-item scale, α = .61)	1,790	5.01	1.24	In general, would you say your health is . . .	1 (*poor*) to 7 (*excellent*)	Ware and Sherbourne (1992)
				I seem to get sick a little easier than other people.	1 (*strongly disagree*) to 7 (*strongly agree*)	
				I expect my health to get worse.	1 (*strongly disagree*) to 7 (*strongly agree*)	
Job satisfaction	1,463	5.14	1.57	How satisfied are you with your current job?	1 (*not satisfied*) to 7 (*very satisfied*)	Developed for the NZAVS
Job security	1,452	5.24	1.70	How secure do you feel in your current job?	1 (*not secure*) to 7 (*very secure*)	Developed for the NZAVS
Satisfaction with standard of living	1,708	6.71	2.43	Please rate your level of satisfaction with the following aspects of your life and New Zealand. . . . Your standard of living.	0 (*completely dissatisfied*) to 10 (*completely satisfied*)	Cummins et al. (2003)
Satisfaction with future security	1,705	5.36	2.67	Please rate your level of satisfaction with the following aspects of your life and New Zealand. . . . Your future security.	0 (*completely dissatisfied*) to 10 (*completely satisfied*)	
Self-esteem (mean of three-item scale, α = .78)	1,790	5.26	1.21	On the whole am satisfied with myself.	1 (*very inaccurate*) to 7 (*very accurate*)	Rosenberg (1965)
				Take a positive attitude toward myself.	1 (*very inaccurate*) to 7 (*very accurate*)	
				Am inclined to feel that I am a failure.	1 (*very inaccurate*) to 7 (*very accurate*)	
Satisfaction with life (mean of two-item scale, α = .80)	1,714	5.07	1.33	I am satisfied with my life.	1 (*strongly disagree*) to 7 (*strongly agree*)	Diener et al. (1985)
				In most ways my life is close to ideal.	1 (*strongly disagree*) to 7 (*strongly agree*)	
K6 psychological distress (mean of six-item scale, α = .84)	1,786	.89	.70	During the last 30 days, how often did . . . you feel hopeless?	0 (*none of the time*) to 4 (*all of the time*)	Kessler et al. (2011)
				During the last 30 days, how often did . . . you feel so depressed that nothing could cheer you up?	0 (*none of the time*) to 4 (*all of the time*)	
				During the last 30 days, how often did . . . you feel restless or fidgety?	0 (*none of the time*) to 4 (*all of the time*)	

(*table continues*)

Table 2 (*continued*)

Outcome variables	*N*	*M*	*SD*	Item content	Units	Reference
				During the last 30 days, how often did . . . you feel that everything was an effort?	0 (*none of the time*) to 4 (*all of the time*)	
				During the last 30 days, how often did . . . you feel worthless?	0 (*none of the time*) to 4 (*all of the time*)	
				During the last 30 days, how often did . . . you feel nervous?	0 (*none of the time*) to 4 (*all of the time*)	
Body satisfaction	1,784	4.16	1.74	Am satisfied with the appearance, size and shape of my body.	1 (*very inaccurate*) to 7 (*very accurate*)	Stronge et al. (2015a)
Relationship satisfaction	1,319	5.87	1.40	How satisfied are you with your relationship with your partner?	1 (*not satisfied*) to 7 (*very satisfied*)	
Relationship conflict	1,307	3.07	1.45	To what extent do you experience conflict or disagreement with your partner?	1 (*no conflict at all*) to 7 (*a great deal of conflict*)	Developed for the NZAVS
Self-control (mean of two-item scale, $\alpha = .62$)	1,712	4.25	1.36	In general, I have a lot of self-control.	1 (*strongly disagree*) to 7 (*strongly agree*)	Tangney, Baumeister, and Boone (2004)
				I wish I had more self-discipline.	1 (*strongly disagree*) to 7 (*strongly agree*)	
Hours of exercise per week	1,779	7.00	9.68	Please estimate how many hours you spent. . . . Exercising/physical activity	Stated hours in the last week.	Developed for the NZVAS
Hours watching television per week	1,779	11.51	11.28	Please estimate how many hours you spent. . . . Watching TV/Films	Stated hours in the last week.	Developed for the NZAVS

Note. NZAVS = New Zealand Attitudes and Values Study. Only the units at the endpoints of the measures are labeled (e.g., 1, very inaccurate), with the exception of the K6 measure of psychological distress, in which each point has a label attached.

outlined in Table 1). We included associations between the residuals of all outcome variables, thus allowing for remaining covariances between the outcomes unexplained by our set of predictor variables. We allowed for missing data in the outcome variables, and hence the regression parameters for each outcome are based on differing sample sizes (information about the sample size for each outcome is presented in Table 2). Our model thus assessed the unique concurrent association, or correlation, between individual differences in perceived discrimination, and each outcome variable, using all available data and statistically adjusting for the numerous other covariates: gender, age, household income, regional deprivation, joint identification as European, whether one was religious, a parent, had a partner, was employed, lived in a rural or urban location, BMI, whether one had a disability, sexual orientation, whether one had experienced job loss, or currently smoked.

A Bayesian approach allowed us to estimate a posterior distribution for each of the parameters, as well as the associated 95% credible intervals (i.e., the interval that contains the most likely parameter values). Relative to frequentist models that utilize standard null-hypothesis tests, Bayesian credible intervals provide a more intuitive and informative indication of the likely distribution for each parameter. Bayesian credibility estimates also include information about the accuracy of the parameter estimate for the population of interest, whereas the resulting *p* values reflect the proportion of the posterior distribution for a given parameter that is above or below zero (for discussion of Bayesian estimation techniques, see Kruschke et al., 2012).

Because the many predictor and outcome variables included in our model were scored on

Table 3
Standardized Betas and Credible Intervals for the Unique Association Between Perceived Discrimination and Subjective Rating of Fatigue, Average Hours of Sleep per Night, Subjective Healthcare Access, and Subjective Evaluation of Own Health, Adjusting for Other Covariates Included in the Model

	Subjective rating of fatigue			Average hours of sleep per night			Subjective healthcare access			Subjective evaluation of own health		
Predictor variables	β	95% CI [β]		β	95% CI [β]		β	95% CI [β]		β	95% CI [β]	
Perceived discrimination	.097*	.052	.143	−.070*	−.117	−.022	−.165*	−.211	−.119	−.140*	−.182	−.097
Male	−.052*	−.097	−.007	−.008	−.055	.039	.019	−.027	.065	−.028	−.070	.015
Age	−.244*	−.293	−.194	−.091*	−.144	−.037	.065*	.012	.117	.046	−.001	.094
Household income (log)	−.068*	−.115	−.019	−.018	−.068	.032	.052	.000	.103	.044	−.001	.089
Regional deprivation	−.001	−.050	.048	−.053*	−.103	−.002	−.004	−.054	.046	−.018	−.063	.028
Also identified as European	.045	−.003	.092	−.022	−.072	.027	−.045	−.094	.004	−.033	−.078	.011
Religious	−.024	−.069	.021	.043	−.004	.090	.025	−.021	.072	.026	−.016	.068
Parent	.042	−.009	.093	−.065*	−.118	−.011	−.050	−.103	.002	.038	−.010	.086
Partner	.007	−.041	.056	−.004	−.055	.046	.083*	.033	.132	−.027	−.072	.018
Employed	−.012	−.059	.036	−.034	−.083	.016	−.045	−.094	.004	.028	−.017	.072
Urban location	.027	−.018	.072	−.062*	−.109	−.015	.051*	.004	.097	−.015	−.057	.027
BMI	.069*	.023	.114	−.070*	−.117	−.022	−.067*	−.114	−.021	−.195*	−.237	−.153
Disability	.144*	.096	.190	−.048	−.097	.001	−.050*	−.099	−.002	−.289*	−.330	−.246
Nonheterosexual	.025	−.020	.070	−.008	−.054	.039	−.009	−.055	.038	−.040	−.081	.002
Job loss previous year	−.014	−.061	.033	−.006	−.055	.043	−.118*	−.166	−.069	−.016	−.059	.028
Smoker	.033	−.013	.080	−.039	−.087	.009	−.070*	−.117	−.022	−.136*	−.179	−.094

* $p_{MCMC} < .05$.

a range of different types of units (see Tables 1 and 2 for details), we report standardized regression slopes and associated credible intervals for these standardized parameters. The use of standardized parameters allows for the easy comparison of the relative size of unique associations in terms of standard deviation units. These results are presented in Tables 3–7. We present the results in a series of tables due to the number of parameters; however, it is important to note that all parameters were estimated in a single overarching model (BIC = 110748,

Table 4
Standardized Betas and Credible Intervals for the Unique Association Between Perceived Discrimination and Job Satisfaction, Job Security, Satisfaction With Standard of Living, and Satisfaction With Future Security, Adjusting for Other Covariates Included in the Model

	Job satisfaction (for those employed)			Job security (for those employed)			Satisfaction with standard of living			Satisfaction with future security		
Predictor variables	β	95% CI [β]		β	95% CI [β]		β	95% CI [β]		β	95% CI [β]	
Perceived discrimination	−.133*	−.184	−.082	−.129*	−.179	−.078	−.127*	−.171	−.082	−.156*	−.200	−.111
Male	−.030	−.080	.021	−.075*	−.124	−.025	−.075*	−.119	−.031	.029	−.015	.073
Age	.068*	.007	.128	−.100*	−.160	−.040	−.014	−.063	.036	.018	−.032	.068
Household income (log)	.099*	.044	.153	.100*	.046	.154	.098*	.049	.146	.058*	.009	.106
Regional deprivation	.009	−.046	.064	−.001	−.055	.053	−.104*	−.151	−.056	−.079*	−.126	−.031
Also identified as European	.021	−.033	.075	−.022	−.075	.032	.008	−.039	.055	.013	−.034	.060
Religious	.001	−.049	.052	−.006	−.056	.044	.018	−.027	.063	.008	−.037	.052
Parent	.002	−.056	.059	.060*	.004	.116	−.053*	−.103	−.002	−.029	−.079	.021
Partner	.004	−.051	.058	.039	−.015	.093	.110*	.063	.157	.113*	.066	.160
Employed	.004	−.071	.078	.049	−.027	.124	.037	−.010	.083	.032	−.014	.079
Urban location	−.063*	−.112	−.012	−.020	−.070	.030	−.011	−.055	.033	−.018	−.062	.027
BMI	−.020	−.074	.033	−.007	−.059	.046	−.074*	−.118	−.029	−.104*	−.149	−.059
Disability	−.011	−.066	.043	.017	−.036	.071	−.050*	−.097	−.004	−.088*	−.134	−.041
Nonheterosexual	−.015	−.066	.035	−.016	−.065	.034	.013	−.031	.056	−.005	−.049	.039
Job loss previous year	−.046	−.100	.008	−.152*	−.204	−.098	−.152*	−.198	−.106	−.131*	−.176	−.084
Smoker	−.036	−.089	.016	.042	−.010	.094	−.064*	−.109	−.019	−.079*	−.124	−.033

* $p_{MCMC} < .05$.

Table 5
Standardized Betas and Credible Intervals for the Unique Association Between Perceived Discrimination and Self-Esteem, Satisfaction With Life, K6 Psychological Distress, and Body Satisfaction, Adjusting for Other Covariates Included in the Model

	Self-esteem			Satisfaction with life			K6 psychological distress			Body satisfaction		
Predictor variables	β	95% CI [β]		β	95% CI [β]		β	95% CI [β]		β	95% CI [β]	
Perceived discrimination	−.161*	−.206	−.115	−.149*	−.193	−.103	.175*	.131	.218	−.060*	−.104	−.015
Male	−.029	−.074	.016	−.107*	−.151	−.062	.018	−.026	.061	.092*	.048	.136
Age	.142*	.091	.192	.041	−.010	.091	−.209*	−.256	−.160	.075*	.025	.124
Household income (log)	.065*	.017	.113	.089*	.041	.137	−.104*	−.150	−.058	−.012	−.058	.035
Regional deprivation	.066*	.017	.115	−.018	−.067	.030	−.026	−.073	.021	.032	−.016	.079
Also identified as European	−.058*	−.106	−.010	−.030	−.077	.018	.006	−.040	.052	−.047*	−.093	.000
Religious	.037	−.009	.082	.038	−.007	.083	−.052*	−.095	−.008	.037	−.007	.081
Parent	.027	−.024	.078	−.011	−.062	.040	−.051*	−.100	−.001	.056*	.005	.105
Partner	.047	−.002	.095	.165*	.117	.212	−.045	−.091	.002	−.010	−.057	.037
Employed	.061*	.013	.109	.037	−.010	.084	−.056	−.101	−.010	.020	−.027	.066
Urban location	.011	−.034	.056	−.030	−.074	.015	−.010	−.054	.033	−.033	−.077	.011
BMI	−.106*	−.152	−.061	−.080*	−.124	−.034	.072*	.028	.116	−.344*	−.385	−.302
Disability	−.083*	−.130	−.036	−.078*	−.124	−.031	.115*	.070	.160	−.069*	−.115	−.023
Nonheterosexual	−.022	−.067	.023	−.012	−.057	.032	.022	−.022	.065	−.037	−.081	.006
Job loss previous year	−.001	−.048	.046	−.077*	−.123	−.031	.060*	.014	.105	.028	−.018	.073
Smoker	−.037	−.083	.009	−.044	−.090	.002	.055*	.011	.099	.023	−.022	.068

* $p_{MCMC} < .05$.

DIC = 108312, posterior predictive p value = .445, 95% CI of observed and replicated χ^2 values = [−77.906, 88.998]). The variance in each outcome explained by our model is reported in Table 8.

Experiences of Discrimination

To measure the prevalence of perceived discrimination, the perceived discrimination was transformed into a categorical variable. We re-

Table 6
Standardized Betas and Credible Intervals for the Unique Association Between Perceived Discrimination and Relationship Satisfaction, Relationship Conflict, and Self-Control, Adjusting for Other Covariates Included in the Model

	Relationship satisfaction (for those in relationship)			Relationship conflict (for those in relationship)			Self-control		
Predictor variables	β	95% CI [β]		β	95% CI [β]		β	95% CI [β]	
Perceived discrimination	−.114*	−.164	−.063	.119*	.065	.173	−.076*	−.123	−.029
Male	.016	−.033	.065	−.006	−.059	.046	.043	−.003	.089
Age	−.022	−.078	.034	−.110*	−.170	−.050	.201*	.150	.252
Household income (log)	.034	−.024	.092	−.076*	−.140	−.012	.035	−.016	.085
Regional deprivation	−.017	−.071	.037	−.013	−.071	.044	.037	−.013	.087
Also identified as European	−.047	−.100	.006	−.053	−.110	.004	−.080*	−.129	−.031
Religious	.035	−.015	.085	−.009	−.063	.044	.018	−.028	.065
Parent	−.056	−.114	.004	.067*	.003	.130	.013	−.040	.065
Partner	.350*	.283	.413	−.046	−.126	.036	−.002	−.052	.047
Employed	−.004	−.059	.050	−.053	−.111	.005	−.018	−.067	.031
Urban location	−.014	−.064	.036	.011	−.043	.064	−.014	−.060	.032
BMI	−.040	−.091	.011	.004	−.052	.059	−.137*	−.183	−.090
Disability	−.043	−.096	.010	.035	−.022	.092	−.060*	−.108	−.011
Nonheterosexual	−.007	−.061	.046	−.016	−.075	.043	−.020	−.066	.026
Job loss previous year	−.051	−.104	.002	.064*	.006	.121	.025	−.023	.074
Smoker	−.041	−.094	.013	.048	−.010	.105	−.102*	−.149	−.055

* $p_{MCMC} < .05$.

Table 7
Standardized Betas and Credible Intervals for the Unique Association Between Perceived Discrimination and Hours of Exercise per Week and Hours Watching Television per Week, Adjusting for Other Covariates Included in the Model

Predictor variables	Hours of exercise per week			Hours watching television per week		
	β	95% CI [β]		β	95% CI [β]	
Perceived discrimination	.019	−.028	.067	−.025	−.072	.023
Male	.123*	.076	.169	.042	−.004	.089
Age	.047	−.006	.100	.046*	−.007	.098
Household income (log)	.010	−.039	.060	−.051	−.100	−.001
Regional deprivation	.038	−.013	.089	−.003	−.054	.047
Also identified as European	.010	−.039	.059	−.021	−.070	.029
Religious	.000	−.047	.047	−.008	−.055	.039
Parent	.016	−.037	.069	−.033	−.086	.021
Partner	−.026	−.077	.024	.029	−.021	.079
Employed	−.005	−.054	.045	−.075*	−.125	−.026
Urban location	−.085*	−.131	−.038	−.016	−.062	.031
BMI	−.068*	−.115	−.020	.093*	.045	.140
Disability	−.054*	−.103	−.005	.052*	.003	.101
Nonheterosexual	−.018	−.064	.028	−.009	−.056	.037
Job loss previous year	.068*	.019	.116	−.027	−.076	.022
Smoker	.023	−.025	.071	.078*	.031	.126

* $p_{MCMC} < .05$.

coded responses to the question "I feel that I am often discriminated against because of my ethnicity," from very inaccurate (1) to very accurate (7), so that a score of 1–2 indicated no or minimal perceived discrimination, a score of 3–5 indicated some discrimination (i.e., at least partial agreement with the item), and scores of 6–7 indicated high perceived discrimination. Just over half the sample reported that they perceived no or minimal discrimination: n = 1,017, 57%. However, 43% of the sample reported either some discrimination: n = 609, 34%, or high discrimination: n = 164, 9%. Sole-identified Māori (M = 3.31, SD = 1.83)

Table 8
Variance in Each Outcome Explained by the Full Model Containing All Predictors/Covariates

Outcome variables	R^2	Posterior SD	95% CI [R^2]		p_{MCMC}
Subjective rating of fatigue	.104	.013	.080	.131	<.001
Average hours of sleep per night	.048	.009	.031	.068	<.001
Subjective healthcare access	.097	.013	.073	.124	<.001
Subjective evaluation of own health	.219	.016	.188	.251	<.001
Job satisfaction	.062	.012	.041	.088	<.001
Job security	.097	.016	.068	.129	<.001
Satisfaction with standard of living	.175	.016	.145	.206	<.001
Satisfaction with future security	.173	.016	.143	.205	<.001
Self-esteem	.102	.013	.078	.128	<.001
Satisfaction with life	.148	.015	.119	.178	<.001
K6 psychological distress	.170	.015	.140	.200	<.001
Body satisfaction	.150	.015	.122	.180	<.001
Relationship satisfaction	.177	.024	.132	.225	<.001
Relationship conflict	.080	.015	.054	.112	<.001
Self-control	.096	.013	.072	.122	<.001
Hours of exercise per week	.047	.009	.031	.067	<.001
Hours watching television per week	.045	.009	.029	.065	<.001

reported significant higher levels of perceived discrimination than people who identified jointly as Māori and European ($M = 2.45$, $SD = 1.68$; $F(1, 1788) = 95.09$, $p < .01$).

For the regression model, we used the untransformed, continuous perceived discrimination variable (on a scale of 1–7). We report here the unstandardized betas and their 95% credible intervals, for the standardized betas, see Tables 3–7. Our model indicated that Māori who reported experiencing higher levels of discrimination (higher levels of agreement with the item "Feel that I am often discriminated against because of my ethnicity," treated as a continuous variable on a scale from 1 to 7) reported being significantly more fatigued ($b = .061$, Posterior $SD = .015$, 95% CI of $b = .032, .090$, pMCMC $< .001$) and getting significantly fewer hours of sleep, on average, per night ($b = -.056$, Posterior $SD = .019$, 95% CI of $b = -.094, -.018$, pMCMC $= .002$).

Māori who reported higher levels of discrimination also rated that they were less satisfied with their ability to regularly access a doctor/GP when they needed to ($b = -.239$, Posterior $SD = .035$, 95% CI of $b = -.307, -.171$, pMCMC $< .001$), and subjectively rated their own health as being poorer ($b = -.100$, Posterior $SD = .016$, 95% CI of $b = -.130, -.069$, pMCMC $< .001$).

For those who were employed, Māori who reported higher levels of discrimination were less satisfied with their jobs ($b = -.121$, Posterior $SD = .024$, 95% CI of $b = -.169, -.074$, pMCMC $< .001$) and also reported lower levels of job security ($b = -.127$, Posterior $SD = .026$, 95% CI of $b = -.178, -.077$, pMCMC $< .001$).

Māori who reported higher levels of discrimination reported lower levels of satisfaction with their standard of living ($b = -.177$, Posterior $SD = .032$, 95% CI of $b = -.240, -.114$, pMCMC $< .001$), lower levels of satisfaction with their expected future security ($b = -.239$, Posterior $SD = .035$, 95% CI of $b = -.308, -.170$, pMCMC $< .001$), lower levels of self-esteem ($b = -.112$, Posterior $SD = .016$, 95% CI of $b = -.144, -.080$, pMCMC $< .001$), and lower levels of satisfaction with life generally ($b = -.113$, Posterior $SD = .018$, 95% CI of $b = -.148, -.078$, pMCMC $< .001$).

Māori who reported higher levels of discrimination reported higher levels of nonspecific psychological distress, as indexed by the Kessler-6 population screening measure ($b = .070$, Posterior $SD = .009$, 95% CI of $b = .053, .088$, pMCMC $< .001$), and lower levels of body satisfaction ($b = -.060$, Posterior $SD = .023$, 95% CI of $b = -.105, -.015$, pMCMC $= .005$).

Among those in a relationship, Māori who reported higher levels of discrimination reported lower levels of relationship satisfaction ($b = -.096$, Posterior $SD = .022$, 95% CI of $b = -.039, -.053$, pMCMC $< .001$) and higher levels of relationship conflict ($b = .102$, Posterior $SD = .024$, 95% CI of $b = .055, .149$, pMCMC $< .001$). Māori who reported higher levels of discrimination also reported experiencing lower feelings of control over their lives and circumstances ($b = -.060$, Posterior $SD = .019$, 95% CI of $b = -.097, -.023$, pMCMC $= .001$).

However, levels of perceived discrimination were unrelated to the hours of TV that people reported watching in the last week ($b = -.163$, Posterior $SD = .157$, 95% CI of $b = -.470, .147$, pMCMC $= .151$), or their amount of exercise ($b = .108$, Posterior $SD = .135$, 95% CI of $b = -.156, .373$, pMCMC $= .212$).

Discussion

In this article, we document a reliable association between perceived ethnic discrimination and a wide range of social, economic, and psychological measures of well-being for Māori. This association holds when adjusting for numerous other demographic factors also included in our model. Thus, we assess as closely as possible the variance in health and well-being explained solely by experiences of discrimination among Māori. Across 15 measures over multiple domains, perceived discrimination consistently and significantly predicted poorer well-being in every single outcome.

We found that 43% of the sample reported experiencing at least some form of discrimination; that is, roughly a third agreed that they are discriminated against for their ethnicity, while nearly 1 in 10 reported high levels of discrimination. This is significantly higher than previous estimates which put the prevalence at 1 in 4 (Ministry of Social Development, 2016), which could potentially reflect rising rates of ethnic discrimination. However, the Ministry of Social

Development measured particular incidences of discrimination in a set timeframe, whereas we measure a more general perception of discrimination, which may also account for this higher estimate. Additionally, sole-identified Māori reported significantly higher levels of perceived discrimination than those who identified jointly as Māori and European, as simply appearing more prototypically Māori is a predictor of higher discrimination (Harris et al., 2013; Houkamau & Sibley, 2015).

In line with international research (Paradies et al., 2015; Priest et al., 2013) and research within New Zealand (Harris et al., 2006a, 2012), perceived discrimination was linked with lower self-reported ratings of physical health, and poorer mental health (feelings of hopelessness, depression, anxiety, and stress). However, our results indicated that perceived discrimination was also related to many areas of life beyond those researched in New Zealand before, such as greater levels of fatigue, poorer sleep, poorer access to health care, lowered life satisfaction, lower self-esteem, and relationship dissatisfaction and conflict. Māori who reported higher levels of discrimination also reported being less satisfied with their standard of living, their work, and job security.

Although these results have not been observed previously in New Zealand, they are in line with international research (Chao et al., 2014; Clark et al., 2015; Kwate & Goodman, 2015; Rollins, 2006), suggesting a fairly universal response to ethnic discrimination across countries and cultures. Higher levels of perceived discrimination showed this consistent association with poorer health and well-being outcomes even when adjusting for numerous other "usual suspect" factors that might also contribute to poorer outcomes across the many measures we examined (socioeconomic status in particular). A history of colonization is not unique to New Zealand, and this pattern between discrimination and wellbeing likely applies in multiple contexts. Even as New Zealand has a long way to go in addressing these issues, some data from the 1990's suggests that conditions were improving faster among indigenous New Zealanders relative to indigenous Canadians, North Americans, and Australians (Cooke, Mitrou, Lawrence, Guimond, & Beavon, 2007). The current research should raise concerns about the potential extent and magnitude of the impact of racism in other countries.

The only outcomes not associated with racism in this study were watching TV and exercise. These latter two nonsignificant results are important, as they demonstrate that it was not simply that perceived discrimination was related to absolutely everything, even seemingly completely unrelated variables, such as TV watching and exercise. We make this point because some readers could perhaps be forgiven for wondering if perceived discrimination does tend to correlate with everything else in people's lives, given the extensive and pervasive associations that perceived discrimination does have with the numerous indicators of health and psychological well-being that we examined here. Given that associations are more likely to be significant with increasing sample sizes, we document these relationships to show that relationships with no theoretical links are in fact nonsignificant.

These data support the idea that, although social and economic disadvantage is a reality for many Māori, these things alone do not cause inequalities between Māori and Pākehā. Racism and discrimination contribute to and exacerbate enduring social and economic ethnic inequalities in New Zealand. These results evince the NZHRC claim that racism toward Māori is a genuine social problem that perpetuates Māori disadvantage in New Zealand (NZHRC 2012, 2013; also see Anaya, 2011; Committee on the Rights of the Child, 2011). However, despite the evidence, the continuing public opinion (mainly among non-Māori New Zealanders) is that racism toward Māori is *not* a real social problem and due to the Treaty of Waitangi, Māori receive privileges compared with other ethnic groups (Cumming, 2004; Kightley, 2016; Meihana, 2016). How may we understand this paradox?

In a series of papers, Nairn and McCreanor (1990, 1991, 1997) demonstrate that European/Pākehā are unconvinced that Māori experience racism, and believe that Māori claims of racism actually reflect an "oversensitivity" on the part of Māori who misconstrue the good intentions of well-meaning Pākehā (Nairn & McCreanor, 1990; also see McCreanor, 2012 and Wetherell & Potter, 1992). McCreanor (1995, 1997) further elucidates how Pākehā rationalize and justify the lower socioeconomic position of Māori

by talking about Māori as if they are either "good" (fit in with European/Pākehā) or "bad" (lazy, criminal, and overly concerned with New Zealand's colonial past), effectively supporting the view that if Māori are not succeeding alongside Pākehā, it is due to their own ineptitude rather than unfairness on the part of other New Zealanders.

Furthermore, latent racism may manifest in ways which Pākehā may not be fully aware of (or if they are aware they may not consider their behavior racist), given that latent racism is well hidden and difficult to expose, interrupt, or address. However, latent racism is still disadvantageous for those who experience it, and the psychological impact that minor experiences of racism have on individuals may accumulate over time and exact a psychological toll on those who experience it consistently (Mayeda at al., 2014). Racial microaggressions that may not appear to be an issue to Pākehā, such as mispronouncing names (Kohli & Solorzano, 2012), racist jokes (Nelson & Walton, 2014), or nonverbal behaviour that denigrates and excludes Māori (Sue, 2010; Trepagnier, 2006), can have serious consequences. These data here evince that point, and demonstrate that perceived discrimination costs Māori their sense of well-being, sense of security, life satisfaction, and self-esteem.

Strengths, Limitations, and Future Directions

At the present time there is little empirical research on the incidences and impact of latent racism in New Zealand and the extent to which latent racism perpetuates inequalities between Māori and Pākehā. We believe that our data provide a strong rationale for more research to understand the genesis of racism (latent and blatant) and how it may permeate microlevel social interactions throughout New Zealand society. A key limitation of this study was the measures which we employed to assess perceptions of racism. Our item did not permit respondents to differentiate between different types of racism they may have experienced (i.e., blatant or latent). Future studies should look more closely at different forms of racism and how they affect different groups in New Zealand (including other ethnic minorities such as Pacific peoples and peoples of Asian descent). Understanding when, why, and how racism affects Māori (and other minorities), and to what extent it impacts on those who experience it, may help clarify the ways in which racism can be more effectively addressed in New Zealand society.

Suffice to say, failing to address racism now augers poorly for New Zealand in the long run. Although all ethnic groups in New Zealand will increase numerically over time, the latest projections from the New Zealand Department of Statistics indicate that the Māori population is projected to grow at a faster pace than the total New Zealand population. The Māori population is expected to make up 19.5% of New Zealand's population in 2038, compared with 14.9% in 2013, due to a young population and high birth rates (Statistics New Zealand, 2015). The socioeconomic disparities which currently exist between European/Pākehā and Māori are not likely to decrease over time without a current shift in approach. These inequities will have implications for social equity and general community well-being because a large sector of New Zealand society will not be reaching their full potential as citizens (The Māori Economic Development Panel, 2012).

The increasing Māori population also means a rapidly increasing population of Māori youth, expected to make up a third of all New Zealand children in 2038 compared with a quarter in 2013 (Statistics New Zealand, 2015). Although this research makes use of a sample that is broadly representative of Māori adults, it does not contain anyone below the age of 18 and therefore we cannot generalize these results and experiences to those of Māori youth. However, extant research among Māori adolescents seems to report similar results, with those who reported experiencing ethnic discrimination having poorer self-rated health and engaging in more risky health behaviors (Crengle et al., 2012). More comprehensive research among Māori youth is an important next step. Future research should also take into account potential gender effects. It has been suggested that both the prevalence and the impact of discrimination can increase when discrimination comes from multiple sources (i.e., gender discrimination as well as racial discrimination; Beal, 1970). Interestingly, our results seemed to indicate that where there were gender differences, Māori men in fact had lower well-being and poorer health.

This study is limited by its cross-sectional design, and so cannot address the issue of causality in regards to racism's impact on health and well-being. However, the casual direction of the relationship is well supported by past longitudinal research and longitudinal meta-analysis, which indicates that exposure to discrimination is related to poor health and well-being later on (Gee & Walsemann, 2009; Schmitt, Branscombe, Postmes, & Garcia, 2014). Additionally, we note that the effect sizes in the current research are generally on the small side. However, we argue that these results demonstrate the subtle but consistent effect of discrimination. Even acts of discrimination that seem relatively small (e.g. microaggressions) can work as a chronic stressor when they occur daily and across multiple contexts, forming one's perception of society as unrelentingly racist (Bhugra, Cochrane, & Royal, 2001). The results here demonstrate that such acts can have an insidious, negative impact on Māori health and well-being.

We end with a note that, despite the challenges facing Māori today, there can be many positive experiences too. Both the "culture as cure" model (Houkamau & Sibley, 2011) and the rejection-identification model (Branscombe, Schmitt, & Harvey, 1999) suggest that having a strong ingroup identity provides protection against racism and other negative experiences. Sole-Māori experience higher levels of psychological distress than mixed Māori-European, but this difference disappears among Māori who have a high sense of cultural efficacy and are actively engaged with Māori culture (Muriwai, Houkamau, & Sibley, 2015). Discrimination can even increase identification with other Māori, which can in turn predict better well-being (Houkamau & Sibley, 2011) and increased support for the rights of Māori (Stronge et al., 2016).

As we observed in the introduction, if significant inequities exist between Māori and Pākehā, the Treaty compels the New Zealand Government to address these through practical intervention. What practical steps can be taken, then, to combat latent racism? For Māori health, Durie (1999) and Ware and Walsh-Tapiata (2010) both emphasize the importance of ensuring Māori have access to Māori culture and resources, with a particular focus on Māori youth. In addressing racism itself, Er-rafiy, Brauer, and Musca (2010) had some success with relatively simple approaches such as posters that emphasize the heterogeneity of minority ethnic groups, and educate majority groups about minority experiences of discrimination. This method may fit well with the sort of casual racism (such as racist jokes) experienced by Māori on a day-to-day basis. However, racism is also embedded in institutions, health care, our police force, and in the education system; addressing racism is likely to be a long and difficult process. We hope that the results here, adding to a large body of similar findings, emphasize the importance of this task.

Conclusion

Whether blatant or latent, the underlying issue remains the same: racism has a consistent negative impact. In this respect, our data contribute to an existing body of research which clearly demonstrates racism has a range of harmful effects on those who experience it including limiting access to employment, health services, and education. In fact, racism was negatively associated with every measure of health and well-being available within the NZAVS. The prevalence and impact of racism toward New Zealand Māori (sole-Māori in particular) underlines the need for a greater discussion and understanding of how blatant and latent racism manifest and how racism may be interrupted constructively when it occurs. A lack of communication about racism may actually help perpetuate the status quo because it allows racism to go unaddressed. The attitudes of Pākehā who feel disadvantaged by the Treaty of Waitangi should not be dismissed either. These too need to be heard and understood if interethnic relations are to be improved. Ironically, New Zealand has a history in promoting the ideals of biculturalism. We believe the conditions certainly exist for those ideals to be achieved; however, there is still much work needed to narrow that gap between the ideals of biculturalism and the realities of New Zealand society.

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